Vestibular, Balance and Falls SIG Business Meeting – 02/03/2006
Officers attending: Denise Gobert, Christine Letgers, Diane Wrisley, Michelle Gutierrez, Laura Morris, Danielle Nightshade, Betsy Grace, Lisa Shelby-Silverstein
Newsletter editor: Sharan Zirges
Practice Liason: Kim Gottshall

Total Attending: Approximately 200

1. Welcome by Denise Gobert
2. Chair Report: 2005 Vestibular Balance and Falls Year in Review
    a. Advocacy – Reimbursement issues in Iowa, Delaware, Florida and California
    b. Letters- PT practitioner of choice for reimbursement
        i. Possibly Virginia and Maryland
    c. Merger VBF
        i. Webpage update
    d. VR database
    e. Neruo Section Strategic Plan (2006-2011)

3. Mike Studor – Vice Chair Neuro Section:
   VBF SIG will change back to Vestibular RehabilitationSIG and Balance and Falls SIG. He explained that last year it was and executive decision to dissolve the joint partnership of B&F with Geriatrics, but did not involve membership input, and they realized that a mistake was made. Now B&F will be a Neuro SIG and Geriatrics has B&F SIG, and they will do joint programming, but have their own officers each.

4. Sponsor for this evening is Neurocom International, Inc.- Thank you to Marcia Hall

5. Vice Chair- Diane
   Programming:
   Mild Head Injury and Dizziness by Laura Morris tomorrow. (our very own Clinical Excellence Award recipient)
   Roundtables:
   Coding (Fearon)
   The Do's and Don'ts of Migrainous Vertigo (Grove)
   Any suggestions for future programming?
   Vice Chair- Chris
   BF SIG- watch the website for updates
   Programming: Roundtable: Bubbles, Balloons and PVC. (Griffith)

6. Secretary: Michelle

VR database- link from the website- we have control of this now, if you would like to be included- must be a Neuro section member. Please send your info to mlgutierrez@zianet.com
Please check your info, if you are included, for any updates/corrections.

7. Nominating Committee report – by Laura Morris (Danielle Nightshade, Betsy Grace, Lisa Shelby-Silverstein, Bob Wellmon)
    a. Need to fill vacancies for Nominating Committee- outgoing Laura Morris and Lisa Shelby-Silverstein
    b. People who have agreed to run for Nominating Committee: Rebecca English, Jennifer Braswell, Danielle Guzman, Barbara Baker, and Patricia Winkler
    c. Next year need to fill vacancies for Vice Chair and Nominating Committee.

8. Newsletter: Sharan
   Posted on the website 2 times a year.
   Any ideas for newsletter are welcome.

9. Webpage: Patrick Sparto

10. Practice Liaison: Kim Gottshall

11. Programming: Joint programming with Brain Injury SIG

Vestibular Disorders After Head Trauma: Cutting Edge Diagnosis and Management. The Team Approach
By Michael E. Hoffer, CDR MC USN
Kim R. Gottshall, COL AMSC USA
Angela Drake, PhD
Christine Parrish, MA, CCC-SLP

Summary: Participating Institutions-Navel Medical Center Spatial Orientation Center, Naval Medical Research Center, and Defense Veterans Brain Injury Center.

Team approach for head trauma patients have multi-modality disorders- so coordinated care is essential for proper medical management, better sort and long term outcomes (effects of multi-layer care are multiplicative)

Team includes, PT with vestibular training, Otolaryngologist with vestibular training, audiologist, speech therapist, neurophysiologist, and case manager.

TBI is second most common neurological disorder- incidence of over 500/100,000 individuals, costs the US over $40 billion/year.

Classes of TBI- mild- GCS 13-15, severe- GCS <8, moderate- GCS 9-13

TBI and dizziness- reported to occur “frequently” after TBO, little literature documenting nature, duration, evaluation and treatment of the dizziness. Goals: to characterize this dizziness, to compare moderate and severe TBI to the mild TBI patients on which they previously reported
Evaluation- Hx and physical exam, audiogram, neuro-vestibular testing (dynamic computerized posturography, rotational chair, step-velocity, high speed head rotation), standardized assessment instruments (DGI, DHI, ABD, VADL, BESS), MRI scan.

Classification: Post-traumatic positional vertigo, Post-traumatic exertional dizziness, Post-traumatic migraine associated dizziness (PTMAD), Post-traumatic spatial disorientation.

All 198 patients(75%-mild, 13%- moderate, 12%- severe, under went vestibular rehab, all migraine patients received medicines.

Vestibular Rehabilitation- treatments that allow individuals to adapt to, compensate for, or respond to a balance disorder. Included therapeutic exercises, therapeutic maneuvers, physical conditioning, coping skills, and devices.
Sites at which to intervene- Vestibular-ocular reflex (head and eye interaction), vestibular-spinal reflex (head and spine interaction), Posture, Gait, General Conditioning.
Basic VR therapy: VOR, COR, Depth Perception, Somatosensory, Gait Training, Positional Exercises, Proprioceptive Neuromuscular Facilitation, Aerobic Conditioning.

Role of the Speech Pathologist: Eval, Recommendations, Treatment Plans, Counseling Needs, Referrals.
Common Cognitive Deficits Associated with Vestibular Disorders: impaired memory, attention, concentration, attention shifting, reasoning, & problem-solving, slowed information processing, decreased initiation, planning & organization, reduced self-awareness, decreased frustration tolerance, and increased & frequent sense of being overwhelmed.
Additional Concerns: Vestibular patients tend to be more “high level” brain injuries with subtle impairments, special needs and concerns of the Active Duty Military Population, lack of understanding of patient impairments, long term career and educational support needs.

Defense Veterans Brain Injury Center Approach: assessment services and education about topics related to TBI provided, specific rehab plans are developed based on multidisciplinary evaluations by the team, a TBI case manager works directly with the patients to help coordinate care.

Mild TBI management issues: patents benefit from swift interventions focused on specific symptom clusters, dizziness and vestibular dysfunction are frequently overlooked in the primary care setting, these issues directly affect other management issues, including functional recovery, return to work and exercise, one of the most common

problems following MTBI is headache, which is frequently complicated by vestibular dysfunction.

Findings – functional outcome not dependent on injury severity, functional outcome dependent on dizziness class, more sever CHI does worse because more likely to be in "worse" dizziness class.

Recovery rates- literature indicates that dizziness following TBI will resolve over time (3-9 months) but dizziness lasting > 1 year in 10-15%. Their study indicates that 73% of their patients (position, exertional and PTMAD groups) respond in 1-8 weeks indicating a possible positive effect of vestibular rehabilitation and active treatment in these three groups. The spatial disorientation group more closely follows the literature with average time to resolution of 32 weeks. Only 4% had symptoms at one year indicating a possible benefit of therapy in this group as well.

Respectfully submitted,

Michelle Gutierrez
Secretary, VBFSIG
06/04/06