

HOW DO WE RECOGNIZE BENIGN PAROXISMAL POSITIONAL VERTIGO?

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In the diagnosis of vestibular disorders the presence of nystagmus or vertigo provoked by different head movements or head positions is always looked for. It is not unusual for the physician to meet a patient who has no vertigo or spontaneous nystagmus in upright position but vertigo and nystagmus is encountered during positional maneuvers.

Dix-Hallpike test is the definitive diagnostic test for disturbance in the vertical semicircular canals

The diagnosis of lateral canal disturbance is based on the typical finding of the horizontal positional nystagmus induced by the Pagnini-Mc Clure manoeuvre. It may be directed to the undermost ear (geotropic nystagmus) or to the uppermost ear (ageotropic nystagmus).

Geotropic nystagmus is thought to be caused by free-floating debris (canalithiasis) gravitating ampullopetally as the patient is lying on the affected side. This provokes a transient ampullopetal deviation of the cupula, resulting in transient

nystagmus directed to the affected ear. When the patient lies on their non-affected side the debris moves ampullofugally, giving rise to an ampullofugal deviation of the cupula with nystagmus directed to the non-affected side.

The other form of positional nystagmus is apogeotropic nystagmus and it is persistent. It is suggested that the debris has become attached to the cupula (cupulolithiasis), making the cupula heavy relative to the surrounding endolymph - "heavy cupula". As the patient is lying on his affected side the cupula (due to its increased weight) is continuously deviated ampullofugally and the nystagmus beats persistently to the non-affected ear. When the patient lies on his non-affected side the nystagmus beats to the affected ear.

In the diagnosis of BPPV is very important to recognize combinations of nystagmus direction and position to use exact variant of liberatory maneuver.