NeuroDash

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THE DIZZY PATIENT — TREAT OR REFER?

A one-page clinical-reasoning cheat-sheet for the PT student & new grad — posterior-canal BPPV.

STEP 1 · SAFETY FIRST — STOP & REFER if you see ANY of these

- **Constant / continuous** vertigo (not brief, positional spells).
- Sudden severe or “first or worst” **headache**, neck pain, or recent head/neck trauma.
- **Neuro signs** — the 5 D’s: diplopia, dysarthria, dysphagia, dysmetria, ataxia — or any focal weakness / numbness.
- Nystagmus that is **vertical** (esp. down-beating), purely torsional, direction-changing, or gaze-evoked.
- Nystagmus with **no latency** that **does not fatigue**.
- New **hearing loss** or tinnitus; or imbalance so severe the patient can’t stand/walk.

→ **Do not perform repositioning. Refer urgently — think central cause / stroke.**

STEP 2 · TEST

No red flags? Screen for posterior-canal BPPV with the **Dix–Hallpike** (the gold-standard test).

- **A positive test** = after a short **latency** (~1–5s), a **transient** (<60s) **up-beating + torsional** nystagmus (top poles toward the lower ear) with vertigo; it **fatigues** on repetition.
- The side that provokes it is the **affected ear**.

STEP 3 · TREAT

Treat posterior-canal BPPV on the affected side with the **Epley** (canalith repositioning). Hold each position until the nystagmus/vertigo settles (≥30s).

- Start in the **Dix–Hallpike** position (head 45° to the affected side, slightly extended). Hold.
- Turn the head **90° toward the unaffected side**. Hold.
- Roll onto the unaffected shoulder; turn the head a further **90°** so it faces ~45° toward the floor. Hold.
- Sit the patient up **slowly**.

STEP 4 · RE-TEST & PLAN

- **Re-test** with the Dix–Hallpike to confirm it’s cleared.
- Tell the patient it may take **more than one session**.
- Arrange **follow-up** + safety-net advice: return if any new neuro signs appear.

REFER — don’t Epley — when

- Findings suggest **horizontal-, anterior-canal, or atypical** BPPV.
- Diagnosis uncertain or nystagmus atypical.
- **No improvement after 2–3** repositioning attempts, or rapid recurrence.
- Any **red flag** appears at any point.
- Cervical-spine, vascular, or ROM issues that make positioning unsafe.

Educational decision support, drafted from the AAO-HNS Clinical Practice Guideline: Benign Paroxysmal Positional Vertigo (Bhattacharyya et al., 2017). It supports your clinical judgment — it does not replace it, your examination, or local protocols. Authored by NeuroDash — not board-certified and not reviewed by an outside specialist.

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