

PSEUDOTUMOR CEREBRI

All Classes
(Updated 01/25/2023)

DISEASE/CONDITION	EVALUATION DATA	DISPOSITION
<p>Pseudotumor Cerebri</p> <p>Idiopathic intracranial hypertension</p> <p>(Previous name: Benign Intracranial Hypertension)</p>	<p>Submit the following for FAA review:</p> <ol style="list-style-type: none"> 1. A current, detailed neurological evaluation that meets FAA Specifications for Neurologic Evaluation generated from a clinic visit with the treating neurologist no more than 90 days before the AME exam. 2. *MRI of the brain performed no more than 90 days before the AME exam. 3. A current, detailed Clinical Progress Note generated from a clinic visit with the treating ophthalmologist or neuro-ophthalmologist no more than 90 days before the AME exam. It must include: A detailed summary of the history of the condition; current medications, dosage, and side effects (if any); physical exam findings; results of any testing performed; diagnosis; assessment and plan (prognosis); and follow-up. 4. Visual Field graphs (24-2 or 30-2) with narrative interpretation by the treating eye specialist. 5. If surgery was performed, it should indicate follow-up results and note any complications. <ul style="list-style-type: none"> • If a shunt was placed as part of treatment, a minimum recovery period of two (2) years is required. 6. Records from any hospitalization to include: 	<div style="background-color: red; color: black; text-align: center; padding: 5px;">DEFER</div> <p>Submit the information to the FAA for a possible Special Issuance</p> <p>Annotate (elements or findings) in Block 60.</p>

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	<ul style="list-style-type: none"> • Admission History and Physical; • Hospital discharge summary. (Typically, the patient portal notes or after visit summary (AVS) that can be printed from an electronic medical record are NOT sufficient for pilot medical certification purposes.); • Emergency Medical Services (EMS)/ ambulance run sheet (if applicable); • Hospital consultant report(s) (such as neurology, cardiology, internal medicine, or other specialists); • Lab report(s) including all drug or alcohol testing performed; • Operative/procedure report(s); to include lumbar puncture(s); and • Pathology report(s) <p>7. *Radiology report(s). The interpretive report(s) of all diagnostic imaging (CT scan, MRI, MRA, MRV, X-ray, ultrasound, or others) performed.</p> <p>*For MRI or other diagnostic imaging: Submit the interpretive report on paper and imaging on CD in DICOM readable format (there must be a file named 'DICOMDIR' in the root directory of the CD-ROM). Please verify the CD will display the images before sending. You may wish to retain a copy of all films as a safeguard if lost in the mail.</p>	