Benign paroxysmal positional vertigo adalah pdf free printable template

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PRESENTASI KASUS BANGSAL

VERTIGO

Oleh : [illegible]

A. Pendahuluan

[illegible]

B. Definisi

[illegible]

VERTIGO SENTRAL

[illegible]

Epidemiologi

[illegible]

BAHASAN TERKAIT Pada PASIEN YANG
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[illegible]

Fact Sheet:

Vertigo (BPPV)

What is vertigo?

BPPV, also known as paroxysmal positional vertigo, is a spinning sensation of the head (vertigo) brought on by a certain position of the head, usually sudden changes of position.

The word "benign" means it is not a serious condition and is likely to get better with treatment.

Causes

The most common cause of vertigo is called *benign positional paroxysmal vertigo* or BPPV. BPPV happens when tiny particles in the balance centre of the inner ear are disturbed, caused usually by sudden movement. This causes the spinning sensation. It is a common problem that can affect people of all ages.

Activities that bring on a dizzy spell can vary. They often involve moving your head into a certain position suddenly, such as:

- Looking up
- Lying on one ear
- Rolling over in bed
- Getting out of bed
- Bending over

There are other causes of vertigo, including head injuries, stroke, circulation problems, infections, inner ear disorders, and the degeneration of inner ear structures.

Symptoms

- Dizziness – this begins seconds after a certain head movement and lasts less than a minute.
- Feeling light-headed
- Impaired balance
- Nausea – These symptoms usually get better once you are in a different position.

Pain, ringing in the ears (*tinnitus*) or deafness is not common.

Please Note: If you have more serious symptoms – speech difficulty, double vision, unsteady walking, difficulty swallowing, altered strength or feeling in your legs or arms, ringing in your ears or deafness – you should seek medical help.

Treatment/ Advice

Treatment of BPPV can include:

- Physiotherapy exercises – Brandt-Daroff exercises as per the next page. [*See over the page*].
- Medication – motion sickness medication can sometimes help with nausea. It will not prevent vertigo attacks.
- Avoid head positions that provoke an attack.
- Avoid sleeping on the affected or "bad" side.
- Elevate (raise) your head on two pillows when resting.
- In the morning get up slowly and sit on the edge of the bed for a minute.
- Take prescribed medications as directed.
- Do not drive until your symptoms have completely resolved.

What to expect

The attacks usually come in bursts. If the exercises are done regularly, the symptoms should settle over the next 10 days, although it can take longer. Most people return to work or normal activities within a week. About one in three people will have a new attack within a year. While these attacks can cause discomfort there is usually no long-term damage.

2016, 26: 409-415. Subjective BPPV BPPV Subjective It is the sensation of vé © rtigo during provocative maneuvers without nystagmus. â † ‘5.0 5.1 von Brevern M et al. Vestibular paroxysm: diagnostic criteria. They differ with respect to how debris influence cell dynamics: chanalithiasis â € "proposes that free float particles, Otoconia, have moved from the utrrigo and are revived near the scan of the affected SCC. â † ‘Staab JP et al. â † ‘Lempert T, Tiel-Wilck K. The diagnosis can be performed on the basis of arterial pressure measurements while the patient is supine and standing [2] [8]. Neurophysiology clovenics 2019, 4: 97-111. Gravity throws the Otoconia through the Endolymph channel, creating an effect similar to the world that causes ipididsectional vascular displacements [2] [3]. Audiol Neurotol 2014, 19 (5): 336-341. Nystagmus must be observed during a maneuver that causes as described below to confirm BPPV [5]. â † ‘2.00 2.01 2.02 2.03 2.04 2.05 2.07 2.08 2.09 2.10 2.11 2.13 2.14 2.15 Bhattacharyya N et al. Practice neurol. Aã ± adir collaborating editors: AÃ ± adir vé © positionalosalosalososos paroxysmal The bed, lying and sitting with a supine position) [1]. â † ‘Popkirov S et al. 2018, 18 (1): 5-13. Vulibular neuritis or labyrintitis â € “generally preceded by a viral produce, and the v © rtigo has a gradual beginning, followed by a sustained level of life -new levels. Nystagmus observation during a provocative maneuver helps determine the diagnosis of VPP in patients with typical history and can identify the affected specificity and the affected specific channel [1]. â † ‘8.0 8.1 8.2 8.3 ARGAET EC, et al. A positive response to carbamazepine or oxcarbazepine treatment is the Current treatment options in neurology 2000, 2: 417-427. References â † ‘1.0 1.1 1.2 1.3 1.4 1.5 1.6 SOLOMAN D. â †’ 3.0 3.0 3.2 3.3 3.4 You P et al. Persistent postural-perceptual dizziness (PPPD) ¢ÂÂÂ one or more symptoms of dizziness, unsteadiness or non-spinning vertigo on most days for at least 3 months, last for hours at a time, and usually wax and wane in intensity. Findings of down beating nystagmus on the Dix-Hallpike maneuver or direction-changing nystagmus occurring without changes in head position suggests a neurologic/central cause of vertigo and not peripheral, such as BPPV[2]. Audiol Neurotol 2011, 16:175-184. Apogeotropic ¢ÂÂÂ elicits horizontal nystagmus that beats toward the uppermost ear. Migrainous vertigo presenting as episodic positional vertigo. Compared to posterior semicircular BPPV, horizontal semicircular BPPV may have no latency, responses do not fatigue and the duration may be greater than 60 seconds[1][6]. Patients typically have no hearing loss or other neurologic complaints. BPPV may trigger or coexist with PPPD, but BPPV has distinct bouts of vestibular symptoms and nystagmus associated with positional changes, while PPPD is not associated with head motion-provoked vertigo, and has chronic waxing and waning dizziness, unsteadiness and non-spinning vertigo[11][12]. The 2 types of lateral semicircular canal BPPV have different nystagmus findings: Geotropic ¢ÂÂÂ elicits horizontal nystagmus that beats toward the earth when the patient head is rolled to the pathologic side. Vestibular paroxysmia ¢ÂÂÂ recurrent, spontaneous attacks of vertigo lasting seconds to minutes due to vascular compression of the vestibular nerve. Neurology 2004, 62(3):469-72. A Positional Maneuver for Treatment of Horizontal-Canal Benign Positional Vertigo. However, recurrence of BPPV episodes are common in the next one to five years. Benign Proxysmal Positional Vertigo. Patients with BPPV due to vestibular neuronitis and trauma may have a prolonged course than those with idiopathic BPPV. Prognosis BPPV has an overall favorable prognosis Recovery because untreated BPPV episodes are usually resolved spontaneously [2] [13]. After repeated tests, nistagmus is probably fatigue, although it is not recommended to repeat the manoeuvre several times due to patient discomfort [1] [2] [4]. When the head of the patient rolls to the other side, it again causes a horizontal nistagmus that hits the upper ear, but the direction of the nistagmo has changed [2]. † ‘Casani AP, et al. Persistent posturel-perceptual dizziness (PPP): a common, characteristic and treatable cause of chronic dizziness. Vertigo is present at rest and does not necessarily require positional changes for its beginning; vertigo may also be accompanied by sustained and severe levels of nausea,

vomiting, sweating and paleness [2]. Diagnosis and management of benign paroxytic (BPPV) positional vertigo. Horizontal/lateral Semicircular Channel BPPV The horizontal or lateral semicircular channel BPPV should be considered when the patient has a BPPV compatible history and the DIX-Hallpike test causes horizontal or no nistagm. Cupulolitiasis, proposes that the otoconial remains join the affected SCC dome instead of floating freely in the endolinfa. The subsequent BPPV channel commonly uses the Epley and Semont manoeuvres [1], and the Epley manoeuvre can be more effective than the Semont manoeuvre [13]. Laryngoscope Investigative Otolaryngology 2019, 4 (1): 116-123. Horizontal Semicircular Channel Benign benign positional vertex: effectiveness of two different treatment methods. The roles of the ophthalmologist are to ensure that there are no ophthalmological signs of central vestibulopathy (rather than peripheral) (e.g., purely rotative or purely vertical nistagmus (optimist or break)); to look for other findings of the eye motor (e.g. ophthalmoplegia, biased deviation) or papiledema that may suggest etiologiesinstead of peripheral for vestibule symptoms; and recognize the distinctiveof visual environmental hypersensitivity triggers the persistent persistent disorder of perceptual position (PPPD) that sometimes follows BPPV. When the patient's head is wrapped to the healthy side, he again causes horizontal nystagmus hitting the earth (the lowest ear), but the direction of the Nystagmus has changed [2]. The latency of the beginning between the beginning of Dix-Hallpike and the beginning of the life or nystagmus can vary between 2-20 seconds, and the intensity of the nystagm . The nystagmus can reverse directions when the patient is returned to vertical position. The alterations resulting from cell deflexion lead to pathological perceptions of movement [2] [3]. Benign positional, diagnostic, treatment and mimics. Positional triggers are different from BPPV and you don't see a crescendo-decrescendo patron of Nystagmus. Diagnostic Meniere's disease - characterized by spontaneous life of minutes. â † ‘Steddin S et al. Horizontal channel Benign Paroxysmal Positioning vé © rtigo (H-BPPV): transiction of canalolithiasis to the cystic. â † ‘Parnes Ls et al. The vulibular migraine â € “In contrast to the VPPB, the episodes tend to be of less duration with frequent recurrences, and a migraine headache generally accompanies or follows the v © rtigo spell [5] [10] . Patients with horizontal channel BPPV have a higher recurrence rate [2]. The central positional life can occur with cerebellum injuries. CMAJ 2003, 169 (7): 681-693. Benign Postiteional Paroxysmal Vertigo. A multi -curmenter study of random dual -blind: comparison of the maneuvers of the PãºrpuraSemont and Sham for the treatment of the Benign position of the posterior channel. Other postural hypotension/orthosis â € "may occur as epissed or dizziness, but symptoms only occur when they arise from a lying or sitting and not due to changes in the head position relative toWhile the vertigo typically does not present ophthalmologists, the symptoms of the sensation of movement (i.e. oscilopy,) blurred vision and the presence of nistagmus make it important for ophthalmologists to have some understanding of the vertigo, including bppv. Unlike bppv, the vertigo in this syndrome is induced by pressure changes, not positional changes in relation to gravity [2.] recurrent episodes of vertigo may be accompanied by naoa and vomiting and may be used periodically for weeks or months. 2015, 25 (3-4): 105-17. horizontal bppv can be evaluated using the supine roll test (also called Pagnini-McClure manoeuvre) [2] [3.] the lack of a torsional component to the nistagmo central positional nistagmo of that with the previous channel bppv [2] [8]. this can be due to the subclinical nistagm, an active or bppv feeling less severe. bppv management can usually be treated using particle repositioning manoeuvres. These vertigo spells may be associated with naoa and vomiting, but patients do not complain of hearing loss or other neurological symptoms. summarized ophthalmologists must be aware of bppv. the later scc is most commonly affected [1.] benign paroxysm positional vertigo: diagnostic criteria. clinical presentation patients with bppv present recurrent episodes of vertigo that last less than 1 minute and are caused by changes in the movements of the head in relation to gravity [4.] â † ‘13.0 13.1 lee jd et al. ppnytagmo presents subsequent bppv se aicneucerf aicneucerf ajab ,sutinnit neyulcni setnautculf sovitidua samotnÃs sol ,VPPB ed aicnerefid A .atn©ÃB dadeicoS al ed seralubitsev sonrotsart sol ed n³ÃicacifisalC al arap ©ÃtimoC led osnesnoc ed otnemucoD .otneimivom .lanoicisop otneimivom noc ogitr©Âv ed n³Ãicasnes al asuac otnat ol rop y ,n³Ãicisop al ne soibmac noc odaiporpani hpmylodne otneimivom nu nacovorp CCS le ne sorbmocse soL .la te M nreverB nov â .802-191:)4(72 ,7102 .la te M ppurtS â .]3[]2[VPPB ed n³Ãicca ed omsinacem le arap saÃroet sod netsixE ygoloisyhpotaP .sonretxe sovitidua selanac sol ed n³Ãiserp ed soibmac o avlaslaV ed sarboinam ,setreuf sodinos ed etnanedacnesed nu ed s©Ãupsed)etnaleda aicah y s¡Ãrta aicah odnaedno n¡Ãtse sotejbo sol euq ed n³Ãicasnes al(aispolicso y ogitr©Âv ed seuqata â roirepus lanac led n³Ãicatardihsed ed emordnÃS .oirotisnart omgatsin nu eneit euq VPPB le noc etsartnoc ne ,avitacovorp n³Ãicisop al sartneim etsisrep y ocit¡Ãtse se sumgatsyn lE .229-819:04 ,6991 lorueN nnA .]51[]41[inofuG sarboinam y trepmeL ollor le azilitu VPPB latnoziroh lanac lE .DPPP led acitsÃretcarac acitsÃretcarac anu se)ocif¡Ãrt le odnarim ,olpmeje rop(seliv³Ãm o sojelpmoc solumÃtse sol rarim ed lausiv dadilibisnesrepih aL .lamsixorap ongineb lanoicisop ogitr©Âv led n³Ãitseg y ocits³Ângaid ed soiretirc ,n³ÃicacifisalC .874-674:)4(601 ,6991 epocsognyraL .la te T iamI 1.4 0.4 â .ralugna azebac al ed sen³Ãicareleca natceted etnemlamron euq ,)CCS(seralucricimes selanac sol ed ortned oiclac ed sorbmocse sol a etnemnºÃmoc eyubirta es VPPB .odatcefa odÃo le aicah °Â54 adarig azebac al noc anipus al a lacitrev n³Ãicisop al ed odavell se etneicap le euq al ne arboinam al etnarud lanoisrot-roirepus omgatsin nu a ecudnoc laretalispi roirefni laretalartnoc y oucilbo roirepus otcer led n³Ãicavitca aL .lausiv etnairav ogitr©Âv omoc econoc es n©Âibmat otsE .)etadpU(lamsyxoraP ongineB loicisoP ogitreV :acinÂlc acitc¡Ârp ed zirtceriD .74S-1S:)lppus_3(651 ,7102 yregruS kceN dna daeH â ygolognyralotO .seR bitseV J .]8[]2[setneserp n¡Ãtse dutinelp al y adidr©Âp aL

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