**Medical Report for User: 68d7b5cacbe6485b12e35c42**

**1. Present Illness**

Generated HPI:
The patient is a 48-year-old right-handed female with a past medical history of migraine without aura who presents for evaluation of a new and distinct headache pattern that began approximately six weeks ago. She describes a daily, holocranial, pressure-like headache, which is most severe upon awakening and is significantly exacerbated by coughing, bending forward, or straining. The intensity is rated as 7/10, a notable change from her baseline intermittent throbbing migraines. Over the past two weeks, the headaches have become associated with transient visual obscurations in both eyes, lasting several seconds, and a subjective "whooshing" sound in her ears, synchronous with her heartbeat (pulsatile tinnitus). She denies any associated photophobia, phonophobia, aura, nausea, or vomiting. There is no report of recent head trauma, fever, neck stiffness, focal weakness, sensory changes, diplopia, or alteration in gait or consciousness. Her typical migraine abortive therapies, including sumatriptan and NSAIDs, have provided no relief for these current headaches.

**2. Analysis and Plan**

Assessment
This 48-year-old female with a history of migraine presents with a six-week history of a new daily persistent headache, which has features highly suggestive of elevated intracranial pressure (ICP). The clinical diagnosis is strongly weighted towards Idiopathic Intracranial Hypertension (IIH), given the constellation of a daily pressure headache exacerbated by Valsalva maneuvers, morning predominance, transient visual obscurations, and pulsatile tinnitus. This new headache pattern is clinically distinct from her prior migraines and lacks response to her usual abortive therapies, making a simple transformation of migraine less likely. The presence of transient visual obscurations is particularly concerning as it suggests optic nerve head swelling (papilledema) and an immediate risk to her vision. While IIH is the leading diagnosis, it remains a diagnosis of exclusion; therefore, it is imperative to urgently rule out secondary causes of intracranial hypertension, most notably an intracranial mass lesion or cerebral venous sinus thrombosis.
Plan
The immediate plan is to proceed with an urgent evaluation to confirm the suspected diagnosis and rule out ominous secondary etiologies. We will obtain an MRI of the brain with and without contrast and an MR venogram (MRV) of the head to exclude any structural lesions, hydrocephalus, or venous sinus thrombosis. An urgent consultation with Ophthalmology has been placed for a dilated funduscopic exam to evaluate for papilledema, as well as formal visual field testing to assess for any optic nerve compromise. Pending imaging that shows no evidence of a mass effect or obstructive lesion, we will proceed with a lumbar puncture to measure the opening pressure and obtain cerebrospinal fluid for analysis, including cell count, protein, and glucose. If intracranial hypertension is confirmed with an elevated opening pressure, we will initiate treatment with acetazolamide to lower intracranial pressure and mitigate the risk of permanent vision loss. The patient will be counseled on the critical role of weight management in the long-term treatment of this condition. We will arrange for close follow-up in the clinic within one to two weeks to review the results of this comprehensive workup and monitor her response to therapy.