

Vertigo—Antihomotoxicological Treatment Possibilities

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Summary:

Vertigo encompasses equilibrium disorders caused by the lack of coordination between vestibular and somatosensory sensations on the one hand and optic sensations on the other. This article describes the different forms of vertigo and presents therapeutic possibilities, in particular antihomotoxicological approaches.

Introduction

Vertigo is a condition frequently encountered in the doctor's office, especially among older patients.

The first step in the diagnostic clarification of vertigo as a symptom is to distinguish between systematic vertigo (specific, vestibular vertigo) and unsystematic vertigo (nonspecific, nonvestibular vertigo).

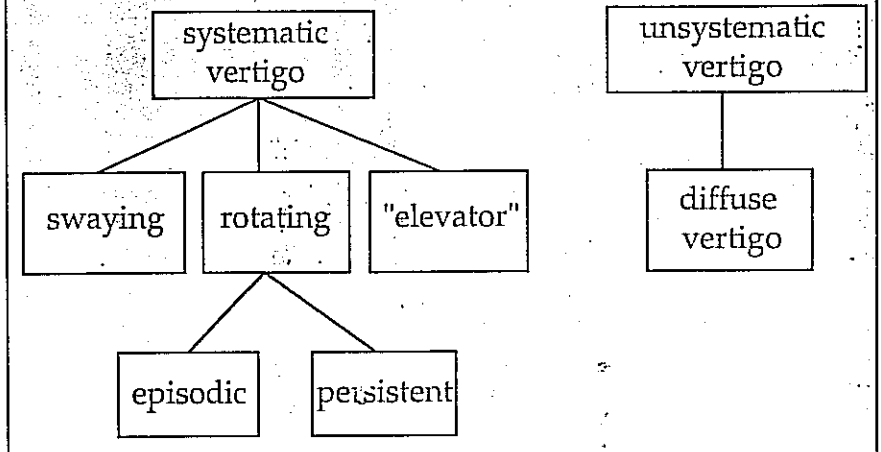
Systematic Vertigo

In cases of systematic vertigo, the lesion can be located in either the peripheral or the central portion of the vestibular apparatus. We must distinguish between these two types of cases by asking the patient whether the vertigo is acute or recurrent and by inquiring about accompanying symptoms that point the way for further investigation:

- * tinnitus: labyrinthine disease
- * cerebellar and trigeminal symptoms: tumor of the cerebellopontine angle
- * nystagmus, psychomotor seizures: temporal lobe involvement

In most cases, what underlies the vertigo is a degenerative (i.e. arteriosclerotic) constriction of the vessels supplying the brain. Classical syndromes of this sort are vertebrobasilar insufficiency and basilar migraine.

Figure 1: Pathophysiological view of clinical vertigo



The major causes of the peripheral, labyrinthine form of vertigo are degenerative and inflammatory diseases of the labyrinth or of the vestibular nerve. Table 1 lists typical syndromes.

Table 1: The spectrum of causes of systematic, central vestibular and peripheral, labyrinthine vertigo

Central vestibular

- * vertebrobasilar insufficiency
- * basilar migraine
- * multiple sclerosis
- * acoustic neurilemmoma
- * Parkinson's disease
- * lesion in the pons or medulla of the brain stem (dysplasia, tumor, inflammation)

Peripheral labyrinthine

- * Menière's syndrome
- * herpes zoster oticus
- * vestibular neuritis
- * benign paroxysmal positional vertigo

Menière's syndrome, with its symptoms of tinnitus, a feeling of pressure in the ear (endolymphatic hydrops), episodic vertigo, and nausea or vomiting, requires prompt treatment.

As a general rule, neurological and otolaryngological consultations should be arranged for patients with systematic vertigo.

While systematic vertigo can be described as a feeling of swaying, rotating, or "being in an elevator," patients with nonsystematic vertigo complain of "diffuse vertigo," feelings of insecurity, being in a daze, or feeling drunk.

Nonsystematic Vertigo

In nonsystematic vertigo, we are dealing with a broad spectrum of sensations that are not vestibular in origin, but are due to underlying cardiovascular or metabolic disorders, or to ocular, psychosomatic, neural, vertebral, or medication-induced causes. Patients describe symptoms such as feeling dazed or empty-headed, visual disturbances (seeing blackness or flickering lights), nausea, weakness in the legs, irregular heartbeat, and a tendency to collapse without losing consciousness.

When the causes are cardiovascular, these symptoms are ultimately based on inadequate cerebral blood circulation and subsequent hypoxic metabolic disturbances of the central nervous system.

Vertigo can also accompany diabetes (hypoglycemia), diabetic neuropathy, anemic and polycythemic syndromes, endocrine disorders such as hypo- and hyperthyroidism, Addison's disease, primary aldosteronism, pheochromocytoma, and disturbances in electrolyte balance.

In addition to the endocrinopathies that have already been mentioned, visual and somatosensory causes may also come into question in older patients. In particular, endogenous depression should also be mentioned here.

The possibility of medication-induced episodes of vertigo should also be investigated. The pharmaceuticals in question are listed in Table 3.

Diagnosis by the Family Practice Specialist

Paragraph 12, Section V of the German Social Security Code mandates that diagnosis and therapy be adequate, effective, and economical and not exceed standards of what is necessary. Within these guidelines, vertigo can be specifically diagnosed according to the following principles:

<p>Table 2: Cardiovascular, endocrine, visual, somatosensory, and other causes of diffuse vertigo</p> <p>Cardiovascular</p> <ul style="list-style-type: none"> * hypotonia (vasomotor instability) * hypertonia * valvular heart disease (aortic sclerosis, mitral stenosis) * coronary heart disease * arrhythmias (carotid sinus syndrome, sick sinus syndrome, tachycardia, bradycardia) <p>Endocrine</p> <ul style="list-style-type: none"> * diabetes mellitus * hypertonic dehydration (exsiccosis in older people)

Visual

- * refractive anomalies
- * monocular or binocular double vision
- * nystagmus

Somatosensory

- * polyneuropathic syndrome

Psychosomatic

- * phobic vertigo (differential diagnosis: agoraphobia)
- * hypochondriacal depression
- * conversion symptoms, conflict avoidance

Disorders of the spinal cervix

- * rheumatoid arthritis
- * Bechterew's syndrome
- * reactive arthritis (Reiter's syndrome)
- * primary fibromyalgia
- * functional disorders

Medication-induced

- * nonsteroidal anti-inflammatory drugs (NSAIDs)
- * tricyclic antidepressants

Anamnesis and initial diagnostic steps lead to a hypothetical or working diagnosis. After ruling out serious illness (such as a brain tumor), we can responsibly apply the family practitioner's principle of "wait and see." This approach warrants a follow-up examination in one year's time.

In addition to anamnesis, basic diagnosis by the family practitioner includes a physical examination of the cardiovascular system, an initial neurological exam, and simple tests of otolaryngological function.

Diagnosis by the Internal Medical Specialist

Along with ergometry that includes a standard EKG, ambulant long-term electrocardiography over the course of 24 hours is indispensable in investigating arrhythmias. In both hypotonic and hypertonic disturbances in regulating circulation, ambulant 24-hour blood pressure tests are indicated. Although diagnostic X-rays are considered less

informative than echocardiography they still remain useful in diagnosing lung diseases and changes in the thoracic aorta as well as calcifications of the heart valves, pericardium, and coronary arteries.

The movements of the chambers and valves of the heart can be viewed with the help of echocardiography, while Doppler and color Doppler sonography are indispensable in diagnosing morphological and functional disorders. Aneurysms and three-dimensional processes such as thrombi or tumors in the heart cavity will register on a transesophageal echocardiogram.

<p>Table 3: Vertigo as a side effect of medications</p> <ul style="list-style-type: none"> * classic antihypertensives (reserpine, methyldopa, clonidine, and others) * peripheral vasodilators (nitrates, dihydralazine, diasoxide, prazosin, and others) * calcium channel blockers (verapamil, diltiazem, nifedipine and others) * alpha-blockers * beta-blockers * ACE inhibitors * diuretics * cardiac glycosides (digitalis) * antiarrhythmics * tranquilizers * barbiturates * tricyclic antidepressants * anticonvulsants * fibrinolytic drugs * antibiotics (tetracycline, aminoglycosides, sulfonamides) * oral hypoglycemics * non-steroidal anti-inflammatory drugs (NSAIDs) * contraceptives * anti-Parkinson drugs * other individual medications: clomethiazol, insulin, isoniazid, piperazine, nicotinic acid, prostaglandins (PGE-2), and others.

Table 4: Basic diagnosis of vertigo by the family practice specialist

- A. Anamnesis
- B. Physical Examination
- * **Cardiocirculatory**
 - blood pressure
 - carotid pressure test
 - * **Initial neurological findings**
 - test of cranial nerve function
 - Romberg's test
 - * **Simple tests of otolaryngological function**
 - nystagmus
 - cervical nystagmus when turning the head
 - Weber's test and Rinne's test
 - otoscopy

Doppler or two-dimensional sonography is indispensable in diagnosing vascular stenosis of the arteries serving the brain (e.g. carotid stenosis).

Initial diagnostic lab work includes ESR, complete blood count, electrolytes, kidney and liver function, and blood sugar level with daily profiles and glucose load if necessary. Only in exceptional cases are endocrinological tests, or tests to determine levels of medications or toxins, necessary. Internal medical problems that can be associated with vertigo are summarized in Table 5.

Vertigo is rarely caused by primary or essential hypertension; orthostatic regulatory disorders are usually the cause. Secondary (i.e. symptomatic) hypotonia occur in heart function disorders, endocrinopathies, and hepatopathies, in dumping syndrome and neurogenic diseases, and after taking medications that slow blood circulation.

Vasovagal reactions can be triggered by anxiety, visual influences, or pain.

Fluctuating blood pressure—in either primary hypertension or secondary forms of hypertonia—can lead to vertigo. Precapillary pulmonary hypertension can also be causative here.

To a considerable extent, both brady-

cardiac and tachycardic disorders influence the ejection fraction and therefore also the perfusion of the brain. We must distinguish not only supraventricular and ventricular extrasystoles and sinus node, carotid sinus, pre-excitation, and Q-T syndromes, but also pacemaker-induced disorders up to and including so-called "pacemaker syndrome" (for example, a decrease in heart volume and blood pressure as ventricular stimulation begins).

Congenital and acquired heart defects as well as myocardial insufficiencies due to myocarditis, hypertensive heart disease, or cardiomyopathy can reduce central hemodynamics, especially during physical exertion. Vertigo is also a frequent symptom and early sign of hypertrophic obstructive cardiomyopathy.

We also find vertigo as a symptom accompanying hypoglycemia, anemic or polycythemic syndromes, endocrinopathies (for instance, thyroid

disorders, Addison's disease, Cushing's syndrome, primary aldosteronism, pheochromocytoma, diabetic neuropathy, disturbances in electrolyte balance).

Diseases of the aorta and obliterations of the supra-aortic branches, including those caused by pressure from tumors, lead to a decrease in the blood flow to the brain and thus to vertigo. Medication-induced attacks of vertigo should also not be ignored. The medications in question have already been summarized in Table 3.

The fact that a great number of diseases can be associated with vertigo requires both systematic differential diagnosis to clarify the cause and close interdisciplinary cooperation among the various medical specialties.

Treating Vertigo

In addition to pharmacotherapy, other therapeutic procedures at our disposal include physiotherapy, psychotherapy, and finally otoneurosurgery.

This article will focus on pharmacotherapy for vertigo. A number of preparations used in conventional medicine are available: antihistamines of the hydroxyzine and phenothiazine families, tranquilizers and sedatives, parasympatholytics, and sympathomimetics.

Suppressive therapy as it has been carried out for decades, aiming at a purely symptomatic suppression of sensations of vertigo, is now used only in treating acute cases. Two or three days later, therapy that activates the body's compensatory mechanisms is then introduced.

The cause of the vertigo is determined by means of anamnesis and physical and technological examinations. Anamnesis according to homeopathic viewpoints and specific modalities leads to specific diagnoses. Reversing the process, diagnosis can lead to a specific homeopathic remedy.

Vertigoheel, a homeopathic combination preparation, can be used in addition to individual homeopathic remedies. The sources of Vertigoheel's com-

Table 5: Differential diagnosis of vertigo by the internal medical specialist

- * hypotonic regulatory disorders
- * arterial hypertonicity (aortic stenosis)
- * arrhythmias (pacemaker malfunctions, proarrhythmic effects of antiarrhythmics)
- * cardiac malfunctions resulting from:
 - congenital or acquired heart defects
 - myocardial insufficiencies of various origins
 - cardiomyopathies (hypertrophic obstructive cardiomyopathy)
 - coronary heart disease
- * hyperglycemia
- * anemic and polycythemic syndromes
- * specific endocrinopathies
- * diseases of the aorta
- * vertigo-inducing medications

Table 6: Treating vertigo with individual homeopathic remedies

- * Menière's syndrome:
Cocculus 6X, 1 tablet 3 times daily
- * Menière's, acute attack:
Tabacum 12X, 5 drops every 5 minutes
- * Vertigo caused by circulatory problems:
Veratrum album 3X, 5 drops before rising
- * Ocular vertigo:
Causticum 6X, 1 tablet 3 times daily
- * Post-traumatic vertigo:
Arnica 2X, 1 tablet every 30 minutes
- * Vertigo caused by disorders of the spinal cervix:
Gelsemium 12X, 1 tablet 2 times daily
- * Sinogenic vertigo:
Silicea 6X, 1 tablet 3 times daily
- * Benign paroxysmal positional nystagmus
Conium 6X, 1 tablet 3 times daily, later 12X, 1 tablet 2 times daily
- * Throbbing, ringing tinnitus
Petroleum 6X, 5 drops 3 times daily
- * Vestibular neuronitis
Cocculus 6X, 1 tablet 3 times daily
- * Vertigo as a reaction to heights:
Argentum nitricum 12X, 1 tablet 2 times daily

ponents are listed in Table 7, while their target symptoms are presented in Figure 2.

Years of clinical and practical application have confirmed Vertigoheel®'s effectiveness in treating vertigo. Other advantages include its lack of side effects or sedative effects and its lack of interaction with other pharmaceuticals or alcohol. Many publications have verified its effectiveness. It has proven valuable in treating the following disease states:

- * circulatory disturbances that cause vertigo

- * post-concussive vertigo
- * vertigo due to cerebral sclerosis
- * vertigo due to arteriosclerosis
- * Menière's syndrome
- * vertigo caused by orthopedic and cervicovertebral problems
- * brain stem slowness syndrome
- * epidemic vertigo
- * vertigo following abuse of caffeine, nicotine, or alcohol.

Vertigoheel® is a remedy with a broad range of effectiveness. Actual practice has demonstrated its value as a basis for therapy in cases of vertigo of various origins, and it is a valuable adjunct in cases where direct specific treatment of the underlying illness is possible.

Table 7: Individual components of Vertigoheel®

- * Cocculus
Snail-shaped seeds of the Indian cockle, *Ananirta cocculus* (India, Ceylon, Malaysia).
- * Conium
leaves and stems of the spotted hemlock, *Conium maculatum*, (Europe, Asia).
- * Ambergris
wax-like substance secreted by sperm whales.
- * Petroleum
naturally occurring fossil fuel oil.

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Figure 2: Targets of the individual components of Vertigoheel®

