A clinical audit on the management of Benign Paroxysmal Positional Vertigo (BPPV) by a General Outpatient Clinic (GOPC) doctor

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Introduction
BPPV is a common problem encountered in GOPCs but the management provided is usually sub-optimal.

Objectives
By performing a clinical audit on himself, the author hope that his management for BPPV can be improved to reach international standards and will become non-inferior to ENT specialists

Methodology
Ten criteria and standards on the management of BPPV patients were set according to the American Academy of Otolaryngology Head and Neck Surgery (AAO-HNS) guidelines published in 2008 as well as the latest literature. 1) The medical records documented the presence of the characteristic positional vertigo of BPPV. 2) Dix hallpike test should be performed bilaterally for patients presenting with typical BPPV symptoms. 3) If the patient had a history compatible with BPPV and the Dix-Hallpike test is negative, a supine roll test should be performed to assess for horizontal semicircular canal (SC) BPPV. 4) The medical records should document factors that modify management including impaired mobility or balance, CNS disorders, a lack of home support, and increased risk of falling. 5) Patients with posterior SC BPPV should be treated with either Epley manoeuvre or Semont liberatory manoeuvre, while patients with horizontal SC BPPV should be treated with Barbecue roll manoeuvre. 6) Vestibular suppressant medications should not be prescribed routinely to treat patients with BPPV. 7) Patients received PRMs and patients with suspected BPPV should be reassessed either by telephone follow-up or clinic visit within 1 month to confirm symptom resolution. 8) Patients with persistent objective BPPV or unresolved vertigo/dizziness after PRM should be referred to an ENT specialist for further
management. 9) The patients should be counselled on the potential for disease recurrence and the importance of follow-up. 10) The patients should experience complete symptom relieve after receiving proper types of PRMs for their specific subtypes of BPPV. All patients encountered by the author with a diagnosis of BPPV or suspected BPPV were included in the first (n=54) and second cycle (n=43) respectively. The first cycle was performed retrospectively and had lasted for 12 months (Jan to Dec 2010), while the second cycle was performed prospectively for 9 months (Mar to Dec 2011).

**Result**
The main objectives of the clinical audit had fulfilled. In the second cycle, 91.2% of BPPV patients were cured by the specific particle repositioning manoeuvres (PRMs) performed by the author.