

Idiopathic intracranial hypertension differential diagnosis

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1. true mass lesions: tumor, cerebral abscess, subdural hematomas, rarely gliomatosis cerebri may be undetectable on CT and will be misdiagnosed as [Idiopathic intracranial hypertension \(IIH\)](#).

2. cranial venous outflow impairment (some authors consider these as IIH).

a) [dural sinus thrombosis](#)

b) congestive heart failure

c) [Superior vena cava syndrome](#)

d) unilateral or bilateral jugular vein or sigmoid sinus obstruction

e) hyperviscosity syndromes

f) Masson's vegetant intravascular hemangioendothelioma: an uncommon, usually benign lesion that may rarely involve the neuraxis (including intracranial occurrence). Not definitely neoplastic. Organizing thrombi develop endothelialized projections into the vessel lumen. Must be distinguished from other conditions such as [angiosarcoma](#)

3. Chiari I malformation (CIM): may produce findings similar to IIH. 6% of IIH patients have significant tonsillar ectopia, and $\approx$ 5% of patient with CIM have papilledema

4. infection (CSF will be abnormal in most of these): encephalitis, arachnoiditis, meningitis (especially basal meningitis or granulomatous infections, e.g. syphilitic meningitis, chronic cryptococcal meningitis), chronic brucellosis

5. inflammatory conditions: e.g. neurosarcoidosis, SLE

6. vasculitis: e.g. Behçet's syndrome

7. metabolic conditions: e.g. lead poisoning

8. pseudopapilledema (anomalous elevation of the optic nerve head) associated with hyperopia and drusen. Retinal venous pulsations are usually present. Especially deceptive when a patient with migraines has pseudopapilledema: treat the H/A

9. malignant hypertension: may produce H/A& bilateral optic disc edema which can be indistinguishable from papilledema. May also produce hypertensive encephalopathy (p.194). Check BP in all IIH suspects

10. meningeal carcinomatosis

11. Guillain-Barré syndrome (p.184): CSF protein is usually elevated.

12. following [head trauma](#).

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