

Transient unilateral oculomotor palsy in idiopathic intracranial hypertension: An interesting case

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Keywords

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Idiopathic intracranial hypertension (IIH) is defined as elevated intracranial pressure (ICP) without a space-occupying lesion.¹ The clinical presentation is characterized primarily by headache, impaired vision, cranial nerve palsies, olfactory disturbances, cognitive deficits, and tinnitus.¹ We report a rare case with transient unilateral oculomotor palsy with the involvement of pupillary reflex due to IIH.

A 25-year-old woman with a past medical history of polyarteritis nodosa and end-stage renal disease presented to the emergency department with a one-month history of generalized headache and diplopia. Physical examination revealed bilateral papilledema with apparent normal extraocular movement. The next day, she developed complete left third cranial nerve palsy with the involvement of pupillary reflex. Brain magnetic resonance imaging (MRI) showed empty sella, bilateral optic nerve hydrops

and tortuosity, flattening of the posterior aspect of globes, and bilateral transverse sinus stenosis (Figure 1). Contrast MRI was not performed because of impaired renal function. Lumbar puncture (LP) revealed elevated ICP (28 cmH₂O) with normal cerebrospinal fluid (CSF) composition. The patient's symptoms resolved (including the disappearance of third nerve palsy) within one day after CSF drainage and administration of topiramate. Considering history, physical examination, MRI, and quick response to LP, diagnosis of IIH was made.

Currently, modified Dandy criteria are widely accepted for the diagnosis of IIH.² Papilledema, normal neurological examination except for cranial nerve disorders, brain MRI not explaining raised ICP, normal CSF study and measured high ICP compose the criteria. Abducens palsy is quite common and is known as a false localizing sign in patients with IIH.

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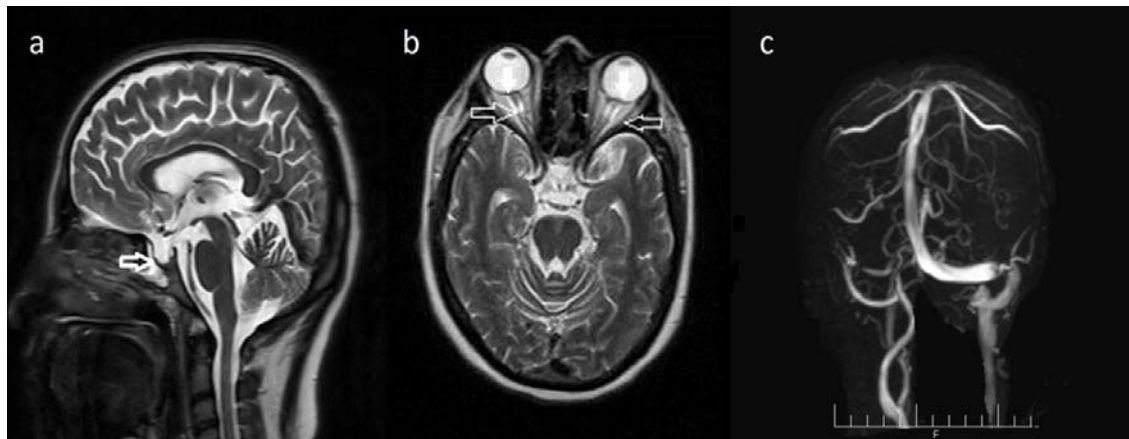


Figure 1. Cranial magnetic resonance imaging (MRI) of the patient. (a) Sagittal T2-weighted image through the midline shows a partial empty sella (arrow). (b) Axial T2-weighted image through the level of optic nerves shows prominent subarachnoid space (arrows), and protrusions of optic nerve heads (white arrow) suggestive of papilledema. (c) Magnetic resonance venography (MRV) without contrast shows smooth-bordered stenosis in distal portions of both transverse sinuses (arrow).

Oculomotor,³ trochlear,⁴ and facial⁵ nerves can be affected in these patients.

Conflict of Interests

The authors declare no conflict of interest in this

study.

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