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BENIGN INTRACRANIAL HYPERTENSION WITHOUT PAPILLOEDEMA – A CASE REPORT

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INTRODUCTION

Headaches, especially, of chronic & non-remitting nature pose a very difficult challenge to the managing physician in terms of both diagnosis & treatment. There are few case reports which noted patient diagnosed & treated as migraine later on investigation were found to have other etiologies like space occupying lesions in the brain & benign intracranial hypertension. The incidence if benign intracranial hypertension is steadily growing in the indian sub-continent with more awareness & widening access to quality healthcare, but is as of yet quiet uncommon especially in the ophthalmology out patient clinic. The issue of rare presentations of such uncommon disorders makes such patients especially challenging. This case report deals with one such case whom we encountered & was found to have raised intracranial pressure with any identifiable causative factor & no papilloedema.

CASE REPORT

A 26 year old female patient came with complaints of headache on & off since 4 years. She mentioned that the headaches were usually one sided & were made worse with loud noises & were occasionally severe enough to cause vomiting. She has had a family history of migraine & has been on migraine treatment since around 2 years without any symptomatic relief.

The patient is on oral contraceptive pills & mentions that stressful situations at her work place may be causing her headaches to become worse. She is otherwise healthy & does not have any other medical history. On eye examination, her visual acuity was 6/6 in both eyes unaided, her intraocular pressure was 16mmHg in both eyes, her visual field, colour vision & pupillary reactions were within normal limits. Her blood pressure was 138/86mmHg & pulse rate was 87/min. Her neurological examination was within normal limits.

On repeat history taking, the patient did mention that she had recently put on some weight & on checking her body mass index was around 35. She also mentioned noticing a “pulse-like ringing sensation in her ears”. She also did mention to have noticed very slight blurred vision on certain occasions which would resolve spontaneously, but felt it too trivial a matter to be mentioned. She also mentioned that she had been at her current job since the same time as she had been having the headache & that the stress has caused her to eat more & to have these migraine headaches.

She was counselled about her condition & about a rare condition called Benign intracranial hypertension without papilloedema which fits her current condition. She was advised imaging investigations including MR Venogram, MRI with contrast & was advised to follow the DASH diet plan with emphasis on progressive muscle relaxation & yoga for de-stressing. She was advised to take oral analgesics as needed in case of severe headaches.

Her imaging investigations were unremarkable except for empty sella, she was advised a review in 8 weeks times. She then mentions that her headaches had considerably reduced while she had lost enough weight to bring her body mass index to 31. She was advised to continue with her diet plan & de-stressing routines. After that she came for a review around 3months later, her body mass index now was 25 & she mentioned that she had changed her job to a less stressful job role. She mentioned that her headache have completely stopped since a month & that the last severe attack was more than 6 weeks ago, her tinnitus & visual obscurations had stopped. Her eye examination was once again within normal limits & she mentioned “that she had never felt so great”.

DISCUSSION

Benign intracranial hypertension without papilloedema is quiet a rare disease especially in India. The challenges it offers are especially in the diagnostic areas & a lot has to

do with very little literature available on such presentations in this part of the world.

A similar case report to our considers that the such cases of refractory migraine would need to under go a lumbar puncture for CSF analysis & to check for opening pressures.[1] In our teaching & in routine practice, we never have seen lumbar puncture being done in suspected high intracranial tension cases, but it is done as routine practice in some parts of the world including the United Kingdom.

A study comparing the differences between the symptoms of Benign intracranial hypertension without papilloedema & with papilloedema shows that there are certain variation in symptoms that arise due to a lower intracranial pressure & that all such cases with visual field changes must be treated as non-physiological.[2] In the particular patient in question, weight loss alone without any pharmacologic treatment helped, the corroboratory evidence of imaging showing empty sella together with a strong clinical suspicion help us in her diagnosis.

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