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## LETTER TO THE EDITOR

**“A novel maneuver for diagnosis and treatment of torsional-vertical down beating positioning nystagmus: anterior canal and apogeotropic posterior canal BPPV” by Octavio Garaycochea et al.: some specifications about how authors interpreted some insights of our article. “Anterior canal BPPV and apogeotropic posterior canal BPPV: two rare forms of vertical canalolithiasis”**



Dear Editor,

Our opinions expressed in “Anterior canal BPPV and apogeotropic posterior canal BPPV: two rare forms of vertical canalolithiasis”,<sup>1</sup> for the points I am going to stress, were not properly reported in Garaycochea’s paper.<sup>2</sup> They wrote: “Califano et al. in 2014 described the use of a maneuver named quick liberatory rotation”. Our concept was broader. We wrote: “APC was treated through QLR, a manoeuvre usually used in TPC, because in the Dix-Hallpike test on the affected side, the otoconial mass in the posterior canal always moves towards the most sloping part”. QLR is not a specific maneuver for APC BPPV and any maneuver for Typical Posterior Canal BPPV might also be used for APC: the reason we chose QLR was to standardize our analysis.

The authors wrote: “Califano proposed a differential diagnosis between both etiologies based on the clinical examination... he defined the diagnosis of AC-BPPV as certain when the nystagmus was evoked through the HH test and sometimes through the DH test, and the diagnosis of APC-BPPV as certain when the nystagmus was evoked through the DH test and sometimes through the HH test.(!?) This approach might be somewhat inaccurate because previous studies have described that both etiologies can be triggered through both test and this is consistent with our results. But what is most important... is how to distinguish a right AC-BPPV from a left APC-BPPV and vice versa, and that was not accurately defined by Califano”.

We didn’t write that in our paper: “Differential diagnosis between APC and AC is possible due to the prevalence of the torsional component compared with the vertical one in APC, whereas differential diagnosis between APC and TPC is possible because of the inverted characteristics of the nystagmus, which in APC is downbeating, clockwise in the right Dix-Hallpike position and counter-clockwise in the left Dix-Hallpike position”. Nevertheless, the differential diagnosis remains elusive because the two vectors of nystagmus can be present in both, and accurate diagnosis may not be possible based on these characteristics.

The point that the authors considered “inaccurate” is “inaccurate” because they did not consider that we stated that only the shift into a typical posterior canal BPPV eliminates all “ifs”, all “buts”, all “maybes”, identifying both the affected canal and its side – this is the “certain fom”, in our original grading! – and excluding, in addition, all central suffering: this is our truly “accurate” point that clinically distinguishes what actually causes a positional down beat nystagmus.

## Conflicts of interest

The author declares no conflicts of interest.

## References

1. Califano L, Salafia F, Mazzone S, Melillo MG, Califano M. Anterior canal BPPV and apogeotropic posterior canal BPPV: two rare forms of vertical canalolithiasis. *Acta Otorhinolaryngol Ital.* 2014;34, 189–97.4.
2. Garaycochea O, Pérez-Fernández N, Manrique-Huarte R. A novel maneuver for diagnosis and treatment of torsional-vertical down beating positioning nystagmus: anterior canal and apogeotropic posterior canal BPPV. *Braz J Otorhinolaryngol.* 2022;88:708–16.

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