PPPD — Persistent Postural-Perceptual Dizziness

Clinician Cheat Sheet | Vestibular Medicine for General Clinicians (Topic 8 of 14)

WHAT IS PPPD?

Most common cause of chronic dizziness in adults <65; second commonest overall after BPPV. A POSITIVE diagnosis (Bárány 2017) — not exclusion, not anxiety. Disorder of central sensorimotor processing after a precipitating vestibular event.
Triggered in 70–80% by neuritis, BPPV, vestibular migraine, head injury, panic, or medical illness. Mean time to diagnosis exceeds 4 years — recognition is the single most impactful GP intervention.

BÁRÁNY 2017 DIAGNOSTIC CRITERIA — ALL 5 (A–E) MUST BE MET FOR ≥3 MONTHS

	Requirement
A	Dizziness, unsteadiness, or non-spinning vertigo on most days for ≥3 months.
B	Symptoms exacerbated by THREE factors: (1) upright posture, (2) self-motion, (3) complex visual stimuli.
C	Precipitated by an event causing vertigo / unsteadiness / balance disturbance.
D	Causes significant distress or functional impairment.
E	Not better accounted for by another disorder.

Pearl: The 3 EXACERBATORS in criterion B (posture, self-motion, visual) are the diagnostic fingerprint. Asking about all three takes <60 seconds and is highly diagnostic.

PATIENT LANGUAGE TO LISTEN FOR	KEY HISTORY POINTS
"Like walking on a boat or trampoline."	Daily symptoms ≥3 months.
"Floor moves when I am still."	Non-spinning quality (no rotational vertigo).
"Head feels disconnected."	Worst late afternoon / evening.
"Worse in supermarkets, computer screens, busy environments."	Eased by lying down.
"Worse late in the day after standing."	Rarely present on first waking.
"Started after labyrinthitis / migraine / accident months ago."	Identify the precipitating event in 70–80%.

DIFFERENTIATING PPPD FROM COMMON MIMICS

Feature	PPPD	Vestibular migraine	Bilateral vestibular loss	Anxiety
Duration / episode	Continuous, daily	Min – 72 hr	Continuous	Variable
Visual trigger	Prominent	Present	Absent / mild	Absent
Postural trigger	Worse upright	Variable	Worse with motion	Unrelated
Oscillopsia walking	Absent	Absent	Present	Absent
Better when lying	Yes	Variable	Yes	No pattern

Important: Oscillopsia (bouncing vision) on walking → NOT PPPD. Suspect bilateral vestibulopathy and arrange formal vestibular function testing before applying a PPPD label.

BEDSIDE EXAM — WHAT YOU SHOULD FIND

Examination is most useful for what it does NOT show — confirming a normal exam strengthens the diagnosis. Check:

Test	Expected in PPPD	If abnormal — consider
Spontaneous / gaze nystagmus	Absent	Central or peripheral lesion
Head impulse test (HIT)	Normal	Vestibular neuritis (unilateral); BVL (bilateral)
Dix-Hallpike / Roll	Negative	Coexistent BPPV — TREAT first
Orthostatic vitals	Normal	Orthostatic hypotension (LR09)

INVESTIGATIONS — RESIST THE URGE TO OVER-TEST

PPPD is a positive diagnosis. Do NOT repeat MRI / Holter / tilt-table on patients who fit Bárány criteria — each negative test delays treatment and worsens illness behaviour.

REASONABLE	AVOID
Audiometry (if not done) — exclude Ménière's, schwannoma. MRI brain + IAM — only if abnormal exam, focal headache, or asymmetric hearing. vHIT / calorics / VEMPs — if oscillopsia or unclear prior diagnosis. Orthostatic vitals — mandatory in every chronic dizziness.	Repeat MRI in a structurally normal scan. Holter / tilt-table when no syncope features. Empirical betahistine, prochlorperazine, cinnarizine. Open-ended "rule out" investigations.

MANAGEMENT — THE THREE-PILLAR APPROACH (DEPLOY IN PARALLEL)

Pillar	What to do	Duration / target
1. Vestibular rehab	PPPD-adapted graded exposure with trained vestibular physio. Use provocation, not avoidance.	8–12 weeks
2. SSRI / SNRI	Low-dose start, slow titration. See dosing table below.	Min 6-month trial
3. CBT / education	Address hypervigilance, catastrophising, avoidance. Online CBT via Black Dog acceptable.	4–8 sessions

SSRI / SNRI DOSING — PILLAR 2 IN DETAIL

Agent	Start dose	Target	Titration	When to choose
Sertraline (SSRI)	25 mg mane	50–100 mg	↑ 25 mg q1–2 wk	First-line; well tolerated
Escitalopram (SSRI)	5 mg mane	10–20 mg	↑ 5 mg @ 2 wk	Alternative if sertraline poorly tolerated
Venlafaxine XR (SNRI)	37.5 mg mane	75–150 mg	↑ 37.5 mg q1–2 wk	Useful where vestibular migraine coexists
Fluoxetine (SSRI)	10 mg mane	20–40 mg	↑ 10 mg @ 2 wk	Long half-life — gentler discontinuation

Counsel patient: Initial transient flare in dizziness, nausea, sleep disturbance for 1–2 weeks is expected. Benefit emerges over 6–12 weeks. Do not stop early. Minimum 6-month trial.

COMMON PITFALLS	RED FLAGS — NOT PPPD
"Anxiety" label without offering PPPD pathway. Ongoing vestibular suppressants / benzodiazepines. Trigger avoidance instead of graded exposure. Stopping SSRI early because of initial flare. Failing to treat coexisting BPPV / VM / OH. Delaying rehab while awaiting more tests.	Oscillopsia walking → bilateral vestibulopathy. Asymmetric / progressive hearing loss → schwannoma. Focal neurological signs → image, central cause. Persistent or direction-changing nystagmus. Episodic spinning vertigo — reconsider VM, BPPV. Orthostatic BP drop ≥20 mmHg → see LR09.

WHEN TO REFER TO A VESTIBULAR PHYSICIAN

- Diagnostic uncertainty — oscillopsia, progressive hearing loss, or central features.
- No meaningful improvement after 3–6 months of three-pillar therapy.
- Complex comorbidity (vestibular migraine, Ménière's, BVL, severe mental illness).
- SSRI / SNRI intolerance requiring alternative pharmacotherapy.
- Patient requests expert confirmation before committing to long-term treatment.

Patient explanation that works: "Your inner ears and brain are structurally fine, but after what you went through your balance system is running in high-alert mode — like a car alarm that keeps going off. The three-part plan — exercises, medication, and a way of thinking about it — re-teaches the system to switch off."