



SOT Cranial and TMJ therapy for unresolved BPPV: A case report.

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Purpose and Background

Vertigo, also called dizziness, accounts for about 6 million clinic visits in the U.S. every year, and 17–42% of these patients eventually are diagnosed with benign paroxysmal positional vertigo (BPPV). Two-treatments have been found helpful for BPPV: the canalith repositioning procedure (CRP) or Epley maneuver, and the liberatory or Semont maneuver¹. The following is a case study that discusses another possible treatment for BPPV.

A 37-year-old female with acute benign vertigo was referred to this office by her allopathic physician to determine the need for interdisciplinary care. The patient had 2-3 months of constant vertigo, diagnosed as BPPV. She had been treated with the Epley Maneuver and various medications, but her symptoms were unresponsive. Her vertigo would last the whole day, with peaks and valleys related to intensity. This affected her ability to function at home, drive her car and even walk “out of the door” of her home.

Methods

Patient presented with a sacro occipital technique category two (sacroiliac joint hypermobility syndrome)², right temporal bone with external rotation, and significant malocclusion with clenching and anterior interferences. Her malocclusion was affected by the stress of the anterior interferences, particularly on the right side, and the repetitive stress on occlusion appeared to create right temporomandibular (TMJ) stress summing at the right temporal fossa. It was theorized this possibly contributed to the patient’s vertigo presentation³.

Category two protocols for the pelvis were applied² and an intraoral cranial adjustment to the temporal bone, maxilla, sphenoid, and zygoma were performed⁴. Reduction of palpatory pain in and around the TMJ along with joint translation was used to help guide treatment. Cotreatment with a dentist was used to help stabilize and maintain the chiropractic cranial and TMJ corrections.

Results

By the 7th-office visit (3-4 weeks of care) the patient’s vertigo had resolved. In addition her TMJ translation and opening had improved significantly with right TMJ and related tissue pain eliminated. The anterior interferences were treated with a nighttime dental appliance that allowed the patient to have bilateral posterior teeth contact and reduced contact to the front teeth.

Discussion

Occlusion and condylar position is purported to be affected by or affect cranial bone distortion patterns⁵. When there is malocclusion affecting the cranial suture and local periosteal tissue, it is theorized that with some patients -- possibly the internal periosteal dura, CSF circulation, and related cortical region might be affected⁶⁻⁸.

On the other hand relieving the stressors of restricted cranial motion and malocclusion could lead to improved function just by reducing global stress to the CNS due to reduced pain and related myofascial tension⁵.

Conclusion

In this case report the patient’s response to care was quite dramatic. She was unresponsive to prior care and her quality of life was profoundly affected. It is difficult to extrapolate from this one case and apply this to the general population however the patient’s rapid response to care suggests that further investigation into this method of care for patients presenting with vertigo be considered.

References

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