

ON THE LEVEL

A QUARTERLY NEWSLETTER OF THE VESTIBULAR DISORDERS ASSOCIATION



INFORMATION

SUPPORT

AWARENESS

ADVOCACY



A Gift No One Wants To Receive

By Natasha Daly

Vestibular Migraine: "A migraine, with or without headache, featuring dizziness as the predominant symptom."¹

July 2016: Sitting on a platform at Fenchurch Street with my head in my hands, swaying and feeling like I want to vomit. Curious glances from Saturday visitors to town. Concerned looks from train guards who don't want to clear up vomit from someone who can't hold their drink. "Bit early, isn't it?" their looks say. That was one of my low points. I sat on that platform for almost a full hour. It was also on that platform that I experienced for the first time what I would come to recognize as a panic attack.

Panic attacks often become a secondary condition to VM, or vestibular migraine. Anxiety and depression seem to follow the condition like a loyal dog, never far behind. I know all this now because I've spent months researching, but at the time I thought I was about to collapse.

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TOP LEFT: NATASHA GETTING SOME CANINE THERAPY
BOTTOM LEFT: NATASHA & HER PARTNER, OUT ON THEIR FIRST DATE IN 6 MONTHS
BOTTOM RIGHT: NATASHA WITH HER SONS IN CANADA, PRE-DIZZINESS

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A GIFT...CONTINUED FROM PAGE 1:

I'd developed a condition that is the "second most common cause of vertigo and the number one cause of spontaneous, episodic vertigo,"² and yet, it appears to be relatively unheard of to a large number of primary care providers. It is a migraine associated condition, therefore if you suffered from migraines that stopped in your teens or twenties and often additionally have a history of motion sickness you are a prime candidate for the condition. Women are more often diagnosed than men, and the condition most commonly strikes between twenty and forty years of age.³

I know this now. I did not know this in January 2015, when, during a meeting I felt the walls shift and saw things moving that shouldn't. I ended up at my doctor's surgery via the office floor. Labyrinthitis was the diagnosis, and anti-nausea medication the prescription. I felt better after a day or two, and when I continued to experience intense but fleeting dizzy spells for the next year I was reassured by a simple search that labyrinthitis could cause dizzy spells for up to two years after the event, so I carried on as normal.

Over the next year I continued to experience periodic dizzy spells, which intensified in June 2016, so I visited my GP to explain my symptoms. I had developed an unsteady, floaty, off-balance feeling, like I'd just stepped off a fast ride. I struggled to make eye contact. I felt nauseous. At its worst the dizziness made me lose access to my vocabulary and I struggled to maintain my train of thought. Eventually I had to take a three-month leave from the job I loved.

Following a referral to an ENT, I was relieved to be assured that I had a condition known as BPPV, and that I'd be fine the next day, after he performed a specialist maneuver. But tomorrow came and so did the dizziness.

A vestibular therapist I found online instantly diagnosed vestibular migraine (VM) and told me to restrict my diet to avoid known triggers and start taking an anti-depressant to constrict the blood vessels and prevent the migraines that were causing the attacks. "What a quack," I thought. It took further appointments, including a private appointment with a neuro-otologist, for the diagnosis to be confirmed, and for me to *accept* a diagnosis of VM.

Dr. Surenthiran is one of the UK's leading specialists in the management of balance. He is a neuro-otologist at the Balance Centre, Medway Maritime Hospital and has seen thousands of people with VM. As he told me on my first visit: "By the time people get to me they have lost jobs, even partners." GPs just do not seem to be aware of it. Visitors to VM discussion boards have stories of living not only years but decades with the condition, undiagnosed and untreated.

The fact is that with the right combination of diet, lifestyle, preventative medication, supplements and avoidance of known migraine triggers people can become balanced again. Some avoidable triggers include chocolate, alcohol, dairy, caffeine, citrus, aged cheese, and MSG. Unavoidable triggers include stress, hormones and barometric pressure changes⁵. It is not, in the majority of cases, a lifelong condition, but it feels like it when no one understands why you are still dizzy after months or even years. It's frustrating, it's disabling, and it carries with it a high risk of associated mental health issues.

"Migraine and anxiety reverberate, and as anxiety escalates, the accompanying presence of migraine becomes more and more obscured as this vicious cycle spins wildly into a maelstrom."⁶

Over the last year I've fallen over in public, sat down in the middle of busy streets, left restaurants, avoided bars and clubs, refused to enter shops and dreaded the sound of the phone notifying me of yet another event or appointment I'd have to refuse. I could feel myself avoiding the things I love because I didn't feel steady.

I've tried three failed medications, which gifted me their own individual side effects ranging from palpitations resulting in no less than six ECGs and one cardiology referral, numb hands and feet, muscle weakness, and mental confusion. I've spent a large amount of money on private appointments for balance therapy, reflexology, CBT (cognitive behavioral therapy), massage, Reiki

and ear candling. I've had a CT scan, an MRI, two rounds of blood tests and countless hours in waiting rooms.

I had barely visited my GP in the two years prior to the start of my VM symptoms, and hadn't had one sick day. Since then I've used ten weeks sick leave and spent three months working from home.

I am currently being seen by the same neuro-otologist and his amazing team of vestibular therapists. I'm making huge progress on medication number four in combination with regular sleep, increased fluid intake, supplements, yoga and a restricted diet. I feel 80% back to normal, and every day that I get to go to a cinema, bar or café I see it with the eyes of the newly well and the hugely grateful.

My VM recovery (a word I use cautiously) is a slippery slope. I take ten steps forward, slide back five, and cry a lot, like an unfairly weighted game of Snakes and Ladders. The process is not linear, and I know I may slide back in my recovery before I am rid of this thing for good, but I am looking at where I came from last year and the contrasted outlook is rosy.

I attribute this to a range of factors, starting with the medical professionals I have encountered on my journey. In addition to my neuro-otologist, I found a GP who is acquainted with VM. She is patient and kind, and tenacious in her efforts to discover what will aid my recovery. She is also thorough in investigating and treating side effects as they occur, bumping into each other in a seemingly unending queue to attack my body and mental state. I'm thankful to the hospital staff, who gently offered me wheelchairs when I was sent for tests and the bright hospital lighting triggered further dizziness, and to the receptionists, who fit me in when my heart was racing out of my chest and I didn't know what to do to calm it down.

Secondly, if we're gleaning positives from the last year, I'd have to put my amazing friends and family at the top of the pile. First and foremost I'd like to thank my children, who



NATASHA AND HER KIDS HAVE FUN WITH 3-D GLASSES, WHICH LOOK JUST AS SILLY AS THE TINTED GLASSES SHE WORE FOR HER MIGRAINES.

CONTINUED ON PAGE 4

have proved to be kind, patient and resilient with a mum who couldn't get out as much as they were used to. Credit also goes to my mum, who dropped everything when the attacks got so bad I had trouble getting things organized for my kids, and who is always there to check on me, and I do mean always. I've begun to wonder what else the woman has time to do. I am grateful for my friends, who checked on me and understood when I couldn't see them at short notice, drove me to the hospital and to appointments, and looked after my children while I went. Friends who seemed to know when to pop in, to find me crying because a new medication had made me feel like I was losing my mind. Friends who arranged a surprise birthday meal of migraine friendly food and alcohol free beer. My partner, who accepts all that seeing someone with VM entails and who sat in with me for months for a never-ending run of film nights because I didn't feel I could make it out and the medication made me fall asleep by 10pm. My children's dad, who collected the kids when I needed him to, and made them tea so I could sit down and stop the world from moving for a bit. Also my dog, for affirming my long held belief that everyone who feels like rubbish, for any reason whatsoever, should have a dog.

In addition to all of these positive people, I also have a great employer. My company has been supportive and understanding and made changes to my job role, which enabled me to return to work.

Lastly, internet forums, enough to make me shudder prior to this period of my life ('just people having a moan') need a mention here too, and I would urge anyone who is living with this condition to seek one out. But choose wisely, because some really are for just that, a chance to let off steam about the condition, which is entirely valid and has its place. But through My Migraine Brain and the wonderfully committed Kelley Nunn⁷ I found a VM Positive Living Group, and the ladies have been a great source of support. They are there when you are nauseous, confused, upset, tired and tired of being tired, with understanding, encouragement and positivity, at any hour of the day or night. Every recovery story is taken as a personal victory

by every one of us, each of us total strangers to each other.

If any one of these elements had not been in place my recovery as it stands would almost certainly be slower and more frustrating, but in its own funny kind of way VM has given me something of a gift. I am surrounded by amazing people and this condition has given me the chance to stop and appreciate their value. That's how I'm choosing to view it. Vestibular migraine - a gift no one wants to receive, but a gift nonetheless.

1 <http://www.mymigrainebrain.com>

2 Bisdorff et al. 2004 via <http://www.mymigrainebrain.com>

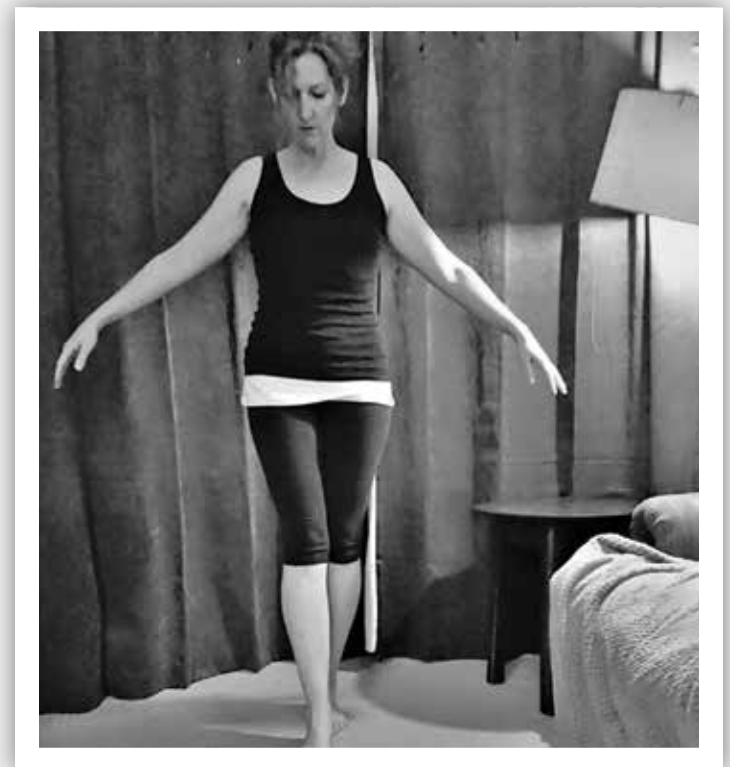
3 <http://www.vestibular.org/migraine-associated-vertigo-mav>

4 <https://www.kims.org.uk/consultant/dr-surenthiran/>

5 <http://www.vestibular.org/migraine-associated-vertigo-mav> - list adapted from Ronald J. Tusa, MD, PhD, "Diagnosis and Management of Neuro-otologic Disorders Due to Migraine," chap. 12 in Vestibular Rehabilitation, ed. Susan J. Herdman, PhD, PT (Philadelphia: F.A. Davis Co., 1994).

6 David Bucholz, MD, Heal Your Headache (New York: Workman Publishing, 2002) 174.

7 <http://www.mymigrainebrain.com>



NATASHA DOING VRT (VESTIBULAR REHABILITATION THERAPY)

Getting Support Online

Shelley Walker was only 35 years old when vestibular madness hit. One morning she woke up and had trouble walking to the bathroom. She was dizzy and nauseous and felt like she was going to fall, symptoms which persist to this day, six years later.

And, six years later, Shelley remains undiagnosed. She's consulted with vestibular healthcare specialists, who think that a virus caused permanent damage to her vestibular system, but physiotherapy has done little to help her regain her balance. In the meantime, her life has changed forever.

Shelley used to work at a hospital, but the stress and computer usage exacerbated her symptoms. She could no longer work and had to apply for disability – a process that took over a year.

For years Shelley was so disabled she needed help bathing and getting dressed. Just trying to put her shoes on would cause her to fall flat on her face. "You go from being an independent person to having to rely on someone else," says Shelley. "This illness makes you feel like you're nobody."

And Shelley wasn't the only person affected. Her 11-year old son and 14-year old daughter had to adjust to a mother who could no longer cook, clean, or drive them where they needed to go.

The most difficult thing, Shelley says, is the brain fog. "It's like you can't think straight or remember things from one moment to the next."

Shelley went to counseling for a time, which was



"PARTICIPATING IN AN ONLINE SUPPORT GROUP HAS BEEN LIFE-CHANGING." - SHELLEY WALKER

helpful, but she still felt alone and isolated. She searched for a local support group, but there were none near her home in Cranbrook, BC. Then Shelley heard about a support group in the UK, who referred her to a support group in BC, who told her about VEDA's new online support groups. Shelley says that participating in an online support group has been life changing.

"It's so great to converse face-to-face and get instantaneous feedback," she says. "Talking to people who know exactly how you feel helps you accept who you are and what's happening to you." Shelley also likes the feeling that she's helping others, especially patients who are newly diagnosed, with tips she's learned for coping with her vestibular disorder.

Even her family recognizes that Shelley seems less stressed. "It helps with the isolation, and puts me in a better state of mind," she says.

VEDA is still experimenting with our online support groups. Currently, there are more people who want to participate than volunteers willing to facilitate a group. **If you are interested in facilitating an online support group, please contact Patient Support Coordinator, Cassey Parrish, at cassey.parrish@vestibular.org, or call 800.837.8428.**

VEDA Welcomes New Board Members

By Sherron Laurel

The VEDA Board of Directors has a history of talented, dedicated members committed to moving the mission of our organization forward, one idea, one initiative, one patient at a time. Today we welcome four new distinguished members to the team. I asked each new member to share a little bit about their professional backgrounds, their hopes for making a difference through VEDA, and one fun fact about themselves.



KAMRAN BARIN, PHD

Kamran spent 25+ years as the Director of The Ohio State University Medical Center's Balance Disorders Clinic, where he pursued developing new and better methods for testing the vestibular system. His philosophy of treatment combined a patient centric focus on understanding both the medical conditions and the social and professional impacts of how symptoms affected patients' lives. He is hoping this hands-on experience will bring a different and enhancing perspective to VEDA. Kamran retired from the OSU Balance Clinic in 2011 and has been a consultant, speaking and teaching nationally and internationally on various topics related to vestibular disorders since that time. He lives in Columbus, Ohio. His "fun fact?" As a young man, he delved into sky diving a few times! The lesson he took away? It's best to get things right the first time. A wish every vestibular patient has for their diagnosis! Welcome to VEDA, Kamran!



ROSE DUNN, MBA, RHIA, CPA, FACHE, FHFMA, CHPS

Rose is a vestibular patient herself and a niece to a Meniere's patient who had to give up his medical practice because of the limitations of his disorder. She understands personally what vestibular patients face. She is the Chief Operating Officer of First Class Solutions, a health information management firm. She has expertise in hospital operational management and lives in Chesterfield, Missouri. She comes to VEDA having had extensive leadership experience serving on national, regional and state boards, including being Board Chair and interim CEO of a large professional association. She is a national speaker and published author on a variety of topics and travels extensively for work – often up to 45-50 weeks a year. She hopes she can fill a current VEDA board geographic void in mid-central USA and promote the organization's vision and mission to her clients. Her "fun fact?" (Have to admit this one makes me hungry!!) When she is able to spend time at home, she makes a "mean" chocolate cheese cake! Welcome to VEDA, Rose!

SANDY EGGE, MSACN



Sandy is the Owner/CEO/VP of Research for Almsbio Nutrasciences, a nutraceutical company based in Lake Oswego, Oregon. She is a clinical nutritionist with 10+ years of experience working with multiple vestibular patients and comes from the naturopathic nutritional side of the medical field. Recently a member of her own family was affected by vestibular illness in addition to her own issues with vertigo, which can last for days and even weeks at a time. One of her goals, based on her compassion for the feelings of “utter hopelessness and despair” experienced by vestibular patients, is to raise awareness of the variability of vestibular disorders in general, and the important role nutritional choices and complementary medicine can play to provide more treatment options and to support positive outcomes. Since Sandy comes from a clinical background, her approach is based in science. Her “fun fact?” She loves the outdoors, walking, biking and hiking. She is very much into music festivals with a particular love of folk and bluegrass, and rumor has it she may bring a fiddle to entertain at a future Board dinner! Welcome to VEDA, Sandy!

ESTEBAN MEDINA ORGAZ, PHD, MBA



Esteban is a Doctor of Public Health who lives in Spain - our first European Board member! He is the co-founder of a telemedicine company (InMiro Healthcare), where he serves as an Executive Board Member. He is a pharmacist by training and currently works as Sales Manager of Onco-Hematology for Roche Pharmaceuticals based in Seville, Spain. He served as an Associate Professor at the College of Medicine, Complutense University of Madrid, where he lectured graduate and post-graduate courses in Preventive Medicine and Public Health, and has served as an Advisory Council Member on the Harvard Business Review. His uncle has Meniere’s disease, which has made him painfully aware of how burdening vestibular disorders can be. His goal in joining the Board is to see how technology can help patients get diagnosed and treated in the most effective and efficient way. He is focused, always, on ensuring that the best quality of care is given. His “fun fact?” He spent many months in Rwanda, Central Africa, living with 10 nuns while working on his PhD. As a result he added Swahili to his list of spoken languages, bringing the current total to five, including his

native Spanish, English, Portuguese and French! Bienvenido a VEDA, Esteban!

FOR MORE INFORMATION ON VOLUNTEERING WITH VEDA,
VISIT [VESTIBULAR.ORG/VOLUNTEER](https://vestibular.org/volunteer).

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A Different Type of Treatment for MdDS

By Dr. Kim Fox, DPT



DR. KIM FOX

M a l d e
D e b a r q u e m e n t
S y n d r o m e (M d D S)
i s a r a r e c o n d i t i o n
i n w h i c h t h o s e
a f f l i c t e d p e r c e i v e a
c o n t i n u o u s r o c k i n g
o r s w a y i n g s e n s a t i o n,
o f t e n r e l i e v e d w h e n
i n m o t i o n a n d
s y m p t o m a t i c w h e n
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s t i l l . T h e d e g r e e o f
s e v e r i t y v a r i e s f r o m
p e r s o n t o p e r s o n
w i t h t y p i c a l o n s e t o f

symptoms occurring following travel, commonly after disembarking a cruise, hence the name of the syndrome. There is variability in the literature defining MdDS but in general when symptoms are transient (2 days or less) it is referred to as "land sickness" while persistent symptoms (>3 days) are referred to as MdDS. ⁽¹⁾

MdDS is thought to be an abnormal weighting of the systems responsible for balance. We have 3 pathways controlling balance: vision, vestibular (inner ear) and somatosensory (sensory information taken in through our skin, muscles, bones, joints, etc). Under normal circumstances, while on firm, stable surfaces, we are using 70% somatosensory, 20% vestibular and 10% vision. While on unstable surfaces (such as walking around on a boat), we are using 60% vestibular, 30% visual cues and 10% somatosensory. ⁽²⁾ It is hypothesized that the re-weighting of the sensory paradigm does not "reset" in MdDS patients. There is no known cure as the exact cause has yet to be determined.

At Asheville Balance & Vestibular Center, we recently trialed a treatment using an automated, multi-axis rotational chair (AMARC) with visual targeting system (VTS) in a single patient with MdDS. The system used in this case is GyroStim, a computerized, multi-axis rotational chair, moving in either or both the pitch and yaw planes with variable speeds between 1 to 30 revolutions per minute (RPM). Four electronic targets are placed around the perimeter of the chair that respond to a laser pointer and are tracked by the computer for accuracy and number of hits. The individual in the chair is using either 1 or 2 laser pointers, held in 1 or both hands, respectfully, or a laser pointer attached to a head mounted strap. There is currently a lack of empirical data in the literature regarding use of an AMARC with VTS, however, profound improvements have been reported by individuals anecdotally.

After seeing a variety of providers, Cindy, a 60 year old female, was officially diagnosed with MdDS by a Neuro-Otologist in 2013. Her



CINDY UNDERGOING TREATMENT FOR HER MAL DE DEBARQUEMENT USING A MULTI-AXIS ROTATIONAL CHAIR.

initial onset of symptoms began in 2006 after disembarking from a cruise. Prior to AMARC with VTS treatment, Cindy experienced a strong internal feeling of continuous movement as well as outwardly observed rocking and swaying, primarily in a side to side motion. She had been unable to work for the last 4 years, ride a bike (unable to start and stop independently), sit still, sleep soundly, perform routine activity such as grocery shopping or eating out in a busy restaurant, and had difficulty thinking clearly. Prior to treatment, she was unable to maintain her balance on compliant (unstable) surfaces with her eyes opened or closed. Her balance tests on compliant and firm surfaces were significantly impaired compared to age and gender matched peers. Her walking speed was slow and guarded, holding onto her spouse for stability or reaching for nearby surfaces while also using a cane. Cindy's sway in sitting was so pronounced (swaying side to side about 60 times per minute) that it actually made the evaluating therapist a little nauseated by the end of the evaluation. Cindy's Dizziness Handicap Inventory (DHI) was 82/100 at her initial evaluation, indicating a severe perception of handicap (the higher the number the worse the perceived handicap with 70-100 noted to be severe).

Cindy had tried traditional vestibular rehabilitation intermittently over the years without success. She worked with psychology in the past to address her depression and suicidal thoughts following her onset of MdDS, which she indicated helped her cope better with her symptoms, however, it did not change her sensation of constant motion. When treatment was implemented using the AMARC with VTS, we began with low levels of movement in either or both the pitch and yaw planes, working to perceive, process, and react to targets which were strategically placed around the perimeter while Cindy "hit" the targets with a laser pointer. Her score and symptoms were monitored to ensure the correct level of stimulation and challenge. Since Cindy naturally felt better in motion and would not have been limited by symptoms to move faster, we were cautious to avoid faster motion if she was not able to satisfactorily perceive or connect with



"MY SIDE TO SIDE SWAY IS GONE (AND) MY BALANCE IS ABOUT 90% BETTER." - CINDY BEAGLE

the targets. The goal was to ensure that vision, vestibular and somatosensory cues matched. Additional cognitive and visual challenges were systematically added when they were appropriate. Cindy was seen for 10 sessions, 2 sessions per day (once in the morning and once in the afternoon) over 5 days. The repetitive sessions in a condensed time were to promote habituation training through repeated stimulation while she stayed in the local area for 1 week, eliminating her extended car rides since she did not reside in close proximity to our clinic. Cindy made continual progress throughout her 5 days. The morning of day 3 was the first time Cindy noticed that she was symptom-free since being diagnosed with MdDS. While a full resolution of symptoms did not persist, her sensation of movement reduced from a 10/10 prior to starting treatment to no greater than 2/10 by the end of treatment. During day 3 of treatment Cindy's sway changed from lateral (side to side) to anterior-posterior (front to back). Modifications in movement were made, which promptly resolved symptoms. Several days into treatment, Cindy reporting lying in bed to go to sleep without symptoms for the first time in years.

By the end of her treatment using the AMARC with VTS, Cindy's walking speed doubled, proud to now be walking faster than her spouse and without external support, her visible sway resolved, and she reported 90% improvements. The only remaining residual symptom noted was a subtle vertical bobbing sensation reported as no greater

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than 2/10 intensity, which was not constant. Following her week of treatment, Cindy's DHI score was 2/100 (0-39 is a low perception of handicap), reduced from 82/100. She could maintain balance on compliant surfaces with her eyes opened or closed and her balance testing on compliant and firm surfaces were normal as compared to age and gender matched peers. She additionally reported resolution of brain fog with the ability to think more clearly and is now able to multi-task.

It has been just over six weeks since the completion of treatment and Cindy continues to report sustained improvements. She is now able to ride a two-wheeled bike, starting and stopping independently, has been driving locally

without exacerbation of symptoms, and is walking regularly with plans to join a walking group. She can go grocery shopping on her own and go out to eat without hesitation. She has times when she is symptom-free and other times when she reports a low sensation of symptoms. She plans to return for one additional week of AMARC with VTS treatment to see if complete and permanent resolution of symptoms is attainable.

1. Van Ombergen A, Van Rompaey V, Maes LK, Van de Heyning PH, Wuyts FL. Mal de débarquement syndrome: a systematic review. 2015. *J Neurol*. 2016 May;263(5):843-854.
2. Peterka RJ, Loughlin PJ. Dynamic regulation of sensorimotor integration of human postural control. *J Neurophysiol*. 2004 Jan;91(1):410-23.

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The Salt Balance

By Sandra Egge, MSACN, VEDA Board Member

Did you know that over 4,000 years ago very early Chinese writings recorded more than 40 types of salt, as well as methods of extracting and processing salt, some of which are similar to methods we still use in today's world? In earlier times, salt was reported to be so valuable that in some places it was traded ounce for ounce for gold, was sometimes used as currency, was used to preserve foods, was gifted as a symbol of friendship, and often - as a valuable commodity - salt was at the center of conflict and war. Today, salt is inexpensive and abundant, and while older civilizations were worried about having enough salt, we now worry about having too much salt.

SO, WHAT'S SALT GOT TO DO WITH VESTIBULAR HEALTH?

Salt is an essential mineral that has the power to affect health for humans, animals, and even plant-life. It is possible to get too much, and it is possible to have too little as well, affecting the delicate electrolyte and fluid balance of the body and action potential of muscles and nerves.

For those experiencing vestibular disorders, reduction of sodium (along with caffeine and alcohol) is one of the well-known dietary modifications that is recommended. Too much dietary sodium can upset the fluid balance of the body by causing the body to retain water. Changes in body fluid may alter the volume and composition of endolymph (fluid in the inner ear), which supports normal hearing, balance and movement. This is important information, because the fluctuation of inner ear fluid is thought to contribute to symptoms of vestibular disorders such as Ménière's disease. So then the question becomes, how much sodium does one actually need to support appropriate cellular health and fluid balance?

According to the Federal Dietary Guidelines for Americans, a maximum of 2,300 milligrams of sodium is the recommended daily limit for 'healthy persons.' To visually gage 2,300 milligrams of

sodium, this is the amount found in one measuring teaspoon. However, the American Heart Association recommends an even lower limit at 1,500 milligrams daily, and the National Heart, Lung and Blood Association reports that a safe minimum intake of 500 milligrams daily is enough to maintain appropriate body functions that require sodium - just a little over one quarter of a teaspoon! Visualize that!



It is reported that the average American consumes more than 3,400 milligrams of sodium daily. You might wonder, "where does it all come from?" Specifically, pre-processed foods and restaurant foods are the main culprits contributing to the salt imbalance in your diet - foods such as processed lunch meats, breads, chips, cheeses, pizza, burgers, sauces, canned soups and vegetables, poultry (often injected with a sodium solution), meats that have been cured or brined, and less we forget, sodas.

Here's where I would like to say:

"JUST EAT REAL FOOD."

But, seriously, let's look at some options to reducing salt intake - it will require work on your part.

YES! I WANT TO HELP PEOPLE SUFFERING FROM VESTIBULAR DISORDERS.

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Thank you for supporting the Vestibular Disorders Association! With your help we can reduce the time it takes to accurately diagnose vestibular disorders and improve treatment outcomes, helping patients live happy, productive lives.

- Choose fresh fruits, vegetables and proteins that are not soaked in brines or salt solutions.
- If you are preparing your own foods, measure out 1/4 teaspoon salt in the morning and make that your limit for the entire day.
- Look for 'Low Sodium' or 'No Sodium' options if purchasing pre-prepared foods.
- Exchange salt for herbs, spices and peppers.
- Salt your food at the end of cooking rather than at the beginning. Just a 'pinch.'
- Know other salt forms: MSG (monosodium glutamate), baking soda, baking powder, disodium phosphate – or any ingredient that has the word 'sodium' in it.
- Swap sodas for unsweetened flavored seltzer water, or infuse your own water with fresh berries.

Whatever you do, be consistent. Consistency is the key to 'salt balance.' If you are an athlete and experience a lot of sweating, consult with your healthcare professional to establish an appropriate

amount of sodium and electrolyte replacement for your individual needs.

Summer is upon us – time for outdoor barbecues and evenings enjoying the warm weather.

Turn the page for a great no-sodium summer recipe!



Watermelon Tomato Salad

Here is a yummy, refreshing, recipe that compliments any summer afternoon or evening get-together, and it's salt-free! It's seriously so good! Enjoy!

- 3 cups watermelon, 1 inch cubed
- 3 cups cucumber, thinly sliced
- 2 cups cherry tomatoes, sliced in half (I use heirloom cherry tomatoes for color)
- 1/4 red onion, thinly sliced
- 3 Tbsp fresh lime juice
- 1 Tbsp agave nectar (maple syrup may be substituted)
- 1 pinch red pepper flakes
- 1/4 cup fresh cilantro, chopped (you may substitute basil or mint)

Gently mix all ingredients in a bowl, chill 1 hour before serving. You may want to re-mix before serving as the lime juice sinks to the bottom.



VESTIBULAR
DISORDERS ASSOCIATION
5018 NE 15th Ave, Portland, OR 97211, USA
800.837.8428 | info@vestibular.org | vestibular.org
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