Falling sensation after the Epley maneuver

Dear Editor:

We read with great interest the well-written article by Alev Uneri, MD, entitled "Falling sensation in patients who undergo the Epley maneuver: A retrospective study" (Ear, Nose & Throat Journal, February 2005, pp. 82-85). A falling sensation after an Epley maneuver is indeed an interesting clinical sign that has not been sufficiently discussed in the literature, and its clinical significance has not been thoroughly evaluated. We would like to highlight a few points we feel are interesting.

We agree that the falling sensation occurs in a certain number of patients and, according to our data, at a rate similar to that cited in Dr. Uneri's article. Like the author, we hold the patient firmly after every Epley maneuver we perform for about 30 seconds, supporting the patient's body from the back. We also agree with Dr. Uneri's instructions to advise patients to remain in the clinic for about 30 minutes following an Epley maneuver and to leave the clinic accompanied by a relative or friend.

We would like to stress that the falling sensation in these cases is quite different from drop attacks. Drop attacks occur with no warning, and vertigo is seldom present, although slower sensations involving apparent tilts of the patient's surroundings may occur.[1] In contrast, a feeling/sense of vertigo is quite common in patients who undergo the Epley maneuver.

We would also like to emphasize that there are two different clinical entities that may occur with dizziness after an Epley maneuver: (1) some patients experience a sense of vertigo at the end of the maneuver, and (2) some report a subjective sensation of lightheadedness or a brief period of imbalance after the resolution of their vertigo during the first 24 hours after treatment.[2]

Although the author's explanation for the falling sensation seems realistic, an alternative explanation could be that the Epley maneuver was not performed properly for a number of reasons attributable either to the patient or the physician. In such cases, it is possible that a number of particles could reverse to the posterior semicircular canal and induce a falling sensation.

References

1. Brandt T. Neurological causes of balance disorders. In: Luxon L, Furman JM, Martini A, Stephens D, eds. Audiological Medicine: Clinical Aspects of Hearing and Balance. London: Martin Dunitz, 2003:819-29.
2. Beynon GJ. A review of management of benign paroxysmal positional vertigo by exercise therapy and by repositioning manoeuvres. Br J Audiol 1997;31:11-26.

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Response:

I thank Drs. Korres, Papouliakos, Balatsouras, and Ferekidis for their comments on my article and would like to respond to some of their points.

First, a mechanism that is theoretically responsible for both the falling sensation and drop attacks is discussed in the article, but this was not meant to imply that these two entities are identical.

Also, it is well known that dizziness and lightheadedness continue for 24 hours after the Epley maneuver. I think that this is because of the stimulation of sensory cells of the utricle by the otoconial bolus.

I disagree with their final point. According to our clinical experience, patients who experience a falling sensation after undergoing the Epley maneuver have the best response to the particle repositioning maneuver. If, as Dr. Korres et al hypothesize, particles reverse to the posterior semicircular canal, we would detect benign positional nystagmus during the day-2 or day-7 control Dix-Hallpike maneuver. We have not detected this phenomenon in any of our patients.

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