LR 13 CHEAT SHEET

Visual-Induced Dizziness

A Clinical Approach to Visual Vertigo and Visual Dependence

WHY IT MATTERS

Visual-induced dizziness (VID) — being made dizzy by busy visual environments — is a hallmark symptom of PPPD, vestibular migraine, MdDS, post-vestibular insult and post-concussive syndromes. Bedside exam is normal; missed daily by GPs.

FIVE-FEATURE VISUAL TRIGGER INVENTORY

- **Supermarket aisles — high contrast, peripheral optic flow, fluorescent strips.**
- **Crowds and markets — many independent moving objects; self-vs-object motion conflict.**
- **Scrolling and screens — phone scrolling, fast video, visual-search on screens.**
- **Patterned floors and carpets — stripes, checks, herringbone; geometry mistaken for self-motion.**

♦ **Three or more positive triggers strongly suggest VID. Highway / passenger driving is the fifth — passengers struggle more than drivers because they lack steering input.**

CONDITIONS WHERE VID DOMINATES

Condition	Typical pattern
PPPD	Daily non-spinning dizziness ≥3 months; worse upright + visual environments.
Vestibular migraine	Episodic vertigo; interictal VID and motion sensitivity; migraine history.
MdDS	Persistent rocking after travel; improves with passive re-motion.
Post-vestibular	Weeks after neuritis, labyrinthitis, BPPV; visual dependence persists.
Post-concussive	Mild TBI; combined cervicogenic and oculomotor features.
Anxiety / SMD	Visually-rich, low-support environments; panic features.
Central	Vertical or direction-changing nystagmus; gait ataxia — refer urgently.

VVAS THRESHOLDS — INTERPRETATION

Total score (0-90)	Action
0 - 14	Normal range — reassure; recheck if symptoms worsen.
15 - 25	Mild VID — start visual habituation; treat any underlying VM/PPPD.
26 - 40	Moderate VID — structured habituation, pharmacotherapy if PPPD; review at 6 weeks.
41 - 60	Severe VID — refer to vestibular physician; SSRI/SNRI consideration.
61 - 90	Disabling VID — urgent vestibular physician referral; multidisciplinary input.

DIFFERENTIAL DIAGNOSIS — QUICK TRIAGE

Condition	Key discriminator
PPPD vs VM	PPPD daily, constant; VM episodic with migrainous features.
VID vs vertigo	VID = non-spinning, provoked by looking; vertigo = attack-based, spinning.
VID vs syncope	Syncope provoked by standing not looking; orthostatic challenge reproduces.
VID vs central	Central: oscillopsia, vertical nystagmus, gait ataxia — image urgently.

♦ **Pearls — PPPD and VM coexist often: treat both. New VID over 50 with vascular risk + central signs = image urgently. "Anxiety dizziness" that improves with habituation was VID with secondary anxiety.**

INVESTIGATIONS — KEEP IT LIGHT

- **VVAS — baseline at first visit; repeat at 6, 12, 24 weeks. Single best objective measure.**
- **Audiometry — only if hearing symptoms; new asymmetric loss → ENT + MRI.**
- **vHIT / VEMPs — not routine; request via vestibular physician when picture mixed.**
- **MRI brain — only with central red flags; over-investigation reinforces illness identity.**

MANAGEMENT — VISUAL HABITUATION FIRST

Three pillars: structured visual habituation, treatment of underlying condition, pharmacotherapy where indicated. Avoid vestibular suppressants and benzodiazepines — they maintain visual dependence.

Intervention	Detail
Visual habituation	Optokinetic stripes / scrolling 1-2 min twice daily; symptom 2-3/10 only; build over 12 weeks.
Real-world exposure	Quiet supermarket → busy → patterned floors → escalators → highway as passenger.
Treat underlying	Migraine prophylaxis if VM (propranolol, topiramate, candesartan); CBT if anxiety dominant.
SSRI / SNRI	First-line if PPPD dominates: sertraline 25-50 mg/day or venlafaxine 37.5-75 mg/day.
Vestibular suppressants	AVOID — prochlorperazine, betahistine, benzodiazepines maintain visual dependence.
CBT	Useful adjunct, particularly if avoidance, panic, or PPPD overlay.
VR / app-based rehab	Emerging adjunct; useful where in-person rehab access is limited.

♦ **AVOID prochlorperazine, betahistine, and benzodiazepines beyond 48 h — they maintain visual dependence and are the dominant modifiable factor in poor recovery.**

VISUAL HABITUATION LADDER

Phase	What to do	Goal
1 — Preparation	Education; baseline VVAS; rule out untreated VM, BPPV, PPPD.	Patient understands mechanism; treatable conditions started.
2 — Optokinetic	Stripes / dot fields / scrolling video, 1-2 min twice daily.	Tolerable provocation (2-3/10); duration extends each week.
3 — Real-world	Quiet aisles → busy → patterned carpets → escalators → highway.	Re-engage with avoided environments without escalating symptoms.
4 — Maintenance	Weekly self-graded exposure; VVAS at 3 and 6 months.	Sustained low VVAS; resume rehab promptly after any flare.

Pavlou (2013) showed structured optokinetic habituation roughly halves VVAS scores over 12 weeks vs generic vestibular rehabilitation. Adherence is the dominant predictor of recovery.

♦ **Reframe to patient — "Symptoms can spike when habituation begins. This is expected and is the regimen working — keep going. Avoidance worsens VID; graded re-engagement is the cure."**

WHEN TO REFER + RED FLAGS

- ► **VVAS over 15 not improving after 6 weeks of structured rehabilitation — vestibular physician.**
- ► **Suspected PPPD (≥3 months daily VID) — refer for confirmation and pharmacotherapy planning.**
- ► **Vertical nystagmus, direction-changing nystagmus, persistent oscillopsia — image urgently.**
- ► **Any focal neuro sign, gait ataxia, new severe headache, or asymmetric SNHL — urgent referral.**
- ► **Post-concussive VID failing to resolve at 4 weeks — multidisciplinary concussion service.**
- ► **Mal-de-débarquement persisting beyond 3 months — vestibular physician for MdDS protocol.**

♦ **Outlook — Most patients with mild-moderate VID respond to 6-12 weeks of structured visual habituation. PPPD requires longer (3-6 months) and benefits from SSRI/SNRI overlay. Avoidance is the enemy.**