PSEUDOTUMOR CEREBRI

All Classes
(Updated 01/25/2023)

DISEASE/CONDITION	EVALUATION DATA	DISPOSITION
Pseudotumor Cerebri Idiopathic intracranial hypertension (Previous name: Benign Intracranial Hypertension)	Submit the following for FAA review: 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** n**o 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. • 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:	**DEFER** Submit the information to the FAA for a possible Special Issuance Annotate (elements or findings) in Block 60.

DISEASE/CONDITION	EVALUATION DATA	DISPOSITION
	• 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) 7. *Radiology report(s). The interpretive report(s) of all diagnostic imaging (CT scan, MRI, MRA, MRV, X-ray, ultrasound, or others) performed. *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.	