

(A Health Awareness Initiative)

## NEURO NEWSLINE

Author

Dr. M. J. Arunkumar, M. Ch., DNB  
Senior Consultant Neurosurgeon  
Hannah Joseph Hospital, Madurai

**BENIGN INTRACRANIAL HYPERTENSION - A reason for headache in women !**

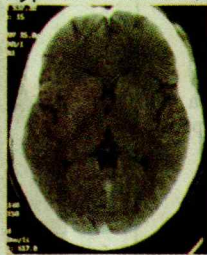
Benign intracranial hypertension (BIH) is a neurological disorder characterised by raised intracranial pressure in the absence of tumour, hydrocephalus or any other disease of the brain. It is also called as 'Idiopathic Intracranial Hypertension' (IIH) or 'Pseudotumour cerebri'. This problem arises due to impaired absorption of cerebrospinal fluid (CSF) that circulates around the brain and spinal cord. Since the reasons for CSF absorption is not known, the term 'idiopathic' is used to denote this disorder. It is common in obese women and can lead to significant visual impairment if left untreated. Prompt recognition and treatment is needed to prevent potentially permanent visual loss.

It commonly affects women in the child bearing age group, especially in their third or fourth decade. Female:Male ratio ranges from 2:1 to 8:1 and upto 90 % of the patients are over weight. There is increased risk in women with menstrual irregularities. Children can also be affected by this disease, though it is frequently self limiting in this group.

**SYMPTOMS AND SIGNS**

Generalised throbbing headache that happens when you wake up in the morning and relieved on taking an erect posture seems to be the first symptom. It is also aggravated by coughing, straining and change of position of the body. Gradual visual

loss, double vision, short episodes of 'wheel flashes' may also occur. These episodes can be accompanied by nausea, vomiting and drowsiness in the most severe forms. Minor symptoms like neck stiffness, dizziness, fatigue and ataxia can be part of the clinical presentation. Usage of drugs like keprone and lindane, conditions like hypervitaminosis A, uraemia, steroid



withdrawal, usage of oral contraceptives can also be associated with benign intracranial hypertension.

**EVALUATION & DIAGNOSIS**

CT/MRI studies will reveal a normal (as shown in the picture) or small sized ventricles without any other intracranial abnormalities or mass. MR venogram is recommended to rule the possibility of thrombosis of cortical venous sinuses. Lumbar puncture is done to find the opening pressure of the cerebrospinal fluid (usually above 20 cm H<sub>2</sub>O, can go upto 40), and also an analysis is done to rule out any other infections of the central nervous system. Neuro-ophthalmological evaluation is done routinely to assess visual status and

fields in a patient diagnosed with this disorder.

**TREATMENT**

Spontaneous resolution is common, sometimes within months or in a year it can resolve. Medical treatment includes fluid and salt restriction, reduction of weight and to stop all possible offending drugs

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the person is taking. Drugs like acetazolamide (Diamox) or diuretics like furosemide (Lasix) are tried, and sometimes steroids are combined with these medications. Surgery is the mainstay if the symptoms are refractory to any of the above treatment especially in a patient who has progressive visual loss due to raised intracranial pressure. The most common surgery done is the lumboperitoneal shunt to divert the cerebrospinal fluid (CSF) into the abdominal cavity. Sometimes optic nerve sheath fenestration is done for patients who have visual deterioration due to persistent papilledema. In general, response to treatment is good though relapse and remissions are common in the medically treated group !

**EMERGENCY & TRAUMA SERVICE****Hannah Joseph Hospital**

Institute of Neurosciences &amp; Trauma

134, Lake View Road, K.K.Nagar, Madurai - 625 020 Ph : 0452 - 2585822 / 23, 2588401.

E-mail : drmjarkumar@gmail.com Website : www.hannahjosephhospital.com