Vestibular Neuritis (VN) - Acute Unilateral Peripheral Vestibulopathy

This condition has many names: vestibular neuritis, vestibular neuronitis, viral neurolabyrinthitis, acute unilateral vestibular failure, acute unilateral peripheral vestibulopathy, acute vestibulopathy of unknown aetiology, acute unilateral peripheral deficit, epidemic vertigo & peripheral acute vestibular syndrome

It is a common cause of severe prolonged dizziness due to a viral injury to the superior vestibular nerve of the inner ear. It is thought to be due a reactivation of a latent herpes simplex virus type 1 infection (the virus of colds sores) of the superior vestibular nerve and is analogous to "Bell's palsy" of the superior vestibular nerve.

The classical history is of patient complains of sudden recurrent rotatory vertigo lasting 24 hours to days with marked unsteadiness for several days with sweating, nausea and vomiting. There is no hearing loss, no tinnitus, no rashes, no pain and no facial weakness. There may be a pre-existing history of a cold.

The patient has severe horizontal spontaneous nystagmus (with a rotational component) toward the unaffected ear. There is a pathologic head-impulse test toward the affected ear and a deviation of the subjective visual vertical toward the affected ear.

Patients stagger towards the affected ear and want to lie still.

The patient has no evidence of a stroke. This is a key issue; to ensure that the cause is not a stroke or "mini-stroke" (transient ischaemic attack) which can mimic vestibular neuritis.

A variation of this classical history is of the patient complaining of much shorter-lived rotatory vertigo lasting 5-30 mins or more. This is thought to be a due to less severe viral eruptions causing more limited swelling of the superior vestibular nerve.

The long-term effects may be insufficient compensation, resulting in a complaint that sudden head movement causes dizziness motion provoked, relieved by being still and lasting a few seconds. The direction of head turn is to the side of the lesion.

Treatment consists of medication to treat the symptoms of acute vertigo and nausea medication, prednisolone 60 mg for 5 days (with PPI and no contra-

indications and side-effects) and valacyclovir* 2g dose with the attack (2 x 1000mg tablets)

If recurrent vestibular neuritis is diagnosed, then valacyclovir (500mg tablets) b.d. for 6 months and possible vestibular therapy.

N.B. Care with small people and dehydrated people as there is a risk of post renal failure with crystallisation.

* https://bnf.nice.org.uk/drug/valaciclovir.html

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