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Opinion
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Benign Paroxysmal Positional Vertigo (BPPV)

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Introduction

BPPV is often misdiagnosed, mistrited and subjected to expensive investigations such as ME brain and Petrous bone. Even otologists are not aware of this condition. Like all cases of vertigo are treated with beta histine, cinnarazine, Nootropil etc. BPPV is common condition in both the sexes in age group of 40-70 years.

The classical symptoms of BPPV of Posterior semicircular canal (PSCC) is precipitation of rotary vertigo on co change of position on affending side in recumbent position. Pt may get awakened from sleep when gets into offending position. Vertigo in BPPV of PSCC is commonly precipitated when patient tries to get up from the bed. Vertigo may be associated with naussea and vomitting or sweating. It can also precipitate on looking up. BPPV of PSCC is only treated by various definitive head positions and none other. Epley's maneuver is the only way of treating BPPV of PSCC. To diagnose one should carry out Dix-Hallpike maneuver to see the laterality of affending PSCC. Watch for nystagmus and observe the type of nystagmus. If the nystagmus is horizontal-rotary (ageotropic) type then BPPV of PSCC is confirmed. Then Epley's maneuver is effective. One such procedure may suffice but recurrences are known, in which case procedure may be repeated. If the Nystagmus on performing Dix-Hallpike maneuver is geotropic or lateral then different head positions are required to be undertaken. When recurrence occurs after Epley's maneuver nystagmus may change into lateral type for which different positions are undertaken. The third type of BPPV is Superior semicircular canal BPPV.

BPPV is of 3 types, Commonest being BPPV of posterior semicircular canal (PSCC), next is BPPV of Lateral Semicircular Canal (LSCC) and lastly BPPV of Superior Semicircular canal (SSCC). There is no medical treatment for all the three types. Most of the cases are misdiagnosed and over investigated. The favorite drug used via many physicians and neurologists Is Tab Vertin (Generic name is beta-histine) Since Tab Vertin goes well with vertigo it happens to be easily remembered and pations are also satisfied with drug because of its close association with Vertigo but without any relief The gold standard for BPPV of PSCC is Epley's maneuver if properly carried out. It is important to inform the patient that he should not lie down for at least 12hrs and also not to look up for at least a week. Especially for men while shaving should not look up, instead they can stick out their head forward and carry out shaving. Patient must also be told that there can be recurrence within or before a month. If there is recurrence same procedure can be repeated. BPPV of PSCC after the maneure can into BPPV of LSCC Many otologists unfortunately do not know how to perform the maneuver. Surgical treatment is not recommended for it is not only invasive but carries morbidity especially selective section of vestibular nerve. Next comes is singular nerve neurectomy. It requires expertise and can also result in severe Sensori-Neural Hearing Loss (SNHL).

Following differential diagnosis in order of occurrence in the authors experience is:

a) Vestibula neuronitis

b) Meniere's Disease

c) Fistula of LSCC

d) Vertebrobasilar artery insufficiency

e) Lateral thalamic syndrome

f) Infarction of cerebellum Thrombosis of Vestibular artery

g) Functional

A detailed ENT and otoneurological examination is required. Base line pure tone audiometry is mandatory. Otoneurological exam must include:

a) Fistula test in all cases of COM.

b) Note nystagmus and degree and direction of nystagmus.

c) Romberg's test.

d) Cerebellar function tests.

e) Gait with eyes open and eyes closed.

f) Tandem gait.

g) Dix-Hallpike maneuver.

h) Electronystagmography (ENG).

i) Vestibular evoked myogenic potentials (VEMP).

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