

**VP 06
CHEAT
SHEET**

Cervicogenic Dizziness — Cheat Sheet for Physiotherapists

Diagnosis-by-exclusion, cervical assessment, manual + vestibular combined therapy.

► **Why cervicogenic dizziness matters**

Cervicogenic dizziness has no single confirmatory test. Get the diagnostic process right (exclude vestibular and central first, then confirm cervical) and combined manual plus vestibular therapy delivers an 8–12 week response in most patients.

Indications — when this approach fits

► **When to use this pathway**

- Unsteadiness, floating or spatial disorientation related to neck movement; not true spinning vertigo.
- Coexistent neck pain, headache, visual disturbance; often after whiplash or chronic postural strain.
- Vestibular tests (vHIT, caloric, VEMP) normal AND positive cervical signs (JPE, SMOR, palpation).

Why cervical dysfunction generates dizziness

Mechanism	Source	Result
Cervical proprioception	Upper cervical muscles, facets	Disordered head-on-trunk signal
Central sensory mismatch	Cervical-vestibular-visual conflict	Perceived unsteadiness, no true vertigo
Pain-driven inhibition	Cervical pain, muscle guarding	Reduced range, altered motor control
Whiplash post-trauma	Strain, somatic dysfunction	Chronic dizziness 6–12 months if untreated

► **Pearl: diagnosis is exclusion plus positive signs**

Cervicogenic dizziness is a diagnosis of exclusion. Always rule out vestibular pathology with vHIT or caloric, and rule out central causes through history and exam, before settling on cervicogenic — and confirm with positive JPE, SMOR or palpation findings.

Assessment battery

Domain	Test	Notes
Joint position error	Laser-on-helmet 45 deg rotation	Greater than 5 deg error = positive
Smooth pursuit + neck torsion	SPNT / SMOR	Catch-up saccades during torsion = positive
Cervical ROM	Flexion / extension / rotation	Document deficits and pain reproduction
Palpation	Upper cervical (C0–C3)	Tender points reproducing symptoms
Vestibular rule-out	vHIT or caloric, VEMP	Must be normal
Self-report	NDI + dizziness VAS	Baseline for re-test

Prescription / treatment cheat list

Category	Frequency	Duration	Progress when...
Manual therapy	2–3x/wk	15–20 min	ROM normalises; pain drops 50%
JPE / proprioceptive drills	1–2x daily	5–10 min	JPE error less than 5 deg
Vestibular exercises	Daily	10 min	Add for vestibular overlap or post-trauma
Postural / ergonomic work	Throughout day	—	Patient self-reports posture awareness
Education + reassurance	Each visit	5 min	Confidence about diagnosis improves

► **Pearl: add vestibular work to manual therapy**

Combined manual therapy plus vestibular exercises beats manual therapy alone in published trials. Add gaze stabilisation and graded balance work to every cervicogenic case where there is any vestibular contribution or whiplash mechanism.

► **Red flags — escalate**

Vertical or direction-changing nystagmus, true vertigo, sudden hearing loss, new focal neurology, occipital headache → image and refer urgently; cervicogenic label requires absence of these features.

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Outcome measures — re-test every 4–6 weeks

Domain	Tool	MCID / threshold
Disability	Neck Disability Index	Drop of 5+ points clinically meaningful
Symptoms	Dizziness VAS (0–10)	Drop of 2+ points clinically meaningful
Cervical proprioception	JPE in degrees	Less than 5 deg = normalised
Functional balance	FGA	Up 4 points clinically meaningful
Confidence	ABC scale	Up 10 points clinically meaningful

► **Compliance — what helps adherence**

Frame the diagnosis clearly — patients often arrive frustrated by an inconclusive workup. Use the exclusion rationale as a confidence builder, not a hedge. Pair manual sessions with home proprioceptive drills; week-2 telehealth check-in halves drop-out.

► **When to refer onward**

- No improvement by 6 weeks → re-screen for vestibular hypofunction with vHIT or caloric.
- Suspected vestibular migraine on re-screen → neurology co-management for prophylaxis.
- Persistent whiplash with PTSD or anxiety features → clinical psychology referral.
- Cervical radiculopathy or progressive neurology → spinal surgical opinion.

► **Twelve-second tips**

Diagnose by exclusion plus positive signs. Combined therapy beats single-modality. Re-screen vestibular at week 4 and cervical at week 8. NDI drop of 5+ points and JPE less than 5 deg by 8–12 weeks is the response target.

► **Common pitfalls — and how to avoid them**

- Treating only the neck and missing peripheral vestibular contribution.
- Labelling all post-trauma dizziness as cervicogenic without confirming positive cervical signs.
- Skipping JPE because it feels low-tech — JPE is one of the only objective cervical proprioception tests.
- Forgetting to rule out BPPV after whiplash — Dix-Hallpike and supine roll at presentation.
- Mismatching duration — most cases need 8–12 weeks, not 4.

► **Special populations**

- Whiplash patients — manage cervical and vestibular components in parallel; expect 6–12 months.
- Office workers with chronic strain — postural and ergonomic intervention is essential.
- Older adults with cervical spondylosis — modulate manual therapy intensity and emphasise home drills.
- Athletes returning to contact — combined manual and VOMS-guided vestibular work pre-clearance.

► **Patient communication scripts**

"Your neck is sending mixed signals to the balance system — once we calm those signals, the dizziness settles." | "We are looking for symptoms tied to neck movement, not head impulse — that distinction is the diagnosis." | "Most cases respond in 8–12 weeks of combined hands-on and home work."

► **References / further reading**

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