VP 12 CHEAT SHEET

Vestibular Migraine — Rehab Cheat Sheet for Physiotherapists

Bárány criteria · trigger management · cautious dosing · co-management.

▶ Why VM rehab is different

VM patients sensitise rather than habituate at standard VRT doses. Cautious dosing — 25–30% of standard VRT volume — and lifestyle pillars are the foundation. Aerobic exercise has Level A evidence — lead with it; layer VRT cautiously over 2–3 weeks.

Bárány / IHS diagnostic criteria — all 4 required

▶ Diagnostic criteria

▶ ≥ 5 episodes of moderate–severe vestibular symptoms (5 min – 72 h).
▶ Current or prior migraine history per ICHD-3 criteria.
▶ 1+ migraine feature (headache, photophobia, phonophobia, visual aura) in ≥ 50% of episodes.
▶ No better explanation by another vestibular or central diagnosis.

Trigger wheel — six categories

Category	Examples	Strength
Sleep	Insufficient / excessive, irregular schedule	Strong
Hydration	Dehydration, especially in heat	Moderate
Dietary	Tyramine, MSG, nitrates, caffeine swings, alcohol	Variable
Hormonal	Menstrual cycle, perimenopause, oestrogen withdrawal	Strong (♀)
Sensory	Bright / flickering light, smells, busy visuals, noise	Strong
Stress / weather	Stress, post-stress let-down, barometric change	Moderate

▶ Pearl: 2-week symptom diary

A 2-week diary capturing sleep, food, stress, hormonal events and episode timing identifies dominant triggers in ~70% of patients. Diary beats any test for guiding lifestyle prescription.

Cautious dosing — VM vs standard VRT

Exercise	Standard dose	VM cautious dose
VOR x1 (gaze stab)	3–5× daily, 1–2 min/axis	1–2× daily, 30–60 sec/axis; eyes-only first
Habituation	2–3× daily until 50% sx ↓	1× daily; tolerate mild flare; slow progress
Visual stimulation	Standard busy scenes early	Graded — simple → complex over weeks
Aerobic exercise	Adjunct	PRIMARY — 30 min, 4–5×/week, Level A
Balance / gait	Standard progression	Standard progression — usually well tolerated

Lifestyle pillars — what carries the prescription

Pillar	Target	Action	Why it matters
Sleep	7–8 h regular	Fixed bed/wake; no screens 1 h before	Strongest single trigger
Hydration	≥ 30 mL/kg/day	Daily target; increase in heat	Cumulative; easy to forget
Diet	Steady, diary-led	Eliminate identified triggers only	Individual — diary beats generic list
Aerobic	30 min × 4–5 / week	Lead with this — Level A evidence	Strongest non-drug intervention
Stress	Daily downregulation	Sleep + exercise = stress buffer	Often the perimenopause trigger

▶ Pearl: lead with aerobic

Aerobic exercise is the only Level A non-pharmacological intervention in VM. Most VM patients tolerate cardio better than VRT in early weeks. Lead with aerobic; layer VRT cautiously over 2–3 weeks.

▶ Red flags — escalate

New focal neurology, acute severe occipital headache, sudden-onset hearing loss, or progressive cerebellar signs → urgent neurology / vestibular physician review. Not VM.

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Outcome measures — re-test at 6 and 12 weeks

Domain	Tool	MCID / threshold
Patient handicap	Dizziness Handicap Inventory (DHI)	≥ 18-pt ↓ MCID; baseline often 50+ in VM
Visual vertigo	Visual Vertigo Analogue Scale (VVAS)	Target 50% ↓ over 12 weeks
Motion sensitivity	Motion Sensitivity Quotient (MSQ)	Baseline often > 30; target 50% ↓
Headache impact	HIT-6	Track in parallel with DHI
Episode frequency	Symptom diary (episodes / month)	Target < 2 / month at 6 months

▶ Compliance — what helps adherence

Lead the diagnosis conversation with the neurobiology rationale — "your brain is hyperexcitable to motion." Pair lifestyle-pillar conversation with the symptom diary at session 1. Most patients become collaborators when they own the trigger map.

▶ When to refer to vestibular physician

- ▶ Episode frequency > 4 / month despite lifestyle optimisation → prophylaxis review.
- ▶ DHI remains > 50 at 12 weeks → escalate prophylaxis or add psychology.
- ▶ Current prophylaxis fails or is poorly tolerated → switch class.
- ▶ New neurological features or change in episode pattern → re-evaluate diagnosis.

▶ Twelve-second tips

Dose-cautious and slow. Lifestyle and aerobic come first. Layer VRT in week 2–3. Plateau is normal — expect 3–6 months. Co-manage with the vestibular physician for prophylaxis. Mild flare is dose; severe flare past 24 h means halve, not stop.

▶ Common pitfalls — and how to avoid them

- ▶ Standard VRT volume in week 1 — flares VM and loses the patient; start at 25–30%.
- ▶ Skipping the symptom diary — without trigger data the prescription is generic and weak.
- ▶ Treating headache and vertigo as separate problems — they share neurobiology and prophylaxis.
- ▶ Stopping rehab at 6–8 weeks — VM trajectory is 3–6 months; track DHI, not session count.
- ▶ Forgetting hormonal triggers in perimenopausal women — gynaecology / endocrine input unlocks recovery.

▶ Special populations

- ▶ Children — diagnosis underused; family history common; lifestyle and reassurance dominate.
- ▶ Perimenopausal women — hormonal trigger profile; joint gynaecology / neurology input often unlocks recovery.
- ▶ Older adults — exclude vestibular schwannoma or central pathology before VM diagnosis.
- ▶ PPPD overlap — VM and PPPD frequently coexist; treat both with cautious VRT + CBT.

▶ Patient communication scripts

"Your brain is hyperexcitable to motion — that is what we are calming with lifestyle and slow exercises."

"We start with aerobic exercise because it has the strongest evidence in vestibular migraine."

"Mild flare is acceptable — it is the dose working. Severe flare past 24 hours means we halve the dose, not push through."

▶ References / further reading

- ▶ Lempert T et al. Bárány VM diagnostic criteria. J Vestib Res 2012; 22(4): 167–172.
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- ▶ Beh SC. Spectrum of VM — clinical features and prognosis. Curr Pain Headache Rep 2018; 22: 14.