Launch date 3/6/2024

IN THE EMERGENCY DEPARTMENT:

1. Ophthalmology consult to grade papilledema, also to enable follow up.
    a. It's possible that the patient came from an outpatient ophthalmologist and we have the notes reflecting bilateral papilledema, including grade. If the ophthalmology resident can review these results, feels confident that the results meet these criteria, and feels confident that the results are reliable, ED ophthalmology consult can be deferred until after imaging.
2. STAT noncon hCT and CTV.
    a. If the patient ends up discharging and following the outpatient pathway, AND the ED imaging studies are over-read with a concerning finding, the ED QI team will contact patient and have them return to ED.
3. If there is concern for an etiology other than IIH (e.g. meningitis, inflammation), urgent/ED bedside LP if possible.
4. If there is concern for severe/fulminant IIH (including if the patient is having TVOs), urgent/ED MRI brain with and without contrast.
5. Neurology consult if (1) the patient needs admission for inpatient pathway criteria, or (2) there is suspicion for non-IIH etiology requiring Neurology consultation.
    a. Full Neurology consult can be deferred if the suspected etiology is IIH and the patient will fall into the outpatient pathway. If all that's needed is to ensure outpatient Neurology follow up, the ED only needs to FYI a neurology consult resident about the patient so the neurology resident can ensure follow up (see pathway details below).

OUTPATIENT PATHWAY:

1. **Criteria for outpatient pathway:**
    a. **Traditional risk factors (female, of childbearing age, BMI > 30, etc.)**
    b. **No past history of cancer or systemic autoimmune disorder**
    c. **No symptoms of CNS infection or inflammatory process**
    d. **No transient visual obscurations (TVOs)**
    e. **Normal vision on Ophthalmology exam.**
    f. **Papilledema is none-to-mild on Ophthalmology exam.**
2. Follow up plan:
    a. Urgent Neurology follow up (meaning within 1-2 weeks).
        i. ED will to refer to Neurology (use RIH NEUROLOGY and make priority URGENT).
        ii. Neurology resident is responsible for messaging JJ and ensuring the referral is received.
    b. Urgent Ophthalmology follow up (meaning within 1-2 weeks).
        i. The ophthalmology resident will refer to Ophthalmology, as is their practice.
        ii. If the patient can have solid follow up with their own ophthalmologist already, then the patient can skip Lifespan ophthalmology follow up.
    c. Outpatient testing will be ordered by the outpatient physicians. The ED does not need to order any outpatient tests.

    d. Outpatient medications will be ordered by the outpatient physicians. The ED does not need to order any outpatient medications.
3. Urgent outpatient MRI with and without contrast (ideally before LP).
    a. Whichever group sees the patient first (ophthalmology or neurology) will order it and follow it up.
4. Urgent outpatient bedside LP if possible.
    a. Neurology will help the patient get the LP.
    b. If bedside LP isn't possible, then a VIR LP will be pursued so at least basic CSF labs can be obtained.

INPATIENT PATHWAY:

1. Criteria for inpatient pathway:
    a. Anybody who doesn't meet the criteria for outpatient.
2. Admit to appropriate neurology or neurosurgery service, depending on imaging findings.
3. Inpatient MRI with and without contrast (BEFORE LP IF POSSIBLE).
    a. If there is concern for severe/fulminant IIH, including if the patient is having TVOs, the ED should be ordering a STAT MRI brain with and without contrast. The purpose is to get STAT imaging, ideally within 6 hours of the order. The patient does not need to wait in the ED for the MRI to be performed.
4. Inpatient bedside LP if possible.
    a. If bedside LP isn't possible, then a VIR LP will be pursued so at least basic CSF labs can be obtained.

Reference: Idiopathic intracranial hypertension: consensus guidelines on management. PMID: 29903905. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6166610/