Summary of Updated BPPV Clinical Practice Guideline

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Fact Sheet

The purpose of this guideline is to improve the quality of care and outcomes for individuals with BPPV. The BPPV clinical practice guideline of 2008 was updated in 2017 by a group of experts including physicians, researchers and a vestibular PT specialist. (1). Changes were made following new evidence from two clinical practice guidelines, 20 systematic reviews, and 27 randomized controls, with enhanced emphasis on patient education and shared decision making, as well as expanded recommendations for diagnosis and management of BPPV

The following are Key Action Statements taken directly from the Updated Guidelines:

1. **Diagnosis of posterior semicircular canal BPPV**

- Clinicians should diagnose posterior semicircular canal BPPV when vertigo associated with torsional, up beating nystagmus is provoked by the Dix-Hallpike maneuver, performed by bringing the patient from an upright to supine position with the head turned 45° to one side and neck extended 20° with the affected ear down. The maneuver should be repeated with the opposite ear down if the initial maneuver is negative.

1b. Diagnosis of lateral (horizontal) semicircular canal BPPV

- If the patient has a history compatible with BPPV and the Dix-Hallpike test exhibits horizontal or no nystagmus, the clinician should perform, or refer to a clinician who can perform, a supine roll test to assess for lateral semicircular canal BPPV.

2a. Differential diagnosis

- Clinicians should differentiate, or refer to a clinician who can differentiate, BPPV from other causes of imbalance, dizziness, and vertigo.

2b. Modifying factors

- Clinicians should assess patients with BPPV for factors that modify management, including impaired mobility or balance, central nervous system disorders, a lack of home support, and/or increased risk for falling.

3a. Radiographic testing

- Clinicians should *not* obtain radiographic imaging in a patient who meets diagnostic criteria for BPPV in the absence of additional signs and/or symptoms inconsistent with BPPV that warrant imaging.

3b. Vestibular testing

- Clinicians should *not* order vestibular testing in a patient who meets diagnostic criteria for BPPV in the absence of additional vestibular signs and/or symptoms inconsistent with BPPV that warrant testing.

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4a. Repositioning procedures as initial therapy

- Clinicians should treat, or refer to a clinician who can treat, patients with posterior canal BPPV with a canalith repositioning procedure.

4b. Postprocedural restrictions

- Clinicians should *not* recommend post procedural postural restrictions after canalith repositioning procedure for posterior canal BPPV.

4c. Observation as initial therapy

- Clinicians may offer observation with follow up as initial management for patients with BPPV.

5. Vestibular rehabilitation

- The clinician may offer vestibular rehabilitation, either self-administered or with a clinician, in the treatment of BPPV.

6. Medical therapy

- Clinicians should *not* routinely treat BPPV with vestibular suppressant medications such as antihistamines and/or benzodiazepines.

7a. Outcome assessment

- Clinicians should reassess patients within 1 month after an initial period of observation or treatment to document resolution or persistence of symptoms.

7b. Evaluation of treatment failure

- Clinicians should evaluate, or refer to a clinician who can evaluate, patients with persistent symptoms for unresolved BPPV and/or underlying peripheral vestibular or central nervous system disorders.

8. Education

- Clinicians should educate patients regarding the impact of BPPV on their safety, the potential for disease recurrence, and the importance of follow-up.

Reference

Bhattacharyya N, Gubbels SP, Schwartz SR, et al. Clinical Practice Guideline: Benign Paroxysmal Positional Vertigo (Update). *Otolary–Head and Neck Surgery* 2017;156(3S):S1–S47.

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