Meniere's Disease

Latest Clinical Practice Guidelines

Meniere's is thought to be caused by pressure changes in the fluid within the inner ear. It is characterised by sudden, unpredictable attacks of vertigo, which can last for minutes or several hours at a time. It is usually also associated with some degree of hearing loss, and often accompanied by tinnitus and a feeling of fullness in the ear.

There is currently no known cure for Meneire's. Treatment aims to reduce the severity of symptoms and support sufferers in managing their condition.

New guidelines for diagnosis and management of Meniere's have been published in *Otolaryngology – Head and Neck Surgery,* April 2020*.The article sets out 16 key statements with recommendations based on the strength of the current evidence available.

I have summarised some of the key statements in this document. If you wish to read the full article, click on the link in the footer. The statements are accompanied by the following terms:

Strong Recommendation: evidence for the recommended action is of high quality, and the benefits far exceed any possible harms. Clinicians should follow this advice as standard.

Recommendation: The quality of evidence is good overall and the benefits outweigh the risks. Clinicians should follow this advice but be aware of new evidence as it emerges.

Option: Either there is poor quality of evidence to support this approach, or there is high quality evidence that shows little advantage to this approach over another. Decisions should be made on an individual basis with patient preference taken into account.

Diagnosis of Meniere's Disease

Recommendation: 'Clinicians should diagnose definite or probable Meniere's disease in patients presenting with 2 or more episodes of vertigo lasting 20 minutes to 12 hours (definite) or up to 24 hours (probable) AND fluctuating hearing loss, tinnitus, or pressure in the affected ear, when these symptoms are not better accounted for by another disorder.' *

*Reference: https://journals.sagepub.com/doi/pdf/10.1177/0194599820909439

There are many traits of Meniere's disease that are similar to *Vestibular Migraine.* It is **recommended** that clinicians determine if the patient meets the diagnostic criteria for vestibular migraine as an alternative or accompanying diagnosis.

It is **strongly recommended** that all patients receive an audiogram in order to diagnose Meniere's. MRI of the inner ear is an **option**. The guidelines **recommend against** routine vestibular function testing for Meniere's diagnosis.

Management of Acute Episodes

This refers to management during and shortly after an acute attack of vertigo. A short course of vestibular suppressants is **recommended**. Vestibular rehabilitation is **not recommended** during acute episodes or while patients are experiencing frequent acute attacks.

Longer-Term Management

Education regarding dietary and lifestyle modifications that may reduce or prevent symptoms is **recommended**. This is very similar to migraine advice – see advice leaflets on my website: https://mobilejointsphysiotherapy.com/

Vestibular rehabilitation is recommended if chronic dizziness or imbalance persists between acute episodes. Longer term use of diuretics or Betahistine is an **option** for these patients.

Referral to an audiologist for help with hearing loss is **recommended**.

The article also goes into some detail regarding evidence and recommendations around more invasive procedures:

- **Surgical labyrinthectomy,**
- **Intratympanic Gentamicin,**
- **Intratympanic steroid injections**.

These can all have significant side effects and the balance of benefit over harm needs to be discussed on an individual basis with a specialist ENT consultant. For more information, read statements 11, 12, and 13 of the full article.

*Reference: https://journals.sagepub.com/doi/pdf/10.1177/0194599820909439