EVS
CHEAT SHEET

Episodic Vestibular Syndrome

ED Differential Diagnosis

▸ What is EVS?

Recurrent discrete episodes of vertigo lasting seconds to hours, with return to normal between attacks.
Key diagnostic challenge: BPPV vs vestibular migraine vs TIA vs Meniere's disease vs other causes.

Episode Duration — Diagnostic Clue

Duration	Most Likely Diagnosis	Key Features
Seconds (less than 1 min)	BPPV	Triggered by head position change; torsional nystagmus on Dix-Hallpike
Seconds (less than 1 min)	Orthostatic hypotension	Triggered by standing; BP drop on lying-to-standing
Minutes (1–20 min)	Posterior circulation TIA	Vascular risk factors; may have neurological signs; ABCD2 score
Minutes to hours (20 min–12 h)	Meniere's disease	Unilateral hearing loss + tinnitus + aural fullness
Hours (4–72 h)	Vestibular migraine	Migraine history; photophobia/phonophobia; may have headache
Variable	Anxiety / panic disorder	Constant low-grade dizziness + episodic worsening; situational triggers

High-Risk EVS — Posterior Circulation TIA

▸ Do not miss posterior TIA

Isolated vertigo is the presenting symptom in ~10% of posterior circulation TIAs.
ABCD2 score has poor sensitivity for posterior fossa TIA — clinical gestalt + MRI essential.
Vascular risk factors + new onset episodic vertigo = stroke workup until proven otherwise.
Consider HINTS Plus (+ audiometry) if concurrent auditory symptoms.

Red Flag Feature	Action
Vascular risk factors + new episodic vertigo	MRI DWI + MRA; stroke team consult
Diplopia, dysarthria, ataxia during episodes	Immediate stroke protocol
Headache + vertigo + vomiting	CT head first; exclude haemorrhage
Episode lasting over 30 minutes	TIA/stroke workup; ECG, echo, lipids, BSL
First-ever attack in patient over 50	Low threshold for admission and imaging

Vestibular Migraine — ICHD-3 Criteria (Probable)

Criterion	Detail
A — Episodes	At least 5 episodes of vestibular symptoms (vertigo, dizziness, visual vertigo) lasting 5 min–72 h
B — Migraine history	Current or past history of migraine with or without aura (ICHD-3 criteria)
C — Migraine features	At least 50% of vestibular episodes accompanied by headache, photophobia/phonophobia, or visual aura
D — Not better explained	No other vestibular diagnosis accounts for symptoms

Episodic Vestibular Syndrome — *continued*

Meniere's Disease — Diagnostic Criteria

Criterion	Detail
Vertigo episodes	Two or more spontaneous episodes lasting 20 min–12 h
Hearing loss	Low-to-medium frequency SNHL on audiogram in affected ear (during or after an episode)
Aural symptoms	Fluctuating tinnitus or aural fullness in affected ear
Exclusion	Not better explained by another vestibular diagnosis

▸ ED approach to probable Meniere's

Acute attack: prochlorperazine or betahistine for symptom control.
Refer to ENT or vestibular physician for audiogram, electrocochleography, and long-term management.
Avoid diagnosing definite Meniere's in ED — audiometric confirmation required.

BPPV in EVS Context — Quick Recap

Feature	Detail
Trigger	Rolling over in bed, looking up, bending forward
Duration	Less than 1 minute per episode
Diagnosis	Positive Dix-Hallpike: torsional-upbeat nystagmus, 2–20 sec latency, fatigues
Treatment	Epley manoeuvre — 80% first-attempt cure rate

Investigation Pathway in ED

All EVS	If TIA/Stroke Suspected	If Meniere's/Migraine Suspected
BP both arms (lying and standing)	CT head (exclude bleed)	Pure tone audiogram (outpatient)
BSL, UEC, FBC	MRI DWI + MRA	Ophthalmology / neurology referral
ECG (AF screen)	Carotid Dopplers / echo	Vestibular physician referral
HINTS if ongoing nystagmus	Stroke unit admission	Migraine prophylaxis initiation

Disposition Guide

Diagnosis / Clinical Picture	Disposition
BPPV confirmed, Epley successful	Discharge; GP / vestibular physio follow-up
Vestibular migraine (first presentation)	Discharge; neurology or vestibular physician referral; migraine diary
Probable Meniere's (known or new)	Discharge if safe; urgent ENT/vestibular physician referral; audiogram
Posterior TIA — suspected	Admit; stroke unit; MRI DWI; antiplatelet therapy
Orthostatic hypotension identified	Discharge if safe; GP to review medications and BP management
Diagnosis unclear / high-risk features	Admit for observation; senior review; delayed MRI