AICOG 2025
Mumbai
67th All India Congress of Obstetrics & Gynaecology
FOGSI celebrates 75 years – Diamond Jubliee

Poster Number: EP 89 Name: Dr. Roshni Nithya Priya S, MS OG Final year
Sri Ramachandra Medical College Hospital and Research Centre

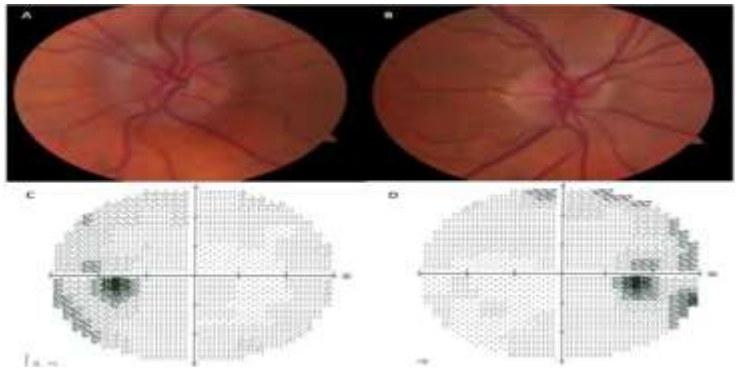
Title: **Idiopathic Intracranial Hypertension in Pregnancy – More than just a headache!**

INTRODUCTION

Idiopathic intracranial hypertension (IIH)/ Primary pseudotumour cerebri syndrome, is characterized by raised intracranial pressure without evidence of an underlying structural or vascular lesion and normal CSF composition obese reproductive age females often encountered in pregnancy, either pre-existing and exacerbated by weight gain and hormonal changes or arising de novo.

CASE HISTORY

•A 22year old Primigravida presented at 14 weeks of GA with intractable headache radiating to neck for 3 days, 3 episodes of projectile vomiting, evaluated with Ocular tomography, RFNL screening and diagnosed with B/L papilledema. Lumbar puncture showed raised CSF pressure in manometry, started on T.Acetazolamide 250mg BD till 36weeks. CSF GeneExpert, gram stain was negative. MRI Brain/Venogram- hypoplastic left transverse, sigmoid sinuses. MRI cervical spine-no signs of compression. Neurology opinion obtained, patient went into spontaneous labour at 38 weeks, later was taken up for Emergency LSCS in view of failed induction. Postoperative period was uneventful. A 33yr old Primi at 20 weeks/ Class IV obesity (BMI-47kg/m2) with a 6-month history of blurred vision and headache. IIH was diagnosed 12 years prior but resolved following significant weight loss. Her medical history included PCOS, anemia, fundoscopy revealed Frisen grade IV B/L Papilledema. Lumbar puncture under fluoroscopic guidance revealed opening pressure of 29cm H2O. MRI/MRV brain showed narrowed left transverse sinus. Therapeutic lumbar punctures were performed at 25, 26 weeks draining 27ml CSF. There was a temporary improvement of headache after 12hrs. Patient was induced into labour at 37 weeks due to severe intractable headache, had an uncomplicated vaginal delivery.



DISCUSSION

Management of IIH in pregnancy involves multidisciplinary approach involving senior obstetricians, neuro-ophthalmologists, neurosurgeons, obstetric anesthetists. Acetazolamide is a category C FDA approved drug, a carbonic anhydrase inhibitor that reduces CSF production by altering ion fluxes across ependymal cells of choroid plexus. The IIH Treatment Trial(IIHTT) in non-pregnant patients, compared diet with acetazolamide in increasing dose till 4g showed improvement in 6 months. Considered safe upto 1g/day in breastfeeding mothers. Serial lumbar puncture and drains are temporizing measures, a bridge to definitive surgical therapy or delivery. Underlying transverse sinus stenosis causes raised ICP. Lumbar drains is for fulminant IIH, only when surgery is delayed >24hrs. Ventriculoperitoneal shunt is indicated for patients experiencing rapid visual loss. Optical nerve sheath fenestration (ONSF) is performed for fulminant IIH in pregnancy with worsening visual loss. High CSF opening pressure(>50cmH2O) have increased risk of ONSF failure. IIH is not a contraindication for vaginal delivery/ epidural or spinal analgesia nor is the presence of CSF shunt.

CONCLUSION

Emerging data for lumbar puncture or temporary lumbar drainage to alter the course of IIH raise the prospect of avoiding neurosurgery during pregnancy. Pre-conceptional counselling for weight loss prior to pregnancy is important. Frequent visits are necessary.

REFERENCE

1.Grech O, Mollan SP, Wakerley BR, et al. Emerging themes in idiopathic intracranial hypertension. J Neurol 2020;267:3776-84.
2.Thirumalaikumar,L,Ramalingam,K, Heafield,T. Idiopathic intracranial hypertension in pregnancy . The Obstetrician& Gynaecologist 2014;16:93-=97. Tang RA. Management of idiopathic intracranial hypertension in pregnancy MedGenMed. 2005;7(4):40.Published 2005.