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Clinical Practice Guideline for Ménière Disease (2020)

About the Guideline

- The guideline was created over an 18-month period and funded by the American Academy of Otolaryngology—Head and Neck Surgery (AAO-HNS). A total of 27 randomized control trials were reviewed by 21 experts in the fields of emergency and family medicine, otolaryngology, otology and neurotology, otolaryngic allergy, neuroradiology, neurology, audiology, advanced practice nursing, and consumer advocacy.
- The purpose of the guideline is to enhance clinical care by reducing misdiagnosis and improving the management of Ménière disease (MD) through more accurate diagnostic methods and better quality symptom control, resulting in better patient outcomes.
- The guideline should not be considered a replacement for professional assessment and should instead be used as a guide to enhance diagnostic accuracy, limiting variations in testing and/or imaging. Consideration of a patient's individual needs and resources should assist in determining the course of treatment.

Key Clinical Considerations

Become familiar with the recommendations and best-practice statements provided in this guideline especially if you work in an acute care or an ambulatory care setting.

Categories and Diagnosis

Categories of Ménière Disease

- Definite MD
    - Sudden onset of vertigo, defined as normal head movement but with the sensation of rotary spinning or rotation or spinning, lasting 20 minutes to 12 hours in two or more episodes.
    - Hearing loss in the involved ear that is documented audiometrically either before, during, or after an episode of vertigo.
    - Fluctuating hearing loss, or fullness or ringing in the ear, known as an aural symptom, in the ear involved.
    - Diagnostics that rule out other causes.
- Probable MD
    - Vertigo or dizziness lasting 20 minutes to 24 hours for a minimum of two episodes.
    - Fluctuating hearing loss, fullness or ringing in the ear, known as an aural symptom in the involved ear.
    - Diagnostics that rule out other causes.
- Episodes can occur as often as 6 to 11 times per year and then not occur again for months or even years. Therefore, the clinical diagnosis of MD may take multiple visits after numerous episodes of symptoms, which usually occur in one ear.

Diagnosis of Ménière Disease

- MD should be diagnosed as either definite MD or probable MD after ruling out other causes.
    - A history and physical should be conducted, with a description of the patient's presentation reflecting actual vertigo.
    - Passing out and loss of consciousness are never symptoms of MD.

Vestibular Migraine

- Because vestibular migraine (VM) may mimic MD, it is necessary to determine whether the patient meets the diagnostic criteria for VM.
- Accurate diagnosis of VM can lead to the appropriate early treatment and better outcomes. However, misdiagnosis of VM as MD can lead to unwarranted and costly diagnostic testing and treatment.
    - VM and MD can occur at the same time and are more common in younger females.

Audiometric Testing

- Audiogram testing is strongly recommended for the diagnosis of MD.
    - Hearing loss is what differentiates definite MD from probable MD.

Utility of Imaging

- Patients who present with MD and asymmetric sensorineural hearing loss confirmed by audiogram should be offered a scan of the internal auditory canal and posterior fossa using magnetic resonance imaging (MRI).
    - The MRI can assist with ruling out retrocochlear or inner-ear lesions in patients presenting with hearing loss, unilateral or bilateral, with or without vertigo.

Vestibular or Electrophysiologic Testing

- Diagnosing MD with routine vestibular function testing or electrocochleography (ECochG) is not recommended.

Patient Education

- Patient education on the course of MD, therapy options, management, and expected outcomes is recommended.

Management and Treatment

Symptomatic Management of Vertigo

- For patients with MD, it is only during an acute episode of vertigo that a limited course of treatment with vestibular suppressants is recommended.
    - The recommended vestibular suppressants are first-generation antihistamines, anticholinergics, and benzodiazepines.

Symptom Reduction and Prevention

- Provide patient education on adjustments to diet and lifestyle modifications to reduce or prevent symptoms of MD.
    - Some causes of MD can be related to allergies, stress, or the consumption of too much salt and caffeine, all of which can be modified.

Oral Pharmacotherapy for Maintenance

- Diuretics and/or betahistine are options that can be offered as an ongoing treatment to decrease or prevent MD symptoms.
    - This maintenance therapy is not intended to eliminate symptoms during an acute episode of MD. It is instead intended for those patients with chronic, ongoing MD symptoms.

Positive Pressure Therapy

- Positive pressure therapy for MD is not recommended.
    - Positive pressure devices, which operate with small pressure pulses via an earpiece placed in the external ear canal, should be avoided.

Intratympanic (IT) Steroid Therapy

- When noninvasive therapy is unsuccessful, IT steroids can be offered to patients by a provider who is experienced in this treatment.
    - MethylPREDNISolone and dexamethasone are the more frequently used steroids for this treatment, and both have minimal side effects and complications.

Intratympanic Gentamicin Therapy

- When noninvasive therapy is unsuccessful, IT gentamicin is recommended for patients if it is administered by a provider who is experienced in this treatment.

Surgical Ablative Therapy

- When patients with active MD have nonfunctioning hearing and have failed other less invasive therapy, a labyrinthectomy performed by a qualified provider is recommended.

Vestibular Therapy for Chronic Imbalance

- For patients with MD and chronic imbalance who suffer from interictal unsteadiness following ablative therapy either with medication or labyrinthectomy, vestibular physiotherapy is recommended.

Vestibular Therapy for Acute Vertigo

- Vestibular physiotherapy is not recommended for managing episodes of acute vertigo in patients with MD since the benefits are unproven.

Counseling for Amplification and Hearing Assistive Technology

- Providers should offer guidance on the use of hearing aids and amplification devices for those patients with MD and hearing loss.
    - Possible use of hearing aid devices requires a shared decision-making process, which in turn gives feedback to providers on the benefits of such technology in improving quality of life.

Patient Outcomes

- Following treatment providers should document outcomes, such as when hearing loss, vertigo and ringing of the ear ends, gets better, or becomes worse, and how it affects the patient's quality of life.
    - Documenting outcomes assists in the management of the patient with MD or other similar etiologies, and it helps determine the effectiveness or ineffectiveness of such therapies.

Reference

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