

Idiopathic intracranial hypertension prognosis

- [Factors influencing the efficacy of surgical repair for spontaneous middle cranial fossa CSF leaks: a systematic review and meta-analyses](#)
- [Treatment of Persistent Headache After Normalization of CSF Pressure](#)
- [Fulminant Idiopathic Intracranial Hypertension-Clinical Characteristics and Continuous Drainage as a Novel Treatment Approach](#)
- [Idiopathic Intracranial Hypertension in Pregnancy. A Systematic Review on Clinical Course, Treatments, Delivery and Maternal-Fetal Outcome](#)
- [Real time intravascular ultrasound evaluation and stent selection for cerebral venous sinus stenosis associated with idiopathic intracranial hypertension](#)
- [The clinical characteristics, treatment and prognosis differences between occipital brain tumors with venous flow obstruction and occipital brain tumors without venous flow obstruction](#)
- [Clinical indications and patient outcomes of intracranial venous sinus stenting beyond overt idiopathic intracranial hypertension: a scoping review](#)
- [Comparison of bariatric surgery and community weight management for idiopathic intracranial hypertension in a multicenter retrospective cohort study](#)

Delay of treatment can cause severe [visual impairment](#) ¹⁾.

Few studies have directly compared headache and visual outcomes across treatment modalities.

A systematic analysis of case series was conducted to compare therapeutic efficacies among currently available interventions. The electronic databases from [EMBASE](#) (1980-17 September 2013), [Medline](#) (1980-17 September 2013), [Cochrane databases](#), and references of [review articles](#) was searched. All [publications](#) reporting headache and visual outcomes following intervention for IIH were included. A total of 457 manuscripts were selected and full text analysis produced 30 studies with extractable data. All studies constituted [Class III evidence](#). Overall, 332 patients treated by [optic nerve sheath fenestration](#) (ONSF), 287 by [lumboperitoneal shunt](#) (LPS), 61 by [ventriculoperitoneal shunt](#) (VPS), and 88 by dural venous sinus stenting, were identified.

Visual acuity improved in 49.3%, 56.6%, 67.2% and 84.6% of patients following VPS, LPS, ONSF, and stent placements, respectively. Resolution of papilledema was noted in 59.9% to 97.1%. Postoperative headache improved in 36.5%, 62.5%, 75.2%, and 82.9% of patients treated with ONSF, VPS, LPS, and stenting, respectively. Shunt revision was more frequent for LPS compared to VPS (46% versus 36%; $p < 0.2$). Among the LPS revisions, 87.5% occurred within the first 12 months following initial surgery. A pooled analysis indicated an overall similar improvement in visual outcomes across treatment modalities, and a modest improvement in headache following cerebrospinal fluid shunting and endovascular stent placement. Based on currently available literature, there is insufficient evidence to recommend or reject any treatments modalities for IIH ²⁾.

Quality of Life

IIH affects QOL at time of diagnosis even in patients with mild visual impairment. Vision-specific QOL in patients with newly diagnosed IIH may be as decreased as that for patients with other neuro-ophthalmic disorders. IIH treatment should target visual loss and other symptoms of increased intracranial pressure associated with reduced QOL. Reduced QOL does not simply reflect obesity, an

underlying IIH risk factor ³⁾.

Headache was the only clinical outcome that correlated with enhanced QOL. Effective headache management is required to improve QOL in IIH ⁴⁾.

Patients with elevated CRP and patients with thrombophilia had an unfavorable visual outcome. Increased cortisol levels and abnormal calcium correlated with a higher rate of recurrence. The visual outcome of patients with elevated LDH was better than those with normal LDH. It seems that certain metabolic, inflammatory and coagulation abnormalities may influence the course of IIH. If confirmed in further studies, these findings could contribute to elucidation of the etiology and prognosis of IIH. ⁵⁾.

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