



**Royal College of Paediatrics and Child Health**  
**BPSU SURVEILLANCE CASE NOTIFICATION FORM**  
**Childhood Idiopathic Intracranial Hypertension Questionnaire**

**BPSU case ref.** \_\_\_\_\_

Please complete this questionnaire as appropriate about any new diagnosis of idiopathic intracranial hypertension (suspected or confirmed) in a patient 1-16 years of age (not including 17<sup>th</sup> birthday)

**Reporting Clinician Details: (please print)**

Name of reporting clinician: \_\_\_\_\_

Hospital name & address: \_\_\_\_\_

\_\_\_\_\_

Contact telephone number: \_\_\_\_\_ Contact e-mail: \_\_\_\_\_

**Date of completing questionnaire (dd/mm/yy):** \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

**Patient Details**

*We will store this front page separately from the rest of the questionnaire so all clinical data for analysis are anonymous.*

**Please tick or supply details as appropriate:**

Date of Birth (dd/mm/yy): \_\_\_\_/\_\_\_\_/\_\_\_\_ Gender: Male  Female

NHS Number: \_\_\_\_\_

Has the patient in question been referred to you from another hospital?  Yes  No

If YES please give the name of the hospital and the consultant referring the patient (*please print*):

Hospital name: \_\_\_\_\_

Name of referring Consultant: \_\_\_\_\_

Patient's ethnicity:

- |  |   |
|--|---|
| <input type="checkbox"/> <b>White</b>                  | <input type="checkbox"/> <b>Mixed</b> please specify _____              |
| <input type="checkbox"/> <b>Asian or Asian British</b> | <input type="checkbox"/> <b>Black or Black British</b>                  |
| <input type="checkbox"/> Indian                        | <input type="checkbox"/> Caribbean                                      |
| <input type="checkbox"/> Pakistani                     | <input type="checkbox"/> African  |
| <input type="checkbox"/> Bangladeshi                   | <input type="checkbox"/> Any other Black background                     |
| <input type="checkbox"/> <b>Chinese</b>                | <input type="checkbox"/> <b>other ethnic group</b> please specify _____ |

**Please return all 3 pages of the questionnaire in the prepaid envelope to Dr YY Matthews Department of Paediatrics, Wrexham Maelor Hospital, Croesnewydd Road, Wrexham LL13 7TD**

**Any enquiries please email: YIM-YEE.MATTHEWS@new-tr.wales.nhs.uk**



**Royal College of Paediatrics and Child Health**  
**BPSU Surveillance Case Notification Form**  
**CHILDHOOD IDIOPATHIC INTRACRANIAL HYPERTENSION QUESTIONNAIRE**

**Instructions - Please insert a tick i.e.  if applicable (Y= yes, N= no, DK= don't know)**

**1. Please indicate which symptoms were present at presentation:**

Headache	Y <input type="checkbox"/>	N <input type="checkbox"/>	DK <input type="checkbox"/>	Squint	Y <input type="checkbox"/>	N <input type="checkbox"/>	DK <input type="checkbox"/>
Nausea	Y <input type="checkbox"/>	N <input type="checkbox"/>	DK <input type="checkbox"/>	Diplopia	Y <input type="checkbox"/>	N <input type="checkbox"/>	DK <input type="checkbox"/>
Vomiting	Y <input type="checkbox"/>	N <input type="checkbox"/>	DK <input type="checkbox"/>	Blurring of vision	Y <input type="checkbox"/>	N <input type="checkbox"/>	DK <input type="checkbox"/>
Irritability	Y <input type="checkbox"/>	N <input type="checkbox"/>	DK <input type="checkbox"/>	Transient visual loss	Y <input type="checkbox"/>	N <input type="checkbox"/>	DK <input type="checkbox"/>

Others please specify (e.g. photophobia, dizziness, lethargy, mood change, behavioural change, sleep disturbance): \_\_\_\_\_

**2. Please indicate the neurological signs at presentation:**

Papilloedema (even very mild)    unilateral     bilateral     N     DK   
 Normal level of consciousness    Y     N     DK   
 6<sup>th</sup> Cranial nerve palsy                Y     N     DK

others please specify \_\_\_\_\_

**3. Please give growth measurements, available either at presentation or most recent recordings:**

Height \_\_\_\_\_ cm                      Date of measurement (dd/mm/yy): \_\_\_\_/\_\_\_\_/\_\_\_\_\_  
 Weight \_\_\_\_\_ kg                      Date of measurement (dd/mm/yy): \_\_\_\_/\_\_\_\_/\_\_\_\_\_

**4. Please indicate if any of the following medical conditions exist at presentation:**

Hypothyroidism	Y <input type="checkbox"/>	N <input type="checkbox"/>	DK <input type="checkbox"/>	Renal impairment	Y <input type="checkbox"/>	N <input type="checkbox"/>	DK <input type="checkbox"/>
Hyperthyroidism	Y <input type="checkbox"/>	N <input type="checkbox"/>	DK <input type="checkbox"/>	SLE	Y <input type="checkbox"/>	N <input type="checkbox"/>	DK <input type="checkbox"/>
Hypoparathyroidism	Y <input type="checkbox"/>	N <input type="checkbox"/>	DK <input type="checkbox"/>	Migraine	Y <input type="checkbox"/>	N <input type="checkbox"/>	DK <input type="checkbox"/>
Hypocalcaemia	Y <input type="checkbox"/>	N <input type="checkbox"/>	DK <input type="checkbox"/>	Iron deficiency anaemia	Y <input type="checkbox"/>	N <input type="checkbox"/>	DK <input type="checkbox"/>
Vitamin D deficiency	Y <input type="checkbox"/>	N <input type="checkbox"/>	DK <input type="checkbox"/>	Type I Diabetes	Y <input type="checkbox"/>	N <input type="checkbox"/>	DK <input type="checkbox"/>
Otitis media (OM)	Y <input type="checkbox"/>	N <input type="checkbox"/>	DK <input type="checkbox"/>	acute OM <input type="checkbox"/>	recurrent OM <input type="checkbox"/>		

**5. Please indicate and provide details if the following medications were taken at presentation:**

Recent antibiotic course	Y <input type="checkbox"/>	N <input type="checkbox"/>	DK <input type="checkbox"/>	Thyroxine	Y <input type="checkbox"/>	N <input type="checkbox"/>	DK <input type="checkbox"/>
<i>specify name of antibiotic</i>	_____						
Antibiotic as prophylaxis	Y <input type="checkbox"/>	N <input type="checkbox"/>	DK <input type="checkbox"/>	Growth hormone	Y <input type="checkbox"/>	N <input type="checkbox"/>	DK <input type="checkbox"/>
<i>specify name of antibiotic</i>	_____						
Immunosuppressive therapy	Y <input type="checkbox"/>	N <input type="checkbox"/>	DK <input type="checkbox"/>	Phenytoin	Y <input type="checkbox"/>	N <input type="checkbox"/>	DK <input type="checkbox"/>
<i>specify name of the drug</i>	_____						
Steroids (topical/systemic/inhaled)	Y <input type="checkbox"/>	N <input type="checkbox"/>	DK <input type="checkbox"/>	Indomethacine	Y <input type="checkbox"/>	N <input type="checkbox"/>	DK <input type="checkbox"/>
<i>specify the name &amp; formulation</i>	_____						
Oral contraceptive pills	Y <input type="checkbox"/>	N <input type="checkbox"/>	DK <input type="checkbox"/>	Vitamin A analogues	Y <input type="checkbox"/>	N <input type="checkbox"/>	DK <input type="checkbox"/>
<i>specify name of the drug</i>	_____			<i>specify name of drug</i>	_____		

**Instructions - Please insert a tick (i.e. ) if applicable (Y= yes, N= no, DK= don't know)**

**6. Please provide details of the cerebrospinal fluid (CSF) by lumbar puncture at presentation:**

Opening CSF pressure \_\_\_\_\_ cm                      CSF protein \_\_\_\_\_ g/L  
CSF WCC \_\_\_\_\_ x 10<sup>6</sup>/L                      CSF glucose \_\_\_\_\_ mmol/l  
CSF RBC \_\_\_\_\_ x 10<sup>6</sup>/L                      Glucose CSF/plasma ratio \_\_\_\_\_

**7. Please provide details if the following neuroimaging were performed at presentation:**

CT brain                      normal     abnormal     DK     not done

If abnormal please give details \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Has the CT brain shown the presence of optic nerve head Drusen\*? Y  N  DK

\* a degenerative condition consists of deposits of hyaline material within the optic nerve head that results in an apparent elevation of the optic disc

MRI brain                      normal     abnormal     DK     not done

If abnormal please give details \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Has MR venography excluded sinus venous thrombosis? Y  N  DK  not done

**8. Ophthalmological Investigations at presentation**

- i) Has an Ophthalmologist confirmed the papilloedema?                      Y  N  DK
- ii) Has an Ophthalmologist excluded optic nerve head Drusen?                      Y  N  DK
- iii) Has a visual deficit been detected?                      Y  N  DK
- iv) If there is a visual deficit, is this deficit unilateral  or bilateral ?
- v) If there is a visual deficit, is this deficit in visual acuity , field restriction  or both ?
- vi) Is the child too young for visual testing?                      Y  N  DK

**9. Please indicate if the following treatment were instituted following diagnosis:**

Acetazolamide                      Y  N     Furosemide Y  N     Prednisolone Y  N

Therapeutic LP                      Y  N     please specify number of therapeutic LP \_\_\_\_\_

Lumboperitoneal shunt                      Y  N     Referral made for neurosurgical assessment Y  N

Other treatment                      Y  N     If yes please give details \_\_\_\_\_

**Thank you for your time and help in completing this questionnaire. Please return all 3 pages of the questionnaire in the prepaid envelope even if you are unable to complete all items.  
Any enquiries please email: YIM-YEE.MATTHEWS@new-tr.wales.nhs.uk**