

Dizziness and Falls webinar Q & A

1. What is internet based cognitive behavioural therapy?

The internet-based cognitive-behavioural therapy consisted of The Wellbeing and the Wellbeing Plus courses for people aged up to 59 years old and for those aged 60 years and over, respectively. These are internet-based treatment courses designed to teach people about anxiety and depression as well as how to manage their symptoms. The course consists of 5 online lessons, homework assignments, and case-enhanced stories that detail the experiences of adults (older adults in Wellbeing Plus programme) recovering from symptoms of depression and anxiety. Participants also receive weekly contact from registered psychologists during treatment. More detail of this intervention can be found in our article access at <http://journals.plos.org/plosmedicine/article?id=10.1371/journal.pmed.1002620>

More information on the Wellbeing and the Wellbeing Plus course can be found here:

<https://mindspot.org.au/wellbeing-course>
<https://mindspot.org.au/wellbeing-plus-course>

2. What is the usual care for the control group?

During the 6-month trial period, participants assigned to the control group received usual care, i.e., participants were instructed to continue their everyday life as usual. We did not give any specific instructions to the control participants. At completion of the trial, participants were provided with their baseline and reassessment reports and offered referrals for recommended interventions.

3. What was the age spread of for those aged under 65?

At baseline, there were 106 people aged 50-64 years old, median (25th-75th percentile); 61 (57 – 62) years.

4. How do you account for there being no change in falls incidence? / Could you expand at all on the success of the CBT on reducing falls? / What was the falls rate in the intervention group compared to control?

Although we presented some falls data in the webinar, falls were neither primary nor secondary outcomes of the main randomised-controlled trial; as such the study was not designed or statistically powered to prevent falls. Hence, investigating the effect of the CBT (which only involved n= 22 controls and 29 intervention) on falls in our trial is unlikely to provide any meaningful evidence. We collected the falls data alongside the dizziness frequency data with the intention of examining the relationship between dizziness handicap and falls in a prospective manner in additional analyses to the main trial. Total falls were as follow: 114 in the control participants and 101 in the intervention participants.

5. What is the DHI & how is it available?

The Dizziness Handicap Inventory (DHI) is a 25-item scale which assesses an individual's perception of handicap due to dizziness and encompasses emotional, functional, and physical burden (a). Increased DHI scores have been significantly associated with low mental and physical health-related quality of life, as well as with increased emotional distress (b). Scores of 0 to 30 represent mild symptoms, 31 to 60 moderate symptoms, and 61 to 100 severe symptoms (a).

a) Jacobson GP, Newman CW. The development of the Dizziness Handicap Inventory. Arch Otolaryngol Head Neck Surg. 1990;116(4):424-7.
<https://www.ncbi.nlm.nih.gov/pubmed/2317323>

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- b) Weidt S, Bruehl AB, Straumann D, Hegemann SC, Krautstrunk G, Rufer M. Health-related quality of life and emotional distress in patients with dizziness: a cross-sectional approach to disentangle their relationship. BMC Health Serv Res. 2014;14:317

<https://www.ncbi.nlm.nih.gov/pubmed/25052136>

6. Is there any evidence on central (rather than peripheral) reasons of dizziness and falls?

We are not aware of any prospective falls study which would have followed people presenting with dizziness of central origin. This would be very complex to undertake given the heterogeneity of the central nervous system pathologies susceptible to cause dizziness.

7. What about vestibular disorders other than BPPV? / Did you address vestibular disorders other than BPPV?

As part of the randomised-controlled trial of dizziness, we conducted clinical assessments of dizziness (Dix-Hallpike and roll test, head shaking and head impulse test, skew eye deviation, visual tracking, observation of spontaneous and gaze-directed nystagmus in light and darkness) which were used for diagnostic purposes and for allocation into treatment arms. Intervention group participants identified as suffering from a peripheral vestibular disorder at baseline assessment were assigned to undertake vestibular rehabilitation with a vestibular physiotherapist. In brief, this therapy was conducted over 2 to 4 weeks with home-based exercises prescribed according to evidence-based best practice (a) and principles of adaptation, substitution, and habituation (b). Please refer to the paper for further details.

- a) McDonnell MN, Hillier SL. Vestibular rehabilitation for unilateral peripheral vestibular dysfunction. Cochrane Database Syst Rev. 2015;1:Cd005397.

<https://www.ncbi.nlm.nih.gov/pubmed/25581507>

- b) Herdman SJ. Vestibular Rehabilitation, 3rd ed. Philadelphia: F. A Davis Company; 2007.

8. What is the Otago home based exercise program?

The home-based Otago exercise program is an evidence-based fall-prevention programme designed to train lower limb strength and balance (a). It was developed at the University of Otago NZ, hence its name. More details of the exercise program can be found in our paper and online as it is publicly available: <https://www.acc.co.nz/assets/injury-prevention/acc1162-otago-exercise-manual.pdf>

- a) Campbell AJ, Robertson MC, Gardner MM, Norton RN, Tilyard MW, Buchner DM. Randomised controlled trial of a general practice programme of home based exercise to prevent falls in elderly women. BMJ. 1997;315(7115):1065–9

<https://www.ncbi.nlm.nih.gov/pubmed/9366737>

9. Was the falls clinic run by Drs?

The falls clinic addressed cardiovascular problems and multiple comorbidities. It was run by a Geriatrician and a Physiotherapist. – see main paper.