Title

The Bidirectional Relationship Between Migraine and Meniere Disease

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As Weeks and Weinstein highlight in their own previous article, "an examination of the different cost layers highlights the distinction between variable costs, such as supplies and medications, where reduced use produces true savings, and fixed costs, such as facilities and ancillary services, where the costs persist despite reduced use."[2] Although financial analyses indicating projected cost savings by avoiding additional labor hours to meet the requirements of increased operative volume could have been included, the manuscript intentionally reflects only the conservative change in direct variable costs for operating room supplies, where reduced use of surgical instruments prevented consumption, need for replacement, and ensured availability for later use. As discussed, inclusion of instrument depreciation, with reduced processing decreasing natural wear and tear and extending the useful life of the asset, would only further bolster estimated savings; however, the article presents only conservative, realized cost savings accounted by the institution's SPD as per the original study design.

Through durable standardization of streamlined surgical trays for high-volume procedures in the head and neck surgery service, this intervention both reduced routine processing of unused instruments and allowed for capacity adjustment to accommodate for changes in operative volume over time. Since implementation, this streamlined surgical tray initiative has expanded to additional surgical services and generated nearly half a million dollars in direct variable cost savings for operating room supplies. Incentive-based programming at a departmental level, such as providing a percentage of institutional cost savings for capital improvement requests or to fund a surgical innovation grant system, may facilitate broader expansion of institutional cost containment efforts. As we consider reducing waste in care delivery, clinician-driven cost containment processes offer the opportunity to drive efficiencies as we seek to provide high quality care while considering thoughtful allocation of limited labor, supply, and energy resources.

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The Bidirectional Relationship Between Migraine and Meniere Disease

To the Editor We read with great interest the article titled "Association Between Meniere Disease and Migraine" by Kim et al.[1] In this large case-control study, the authors aimed to investigate the possibility of bidirectional association between Meniere disease (MD) and migraine. Their findings demonstrated a higher occurrence of migraine in patients with MD and vice versa, implying a bidirectional relationship between MD and migraine. We commend the authors for their extensive analysis of this immense population data and for presenting such valuable results. We agree with their conclusion and would like to provide a few insights from our previous studies on this hypothesis.

Although the authors stated that we have to consider migraine medications in patients with MD combined with migraine, we believe that the criteria for migraine diagnosis set by the International Headache Society (IHS) are too strict, and prevent many patients from receiving the proper treatment. There is a growing body of evidence of the association between migraine and the development of cochlear symptoms such as hearing loss and tinnitus.[2] Many migraine characteristics, such as family medical history of migraine, motion sickness, and visual motion sensitivity, which are high indicators for migraine etiology, are found in patients with MD who do not fulfill the IHS criteria.[3] For this reason, we believe patients with MD should be treated with migraine prophylaxis, regardless of whether the IHS criteria for migraine are met or not. Again, we applaud the authors for their outstanding work and support their statement on the bidirectional association between MD and migraine.

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