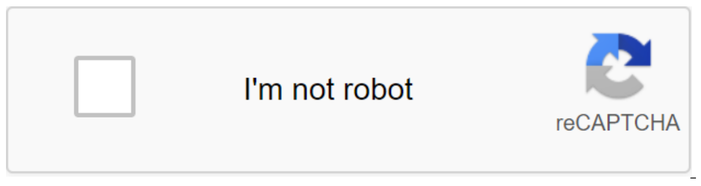
Vertigo postural paroxistico benigno fisiopatologia pdf



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Dizziness is a relatively common complaint. They may refer to conditions such as presynope or postural hypotension, imbalance and dizziness. Vertigo can also be divided into: -Vertigo related to imbalance - Patient reports that he has difficulty balancing, citing a sense of hesitation. -Vertigo rotation pattern - The individual has a feeling that revolves around objects. Benign paroxysmal positional vertigo (BPPV) is by far the most common cause of rotational vertigo, with a prevalence of between 10.7 and 64.0 cases per 100,000 inhabitants and a prevalence of 2.4%. The condition is characterized by a brief sensation of rotating vertigo, usually lasting less than one minute, which is usually caused by a change in the position of the head in relation to gravity. Dizziness usually occurs when the patient enters or leaves the bed, rolls into bed, tilts his head backwards or leans forward. Although patients with BPis sometimes report persistent dizziation and imbalance, a thorough history almost always shows that their symptoms are worse with changes in the head position. Many patients also have nausea, sometimes with vomiting. BPPV attacks usually have no known cause, although in some cases this may be due to a head injury, prolonged lying down position (e.g. in an office or hairdresser), symptoms also tend to get worse early in the day and improve significantly with rest or avoiding head movement. Although BPPV is characterized by an acute cause of dizziness, remissions and relapses are frequent; and the annual recidivism rate is about 15 per cent. Patients with BPPV have an increased risk of falls and impaired performance of daily activities. The prevalence of idiopathic BPPV increases in the elderly and among women, with peak start between 50 and 60 years with women 2 to 3 times more affected than men. BPPV has also been reported as being associated with osteopenia or osteoporosis and with reduced levels of vitamin D in serum, associations that are not explained by age or gender. The pathophysiology of the Fundamental Pathophysiological Process in BPPV involves displacing otoconia from the macula due to the dethicular otolithy that enters the semicircular channels. When the static position of the head changes in relation to gravity, the otolitic debris moves to a new position inside the semicircular channels, resulting in a false sense of rotation. BPPV usually originates from the rear semicircular channel, which is the most gravity-dependent channel; this type of BPPV accounts for 60 to 90% of all cases. However, the share of with BPPV, which affects the horizontal semicircular channel may be underestimated, since participation in this site is most likely in cases with spontaneous remission of symptoms compared to cases involving the rear channel. BPPV rarely includes the front semicircular channel channel, due to its higher position in the maze, where opolitic debris is unlikely to be trapped. The differential diagnosis of BPPV should be distinguished from the more severe causes, causes of acute or episodic dizziness. Anamnesis and neurological examinations often allow differentiation between strokes, vestibular neuritis and BPPV. The examination should include analysis of eye movements in stable nystagmus, external movements. The altered level of consciousness is associated, for example, with dizziness associated with toxic, metabolic or infectious diseases. The presence of other neurological deficits, such as hemipares, suggests a central condition as a cause of dizziness. Sensitivity can be changed in peripheral neuropathies. When assessing the eye motryability, you should take care of the presence of nystagmus and deviations of the eye. The phenomenon of ossillopsia occurs when the patient reports that objects fluctuate around him, in a constant, constant feeling, causing oscillation, and is usually associated with the presence of nystagmus. External eye mosses are evaluated in nine positions of view, with the evaluation of the subsequent look and were made in the study of paresis III, IV and VI, suggesting the participation of several cranial nerves, and changes in the balcony suggest cerebellar participation. The study of vestibulcular reflex helps in assessing vertigo, since a change in one side indicates, in the vast majority of cases, the involvement of the peripheral vestibular system in patients with isolated rotary vertigo. The study of vestibulukacular reflex is done with the patient sitting in front of the examiner. The patient is instructed to fix his gaze on the eye height of the examiner, while performing a quick rotation maneuver, for each side, up to 30 degrees, returning to the middle line at the end of each invasion. In a normal reaction, the patient keeps his gaze fixed at a oriented point from the beginning to the end of the head rotation. When this reflex changes, the patient folds the eyes together with the movement of the head, adjusts to the original position after the end of the movement, which also implies a central change. Among the central pathologies that cause dizziness, it is necessary to remember cerebrovascular accidents involving the brain stem, secondary lesions of the posterior pit, epilepsy, tumors with a point cerebellar angle and neuropathy of cranial vapors. Other causes of vertigo origin include vestibular neuritis, which usually occurs after viral conditions, dizziness is more intense on the first day of acute installation, can worsen with head movement, but this is much less obvious than in BPPV. Another important cause of vestibular vertigo is Meniere's disease, which causes excess endolymph, causing rotational dizziness, tinnitus, auditory fullness and transient hearing loss, and is treated with drugs such as acetazolamide. Evaluation in nystagmus studies, the presence of horizontal nystagmus suggests vestibular pathology, while the model with central nystagmus forcibly forces the central pathology to think. The presence of vertical nystagmus has greater accuracy for diagnosing the central cause of vertigo than computed tomography or early use of magnetic resonance imaging. Diagnosis of BPPV is likely if changes in the position of the head in relation to severity cause symptoms and cause characteristic BPPV models. The fact that most doctors are not familiar with the specific anatomical relationships of the semicircular channels of the skull can be a challenge to interpret the different models of nystagmus positioning and perform the correct maneuvers. BPPV sometimes involves multiple channels in one ear, or two-sided, making it difficult to identify nystagmus models and choose the best treatment. Typically, these cases should be referred to a specialist in addition to fire-resistant cases for treatment. Diagnosis Physical examination shows the position of nystagmus in more than 70% of patients with BPV. This conclusion is caused by specific maneuvers, depending on which channel is affected. 1- Semicircular rear channel: In patients with BPPV involving the back of the canal, nystagmus is usually induced with the Dix-Hallpike maneuver. This classic maneuver was first described by Dix and Hallpike in 1952 and aims to displace calcium particles that float in the endolimph semicircular canals. When otolitic debris circulates in the back channel, distancing from the dome, the rear channel is stimulated. The resulting nystagmus is beaten and twisted, towards the ear in the lower position (in this case, the patient's head is turned to one side). Nistagmus usually develops after a short period of delay (from 2 to 5 seconds), allows for one minute (usually within 30 seconds), and changes direction when the patient stands. With repeated tests, nystagmus decreases due to fat intensity. If otoconia is associated with the dome, the nystagmus is similar to that observed in canalolithiasis, but usually longer in duration. A positive response to where nystagmus gets in the right direction is the standard for diagnosing BPPV

involving the rear channel, which is its most common form. The manoeuvre is performed with the patient sitting at the table, and then his head rotates 45 degrees, while the expert quickly puts the patient holding his head hanging from the exam table. Approximately a quarter of symptomatic patients have virtually no nystagmus. Treating these patients can still be helpful if their symptoms correspond to the usual clinical picture. 2-Seven Round Horizontal Channel: A BPPV involving a horizontal channel is usually diagnosed with a second test, with the head bearing about 90 degrees left and right with the patient lying down. Horizontal nystagmus arises with a head turned in any direction, and in both positions it falls either towards the earth (geotropical nystagmus) or towards the ceiling (apogeotropic nystagmus). Proper BPPV treatment involving a horizontal channel requires knowledge of which ear is involved. When the nystagmus is more intense with the head facing one side than with the head facing the other side, the nystagmus beat occurs towards the affected ear. 3-Seven-round front channel: BPPV with the participation of the front channel is extremely rare, and its pathophysiology is poorly understood. Its main feature is the positional downed nystagmus with a winding nystagmus, in which the upper part of the eye pillars slams to the involved ear. Patients with this type of nigtagma should be evaluated for central lesions, although such lesions are rare. BpPV treatment is usually permitted without treatment. Prospective longitudinal study showed that the average interval between the onset of symptoms and spontaneous resolution in untreated patients was seven days when the horizontal canal was affected, and 17 days when the posterior canal was affected. However, odocoonia repositioning maneuvers can be used to treat BPPV quickly and efficiently. Medications are mainly used to relieve severe nausea or vomiting. Operations, such as posterior nerve amputation and obstruction of the canal involved, are rarely necessary and should be considered only for patients whose symptoms are intractable and disabling and who have not had a reaction to repositioning maneuvers. 1-Seven-circular rear channel: Repositioning canalites can be performed with the Epley maneuver, which was designed to remove olitic debris from the back channel and back into the lobby. The odocoonias move across the channel with each step of the manoeuvre and eventually outside to the lobby, where they can be reabsorbed. Each position must be maintained until nystagmus or induced vertigo improves, and always for at least 30 seconds. The success of the Epley maneuver is about 80% after one session and increases to 92% with repetition up to four times. Clinical trials showed that bpPV patients involving the back channel who were treated with epley maneuver, compared to patients treated with simulated maneuvers and untreated control, had significantly higher rates of improvement in symptoms, although some doctors favored the use of a vibrator side vibrator on the side of the involved parties as an alternative to the treatment. The Epley maneuver is also performed with the patient sitting at the table, the head rotates 90 degrees towards the unaffected side, lying on the table with his head hanging from the table, thereby moving the olitic debris to the lobby, then the head rotates in another 90 degrees getting completely deflected, and then the patient returns with the help of a doctor in a sitting position, so that the casts go out into the lobby. It should be recommended that patients limit the movements of the head and body after treatment. Some authors recommend that the patient stay upright for about 15 minutes after treatment and then gently start walking. The nystagmus pattern during the epley maneuver helps predict the success of the treatment. When the head is turned 90 degrees away from the face affected (after being placed in the original position of Dix-Hallpike), the positioning nystagmus appears from time to time. In patients who have nystagmus in the same sense as the original nystagmus, symptoms are resolved after one or two more uses of the Epley maneuver, while a minority of patients whose nystagmus has been moved in the opposite direction are treated. However, even in patients with nystagmus in the opposite direction, debris can be removed from the back canal with partial relief of symptoms. The Semont maneuver can also be used to treat BPPV involving the rear channel, in this maneuver the patient quickly turned at a high acceleration at a 180 degree angle from the position lying on the unaffected side to lie on the affected side, with the movement completed within 1.3 seconds. This maneuver can be used instead of the Epley maneuver in patients who have difficulty extending their neck. The maneuvers of Epley and Semont can be repeated several times until the nystagmus is triggered. Patients in need of multiple treatments may be instructed to perform maneuvers at home. In the A randomized, controlled study had a success rate of 95% with the Epley maneuver self-government and 58% with the Semont self-governing maneuver. Nausea, vomiting, and dizziness can occur during these maneuvers, and many patients have a feeling that is out of balance and transient dizziness with head movement for a few days or more, even after successful treatment. In some situations, a short episode of vertigo occurs a few minutes after the maneuver. Another possible complication of BPPV treatment maneuvers involving the rear channel, which occurs in less than 5% of cases, is the conversion to BPPV involving a horizontal channel. This condition can develop when debris comes out of the back channel and enters the horizontal channel. This complication can be treated with the same maneuvers that are used for BPPV involving a horizontal channel. (Geotropic or apogeotropic) as described below. 2-Horizontal Channel: There are two types of BPPV involving a horizontal channel, one with geotropic nystagmus and the other with apogeotropic nystagmus. First, with a head rotation sequence of 90 degrees, first to the affected ear and then to the affected ear. With this maneuver, the debris will eventually leave the horizontal canal lobby. Another type of treatment is the so-called long-term Vanunki maneuver, in which the patient remains on the side of the affected ear for about 12 hours. This treatment is performed exclusively in patients with severe symptoms that worsen with successive changes in position and for those who do not have a clear ear effect. If lying on one side for a long period is ineffective, the patient may try to lie on the other side for 12 hours. An alternative treatment is the Gufoni maneuver, in which the patient quickly falls on the side of the affected ear and stays in this position for 1 to 2 minutes until the nystagmus improves. The head then turns 45 degrees to the ground and is held in this position for another 2 minutes, after which the patient returns to an upright position. BPPV involving a horizontal channel with apogeotropic nystag is attributed to oolitic debris attached to a dome or floating in an endolymph in front of a horizontal semicircular channel next to the dome. Processing includes manoeuvres designed to highlight the oolitic fragments of the dome or to move debris from the front of the horizontal channel to the back hand. Possible pharmacological strategies for this type of BPPV include repeatedly shaking your head in a horizontal plane for 15 seconds and modified versions of the Semont maneuver and gufoni maneuver. Pharmacological treatment with low doses of clonazepam may help improve symptoms all как forms де VPPB, other symptomatic agents that can be used and include dimenhydrarate and бета-гистидина. Референсьяс 1-Ким JS и др. Доброкачественные Пароксизмальные Позиционные Vertigo. New England J Med 2014; 370: 148. 2- Бхаттачарья N, Бо РФ, Орвидас L, и др. Руководящие принципы клинической практики: доброкачественное пароксизмальное позиционное головокружение. Otolaryngol Голова шеи Surg 2008;139:Suppl 4:s47-S81. 3- Балох RW. Эпизодическое головокружение: причины центральной нервной системы. Curr Opin Neurol, 2002; 15(1): 5-10. 5-10. vertigo postural paroxistico benigno fisiopatologia pdf