EDITORIAL

Vestibular Migraine: An Emerging Diagnosis

Migraña vestibular: un diagnóstico emergente

Migraine and recurrent vertigo are two of the most frequent reasons for attending a primary health-care clinic and represent a health problem of great magnitude with both personal and work-related repercussions. In Europe, migraines have a prevalence of 14%, while vestibular vertigo affects 7.4% of the general population at some point during their life. These two symptoms often co-exist in the same patient. Several case-control studies have shown that dizziness and vertigo are more common in patients with migraine compared to age- and gender-adjusted control subjects. In the same way, patients with vertigo, especially those without a precise diagnosis, suffer migraine more often than the corresponding controls. If this co-morbidity were due to mere chance, the expected lifetime prevalence would be 1.1%; however, population-level epidemiological studies have found a prevalence of 3.2%. In view of this, clinicians faced with a patient suffering from migraine and recurrent vestibular symptoms must determine which disorder is present in the patient. Whether it is a mere coincidence, or if it is a vestibular migraine (VM), or else if it corresponds to benign paroxysmal positional vertigo (BPPV) or Menière’s disease, the two entities epidemiologically related to migraine and, at times, difficult to distinguish from VM, as they display a certain degree of overlap.

Most authors consider VM to be the second most frequent cause of recurrent vertigo behind BPPV, and the first cause of recurrent spontaneous vertigo, affecting 1% of the adult population. VM is under-diagnosed, probably as a result of multiple circumstances: the bout of VM may have a highly variable duration, ranging from seconds to several days, even within the same patient, thus distancing itself from the aura duration criterion of the IHS; the time connection with migrainous cephalaea is often missing, which has led in the past to these symptoms being considered as a kind of aura without migraine or, as it was previously called, migraine equivalent.

Various terms have been used to date to refer to this clinical entity: migrainous vertigo, migraine-associated vertigo or dizziness, migraine-related or migraine-induced vestibular pathology. All these terms, albeit synonymous, must be avoided and that of vestibular migraine used instead. Many patients diagnosed as having benign recurrent vertigo or Menière’s vestibular disease probably also correspond to this same entity, particularly if they suffer from migraine.

As with migraine, we do not currently have any biological marker for the diagnosis of VM. Several authors have proposed diagnostic criteria for VM based on case history, with the ones most accepted to date being those established by Neuhauser et al., who distinguish between definitive and likely VM. A model has also been developed for a structured clinical interview for VM. This issue of *Acta Otorrinolaringológica* presents the Spanish version of the definition of VM, a consensus document published by the Bárány Society and the International Headache Society (IHS).

The Bárány Society is an international association made up of professionals from a range of different disciplines (otorhinolaryngologists, neurologists, physiotherapists, psychiatrists, psychologists, engineers, neuro-physiologists and basic researchers), all interested in promoting research into and understanding of the vestibular system. In 2008, a group of neurologists and otorhinolaryngologists set up a Committee to develop an International Classification of Vestibular Disorders, in order to be able to establish clinical diagnostic criteria for the most frequent disorders, following the IHS model for the definition of headaches (*International Classification of Headache Disorders* [ICHD]).

The Committee has initially developed definitions for the signs and symptoms so as to unify the terminology. The classification’s architecture comprises three strata: signs and symptoms, syndromes (acute vestibular syndrome, episodic vestibular syndrome and chronic vestibular syndrome), and illnesses, summarizing the current knowledge of vestibular disorders.

The current definition includes two diagnostic categories: vestibular migraine and likely vestibular migraine, following the elimination of the category of potential vestibular

---

migraine that appeared in the first drafts. The definition of vestibular migraine has gained considerably in precision as it requires a minimum of 5 bouts of vestibular symptoms, a prior personal history of migraine as per IHS criteria (a family history as an alternative criterion has disappeared), and at least 50% of the bouts of vestibular symptoms associated with migraine (at least 3 episodes of migraine associated with vestibular symptoms). In addition, if there is another vestibular disease present (e.g. Menière’s disease) or an ICHD attributable diagnosis (e.g. basilar type migraine), then the patient should not be diagnosed as having vestibular migraine.

It seems evident that the diagnostic criteria are now more demanding and that a detailed understanding of the ICHD is essential for otorhinolaryngologists. Finally, the detailed phenotypic characterization of episodic vestibular syndrome is going to be a key process for the development of accurate medicine in otoneurology.

References

Juan M. Espinosa-Sánchez, a,b José A. López-Escámuezb,c,∗
a Servicio de Otorrinolaringología, Hospital San Agustín, Linare, Jaén, Spain
b Departamento de Otorrinolaringología, Hospital de Poniente, El Ejido, Almería, Spain
c Grupo de Otología y Otoneurología CTS-495, Centro de Genómica e Investigación Oncológica (GENYO) Pfizer, Universidad de Granada, Junta de Andalucía, Granada, Spain

∗Corresponding author.
E-mail address: antonio.lopezescamez@genyo.es

(J.A. López-Escámmez).

13 June 2013 20 June 2013