

Post-Concussion Vestibular Rehabilitation

Sub-Symptom Threshold Exercise and Return-to-Play Pathways

Vestibular Physiotherapy for Clinicians

Topic 7 of 12

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Version 2.0 | May 2026

How to Use This Review

Post-concussion dizziness affects 50–80 percent of acute TBI patients and persists in 15–30 percent beyond the first month. Early, guided rehabilitation improves outcomes. This review equips physiotherapists to identify the five concussion trajectories, apply VOMS and Buffalo Concussion Treadmill testing, prescribe sub-symptom threshold exercise, and progress patients safely through return-to-activity pathways.

Audience: physiotherapists with a special interest in vestibular rehabilitation. The document follows a structured clinical format with numbered sections, integrated callout boxes for rapid reference, summary tables, and a references section. It is designed both as a learning resource and a quick-reference tool for practising clinicians.

Callout Box Guide

Key Point: Foundational concepts and summary statements that anchor the core clinical content of each section.

Clinical Insight: Clinically relevant observations for direct application in assessment and management.

Clinical Pearl: High-yield memorable clinical points — the take-home messages most likely to change practice.

Important: Red flags, emergencies, and critical safety points requiring immediate action.

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I. Introduction and Epidemiology

Dizziness and vertigo affect 50–80 percent of patients in the acute concussion period and persist in 15–30 percent beyond the first month [5,8]. Persistent post-concussion symptoms (greater than three months) occur in 5–15 percent and require multidisciplinary management [19]. Early, guided vestibular rehabilitation reduces symptom burden and accelerates safe return to study, work, and sport [3,12].

Recovery is non-linear and rarely fits the older "rest and wait" model [18]. Active rehabilitation initiated within the first one to two weeks shortens recovery time and reduces the chance of progression to persistent post-concussion syndrome [3,10]. The role of the vestibular physiotherapist is to identify the dominant trajectory, prescribe sub-symptom threshold exercise, and progress through staged return-to-activity gates.

Key Point: Concussion dizziness affects 50–80 percent acutely and persists in 15–30 percent at one month; early active rehab beats prolonged rest in nearly every published cohort.

II. Five Concussion Trajectories

Concussion is heterogeneous: symptoms cluster into five distinct clinical trajectories — vestibular, ocular, cervical, cognitive, and mood/anxiety — each driven by different anatomical substrates and each demanding a different rehabilitation emphasis [8]. The framework was operationalised by Ellis and colleagues from a synthesis of clinical profiles emerging from sport-related concussion cohorts and is now embedded in international practice [8,9]. Most patients show a dominant trajectory plus one or two secondary trajectories, and the dominant pattern identified within the first two weeks predicts the rate-limiting step in recovery and the most effective lead intervention [8,11].

The vestibular trajectory presents with motion sensitivity, gaze instability, dynamic disequilibrium, and disproportionate provocation on the VOMS battery; up to 30 percent of these patients also have superimposed BPPV that must be cleared before vestibular rehabilitation can drive central adaptation [5,11]. The ocular trajectory features convergence insufficiency, accommodative dysfunction, smooth-pursuit interruption, and reading-induced symptoms — these patients tolerate static posture but decompensate during near visual work [7]. The cervical trajectory presents with mechanical neck pain, cervicogenic headache, joint position error, and abnormal cervical relocation testing; it responds to manual therapy combined with sensorimotor cervical retraining as demonstrated in the Schneider randomised trial [4].

The cognitive trajectory presents with processing-speed reduction, working-memory load intolerance, and dual-task interference; it requires graded cognitive load, school or workplace accommodations, and neuropsychology input where impairment persists beyond four weeks [16,19]. The mood/anxiety trajectory features irritability, sleep disruption, and avoidance behaviour, and predicts prolonged recovery if untreated — it warrants early screening with PHQ-9 and GAD-7 and prompt CBT referral [11,19]. Identifying the dominant trajectory directs the lead intervention — vestibular rehabilitation for vestibular-dominant cases, oculomotor work for ocular-dominant, manual therapy plus cervical sensorimotor retraining for cervical-dominant, graded cognitive load for cognitive-dominant, and CBT plus mood support for affective-dominant — while still addressing secondary trajectories in parallel rather than sequentially [8,10].

Trajectory	Lead features	Lead therapy
Vestibular	Dizziness, motion sensitivity,	VRT, VOMS-targeted exercises

	gaze instability	
Ocular	Convergence insufficiency, near-task fatigue	Convergence drills, accommodation work
Cervical	Neck pain, JPE deficit, headache	Cervical manual therapy and proprioceptive retraining
Cognitive	Memory, processing-speed, attention	Graded cognitive load, neuropsych co-management
Mood/Anxiety	Anxiety, depression, irritability	Psychology referral, CBT

Five Concussion Trajectories (Vestibular emphasised)

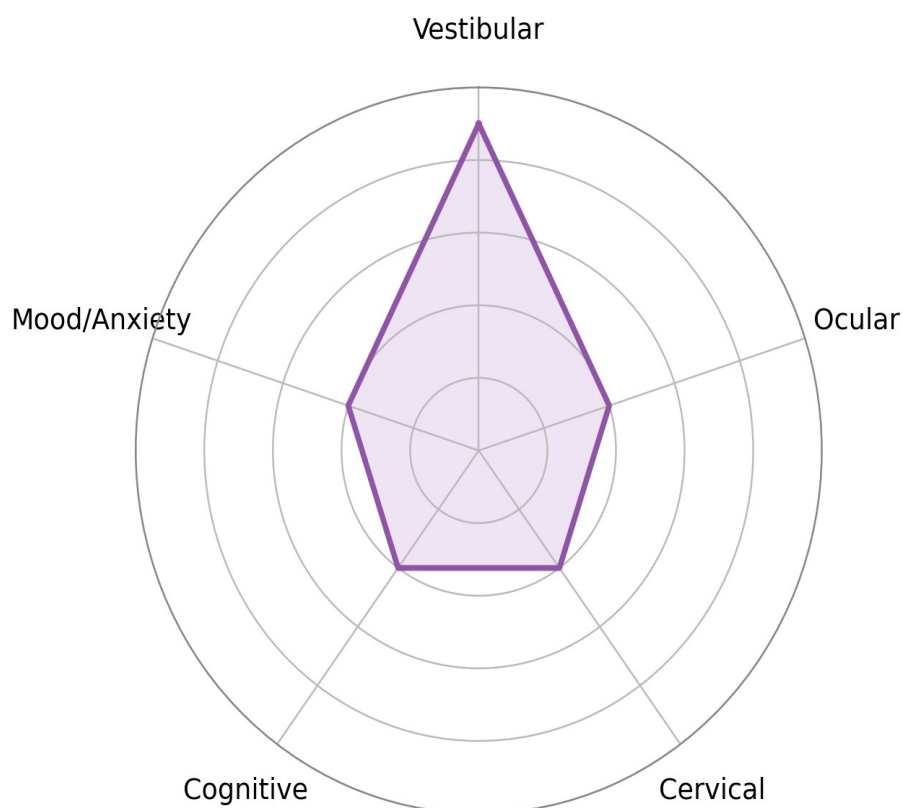


Figure 1. Five concussion trajectories — vestibular emphasised; most patients have one dominant plus one or two secondary trajectories.

Source: Australian Dizziness Clinics, 2026.

III. BPPV in Concussion

BPPV is over-represented in concussion — up to 30 percent of post-concussion vertigo cases have a positional component [5]. The mechanism is mechanical otoconial displacement during the index trauma. Always screen with Dix-Hallpike and supine roll on the first visit, before assuming all dizziness is central or vestibular-trajectory [4].

Important: Untreated post-concussion BPPV will not respond to vestibular rehabilitation alone. Treat the BPPV first with appropriate canal-specific repositioning, then re-screen for vestibular

trajectory features at one to two weeks.

IV. Oculomotor Dysfunction and Convergence

Oculomotor dysfunction is one of the highest-yield post-concussion findings and a leading cause of school- and work-related disability — adolescents and adults return to environments requiring sustained near vision and decompensate when the convergence-accommodation system has not recovered [7]. The mechanism involves disruption of the brainstem oculomotor nuclei and the supranuclear pathways that integrate vergence, accommodation, and pursuit; symptoms emerge whenever the system is loaded by reading, screen work, or rapid head-eye coordination tasks. Master and colleagues found vision-related diagnoses in 69 percent of adolescents seen for sport-related concussion, with convergence insufficiency the single most common diagnosis at 47 percent and accommodative dysfunction at 51 percent [7]. Beyond convergence, look for impaired smooth pursuit (broken or saccadic tracking), inaccurate or hypometric saccades, and reduced VOR cancellation during dynamic visual tasks. Assess near point of convergence (NPC) with a millimetre ruler — bring an accommodative target slowly toward the bridge of the nose, record the distance at which fusion breaks (diplopia), and the distance at which fusion is recovered. Normal is 6–10 cm; a break point greater than 10 cm with reproducible symptoms is diagnostic of convergence insufficiency and predicts response to targeted vergence training [7]. Document near and distance acuity, the King-Devick test for saccadic efficiency, and any photophobia or visual motion sensitivity — these findings shift management toward visual desensitisation in addition to vergence work.

Convergence Rehabilitation

Pencil near-point focusing — sometimes called pencil push-ups — is the simplest first-line exercise: three sets of 10–15 repetitions daily, with the patient maintaining single, clear vision as the pencil approaches the bridge of the nose. The patient stops at the moment of fusion break, holds for two seconds, then withdraws. Progress to Brock string work (three coloured beads on a 1.5-metre string fixed to a wall) which trains accurate vergence and detects suppression. Computer-based vergence and accommodative training programmes derived from the Convergence Insufficiency Treatment Trial framework provide higher-dose stimulation when home exercises plateau, with weekly clinician supervision plus daily home reinforcement producing the largest effect sizes [7]. Combine vergence training with saccadic and smooth-pursuit retraining when these are also impaired — separate dysfunctions require separate exercises rather than a single composite programme. Targets are typically reached at six to eight weeks of consistent practice, mirroring the resolution timeline reported across paediatric and adolescent cohorts [7,16]. Reassess every two weeks with NPC, a symptom-rating scale during a standardised reading task, and the King-Devick test; persistent symptom provocation despite normalised NPC at six weeks should prompt referral to a neuro-optometrist or vestibular physician with concussion expertise [7,11].

V. Assessment: VOMS Screening

The Vestibular/Ocular Motor Screening (VOMS) is the most widely validated bedside vestibular-ocular battery for post-concussion assessment, developed by Mucha and the Pittsburgh group from a derivation cohort of 64 sport-related concussion patients and 78 controls [2]. The instrument is delivered in five to seven minutes, requires no specialised equipment beyond a metronome and a tape measure, and produces a quantifiable provocation profile that maps directly to rehabilitation

prescription. Symptom provocation is rated on four 0–10 visual analogue scales — headache, dizziness, nausea, and fogginess — captured at rest, then re-rated after each item; a two-point or greater rise on any scale, or a near-point convergence break greater than 5 cm, defines a positive result [2]. The seven domains are tested in order: smooth pursuit (horizontal then vertical at 180 degrees per second), horizontal saccades (twenty pairs at approximately 60 degrees per second), vertical saccades, near point of convergence (three trials, mean recorded), horizontal VOR (180 beats per minute against a fixed target), vertical VOR, and visual motion sensitivity (80-degree head and trunk excursions in standing). The original validation reported sensitivity of 89 percent and specificity of 86 percent for distinguishing concussed athletes from controls within the first week of injury [2]. Subsequent work confirmed that VOMS adds independent predictive value beyond computerised neurocognitive testing alone, identifying patients who otherwise look cognitively normal but have ongoing vestibular-ocular dysfunction [13]. The instrument is now embedded in the international concussion consensus assessment toolkit and the SCAT family of instruments [9,20].

Use VOMS as the workhorse serial measure throughout rehabilitation — capture at first visit, weekly during active rehabilitation, and at every return-to-activity gate. Track absolute scores, the provocation pattern across domains, and the symptoms that drive each provocation. Whitney and colleagues showed in a collegiate athlete cohort that elevated acute VOMS scores predict prolonged recovery (greater than 21 days) with strong discriminative power, identifying the patients who need a more graduated rehabilitation timeline rather than the standard symptom-resolution-then-return template [14]. Progressive improvement in VOMS provocation scores across domains is the single most reliable in-clinic indicator of successful adaptation and predicts uneventful return to sport when accompanied by normal aerobic exercise tolerance [13,14]. A persistently abnormal score in any single domain at three to four weeks indicates either inadequate dose of targeted exercise (for vestibular or ocular trajectory), an unrecognised co-existing condition such as BPPV or PPPD overlay, or a need for referral to a vestibular physician [11,14]. VOMS should never be used in isolation: pair it with the Buffalo Concussion Treadmill Test, a focused cervical examination, and a brief mood and sleep screen at every reassessment so each contributing trajectory is being measured and addressed.

VOMS Screening — 7 Domains

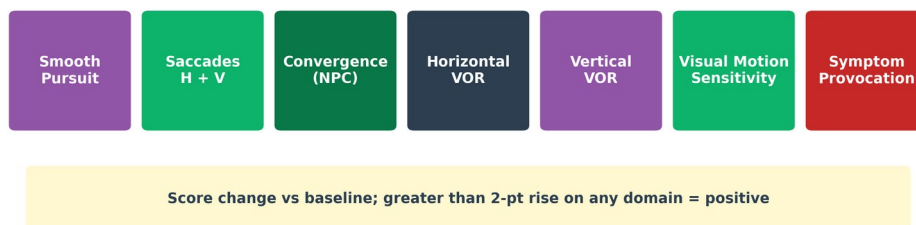


Figure 2. VOMS screening covers seven domains; greater than a 2-point rise versus baseline on any domain is positive.

Source: Australian Dizziness Clinics, 2026.

VI. Buffalo Concussion Treadmill Test

The Buffalo Concussion Treadmill Test (BCTT) is a graded exertion test developed by Leddy and Willer at the University of Buffalo that operationalises the concept of a symptom-exacerbation

threshold and converts it into a prescribable training intensity [3,6]. Procedure: the patient walks on a treadmill at 5.4 km/h (3.3 mph) and the incline is increased by one degree every minute. Heart rate and the four-item symptom VAS (headache, dizziness, foginess, nausea) are recorded at the end of each minute. The test ends at one of three endpoints — a three-point or greater rise on any symptom score (symptom-limited threshold), 90 percent of age-predicted maximum heart rate (HR-limited threshold, indicating physiological recovery), or rating of perceived exertion of 17 or above on the Borg scale (effort-limited). The threshold heart rate at termination becomes the anchor for sub-symptom aerobic prescription [3,6]. The test is feasible and safe in adolescents and children when delivered by an experienced clinician, with no safety incidents reported across multiple paediatric cohorts [17]. Importantly, the BCTT also helps differentiate physiological post-concussion syndrome from other contributors to persistent post-injury symptoms — patients whose symptoms reproduce on the treadmill but resolve with rest are physiologically symptomatic, while patients whose symptoms do not reproduce are more likely to have cervicogenic, vestibular-peripheral, or PPPD-driven contributions and require alternative work-ups [6,8]. Repeat testing every one to two weeks during active rehabilitation tracks both the rising HR threshold and the falling symptom provocation curve, and the rate of threshold rise predicts time to medical clearance [3]. Standardise documentation: symptom scores at each minute, HR at termination, intensity (speed and grade), reason for termination, and the prescribed home HR target (typically 80 to 85 percent of the BCTT threshold).

Core Principles

Three principles drive BCTT-based rehabilitation. First — sub-symptom threshold: exercise intensity must sit just below the level that triggers symptom exacerbation, prescribed at 80 to 85 percent of the BCTT threshold heart rate; this is the level at which Leddy's 2019 randomised clinical trial (n=103 adolescents within ten days of sport-related concussion) demonstrated accelerated recovery and reduced incidence of persistent post-concussion symptoms compared with a stretching control [3]. Second — individualised progression: re-test every one to two weeks and recalibrate the home target as threshold rises; static protocols under-dose patients with recovering autonomic regulation. Third — combination vestibular plus aerobic: pair graded aerobic work with gaze stabilisation, dynamic visual tasks, and balance challenges so the vestibular trajectory is treated alongside the autonomic dysregulation [10,11]. The mechanistic rationale is well documented — sub-symptom aerobic exercise normalises cerebral blood flow regulation, restores autonomic balance, and reduces oxidative stress in the recovering brain, while the vestibular work drives central adaptation when peripheral signals are intact [3,10]. Practical prescription typically delivers 20 to 30 minutes of continuous walking, jogging, or cycling at the calculated target heart rate, five to six days per week, with the vestibular and oculomotor exercise completed separately or layered onto the aerobic session in the second half of recovery.

Stages

- Stage 1: Gentle gaze stabilisation plus walking 40–50 percent maximum heart rate.
- Stage 2: Gaze stabilisation with cognitive load plus 50–60 percent maximum heart rate.
- Stage 3: Vestibular adaptation work plus 60–70 percent maximum heart rate.
- Stage 4: Sport-specific challenges plus 70–80 percent maximum heart rate.

Buffalo Treadmill Protocol — Stages

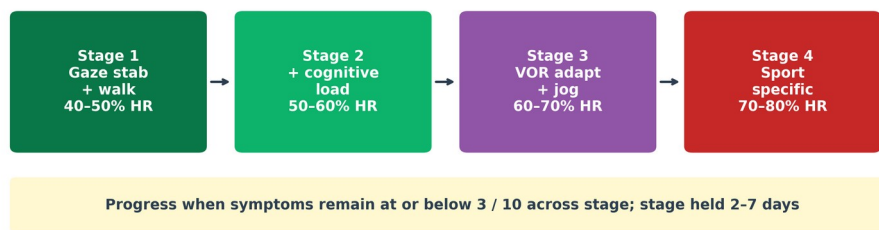


Figure 3. Buffalo treadmill protocol stages — progress when symptoms remain at or below 3 out of 10 across the stage.

Source: Australian Dizziness Clinics, 2026.

VII. Sub-Symptom Threshold Exercise

Exercising above the symptom threshold reinforces symptoms, prolongs autonomic dysregulation, and is the single most common reason rehabilitation programmes fail; exercising at or just below the threshold optimises cerebrovascular and autonomic adaptation and is associated with the fastest documented recovery [3,6]. The clinical method is to rate symptom severity 0–10 at rest, prescribe a target heart rate equal to 80–85 percent of the BCTT threshold, then maintain a flare of 3–4 out of 10 or lower during exercise; reduce intensity if the flare exceeds 4 out of 10 for more than a few minutes or persists at 30 minutes after exercise. Leddy's 2019 randomised clinical trial (n=103 adolescents within ten days of sport-related concussion) provided the highest-quality evidence for the approach: subjects randomised to sub-threshold aerobic exercise recovered in a median of thirteen days versus seventeen days for subjects assigned to a stretching control, and the incidence of persistent post-concussion symptoms (greater than 28 days) fell from 13 percent to 4 percent [3].

The dose-response relationship is reproducible — patients who consistently train at or above 80 percent of threshold show the fastest threshold rise on serial BCTT and the lowest rate of recovery setback [3,10]. Prolonged rest, in contrast, has been formally retired from international guidance: Buckley and colleagues demonstrated that strict cognitive and physical rest does not shorten recovery and may worsen symptoms via deconditioning and mood deterioration [18]. Early active rehabilitation initiated within the first one to two weeks is now the consensus standard of care across the Berlin and Amsterdam concussion statements and is supported by independent paediatric and adolescent cohorts [1,9]. Document daily symptom scores, exercise duration, target HR achieved, and any post-exercise symptom rebound to titrate the next session; a two-day exacerbation following a session is a signal to drop the target by 5 to 10 bpm rather than withdraw exercise altogether [3,10].

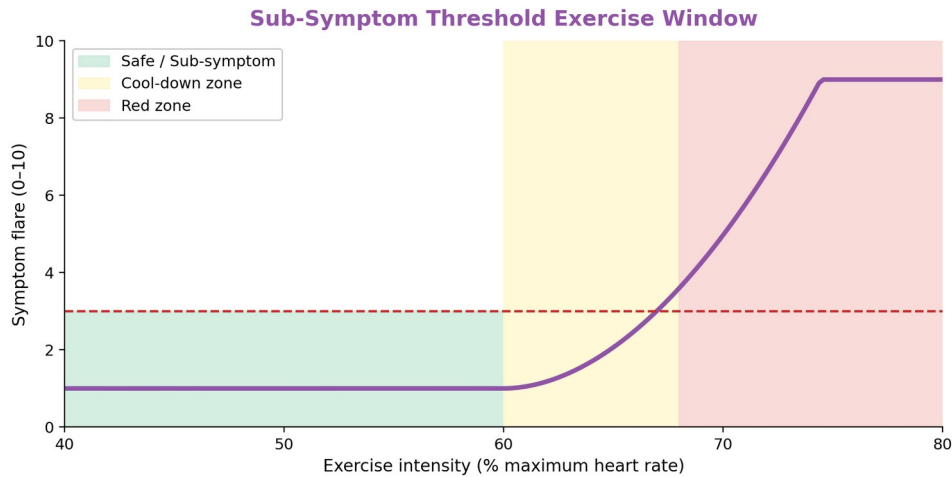


Figure 4. Sub-symptom threshold curve — green safe zone, yellow cool-down zone, red zone above the symptom threshold.

Source: Australian Dizziness Clinics, 2026.

Clinical Pearl: The most common reason post-concussion programmes fail is dosing too high too soon. Cap intensity at the threshold for at least one week, then progress only when the patient is fully symptom-stable across two consecutive sessions.

VIII. Return-to-Activity Progression

Return-to-activity progression follows the six-stage graduated ladder formalised in the Berlin (5th, 2017) and Amsterdam (6th, 2022) international consensus statements on concussion in sport [1,9]. The six stages are: symptom-limited activity (light cognitive and physical activities of daily living), light aerobic exercise (walking or stationary cycling at less than 70 percent of maximum heart rate, no resistance training), sport-specific exercise (running drills or skating drills with no head impact), non-contact training drills (more complex movement patterns, progressive resistance training), full-contact practice (return to normal training activities), and return to play. Each stage takes a minimum of 24 hours symptom-free before progression, and total expected time to return to play is at least one week from full asymptomatic status — often longer in adolescents and children [1,9,16]. SCAT5 — and now SCAT6 — provides the standardised symptom, cognitive, and balance assessment used at each gate to confirm readiness [20].

If symptoms recur during or within 24 hours after any stage, drop back one stage, allow another 24-hour symptom-free period, and re-progress; persistent recurrence after two attempts at a given stage warrants reassessment of the underlying trajectory and may indicate the need for additional rehabilitation rather than stricter rest [1,3]. Common pitfalls include the false-summit trap (a single symptom-free training session is misread as recovery), failing to escalate dose at later stages so the patient is undertested before contact return, and missing the cervical or vestibular contribution to lingering symptoms that present as exertion-limited rather than rest-limited [1,4,11]. Document at each gate: symptom score, BCTT threshold heart rate, VOMS provocation pattern, time spent at the stage, and the criterion that triggered progression. Paediatric and adolescent return-to-activity should always be coordinated with school accommodations — graduated cognitive load typically lags physical clearance by one to two weeks, and full classroom return should precede full return to contact sport [16,17].

Return-to-Activity Progression

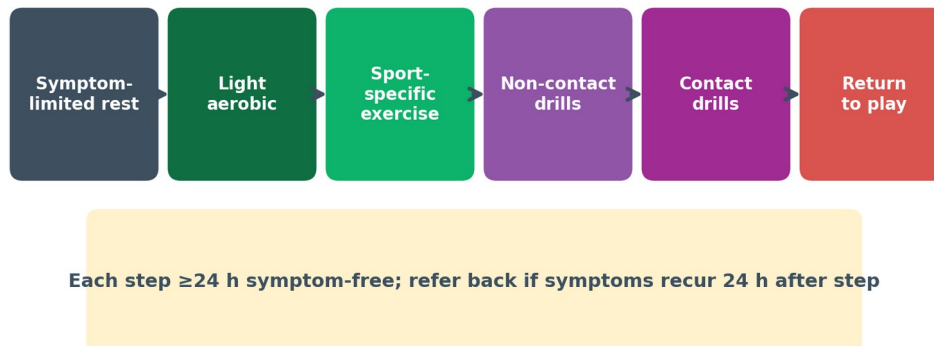


Figure 5. Six-step return-to-activity ladder — each step ≥ 24 hours symptom-free before progression; recurrence drops back one stage.

Source: Australian Dizziness Clinics, 2026.

Important: Avoid the false-summit trap — a single symptom-free training session is not sufficient for return to contact play. Hold each step for at least 24 hours of full symptom freedom before progressing; this is where most early re-injuries occur.

IX. Paediatric and Persistent Symptoms

Children and adolescents under 18 years have longer recovery than adults [15,16]. Developing brains may be more vulnerable to repeated insult, and the vestibular and oculomotor systems are still maturing [16]. Recommend a longer baseline of relative rest (3–7 days), slower progression, and proactive school accommodations such as reduced screen time, frequent rest breaks, and quiet supervised environments during the first 1–2 weeks [16,17].

Persistent Post-Concussion Symptoms

Five to fifteen percent of patients experience persistent symptoms beyond three months [19]. Multidisciplinary management is required: vestibular physiotherapy, neuro-ophthalmology, neurology, and clinical psychology [10,11]. A combined sub-symptom aerobic programme plus targeted vestibular and oculomotor exercises plus CBT for mood and anxiety produces the best long-term outcomes in published cohorts [10,11].

Key Point: Paediatric concussion needs slower progression and school accommodations; persistent symptoms (>3 months) need multidisciplinary care including psychology.

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