Chronic Inflammatory Demyelinating Polyneuropathy Mimicking Symptoms of Intracranial Hypertension

İtrakraniyal hipertansiyon bulgularını taklit eden kronik inflamatuar demiyelinizan polinöropati

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To the Editor,

Chronic inflammatory demyelinating polyneuropathy (CIDP) is a disorder characterized pathologically by multifocal inflammatory demyelination and clinically by motor and sensory neuropathy that lasts at least for two months (1). It usually emerges with polyneuropathy symptoms. Its primary symptoms are hyporeflexia/areflexia and sensory loss in extremity weakness and gloves and stocking distribution (1,2). The diagnosis is made through clinical findings, symptoms, electrophysiological examinations, lumbar puncture, laboratory tests and sometimes nerve biopsy. It has a slow or recurrent course (3). This paper presents a case with CIDP who was admitted with symptoms of intracranial hypertension.

A 67-year-old patient was admitted with complaints of headache and diplopia that had been continuing for ten days; his anamnesis showed diabetes and hypertension while his neurological examination showed bilateral peripheral vision limitation and papilledema, hyporeflexia in all extremities, minimal muscle strength loss in the right lower extremity and glove and stocking hypesthesia. His brain magnetic resonance (MR) and MR venography examinations were normal. His cerebrospinal fluid (CSF) examination was cell-free, it was found to have a pressure of 26 cm H2O and protein content of 240 mg/dl. The complaints of headache and diplopia recovered completely through acetazolamide treatment. Five months later, symptoms of symmetric demyelinating polyneuropathy were found in the nerve conduction studies of the patient who was evaluated with a complaint of weakness of legs. Complaints regressed with a treatment of corticosteroid and azathioprine, during the third month of the treatment, there was an increase in weakness and it was treated with monthly intravenous immunoglobulin (IVIg).

Cranial nerve involvement is rarely seen in CIDP; however, it usually has a moderate course and it is not a presenting symptom. Papilledema is seen in about 1-7% of the cases while diplopia secondary to ophthalmoplegia is seen in about 8%. (4,5) There are few papers on headaches, papilledema and intracranial hypertension in the course of CIPD; this is probably due to BOS protein which is increased as a result of polyneuropathy (1-3).

Conflicts of interest

There are no conflicts of interest.
References


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