CLINICAL GUIDELINE

Papilloedema Pathway, Diagnostics

A guideline is intended to assist healthcare professionals in the choice of disease-specific treatments.

Clinical judgement should be exercised on the applicability of any guideline, influenced by individual patient characteristics. Clinicians should be mindful of the potential for harmful polypharmacy and increased susceptibility to adverse drug reactions in patients with multiple morbidities or frailty.

If, after discussion with the patient or carer, there are good reasons for not following a guideline, it is good practice to record these and communicate them to others involved in the care of the patient.

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Approval Group:	Diagnostics Clinical Governance Group

Important Note:

The Intranet version of this document is the only version that is maintained.
Any printed copies should therefore be viewed as 'Uncontrolled' and as such, may not necessarily contain the latest updates and amendments.

NHSGGC Papilloedema Pathway

V1.4 Sep 2022

This pathway is designed to fast track the diagnosis of idiopathic intracranial hypertension. Before following the pathway please refer to the exclusion criteria.

GP/ ED/ optician identifies suspected papilloedema

- **Ensure no exclusion criteria** (see bottom left).
- Ophthalmology referral for the next available clinic.

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Ophthalmology referral for confirmation and assessment of vision

- If pseudopapilloedema suspected then OCT+-US eye prior to referral.
- If IIH previously diagnosed then assess vision and only refer for emergency medical assessment if vision at risk or other concerns. Consider referral to IIH clinic.
- If proceeding with a referral to medicine then document visual acuity, visual fields, blind spot and OCT findings under clinical notes on portal. A paper referral letter is not required.

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Medical receiving unit referral for next day review at 0830

- Prepare the patient for a whole day attendance and the possibility of a lumbar puncture. Ensure the patient's catchment area is correct.
  - **QEUH**= AECU (0141 452 2468)
  - **RAH**= MAU (0141 314 9764) *These patients are not appropriate for VoL
  - **IRH**= MAU (page #51000)
  - **GRI**= AAU (0141 211 5876)
- On arrival observations, bloods including coag, IVA, history, neuro exam and consider secondary causes of raised ICP including medications.

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Radiology request for same day neuroimaging and venography

- Tandem CTB and CTV are the default imaging modalities due to ease of availability.
- MRV can be requested if avoidance of ionising radiation is desired, known contrast allergy or local expertise.
- Liaise with radiology to ensure same day neuroimaging. Emergency out of hours neuroimaging should only be requested in exceptional circumstances.

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LP with opening pressure if no cause found on neuroimaging

- Document opening pressure clearly. Normal=5-20cmH2O.
- Remove 10-20mls if >30cmH2O and send for CSF glucose/ protein/ cell count+ culture. Oligoclonal bands and other advanced tests in certain situations.

Diagnostic criteria for idiopathic intracranial hypertension- IIH (all required)

1. Papilloedema (not mandatory if imaging suggestive)
2. Normal neurological exam (VI nerve palsy allowed)
3. Normal neuroimaging and sinus thrombosis excluded
4. CSF constituents normal
5. Elevated CSF opening) pressure (>25cmH2O)

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Onward referral and discharge

- If a diagnosis of IIH suspected and secondary causes of raised ICP are excluded then discuss with the INS SpR prior to discharge. Acetazolamide can be issued at INS's request.
- If the INS SpR agrees primary or secondary IIH is the diagnosis then write/ dictate a letter to the neurology secretaries for an outpatient appointment.
- Patients with swollen discs with a normal opening pressure should be referred back to ophthalmology.

Exclusion Criteria- *if present arrange immediate admission*

- Focal neurology including 6th nerve palsy
- Systemic illness or vomiting
- Severe hypertension (>180/110mmHg)
- Known cancer (+benign CNS mass)
- >40 years old
- Short term risk to vision
- Pregnancy
- Disabling headache

Discharge checklist

1. Record height & weight and offer weight management advice if appropriate. Consider referral to GCSWMS.
2. If headache is a feature then optimise headache management.
3. Send a copy of the IDL/ EDL to the referring ophthalmologist.
4. Ensure an appropriate onward referral is made and only give the patient a provisional diagnosis pending specialist review