

**LR 05
CHEAT
SHEET**

Vestibular Migraine

Recognising and managing the most commonly missed vestibular diagnosis

WHY VESTIBULAR MIGRAINE MATTERS

Most common cause of recurrent spontaneous vertigo in adults — lifetime prevalence ~1%. The most commonly missed vestibular diagnosis in primary care: average 5–8 years to correct dx [3]. >30% of patients NEVER have headache during attacks; another 30% have inconsistent headache. Equating migraine with headache = missing VM.

BÁRÁNY / ICHD-3 CRITERIA — DEFINITE VM

- ▶ ≥5 episodes of moderate-severe vestibular symptoms lasting 5 minutes – 72 hours.
- ▶ Current or previous history of migraine (with or without aura).
- ▶ In ≥50% of episodes, ≥1 migraine feature: headache (≥2 of unilateral, pulsating, moderate-severe, aggravated by activity); OR photophobia + phonophobia; OR visual aura.
- ▶ Not better accounted for by another diagnosis.

◆ *Probable VM = same picture without all 5 episodes documented or without consistent migraine features. Treat as VM.*

CLINICAL PHENOTYPE — WHAT EPISODES LOOK LIKE

Feature	Typical pattern in VM
Duration	Minutes to hours, occasionally 1–3 days. Brief seconds-long ≠ VM (think BPPV).
Type	Spontaneous internal vertigo, head-motion intolerance, positional, or visually-induced.
Hearing	Normal in typical VM. Any auditory symptom → audiometry to exclude Ménière's.
Headache	Often absent. Photophobia + phonophobia alone satisfy criteria.
Aura	Visual scintillations / fortifications in a minority — highly specific.
Triggers	Sleep, stress, hormones, dehydration, missed meals, dietary, weather.
Interictal	Visual vertigo, head-motion sensitivity, "VM hangover" cognitive fog.

◆ *Key recognisers — episodic vertigo + migraine triggers + photophobia/phonophobia during attacks + normal interictal exam = VM, even with no headache history.*

DIFFERENTIAL DIAGNOSIS — FAST TRIAGE

Diagnosis	Distinguishing feature
Ménière's	Fluctuating low-frequency SNHL on audiometry (decisive).
BPPV	Seconds-long positional vertigo; +Dix-Hallpike with stereotyped torsional nystagmus.
Posterior circulation TIA	Sudden onset + neuro signs / vascular risk → HINTS-plus + urgent MRI.
PPPD	Persistent (≥3 mo) non-vertiginous unsteadiness ↑ upright posture + complex visual scenes.

INVESTIGATIONS — SELECTIVE USE

- ▶ Audiometry — any auditory symptom (tinnitus / hearing change / fullness). Excludes Ménière's, schwannoma, SSNHL.
- ▶ MRI — only if central red flags (downbeat / persistent nystagmus, asymmetric SNHL, late-onset, vascular risk + first attack, persistent unilateral signs).
- ▶ Vestibular function tests (vHIT, VEMP, VNG) — not required for diagnosis; reserve for mixed clinical pictures.
- ▶ Bloods — targeted only (TFTs, B12, vit D, electrolytes) when comorbid contributors suspected.

STEP 1 — TRIGGER DIARY + UNIVERSAL LIFESTYLE

6-week structured diary: attacks (date / duration / severity), sleep, menstrual cycle, meals, caffeine, alcohol, stress, weather. Most patients identify 2–4 dominant triggers.

Lifestyle measure	Target
Sleep	Fixed bedtime / wake — including weekends. Both deprivation AND over-sleep trigger.
Meals	3 regular meals; do not skip breakfast.
Hydration	1.5–2 L water daily.
Caffeine	≤200 mg/day. Taper if cutting — withdrawal is a potent trigger.
Alcohol	Limit; red wine, fortified wines, beer common triggers.
Exercise	30 min moderate aerobic, 3–5x/week.
Stress	CBT, mindfulness; treat coexisting anxiety.

◆ *Targeted dietary trial > blanket exclusion. Common triggers: red wine, aged cheese, chocolate, citrus, MSG, nitrates, aspartame, high-tyramine foods. Avoid 6 weeks → reintroduce sequentially.*

STEP 2 — PHARMACOLOGICAL PROPHYLAXIS (≥2 ATTACKS/MONTH)

Agent	Dose	When to choose / avoid
Propranolol	40–160 mg/day	Useful: anxiety, hypertension. Avoid: asthma.
Amitriptyline	10–50 mg nocte	Useful: insomnia, chronic pain. Avoid: cardiac conduction disease.
Topiramate	25–100 mg/day	Useful: weight loss desirable. Watch: cognitive side-effects.
Venlafaxine	37.5–150 mg/day	Useful: anxiety/depression, perimenopause.

Trial each agent at adequate dose ≥6–8 weeks before declaring failure. Choose by side-effect / comorbidity match.

◆ *Acute attack — triptans (rizatriptan, zolmitriptan), antiemetics, simple analgesia. Sparing benzodiazepine for severe vertigo. Vestibular suppressants are NOT prophylactic — only acute, briefly.*

WHEN TO REFER + OUTLOOK

- ▶ Diagnostic uncertainty — Ménière's, PPPD, or central cause cannot be confidently excluded.
- ▶ Refractory to adequate trials of 2 first-line agents.
- ▶ Unilateral hearing loss, progressive neurological signs, any red flag.
- ▶ Persistent interictal dizziness or visual vertigo — vestibular rehabilitation indicated.
- ▶ Pregnancy / planning — drug choices constrained.
- ▶ CGRP mAb under consideration (PBS criteria apply).

◆ *Outlook — >50% reduction in attack frequency in majority within 3–6 months; 25–40% near-complete remission. Attacks attenuate over years, often after menopause. Set expectations: reduction, not elimination.*