editorial

Ménière's Disease—Don't Blame the Patient

By Gerard J. Gianoli, MD

A 48-year-old woman presents to you for bilateral hearing loss, aural fullness, vertigo, nausea/vomiting, and tinnitus of two months' duration. When you enter the exam room, she proceeds to tell you about how her "yeast had gotten out of balance" and she was in a "healing crisis" when she had an allergic reaction to Pine-Sol. Audiometry shows an asymmetric mild high-frequency sensorineural hearing loss. She has had two MRI scans with Gd contrast that were both read out as normal. She has already been evaluated by four internists, two otolaryngologists, and two neurologists. One of the otolaryngologists told the patient that temporomandibular joint (TMJ) syndrome was the cause of her problem, and the others gave her anti-anxiety medications.

Keep in mind that this patient presents to you in the middle of a busy clinic day and you are already 30 minutes behind schedule. What do you do with this patient? No, I don't mean "what is the textbook answer?" What would you really do? Would you show compassion to this obviously distressed woman? Or would you just try to figure out what is the fastest way to get her out of your office and into someone else's? As it turns out, this patient is fairly sophisticated and realizes that the diagnosis of TMJ is wholly inappropriate for her symptomatology and suspects that the physicians who prescribed anti-anxiety medications think she is crazy and do not believe she is truly sick.

To have Ménière's disease is truly to be cursed. You experience unexpected bouts of hearing loss, tinnitus, and vertigo. Although the hearing loss can fluctuate, there is always the fear of losing all your hearing, with doctors telling you that there is a 30% to 50% chance that it will happen to both your ears. Tinnitus can be bad enough to drive some patients to the point of suicide or self-mutilation—just ask van Gogh. The vertigo alone can leave even the most independent individuals incapacitated. Probably the worst part of the disease is that your family members, friends, and especially your co-workers don't believe you. You suspect that they think you are exaggerating or making up this condition. After all, you don't have a cast on your arm, you're not in traction, and you can't "show" them your vertigo. There is probably only one thing that could make this worse: if on top of all of that, your physician also thinks you are crazy or malingering. Many Ménière's patients eventually come to suspect they are indeed "crazy" because those around them, including their physicians, seem to think so. Consequently they are referred to psychiatrists, who often treat them for depression—a not-surprising result of the above-mentioned scenario.

"The only thing worse than having a miserable medical problem is to have those who are supposed to be helping you not believe you."

Jerome Groopman, MD, in his recently published book, *How Doctors Think*,[1] discusses cognitive errors that can lead physicians to misdiagnosis and mismanagement of patients. Several of these cognitive errors readily apply in the case of Ménière's disease. Attribution errors occur when patients fit a negative stereotype. The negative stereotype of a neurotic patient with Ménière's disease can lead physicians down the path of inactive management or incorrect diagnosis. Additionally, personality characteristics and comorbid psychiatric disease can compound the issue. When the patients don't improve with standard medical therapy, this leads to physician frustration and, often, blaming the patient. There appear to be three main factors that cloud this issue: (1) the specter of malingering or

continued on page 4

ENToday
JANUARY 2008
VOLUME 3
ISSUE 1

AN OFFICIAL PUBLICATION OF THE TRIOLOGICAL SOCIETY

Wolters Kluwer Health | Lippincott Williams & Wilkins

Published monthly by Lippincott Williams & Wilkins.

Editor: Deborah Wenger
Art Director: Kathleen Giarrano
Editorial Assistant: Angela Munasque
Associate Director of Production: Barbara Nakahara
Production Associate: Nick Strickland
Manager of Circulation: Deborah Benward
Desktop Manager: Peter Castro
Desktop Associate: Monica Dyba
Group Editor: Serena Stockwell
Circulation Associate: Fred Rella
Publisher: Ken Senerth
Executive Vice President, Journals Publishing: Matthew Cahill
Vice President, Executive Publisher: Ray Thibodeau
Director of Advertising Sales:
Michael Guire
Lippincott Williams & Wilkins
1300 Virginia Drive, Suite 400
Ft. Washington, PA 19034
Phone: (215) 643-8140
Fax: (215) 643-3902
Michael.Guire@wolterskluwer.com
Manager of Advertising Sales:
Martha McGarity

ENToday (ISSN 1559-4939), an official publication of the Triological Society, is published monthly for the Society by Lippincott Williams & Wilkins, at 16522 Hunters Green Parkway, Hagerstown, MD 21740. Business, editorial, and production offices are located at 333 Seventh Ave., 19th Fl., New York, NY 10001; (646) 674-6544; fax: (646) 674-6500; e-mail: ENToday@lwwny.com; Web site: **www.ENToday.com**. Printed in the USA.

Subscription information and orders: Physicians who are listed with AMA/AOA as having a primary or secondary specialty related to Otolaryngology or Allergy & Immunology, within the U.S. are eligible for a free subscription. If you are not currently receiving the publication, send an email with your name, address and specialty to: ENToday@dmddata.com. For Customer Service on your *free* subscription, please call (800) 430-5450.

Annual subscription rates: US: $137 individual, $220 institution. All other countries except Japan, $197 individual, $280 institution. Air freight charges of $13 must be added for all destinations outside of the United States, Canada, and Mexico. Single copies $29. In Japan, contact Igaku-Shoin, Ltd., 3-24-14 Hongo, Bunkyo-Ku, Tokyo 113-0033, Japan.

Postmaster: Send address changes to: *ENToday,* 2340 River Rd, Suite 408, Des Plaines, IL 60019-9883.

Editorial

continued from page 3

symptom magnification, (2) reported placebo effect in trials of treatments for Ménière's disease, and (3) concomitant psychiatric disorders.

Malingering

Among patients with potential for secondary gain, malingering is quite prevalent. As we published previously,[2] 76% of patients complaining of dizziness with potential for secondary gain (defined as patients with pending lawsuits, workers' compensation claims, or disability claims) demonstrated nonphysiologic posturography results strongly suggesting malingering or symptom magnification. However, among those without any obvious potential secondary gain, malingering and symptom magnification seem to be quite uncommon. Nonphysiologic posturography results in that same study for these patients was only 8% (and the nonphysiologic results were of a much milder magnitude). Yes, there are somatosizers among vestibular patients. However, even the nonphysiologic results found in the nonsecondary gain group were more suggestive of symptom magnification rather than outright malingering. So, unless there is reason for secondary gain, malingering is very rare.

Placebo Effect

The placebo effect is defined as the therapeutic and healing effects of inert medicines and/or ritualistic or faith-healing manipulations. In no other disease process treated by otolaryngologists has the placebo effect been so emphasized as in Ménière's disease. This is probably because of our poor understanding of Ménière's, but also because there is a long-standing bias that Ménière's disease is psychogenic in nature.

A study by Hrobjartsson and Gotzsche published in the *New England Journal of Medicine* in 2001 regarding the placebo effect failed to show any demonstrable effects for placebo.[3] In a systematic review of 130 trials with patients randomly assigned to either placebo or no-treatment groups, they "found little evidence in general that placebos had powerful clinical effects. Although placebos had no significant effects on objective or binary outcomes, they had possible small benefits in studies with continuous subjective outcomes and for the treatment of pain." In other words, when using objective measurement outcomes, placebo was no different from no treatment (i.e., there was no placebo effect).

There is growing evidence to support Hrobjartsson and Gotzsche's conclusions. The original work on the placebo effect has been called into question for its scientific validity. The very fact that placebos are completely inert or inactive has also been called into question. As early as 1968, Shapiro made the observation that there is no such thing as placebo in the true sense of the word.[4]

Outcomes mistakenly attributed to placebo effect can be accounted for by many factors, including natural termination of the disease process, the cyclic nature of Ménière's disease, errant diagnosis, and temporary improvement confused with cure. We not only have a poor understanding of why Ménière's disease occurs, but also why it terminates. No one suspects the placebo effect when more than 90% of acute otitis media patients have resolution without antibiotics. They rightfully claim natural termination of the disease process, because we understand the pathophysiology of why an ear infection can resolve on its own.

However, probably the most common confusion of placebo effect and resolution of symptoms from Ménière's disease has to do with the statistical phenomenon of regression to the mean. Regression to the mean is the phenomenon by which an extreme outcome score will, for purely statistical reasons, be less extreme at a subsequent measurement. Several sports analogies come to mind: the sophomore slump, the Heisman curse, the Sports Illustrated Cover Jinx, and so on. In all these cases, an athlete has an extremely good year—much better than he or she typically can perform. Consequently, the following year, the athlete's performance is less spectacular.

Many Ménière's patients eventually come to suspect they are indeed "crazy" because those around them, including their physicians, seem to think so.

The negative stereotype of a neurotic patient with Ménière's disease can lead physicians down the path of inactive management or incorrect diagnosis.

Similarly, with Ménière's disease, the patients will seek the most extreme forms of therapy when their symptoms are at their worst. Regardless of the treatment employed, they get better—not because of placebo effect, but because of regression to the mean. As otolaryngologists, we have added to the misery of these patients by emphasizing the placebo effect in Ménière's disease.

Panic Attacks, Anxiety, and Depression

Considering the incidence of depression and anxiety among patients with chronic medical illnesses, it is not surprising to see a fair amount of this in patients with Ménière's disease. However, the presence of panic disorder probably bears mentioning. It is an organic disorder with a 5% lifetime prevalence that is very effectively treated with selective serotonin reuptake inhibitors (SSRIs) and psychotherapy. Among patients with panic disorder, situational or environmental triggers are very common.

For some patients with Ménière's disease, vertigo spells act as a trigger for their panic attacks. This does not imply that their Ménière's symptoms are fabricated or that they are crazy. It simply means they have two concomitant disorders, with one triggering the other. Referral to the appropriate mental health specialist is just as important for this type of patient as the appropriate referral for any other medical condition.

The Rest of the Story

The patient described at the beginning of this article who had the bilateral atypical Ménière's syndrome was found on examination to have a mild right-beating nystagmus. Her past medical history was significant for breast cancer, with a bilateral mastectomy performed one year earlier. Review of the reportedly "normal" MRI revealed bilateral symmetric mildly enhancing masses in the internal auditory canals. The first MRI scan, which had been done a year earlier, revealed no such masses present. A lumbar puncture for cytology was ordered and confirmed the presence of metastatic breast cancer. Believe it or not, although she was distressed by the diagnosis, she was relieved just to have a diagnosis.

To have Ménière's disease is truly to be cursed.

This patient had a very grave diagnosis and very severe symptoms. Physicians may not be able to cure her of this problem, but we can at least show compassion. The only thing worse than having a miserable medical problem is to have those who are supposed to be helping you not believe you. ENT

References

1. Groopman J. *How Doctors Think*. New York: Houghton Mifflin, 2007.

2. Gianoli GJ, McWilliams S, Soileau JS, Belafsky PC. Posturographic performance in patients with secondary gain. *Otolaryngol Head Neck Surg* 2000;122(1):11–18.

3. Hrobjartsson A, Gotzsche PC. Is the placebo powerless? An analysis of clinical trials comparing placebo with no treatment. *NEJM* 2001;344(21): 1594–1602.

4. Shapiro AK. Semantics of placebo. *Psychiatr Q* 1968;24(4): 653–95.

News in Brief

Report on Medicare's VBP Program

Mike Leavitt, Secretary of Health and Human Services, recently delivered to Congress a Report on the Medicare Hospital Value-Based Purchasing Program (VBP), whose purpose is to provide Medicare beneficiaries with higher quality and more cost-efficient health care.

The current payment system, called Reporting Hospital Quality Data for Annual Payment Update, uses a pay-for-reporting model. The proposed payment system would be based on performance. Specifically, the VBP outlines that a percentage of a hospital's base operating payment for each Medicare patient discharge would be contingent on its performance as measured by its total performance score, which takes into account clinical process of care, patient perspectives of care, and clinical outcomes. Under this model, a hospital would be rated against national benchmarks as well as against its own baseline measures.

In addition, public reporting of quality of care via the Center for Medicare and Medicaid Services Hospital Compare Web site (**www.hospitalcompare.hhs.gov**) will be an integral component of the VBP. Medicare beneficiaries and other consumers are able to view data as reported by hospitals, including how soon heart attack patients are given aspirin or how soon pneumonia patients are given antibiotics after arriving at a hospital.

The transition from the current Medicare payment system to the proposed incentive-based system would occur over a three-year period. The VBP program adheres to two of the four cornerstones of the Secretary's initiative to build a value-driven health care system: measuring and publishing quality information, and promoting the quality and efficiency of care.