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*Neurology Care 7 days a Week. Because Your Brain Matters.*

# Dizziness and Vertigo (Vestibular Disorders)

Patient education guide · Brain & Spine Injury and Other · Madison Neurology LLC

## What is it?

Dizziness is among the most common reasons adults see a neurologist, and 'dizziness' covers several distinct sensations: vertigo (the illusion of spinning — a vestibular problem), lightheadedness/presyncope (blood pressure or heart), imbalance (neurological or sensory), and vague floating (often anxiety-related or persistent postural-perceptual dizziness). Identifying which one it is points directly to the cause — and most causes are very treatable.

## How does it happen?

Common vestibular causes: BPPV (dislodged inner-ear crystals causing brief spinning with position changes), vestibular neuritis (viral inflammation of the balance nerve — days of severe vertigo), vestibular migraine (a top cause of recurrent vertigo), and Ménière's disease (vertigo with hearing loss and ear fullness). Neurological causes — stroke, MS — are less common but important to exclude. Presyncope points to blood pressure, heart, or medication causes; imbalance on walking points to neuropathy or central causes.

## Common symptoms

- Vertigo: the room spins, often with nausea — brief positional bursts (BPPV), sustained days (neuritis), or recurrent attacks (migraine, Ménière's)
- Lightheadedness on standing (blood pressure, medications, dehydration)
- Unsteady walking, veering, imbalance in the dark (neuropathy, cerebellar causes)
- Chronic persistent floating/unsteadiness worsened by busy visual environments (PPPD)
- Associated clues: hearing changes (ear), headache (migraine), double vision or slurred speech (urgent neurological signs)

## How is it diagnosed?

The history — what the sensation is and what triggers it — does most of the diagnostic work. Examination maneuvers are powerful: the Dix-Hallpike confirms BPPV; the HINTS exam distinguishes inner-ear from brain causes in acute vertigo. Hearing tests, MRI (for central signs or asymmetry), and blood pressure/heart evaluation complete the workup as indicated.

## How is it treated?

Treatment is cause-specific and often dramatic: BPPV is fixed — usually in one or two visits — with repositioning maneuvers (Epley). Vestibular neuritis recovers with brief steroids early and vestibular rehabilitation exercises. Vestibular migraine responds to migraine prevention. PPPD improves with vestibular therapy plus SSRIs and cognitive approaches. Presyncope management addresses blood pressure and medications. Vestibular rehabilitation therapy retrains balance for most chronic causes.

## What does the future hold?

Excellent for the most common causes: BPPV is curable in minutes (though it can recur), neuritis resolves over weeks with rehabilitation, and migraine- and anxiety-related dizziness respond well to treatment. Red flags — vertigo with double vision, slurred speech, weakness, or severe sudden headache — warrant emergency evaluation to exclude stroke.

## Questions patients commonly ask

**Q: Why did the doctor roll my head around — and why did it fix me?**

A: That's the Epley maneuver for BPPV: gravity guides dislodged ear crystals back where they belong — one of medicine's most satisfying cures.

**Q: Is my dizziness a stroke?**

A: The pattern tells: isolated vertigo with a normal neurological exam is usually the inner ear; vertigo with double vision, slurred speech, or severe weakness is an emergency.

**Q: Why do busy stores make me dizzy?**

A: That visual sensitivity is characteristic of PPPD — a common, treatable chronic dizziness where the brain over-relies on vision for balance.

## National support groups & resources

- **Vestibular Disorders Association (VeDA)** — vestibular.org
- **American Academy of Neurology — Brain & Life patient resources** — brainandlife.org
- **American Sleep Apnea Association** — sleephealth.org

(Organization contact details were current at the time of compilation; please verify online.)

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