# Idiopathic Intracranial Hypertension Etiology

- Myelin oligodendrocyte glycoprotein antibody-associated disease with aseptic meningitis-like presentation in a paediatric patient
- The CXCL16/CXCR6 axis is linked to immune effector cell-associated neurotoxicity in chimeric antigen receptor (CAR) T cell therapy
- Signs of Intracranial Hypertension in Chronic Inflammatory Polyradiculoneuropathies-A Cross Sectional Cohort Study
- Association of ganglion cell-inner plexiform layer thinning with visual function in pediatric papilledema
- Rising consultations for suspected papilledema: clinical and neuro-ophthalmologic insights
- Non-Invasive Detection of Recurrent Intracranial Pressure via Optical Coherence Tomography: A Case Report
- Atraumatic Cranial CSF Leaks
- Treatment of Persistent Headache After Normalization of CSF Pressure

Patients in whom a syndrome of Intracranial hypertension secondary to certain medications develops or who are found to have cerebral lateral sinus thrombosis are nonetheless still classified as having idiopathic intracranial hypertension (IIH).

Idiopathic intracranial hypertension (IIH) is an aetiologically unknown disorder that associates with endocrinological disturbances, including dysfunction of the hypothalamic-pituitary-adrenal-axis.

Although there are multiple hypotheses for the etiology of Idiopathic intracranial hypertension (IIH) mainly focused on obesity and metabolic dysfunction, there is no known cause of the development of IIH. IIH occurs most frequently among obese women of childbearing age [1)].

Transverse sinus (TS) stenosis has been associated with IIH and some authors have suggested a possible pathogenic role of reduced venous outflow in the development of IIH [2)].

IIH accounts for a considerable part of the causes of intractable headache in systemic lupus erythematosus SLE patients and steroids should be considered as a first-line treatment [3)].

Young women are more frequently involved with in half of cases a diffuse proliferative glomerulonephritis. Predisposing factors, like anaemia, must be associated. IH allows SLE diagnose in more than the third of the cases. Then, SLE has to be searched as an etiology of IH, in particular in non-obese patients and when nephritis is associated [4)].

Raggi et al reported for the first time the presence of Binge eating disorder (BED) among patients with idiopathic intracranial hypertension (IIH) and showed that BED is associated to IIH, ICP and history of abuse or neglect [5)].

Ahmed et al report a case of a young female who presented with signs and symptoms of IIH and was subsequently diagnosed with IgA nephropathy and end-stage renal disease. This is the first report of IgA nephropathy presenting as end-stage renal disease in a patient who presented with IIH [6)].

## Risk factors

Risk factors for development of IIH include high body mass index, recent weight gain, and obstructive sleep apnea [7].

## Idiopathic intracranial hypertension after minocycline

see Idiopathic intracranial hypertension after minocycline.

## Avoidant Restrictive Food Intake Disorder

Avoidant Restrictive Food Intake Disorder

[1] , [7]
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[5]
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