Your Questions Answered

INTRACRANIAL HYPERTENSION

Q I have intracranial hypertension. Have there been any recent advances in diagnosis and treatment?

DR. BARBARA SCHEROKMAN RESPONDS:

A Intracranial hypertension (also known as pseudotumor cerebri, benign intracranial hypertension, or idiopathic intracranial hypertension) is a disorder caused by an increase in the pressure of the cerebrospinal fluid in the brain. The most common symptoms are headache and transient visual problems.

The cause is unknown; and while intracranial hypertension is not fatal, if left untreated it can lead to permanent loss of vision. Diagnosis begins with a brain MRI or MR angiogram to rule out a brain mass or other brain disorder causing increased pressure. A lumbar puncture (spinal tap) is performed to measure the cerebrospinal-fluid pressure, and if it is elevated, treatment is started.

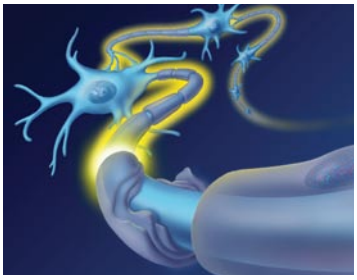
Standard treatment includes weight loss, repeated lumbar punctures, salt and fluid restriction, and diuretic therapy. Most of the time medical treatment works, but when it fails, surgeries may be recommended: either optic nerve sheath decompression (opening the covering around the optic nerve), or a shunt from the low back or head to the abdomen in order to drain the cerebrospinal fluid. In general the procedures are safe. Additionally, a new investigational surgical treatment has been tried that places a stent in the cerebral vein to relieve narrowing, but the safety and efficacy have not yet been determined.

Barbara Scherokman, M.D., is lead neurologist of the Northern Virginia Mid-Atlantic Permanente Medical Group in Fairfax, VA, and a member of Neurology Now's *Professional Advisory Board.*

DO YOU HAVE A QUESTION TO ASK THE EXPERTS?
Send it to neurologynow@lwwny.com.

TRANSVERSE MYELITIS

Q I have had transverse myelitis for nine years but was only diagnosed about two years ago. What causes this condition, and how does it differ from multiple sclerosis?



DR. DOUGLAS KERR RESPONDS:

A Transverse myelitis is caused by inflammation across both sides of spinal-cord segments. Inflammation can destroy myelin, the insulating substance that covers nerve-cell fibers (see illustration, showing neurons and cell fibers in blue and myelin in purple), and damage to myelin causes scars (lesions) in the nervous system that interrupt communication between spinal-cord nerves and the rest of the body. In transverse myelitis there is usually a single lesion in the spinal cord and none in the brain, whereas in multiple sclerosis (MS) there are multiple attacks of inflammation and lesions throughout the brain and spinal cord.

Symptoms of transverse myelitis include the loss of spinal-cord function over several hours to several weeks, lower-back pain, and muscle weakness. MS symptoms include vision loss, unsteadiness, and facial numbness. Some cases of transverse myelitis are idiopathic—that is, without a known trigger—but some are associated with other neurological diseases.

Neurologists first treat the inflammation in the acute phase. Then, they assess whether the inflammation is recurring or is likely to recur by performing an MRI of the brain and spinal cord and a lumbar puncture (spinal tap). Patients are often treated with corticosteroid therapy to reduce inflammation, and those with a high likelihood of recurrence may need chronic immunomodulatory therapy to alter their immune response.

In most cases, transverse myelitis is a one-time event and the inflammation resolves by itself. However, the goal of acute treatment is to hasten the resolution of the inflammation in order to minimize the damage it causes, which often leaves patients with numbness, weakness, and bowel problems. These symptoms can often be managed by medications.

Douglas Kerr, M.D., Ph.D., is associate professor of neurology and director of the Transverse Myelitis Center at Johns Hopkins Hospital in Baltimore, MD.

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