Eye (2021) 35:3455–3456
https://doi.org/10.1038/s41433-021-01495-0

The ROYAL COLLEGE of OPHTHALMOLOGISTS

CORRESPONDENCE

Response to “Magnetic resonance or computed tomography venography in the evaluation of young overweight women with papilloedema”

Anna Kabanovski[1] · Edward A. Margolin[2,3] · Jonathan A. Micieli[2,3,4]

Received: 1 February 2021 / Revised: 1 February 2021 / Accepted: 23 February 2021 / Published online: 11 March 2021

To the Editor:

We thank Moolan and Blanch for their interest in our article. However, we encourage them to take another look at the paper. Our conclusion was not that “cranial venography is unnecessary in the investigation of papilloedema”, rather we indicated that magnetic resonance or computed tomography venography (MRV/CTV) may not be required in some patients with papilloedema, primarily those where the papilloedema was an incidental finding and who have no risk factors or symptoms concerning for dural venous sinus thrombosis (DVST).

The information in our study is not new. Published diagnostic criteria do not require MRV/CTV for patients who have a typical idiopathic intracranial hypertension (IIH) presentation [1]. Routine use of MRV/CTV continues to be debated in the neuro-ophthalmology community for typical IIH patients [2].

We did not exclude patients on oral contraception as they are among the most common medications used in the world with three-quarters of Canadian women take oral contraception at some point [3].

Lumbar punctures (LP) are difficult to obtain and require hospital admission in our region and others. Relying on LP opening pressure has been reported to lead to the overdiagnosis of IIH [4, 5]. Deferring LP did not change the diagnosis in any of our patients who had indirect signs of raised ICP on neuroimaging and improvement in OCT-RNFL thickness, making it unlikely they had pseudopapilloedema.

Moolan and Blanch also mischaracterized the definitions of Group-1 and Group-2 patients. They were not differentiated based on symptoms, but on how they entered the medical system. An otherwise healthy person who has an incidental discovery of papilloedema (Group-1) is extremely low risk for DVST and the likelihood of a false positive was greater than a true positive in this group. This also carries risk to the patient. Many of the documented symptoms of Group-1 patients such as headache were unrelated to raised ICP.

Despite our retrospective design and acknowledged limitations, our study supports our clinical experience and guidelines that indicate MRV/CTV is likely not required for all cases of papilloedema, particularly when it is an incidental discovery in typical IIH patients without risk factors for DVST.

Compliance with ethical standards

Conflict of interest The authors declare no competing interests.

Publisher’s note Springer Nature remains neutral with regard to jurisdictional claims in published maps and institutional affiliations.

✉ Jonathan A. Micieli
jmicieli@kensingtonhealth.org

1 Faculty of Medicine, University of Toronto, Toronto, ON, Canada

2 Department of Ophthalmology and Vision Sciences, University of Toronto, Toronto, ON, Canada

3 Division of Neurology, Department of Medicine, University of Toronto, Toronto, ON, Canada

4 Kensington Vision and Research Centre, Toronto, ON, Canada

References

1. Friedman DI, Liu GT, Digre KB. Revised diagnostic criteria for the pseudotumor cerebri syndrome in adults and children. Neurology. 2013;81:1159–65.
2. Dinkin M, Moss HE. Should magnetic resonance venography be performed routinely in all patients undergoing evaluation for idiopathic intracranial hypertension? J Neuroophthalmol. 2015;35:431–7.

3. Rotermann M, Sanmartin C, Hennessy D, Arthur M. Prescription medication use by Canadians aged 6 to 79. Health Rep. 2014;25:3–9.
4. Fisayo A, Bruce BB, Newman NJ, Biousse V. Overdiagnosis of idiopathic intracranial hypertension. Neurology. 2016;86:341–50.
5. Sengupta S, Eckstein C, Collins T. The dilemma of diagnosing idiopathic intracranial hypertension without papilledema in patients with chronic migraine. JAMA Neurol. 2019. https://doi.org/10.1001/jamaneurol.2019.1696.