Did you know?

The latest from the field of otolaryngology

Meniere's Disease & Benign Positional Vertigo

I have had occasion to see and successfully treat many patients with dizziness and vertigo in our clinic. For example, we have developed a conservative surgical procedure (endolymphatic sac enhancement) which has benefited approximately 5,000 patients who had intractable progressive incapacitating Meniere's disease where medical treatment had failed over a prolonged period of time.

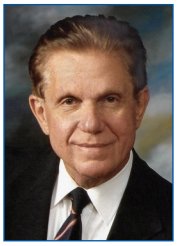
Dizziness is a very common problem particularly as seen in the primary care physician's office. For example, NIH studies have indicated 90M Americans have dizziness and that was a study done years ago, so the number must be higher at the present time. These individuals had dizziness sufficiently severe to consult their primary care physician. The most common of these diseases is benign positional vertigo. Characteristically this is a patient who develops either vertigo or a sense of disequilibrium or imbalance, or often may feel "drunk", but they have had no alcohol. This dizzy spell will last approximately a minute or two and is associated with position change. These patients also may have visually induced vertigo or so called "shopping center nystagmus" where if they see bright lights in the shopping center, people moving around, reading a book, looking at a computer, that often can trigger dizziness as well.

Meniere's disease, on the other hand, is a separate entity which is common in our clinic and it is characterized by deafness, pressure, tinnitus and loudness intolerance emanating from the cochlea and a variety of vestibular symptoms including vertigo, disequilibrium, "drop attacks" and most importantly positional vertigo as well. In a previous study of 500 patients with Meniere's disease, we identified that approximately 80% of patients had motion related dizziness, not only during an episode of vertigo, but between attacks as well. If a patient has Meniere's disease we always treat them medically first and foremost. We advise them to avoid "CATS" which means caffeine, excessive alcohol, tension and salt. We treat them with anti emetic medication such as Meclizine and routinely a diuretic and other medications such as Oxazipan, if needed to allay anxiety as well as vertigo. The majority of patients can be managed medically. However we find in our clinic approximately one in ten ends up with progressive, intractable, incapacitating disease either with severe cochlear symptoms and/or vestibular symptoms and therefore surgery becomes indicated. There are two forms of surgery – conservative surgery consisting of endolymphatic sac enhancement as developed in our office and used over the past decades, or destructive procedures which we reserve as court of last resort if conservative methods do not suffice.

Patients who have dizziness have an appropriate structured history followed by usually a lateral laws view of the mastoid and an appropriate audiogram followed by ABR, ENG and ECoG tests. These help to rule out intracranial pathology as we can usually avoid the expense of an MRI. Again the history represents the most important part of the diagnostic process.

Another important finding that has come from our clinic is that patients who have frequently been diagnosed with benign positions vertigo also have early endolymphatic hydrops or early Meniere's disease. For example patients with benign positional vertigo should have normal findings including normal caloric test findings; they should have no other symptoms such as aural pressure, tinnitus or hearing loss. If a patient comes in with benign positional vertigo and he/she has localized symptoms one side or another, with pressure, tinnitus and even temporary hearing loss when having dizzy spells, even if it's benign positional vertigo, this represents early endolymphatic hydrops or early Meniere's disease as well as positional vertigo. Therefore the patient is treated not only with an Epley maneuver to reorient the calcium carbonate crystals in the utrical, but also with a diuretic just as we treat patients who have Meniere's disease, along with avoidance of CATS, as mentioned above.

The primary care physician has an opportunity to identify and help these patients. Often medical therapy can be enhanced by vestibular rehabilitative therapy in the physical therapy departments of a regional hospital. If intractability or progression continue to get worse, then a consultation with otology/neurotology is in order.



Dr. Michael Paparella, founder of Paparella Ear Head & Neck Institute, is a renowned expert in the field of otolaryngology, having served as Chair of the University of Minnesota's Department of Otolaryngology, authored over 600 scientific publications and 60 books, and trained more than 300 ENT physicians.

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