Central West Specialists
Ear, Nose & Throat Specialist

BENIGN POSITIONAL VERTIGO

BPV is a common peripheral vestibular disorder. It is characterised by brief sensations of vertigo (spinning) which occur when the person's head is moved into provoking positions. Rolling over in bed, bending forward and looking up are frequently described activities which if performed quickly will aggravate vertigo, usually nausea and occasionally vomiting. BPV may come in bouts, lasting several days and then resolving, only to return again months later. BPV does not respond to medication, though the drugs often prescribed will help with the nausea.

The theory is that calcium carbonate crystals break free from an area inside the inner ear and adhere to the cupula of the posterior semi-circular canal. This causes the cupula to respond to the pull of gravity and when the patient lies down the incorrect signal is sent to the brain and the patient feels as if they are spinning. It suggests that the calcium carbonate crystals are free floating in the posterior semi-circular canal rather than adhere to it. This would also create an inaccurate message to the brain when the patient moved in particular ways.

BPV may respond to treatment. Stemetil and Serc do not provide relief. In the majority of cases, the crystals can be repositioned out of the posterior semi-circular canal to another part of the labyrinth which does not create inaccurate information to the brain. In a few cases if this treatment is not effective, then new surgical techniques may be considered to stop the vertigo.

The treatment is not difficult, however it should be performed by a medical professional the first time and instructions should be followed carefully.

Begin the treatment sitting up on a bed. Turn the head to look over the shoulder to the side which has the trouble (this will be determined during the assessment session if not already identified by the doctor). Lie back, flat on your back, head still turned to the side, and slide yourself so the head hangs off over the edge of the bed. Be prepared, this position will usually cause vertigo. Stay in this position until the vertigo stops and for an additional minute. It is important to go slowly. After 1& ½ minutes, gently rotate to the centre looking straight up at the ceiling. Wait again for a minute or more. Then turn as far as possible to the opposite side. Wait again. Then turn your whole body onto the side and stay for another 2 minutes. Then sit up. This may cause another sensation of vertigo. Sit quietly for 10 minutes or so. The treatment may cause vertigo and slight discomfort, however it should not cause pain. Stop if there is any pain and see your referring doctor.

The next 48 hours are very important. Continue to be cautious and try not to perform the activities which cause the vertigo. When reclined, keep the trouble ear on top, ie. Lie on the opposite side. Use several pillows, do not lie flat. Move slowly and not into positions which usually cause the vertigo. Again, this is only necessary for two days. This allows gravity to pull the particles away from the problem area. After two days it is time to try and see if the symptoms are resolved. Try to lie on the side which you have been avoiding. There should be no vertigo. If there is, then repeat the head rotation from beginning and follow the precautions for another 48 hours.

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Please call if you have any problems or questions. If you do not have a positive result with this treatment, then you should consult your referring doctor to discuss other possible solutions to relieve the vertigo. See attached sheet.

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VESTIBULAR DISORDERS

RELEVANCE TO DRIVING TASK

Driving ability is affected by a defect in balance and is therefore dependent on the normal functioning of the vestibular mechanism. Vestibular malfunction can occur suddenly and with sufficient severity to make safe driving of any type of vehicle impossible. It is often accompanied by nystagmus which compounds the disability in regard to driving.

GENERAL CONSIDERATIONS

Driving ability may be affected by unheralded attacks of vertigo which are associated with many vestibular disorders. Many vestibular disorders may vary between symptomatic and asymptomatic with little warning.

Subsequent to an initial attack of vertigo due to acute labyrinthitis, there may be further recurrence of vertigo for up to 12 months. Given that there are no pre-emptory symptoms, a sudden inability to drive may eventuate.

In cases of benign paroxysmal vertigo which causes nystagmus and vertigo when specific head positions are assumed, recurrence of symptoms are likely to present for many years despite treatment. This makes the task of isolating a given phase of the condition where symptoms deleterious to an individual's fitness to drive may be present, quite difficult.

In confirmed Meniere's disease, vestibular malfunction and nystagmus can occur despite treatment. The natural history is of progression associated with increasing deafness until, in the extreme, total loss of vestibular and cochlear function occurs. While sufferers of this condition should not be driving commercial vehicles, they may be able to hold conditional private licence.

MEDICAL STANDARDS

Generally, those who suffer from unheralded attacks of vertigo should not drive. Vestibular function should be assessed by using a simple Romberg test. The opinion of an otorhinolaryngologist may be sought.

MEDICAL STANDARDS – VESTIBULAR DISORDERS

CONDITION	DRIVERS OF CARS AND LIGHT TRUCKS, MOTORCYCLE RIDERS
Acute Labyrinthitis	Should not drive while symptoms persist.
Benign Paroxysmal Vertigo	Should not drive during exacerbations of the condition.
Meniere's Disease	Should not drive during exacerbations of the condition.
Recurrent Vertigo	Should not drive while symptoms persist.

- Practitioners may consider reporting to the Driver Licensing Authority patients who are unwilling to comply with driving restrictions that the practitioner recommends. Original article written by RTA.