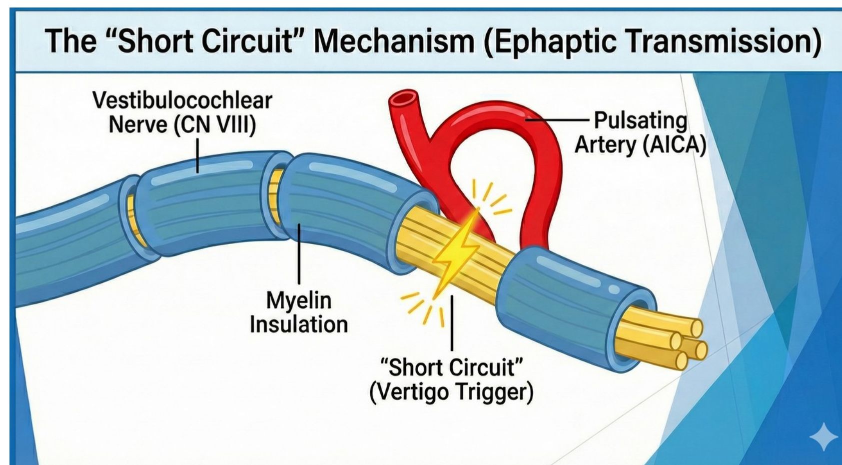
Understanding Vestibular Paroxysmia

Vestibular paroxysmia — information for patients

Your clinician has told you that you have, or may have, a condition called vestibular paroxysmia. This leaflet explains what vestibular paroxysmia is, what the attacks feel like, how it is diagnosed and treated, and what you can do to help yourself. Please bring it with you to your follow-up appointment.

What is vestibular paroxysmia?



Vestibular paroxysmia — a small blood vessel touching the balance nerve causes a brief "short circuit".

Deep inside your head, the nerve that carries balance signals from your inner ear to your brain travels close to several blood vessels. In vestibular paroxysmia, a small artery rests against this balance nerve and presses on it with every heartbeat. Over time this constant pulsing wears away a little of the nerve's insulation, so the nerve misfires from time to time — sending a sudden false "spinning" signal to your brain, rather like a frayed electrical wire causing a brief short circuit. Each misfire is felt as a very short attack of dizziness.

The cause is simply a blood vessel lying against the balance nerve. In most people this happens because, with age, blood vessels become a little longer and more winding, so a vessel that once sat clear of the nerve comes to rest against it. It most commonly begins in mid-life. It is nobody's fault and is not caused by anything you have done.

Key idea: Vestibular paroxysmia is caused by a blood vessel sitting too close to the balance nerve — it is not caused by a stroke, a brain tumour, or anything sinister. Importantly, it usually responds very well to a simple tablet, and most people gain excellent control of their attacks.

What are the symptoms?

- Very brief spinning or dizzy spells — usually lasting only a few seconds, occasionally up to a minute. The world may seem to spin, sway, or tilt.
- Attacks that repeat often — during an active phase you may have many spells in a single day, sometimes dozens, then quieter periods in between.
- Spells that feel the same each time — your attacks tend to be very similar to one another, which actually helps your doctor make the diagnosis.
- Triggers in some people — certain head movements or positions, or a period of fast breathing, can bring on a spell, though many attacks come out of the blue.
- Occasionally a brief ringing — a minority notice a short burst of ringing in one ear during an attack. Marked or lasting hearing loss is not typical and should be mentioned to your doctor.

Between spells most people feel completely well. The attacks are short and self-limiting, but because they come so often they can be unsettling — which is why effective treatment matters.

How is vestibular paroxysmia diagnosed?

There is no single test that proves vestibular paroxysmia. Your vestibular physician makes the diagnosis mainly from the pattern of your attacks — how short they are, how often they come, and how similar they feel each time. A brain scan (MRI) is usually arranged, mainly to rule out other causes of similar symptoms — a routine precaution rather than a sign that anything serious is suspected. A hearing test and simple balance checks may also be done. Often the diagnosis is confirmed by a treatment trial: if your spells settle quickly on the right tablet, that response itself helps confirm the diagnosis.

How is it treated?

The good news is that vestibular paroxysmia is one of the more treatable causes of dizziness — the great majority of people gain excellent control of their attacks.

- The main treatment is a low dose of a medicine that calms over-active nerve signals (carbamazepine, or a close relative, oxcarbazepine). The dose needed is small, and most people see their attacks drop dramatically — often by around 90%.
- Your doctor will usually begin with a small dose and build it up gently to keep side effects to a minimum. If one tablet does not suit you, the other often does. Occasional blood tests may be arranged to check things like your salt levels, especially if you are older.
- Surgery is only very rarely needed. For the small number of people whose attacks are severe and do not respond to tablets, an operation (microvascular decompression) can lift the blood vessel gently off the nerve. This is reserved for selected cases.

Please contact us if: your attacks suddenly change in character or become much longer, you develop new severe headache, double vision, slurred speech, weakness or numbness, marked or lasting hearing loss in one ear, you fall and injure yourself, or you have any new neurological symptom. These features are not typical of vestibular paroxysmia and need rapid review.

What to do during an attack

Because the spells are so short, they are usually over within seconds. If you feel one coming on, stop, stay still, and steady yourself — sit or hold onto something safe until it passes, and fix your eyes on a stationary point. Avoid ladders, heights, or swimming alone until your attacks are well controlled, and follow your doctor's advice about driving until your spells have settled.

What happens over the long term?

The outlook is good. Once you are on the right tablet, attacks usually become rare and most people get on with normal life. After a year or two of good control, your doctor may suggest gently reducing or stopping the medicine; if spells return, simply restarting it brings them back under control. Vestibular paroxysmia does not cause progressive hearing loss or lasting damage to the brain or nerves. The main risk is injury from a fall during a spell, which is why activity precautions matter until your attacks are settled. Anxiety about the next spell is common and treatable — please mention it to your doctor.

Reducing the impact of vestibular paroxysmia on your life

- Keep taking your tablet as prescribed — do not stop suddenly without speaking to your doctor.
- Keep a simple diary of how many spells you have each day — it helps your doctor judge whether the dose is right.
- Take care during a spell — pause, steady yourself, and wait the few seconds for it to pass before moving on.
- Avoid risky activities until control is achieved — heights, ladders, swimming alone — and ask about driving.
- Keep your follow-up appointments — so treatment can be fine-tuned and gently reduced over time.

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