Clinical Practice Guideline: **Vestibular Rehabilitation**

Date of Implementation: **April 17, 2014**

Product: **Specialty**

GUIDELINES

American Specialty Health – Specialty (ASH) considers the use of vestibular rehabilitation, consisting of vestibular rehabilitation exercises, for the treatment of non-specific unilateral and bilateral peripheral vestibular dysfunction (UPVD) as medically necessary.

ASH considers the use of the Dix-Hallpike test for the diagnosis of benign paroxysmal positional vertigo (BPPV) as medically necessary. Additionally, the use of the Epley maneuver and the Semont (liberatory) maneuver for the treatment of BPPV are medically necessary for the treatment of BPPV.

ASH considers manual therapy mobilization or manipulation as not medically necessary for the treatment of isolated cervicogenic dizziness. The literature is insufficient to conclude that it is either clinically effective or ineffective in the treatment of this condition. Additional clinical trials are required to determine the effectiveness of manual therapy mobilization or manipulation for the treatment of cervicogenic dizziness for individual patients in order to determine its benefit:risk profile.

BACKGROUND

Dizziness is a common patient complaint resulting in an estimated seven (7) million doctor visits per year (Hillier et al., 2011). Vertigo is a related symptom that occurs when subjects perceive movement despite being still. In a 2009 review, Neuhauser and Lempert summarized the epidemiology of vertigo (Neuhauser et al., 2009). Per the review findings, community-based surveys indicated that as many as 20-30% of the population reports complaints of dizziness or vertigo. A more detailed neurologic screening indicated that the lifetime prevalence of vertigo is 7.4%, the one year prevalence is 4.9%, and the annual incidence is 1.4% in adults ages 18-79. Additional epidemiology findings showed that the incidence of vertigo is 2.7 times more common in females than males and prevalence increases steadily with age.

According to Hillier et al. (2011), the most common source of dizziness and vertigo is the vestibular system which accounts for 25% of cases. Various conditions can cause vestibular pathology including surgical procedures in this region, head or neck trauma, Meniere’s disease, vestibular neuritis or labyrinthitis, perilymphatic fistula, acoustic neuroma, and benign paroxysmal positional vertigo (BPPV). Differential diagnosis can be difficult, so many studies group patients under the category unilateral peripheral vestibular dysfunction

CPG 173 Revision 9 - S
Vestibular Rehabilitation
Revised – April 20, 2023
To CQT for review 03/13/2023
CQT reviewed and approved 03/13/2023
To QIC for review and approval 04/04/2023
QIC reviewed and approved 04/04/2023
To QOC for review and approval 04/20/2023
QOC reviewed and approved 04/20/2023

(UPVD) or hypofunction (UVPH). Central nervous system pathologies may also cause vestibular dysfunction, but these are less common and are often excluded from studies of vestibular rehabilitation (VR).

Patients with UPVD will report dizziness with associated visual or gaze disturbance, disequilibrium, and balance abnormalities. Oscillopsia may be reported which is a visual disturbance characterized by blurring or movement of the surroundings during gaze. Gaze disturbances may be mediated through interruption of the vestibulo-ocular reflex (VOR), which functions to coordinate eye and head movements to allow for steady gaze as the body moves through space. Various tests and measures have been used to measure baseline status and change over time. There was considerable variation in the applied outcomes measures within the studies under investigation, with authors reporting results on various scales ranging from one item dichotomous (symptom resolution/not), ordinal, or visual analog measures to the Vertigo Symptom Scale (14 items; 0-60 scoring). Gait disturbances may be measured with gait speed or the Dynamic Gait Index (DGI; 8 tasks, 0-24 scale), while the Dizziness Handicap Inventory (DHI) measures participation restrictions. More objective physiological measures such as electronystagmography (ENG) tests for vestibular ocular reflex (VOR) were not considered because they have not been correlated with function (Hillier et al., 2011).

Vestibular Rehabilitation (VR)

Vestibular rehabilitation (VR) is frequently recommended to manage the signs and symptoms of UPVD. VR typically consists of various components, each targeted to a specific aspect of the pathology, including:

- Habituation exercises, which utilize repeated symptom producing motions to decrease the sensitivity to stimuli via neural plasticity. These may also be termed compensatory or neuroplastic strategies (Hillier et al., 2011).
- Adaptation exercises, where patients fix their gaze on a distant point while turning their head in various directions. These are designed to train the VOR and reduce retinal "slip" (Herdman et al., 2013).
- Substitution exercises, designed to sharpen other sensory organs to assist the vestibular system in balance.
- Education on strategies to avoid provocatory motions and promote safe activity despite vestibular hypofunction.

Medications for UPVD such as anti-nausea drugs or vestibular suppressants may be used to reduce symptoms but are seldom long term solutions. Surgery may be used for extreme cases, including procedures such as labyrinthectomy or vestibular nerve resection. They may also be useful for specific pathologies such as an acoustic neuroma or peri-lymphatic fistula (Hillier et al., 2011). Other conservative interventions for vertigo and dizziness include canalith repositioning maneuvers, specifically for BPPV, and manual therapy, advocated for cervicogenic dizziness. These interventions will be reported in a separate section of this paper.

Hillier and McDonnell (2011) provided a comprehensive systematic review of vestibular rehabilitation. Their comprehensive literature review included community dwelling subjects with a physician's diagnosis of UPVD and symptoms of vertigo, dizziness, a balance disorder, and/or visual or gaze disturbances. Subjects with Meniere's disease could be included if they were in later, non-fluctuating stages. There was no age limitation although the majority of patients in the studies were age 65 and over. Studies which utilized exercise and movement-based therapies were included, while studies that focused on specific repositioning maneuvers were excluded. Comparison groups received placebo, sham, usual care, no treatment, specific alternative treatment such as medication or surgery, or another type of vestibular rehabilitation. Relevant outcomes included symptoms, functional measures including balance, or an alternative vestibular rehabilitation approach.

The authors' exhaustive search included articles published through July 2010. A total of 27 studies were included, with 10 additional articles added since the previous update was published in 2007. Sample size for these articles ranged from 14-360 subjects with an average of 64. Four of the studies took place in the acute hospital setting, while the rest of the studies were performed in outpatient clinics. Most studies utilized a combination of therapy approaches (habituation, adaptation, substitution, balance training, and education); only a few studies isolated a particular therapeutic approach. Controls were most often usual care or a sham exercise approach. There was a great deal of heterogeneity in outcome measures, as there appears to be no generally accepted standardized measure of vestibular symptoms. In their assessment of risk of bias, the authors noted generally poor reporting of randomization and allocation procedures with generally low risk of bias in four (4) other categories.

There were 13 studies that compared VR to a sham or usual care control. Most studies favored VR, but the variety of outcome measures made it difficult to formulate an overall summary. When subjective improvement of dizziness was dichotomized (four [4] studies), VR was favored with an OR of 2.67 (95% CI: 1.85-3.86). Hillier and McDonald reported combined standardized mean difference (SMD) of -0.67 on the Vertigo Symptom Scale (three [3] studies), -0.80 on the Dizziness Handicap Inventory (DHI) (four [4] studies), and -0.92 on the Dynamic Gait Index (DGI) (three [3] studies). Various other secondary outcomes also generally supported the use of VR versus a control intervention. VR was compared to alternative treatment in six (6) trials. There were two (2) studies involving subjects with a diagnosis of benign paroxysmal positional vertigo (BPPV). VR was much less effective in "curing" BPPV induced dizziness than physical maneuvers (OR=0.13; 95% CI: 0.03-0.51); however, VR plus physical maneuvers was more effective than physical maneuvers alone for the Dynamic Gait Index (DGI) (SMD=-0.87), while there were non-significant findings for dizziness symptoms. One weak study, which was not included in the meta-analysis due to inadequate data, compared home VR exercise to betahistine medication (a vestibular suppressant) and found VR superior for relief of dizziness symptoms and quality of life. Other studies comparing VR to electrical stimulation or physical maneuvers had either non-significant or mixed findings.

There were five (5) studies that compared one type of VR to another. In general, there were no significant differences between VR approaches. There were significant differences on the Vertigo Symptom Scale for a home VR program plus simulator activities versus home VR alone, and for a formal program for balance and fall prevention versus a home program. Hillier and McDonald noted there were generally low drop-out rates in the studies reviewed and some studies showed gains lasting to twelve (12) months (moderate evidence). The optimal dosage is unclear from the literature, but they noted that "even a minimalist approach" can be effective. No adverse effects were reported in any of the studies included in their review.

A systematic review published by Ricci et al. (2010) focused on the effectiveness of VR in studies published in the previous 10 years that included subjects > 40 years old. They located four (4) studies with subjects >40 years of age, and five (5) with subjects > 60 years of age. Most studies included subjects with general diagnoses such as vestibular hypofunction with subject complaints of dizziness, vertigo or imbalance. They utilized the Physiotherapy Evidence Database (PEDro) criteria for scoring study quality. Nine studies were included, with 4 of 9 rated as "good" quality ($\geq$6/11 on PEDro scale). Most interventions were based on a Cawthorne and Cooksey approach originally developed in the 1940s. Control subjects generally received no exercise or placebo exercise; in one study, control subjects received Tai Chi. These authors reported results that generally favored VR on various outcomes when compared to no treatment or placebo (six [6] studies) but generally no significant differences when compared to an alternative treatment. There were no reports of adverse reactions to VR.

In an informal review of the literature published in 2011-12, Herdman located two additional small randomized controlled trials and one crossover study that supported the effectiveness of VR for patients with dizziness complaints (Herdman et al., 2013). McDonnell and Hillier (2015) completed an update of a Cochrane review first published in 2007 and previously updated in 2011 to assess the effectiveness of vestibular rehabilitation in the adult, community-dwelling population of people with symptomatic unilateral peripheral vestibular dysfunction. Thirty-nine studies involving 2441 participants with unilateral peripheral vestibular disorders were included in the review. Authors concluded that there was moderate to strong evidence that vestibular rehabilitation is a safe, effective management for unilateral peripheral vestibular dysfunction, based on a number of high-quality randomized controlled trials. There was moderate evidence that vestibular rehabilitation resolves symptoms and improves functioning in the medium term. However, there is evidence that for the specific diagnostic group of BPPV, physical (repositioning) maneuvers are more effective in the short term than exercise-based vestibular rehabilitation; although a combination of the two is effective for longer-term functional recovery. There was insufficient evidence to discriminate between differing forms of vestibular rehabilitation. Hall et al. (2016) authored an evidence-based clinical practice guideline on vestibular rehabilitation for peripheral vestibular hypofunction. A systematic review of the literature was performed in 5 databases published after 1985 and 5 additional sources for relevant publications were searched. Article types included meta-analyses, systematic reviews, randomized controlled trials, cohort studies, case control series, and case series for human subjects, published in English. One hundred thirty-five articles were identified as relevant to this clinical practice guideline. Based on strong evidence and a preponderance of benefit over harm, clinicians should offer vestibular rehabilitation to persons with unilateral and bilateral vestibular hypofunction with impairments and functional limitations related to the vestibular deficit. Based on strong evidence and a preponderance of harm over benefit, clinicians should not include voluntary saccadic or smooth-pursuit eye movements in isolation (i.e., without head movement) as specific exercises for gaze stability. Based on moderate evidence, clinicians may offer specific exercise techniques to target identified impairments or functional limitations. Based on moderate evidence and in consideration of patient preference, clinicians may provide supervised vestibular rehabilitation. As a general guide, persons without significant comorbidities that affect mobility and with acute or subacute unilateral vestibular hypofunction may need once a week supervised sessions for 2 to 3 weeks; persons with chronic unilateral vestibular hypofunction may need once-a-week sessions for 4 to 6 weeks; and persons with bilateral vestibular hypofunction may need once-a-week sessions for 8 to 12 weeks. In addition to supervised sessions, patients are to be provided a daily home exercise program.

Arnold et al. (2017) compared the effectiveness of vestibular rehabilitation interventions (adaptation, substitution and habituation) in people with unilateral peripheral vestibular hypofunction, exclusionary of benign paroxysmal positional vertigo and Meniere's disease. Seven papers were selected for inclusion. Results suggest that vestibular therapy for unilateral peripheral vestibular hypofunction is effective. When considering all seven studies included in the review, it was difficult to determine the superiority of one intervention over another in treating unilateral peripheral vestibular hypofunction except when patient outcomes are captured by the dynamic gait index or dizziness handicap inventory. Maslovara et al. (2019) compared the impact of vestibular rehabilitation (VR) in patients with chronic unilateral vestibular hypofunction (UVH) and bilateral vestibular hypofunction (BVH). Authors concluded that well-planned and individually adjusted system of vestibular exercises leads to a significant decrease in clinical symptoms and improvement of functioning and confidence in activities in both the chronic UVH and the BVH patient.

Tramontano et al. (2021) critically assessed the effectiveness of vestibular rehabilitation (VR) administered either alone or in combination with other neurorehabilitation strategies in patients with neurologic disorders. All clinical studies carried out on adult patients with a diagnosis of neurologic disorders who performed VR provided alone or in combination with other therapies were included. Twelve studies were included in the review. All the included studies, with 1 exception, report that improvements provided by customized VR in subject affected by a central nervous system diseases are greater than traditional rehabilitation programs alone. Authors concluded that because of the lack of high-quality studies and heterogeneity of treatments protocols, clinical practice recommendations on the efficacy of VR cannot be made. Results show that VR programs are safe and could easily be implemented with standard neurorehabilitation protocols in patients affected by neurologic disorders. Hence, more high-quality randomized controlled trials of VR in patients with neurologic disorders are needed.

Hall et al. (2022) authored a revision of the 2016 guidelines published by the American Physical Therapy Association and the Academy of Neurologic Physical Therapy and involved a systematic review of the literature published since 2015 through June 2020 across 6 databases. Article types included meta-analyses, systematic reviews, randomized controlled trials, cohort studies, case-control series, and case series for human subjects, published in English. Sixty-seven articles were identified as relevant to this clinical practice guideline and critically appraised for level of evidence. The purpose of this revised clinical practice guideline is to improve quality of care and outcomes for individuals with acute, subacute, and chronic unilateral and bilateral vestibular hypofunction by providing evidence-based recommendations regarding appropriate exercises. The following are reported:

- Based on strong evidence, clinicians should offer vestibular rehabilitation to adults with unilateral and bilateral vestibular hypofunction who present with impairments, activity limitations, and participation restrictions related to the vestibular deficit.
- Based on strong evidence and a preponderance of harm over benefit, clinicians should not include voluntary saccadic or smooth-pursuit eye movements in isolation (i.e., without head movement) to promote gaze stability.
- Based on moderate to strong evidence, clinicians may offer specific exercise techniques to target identified activity limitations and participation restrictions, including virtual reality or augmented sensory feedback.
- Based on strong evidence and in consideration of patient preference, clinicians should offer supervised vestibular rehabilitation.
- Based on moderate to weak evidence, clinicians may prescribe weekly clinic visits plus a home exercise program of gaze stabilization exercises consisting of a minimum of: (1) 3 times per day for a total of at least 12 minutes daily for individuals with acute/subacute unilateral vestibular hypofunction; (2) 3 to 5 times per day for a total of at least 20 minutes daily for 4 to 6 weeks for individuals with chronic unilateral vestibular hypofunction; (3) 3 to 5 times per day for a total of 20

to 40 minutes daily for approximately 5 to 7 weeks for individuals with bilateral vestibular hypofunction.

- Based on moderate evidence, clinicians may prescribe static and dynamic balance exercises for a minimum of 20 minutes daily for at least 4 to 6 weeks for individuals with chronic unilateral vestibular hypofunction and, based on expert opinion, for a minimum of 6 to 9 weeks for individuals with bilateral vestibular hypofunction.
- Based on moderate evidence, clinicians may use achievement of primary goals, resolution of symptoms, normalized balance and vestibular function, or plateau in progress as reasons for stopping therapy.
- Based on moderate to strong evidence, clinicians may evaluate factors, including time from onset of symptoms, comorbidities, cognitive function, and use of medication that could modify rehabilitation outcomes.

In summary, recent evidence supports the original recommendations from the 2016 guidelines. There is strong evidence that vestibular physical therapy provides a clear and substantial benefit to individuals with unilateral and bilateral vestibular hypofunction. Limitations of this guideline includes that the focus of the guideline was on peripheral vestibular hypofunction; thus, the recommendations of the guideline may not apply to individuals with central vestibular disorders. One criterion for study inclusion was that vestibular hypofunction was determined based on objective vestibular function tests. This guideline may not apply to individuals who report symptoms of dizziness, imbalance, and/or oscillopsia without a diagnosis of vestibular hypofunction. These recommendations are intended as a guide to optimize rehabilitation outcomes for individuals undergoing vestibular physical therapy.

Benign Paroxysmal Positional Vertigo

Benign paroxysmal positional vertigo (BPPV) is characterized by short bouts of vertigo or dizziness, often with nausea, brought on by changes in position (e.g., bending down) or rapid head movements, particularly neck extension. Symptoms may resolve spontaneously and may also recur after a period of time without symptoms. BPPV may be associated with a variety of causes such as head trauma (including concussion), vestibular neuritis, and ear infection. Most cases are idiopathic. The female to male ratio is 2:1 for idiopathic; other causes are more evenly distributed. It is more common among ages 50-70. A positive Dix-Hallpike test is diagnostic for BPPV. This maneuver involves taking a patient through rapid changes in position that produce nystagmus, dizziness, and nausea.

Helminski et al. (2010) explain the two mechanisms that have been proposed to explain BPPV. In normal vestibular function, calcite particles (otoconia) are attached to the sensory membrane in the semicircular canals. They serve as weights which make hair-like sensors in the canals sensitive to acceleration movements in their fluid-filled environment. In the mechanism known as canalithiasis, BPPV is hypothesized to result when otoconia break loose and float free in the endolymph, where their movement continues even after the head has stopped moving, thereby causing vestibular symptoms. The other mechanism is termed cupulolithiasis, where the calcite particles become embedded in the cupula, the gelatinous membrane of the canal, causing abnormal weighting in the sensory organ. BPPV may be divided into three types based on canal involvement: posterior, horizontal, and anterior semicircular canal BPPV. The posterior semicircular canal is most often involved in this mechanism. BPPV cases involving the horizontal semicircular canal are reportedly less common and can be more difficult to treat. Anterior Canal BPPV is considered rare and deemed more likely to be self-treated, or resolved, due to gravity. (Gupta, et al., 2019)

The first treatments for BPPV were habituation exercise, first reported in the 1950s. Later, a physical maneuver was advocated by Epley that uses gravity and four (4) position changes designed to move any loose particles through the posterior semicircular canal into the vestibule, where they will not produce symptoms. The success of the Epley maneuver as a treatment for BPPV has led to favoring of the canalithiasis mechanism for BPPV (Hilton et al., 2004). Following, a second physical maneuver known as the Semont or liberatory maneuver was developed to address cases of cupulolithiasis and canalithiasis, involving a rapid 180 degree movement from side-lying on the involved side to side-lying on the uninvolved side to loosen any particles lodged in the cupula. Collectively, these are known as particle repositioning maneuvers. There are home versions of each maneuver and postural/neck range of motion restrictions may be advised for 24-48 hours following treatment.

In an update of a 2004 Cochrane review, Hilton et al. (2014) included studies published through May 2010 that included patients with a positive Dix-Hallpike test, limited to randomized controlled trials studying the Epley versus no treatment, placebo, or an alternative mode of treatment. Key outcomes for inclusion were incidence and severity of vertigo, patient ratings of improvement, and/or a negative Dix-Hallpike test. Their search yielded 22 randomized controlled trials, however 17 were excluded due to high risk of bias (mostly randomization procedure and lack of blinded allocation). For the five (5) studies with low risk of bias, the sample sizes were generally small (36-81 total) and included patients with symptoms less than two (2) weeks. Four of the studies used a sham control while one study used a no treatment control group. Four weeks was the longest follow-up. Meta-analysis revealed a pooled OR of 4.42 (2.62, 7.44) in favor of the Epley maneuver for complete resolution of symptoms, and a pooled OR of 6.4 (3.6, 11.3) for a negative Dix-Hallpike outcome. They found widely varying estimates of natural recovery, from 15-84%. Only one study reported adverse effects – inability to tolerate the Epley maneuver due to vomiting or pre-existing neck pain – but the adverse event rate was not reported.

A companion systematic review by Hunt et al. (2012) focused on adjuncts to the Epley maneuver including limiting cervical movements and maintaining upright posture for 24-48 hours following maneuver, perhaps with a soft collar, and mastoid vibration, using a mechanical device attached to a headband. They included randomized controlled trials involving patients with confirmed BPPV. They located 11 randomized controlled trials that met their inclusion criteria; nine (9) investigated postural restrictions and two (2) studies involved oscillation to mastoid during the Epley maneuver. Sample sizes varied from 38-106, and follow-up was typically one (1) week, although a few studies had a longer follow-up period. They found that the addition of postural restrictions yielded significantly better results for conversion of the Dix-Hallpike test with an RR = 1.13 (1.05, 1.22). Adverse events were tracked in five (5) studies; neck stiffness was more common in the intervention group (27% versus none in one study); development of horizontal BPPV, transient nausea and disequilibrium also occurred rarely but not more common in the experimental versus the control group. The Epley maneuver plus mastoid oscillation was compared to the Epley maneuver alone in two (2) studies; there were no significant differences in conversion of Dix-Hallpike or in the intensity of symptoms.

Helminski et al. (2010) performed a systematic review to determine the effectiveness of particle positioning maneuvers, including the Epley or the Semont (liberatory) method, to treat BPPV. Their search included randomized controlled trials or quasi randomized controlled trials published through 2009. Randomized controlled trials provided strong evidence that the canalith repositioning procedure (CRP) resolves posterior canal (PC) benign paroxysmal positional nystagmus (BPPN); whereas, quasi-RCTs suggested that the CRP or the liberatory maneuver performed by a health care practitioner, or with proper instruction at home by the patient, resolves PC BPPN. Their preferred measure of success was the conversion from a positive to a negative Dix-Hallpike test since vertigo symptoms are dependent on activity levels. Their search yielded 10 studies total:

- There were two (2) true randomized controlled trials (RCTs) and two (2) quasi-randomized controlled trials that all found the Epley maneuver superior (67-95% success) to a sham intervention (10-38% success). In the two (2) true RCTs the odds of resolution of the Dix-Hallpike test were 22-37 times higher for the treatment group.
- There were two (2) quasi-RCTs that compared the Semont (liberatory) maneuver to no treatment that favored the experimental group with 80-85% success versus 35-38% in controls, with an odds ratio (OR) of 7-10.
- There were two (2) quasi-RCTs that compared the Semont (liberatory) maneuver to the Epley maneuver but found no difference overall.
- There were three (3) quasi-RCTs that looked at the effectiveness of self-treatment using a particle repositioning maneuver with or without an in-clinic treatment. They found 90-95% success overall, with 58% for liberatory and 24% for VR exercise only. The OR was 3.5 for Epley + self-administered versus Epley alone. Self-treatment using the Epley maneuver was more effective than using the self-liberatory maneuver (OR = 12.5).

Clinical practice guidelines by the American Academy of Otolaryngology—Head and Neck Surgery Foundation (Bhattacharyya et al., 2008) strongly supported use of the Dix-

Hallpike test for diagnosis and canalith repositioning maneuvers for treatment of posterior canal BPPV. Wegner et al. (2014) evaluated the effectiveness the Epley maneuver compared to vestibular rehabilitation for BPPV. Only five of 373 relevant articles satisfied the eligibility criteria. Results demonstrated that the Epley maneuver is more effective in treating BPPV than vestibular rehabilitation at 1-week follow-up. There is inconsistent evidence for the effectiveness of the Epley maneuver compared with vestibular rehabilitation at 1-month follow-up. An update of the Cochrane Review (Hilton and Pinder, 2014) concluded that there is evidence that the Epley maneuver is a safe, effective treatment for posterior canal BPPV, based on the results of 11, mostly small, randomized controlled trials with relatively short follow-up. There is a high recurrence rate of BPPV after treatment (36%). Outcomes for Epley maneuver treatment are comparable to treatment with Semont and Gans maneuvers, but superior to Brandt-Daroff exercises. Adverse effects were infrequently reported. There were no serious adverse effects of treatment. Rates of nausea during the repositioning maneuver varied from 16.7% to 32%. Some patients were unable to tolerate the maneuver because of cervical spine problems. Oh et al. (2017) compared the efficacy between repetition of Epley maneuver and switch to alternate Semont maneuver in treating posterior canal benign paroxysmal positional vertigo (PC-BPPV) that does not respond to the initial Epley maneuver. 144 (28.5%) patients, who did not respond to the therapy, were randomized to the repetition of Epley maneuver ($n = 70$) or switch to Semont maneuver ($n = 74$). The therapeutic efficacy was determined within 1 hour by a blinded examiner after the trial of each second maneuver. The efficacy did not differ between the repetition of Epley maneuver and switch to Semont maneuver groups. However, the patients with a long duration ($p < 0.001$, linear regression) and latency ($p = 0.01$) of the positional nystagmus during Dix-Hallpike maneuver showed a higher rate of the initial and second treatment failures. Either Epley or Semont maneuver may be applied as a second treatment to the patients with PC-BPPV refractory to the initial Epley maneuver. This study provides Class I evidence that repeated Epley and switch to Semont maneuver shows a similar efficacy in treating PC-BPPV that does not respond to the initial Epley maneuver.

Bhattacharyya et al. (2017) updated the clinical practice guideline. Changes from the prior guideline include a consumer advocate added to the update group; new evidence from 2 clinical practice guidelines, 20 systematic reviews, and 27 randomized controlled trials; enhanced emphasis on patient education and shared decision making; a new algorithm to clarify action statement relationships; and new and expanded recommendations for the diagnosis and management of BPPV. The primary purposes of this guideline were to improve the quality of care and outcomes for BPPV by improving the accurate and efficient diagnosis of BPPV, reducing the inappropriate use of vestibular suppressant medications, decreasing the inappropriate use of ancillary testing such as radiographic imaging, and increasing the use of appropriate therapeutic repositioning maneuvers. The primary outcome considered in this guideline was the resolution of the symptoms associated with BPPV. Secondary outcomes considered included an increased rate of accurate diagnoses of BPPV, a more efficient return to regular activities and work, decreased use of inappropriate medications and unnecessary diagnostic tests, reduction in recurrence of BPPV, and reduction in adverse events associated with undiagnosed or untreated BPPV. The update group made strong recommendations that clinicians should (1) diagnose posterior semicircular canal BPPV when vertigo associated with torsional, upbeating nystagmus is provoked by the Dix-Hallpike maneuver, and (2) treat, or refer to a clinician who can treat, patients with posterior canal BPPV with a canalith repositioning procedure. The update group made a strong recommendation against postprocedural postural restrictions after canalith repositioning procedure for posterior canal BPPV. The update group made recommendations that the clinician should (1) perform, or refer to a clinician who can perform, a supine roll test to assess for lateral semicircular canal BPPV if the patient has a history compatible with BPPV and the Dix-Hallpike test exhibits horizontal or no nystagmus; (2) differentiate, or refer to a clinician who can differentiate, BPPV from other causes of imbalance, dizziness, and vertigo; (3) 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; (4) reassess patients within 1 month after an initial period of observation or treatment to document resolution or persistence of symptoms; (5) 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; and (6) educate patients regarding the impact of BPPV on their safety, the potential for disease recurrence, and the importance of follow-up. The update group made recommendations against (1) radiographic imaging for a patient who meets diagnostic criteria for BPPV in the absence of additional signs and/or symptoms inconsistent with BPPV that warrant imaging, (2) vestibular testing for a patient who meets diagnostic criteria for BPPV in the absence of additional vestibular signs and/or symptoms inconsistent with BPPV that warrant testing, and (3) routinely treating BPPV with vestibular suppressant medications such as antihistamines and/or benzodiazepines. The guideline update group provided the options that clinicians may offer (1) observation with follow-up as initial management for patients with BPPV and (2) vestibular rehabilitation, either self-administered or with a clinician, in the treatment of BPPV.

Rodrigues et al. (2019) evaluated the additional effects of vestibular rehabilitation exercises as a therapeutic resource in the treatment of BPPV, to improve symptoms and reduce recurrence. Thirty-two individuals, both men and women, over 18 years of age with BPPV were randomly assigned to two groups: the control group (n=15) performing only the maneuver technique as treatment and the experimental group (n=17) performing the maneuvers and vestibular rehabilitation exercises. Results demonstrated that the experimental group had a lower level of dizziness in the posttreatment period ($p<0.05$) and a lower incidence of recurrences ($p=0.038$) than the control group. Authors concluded that vestibular exercises performed after repositioning treatments for BPPV increased the overall efficacy of treatment by improving symptoms with a lower rate of recurrence. Power et al. (2020) outlined the incidence of BPPV in specialised vestibular physiotherapy clinics and discusses the various nuances encountered during assessment and treatment of BPPV. Interventions included canalith repositioning manoeuvres (CRP) for posterior canal (PC) or horizontal canal (HC) BPPV depending on the canal and variant of BPPV. Outcome measures included negative Dix-Hallpike (DHP) or supine roll test (SRT) examination. Results indicated that in 91% of cases, PC BPPV was effectively treated in 2 manoeuvres or less. Similarly, 88% of HC BPPV presentations were effectively managed with 2 treatments. Bilateral PC, multiple canal or canal conversions required a greater number of treatments. There was no noticeable difference in treatment outcomes for patients who had nystagmus and symptoms during the Epley manoeuvre (EM) versus those who did not have nystagmus and symptoms throughout the EM. Nineteen percent of patients experienced post treatment down-beating nystagmus (DBN) and vertigo or "otolithic crisis" after the first or even the second consecutive EM. Authors concluded that based on the data collected, repeated testing and treatment of BPPV within the same session is promoted as a safe and effective approach to the management of BPPV with a low risk of canal conversion. Secondly, vertigo and nystagmus throughout the EM is not indicative of treatment success. Thirdly, clinicians must remain vigilant and mindful of the possibility of post treatment otolithic crisis following the treatment of BPPV. This is to ensure patient safety and to prevent possible injurious falls.

Li et al. (2022) compared the efficacy of different treatments for posterior semicircular canal benign paroxysmal positional vertigo (PC-BPPV) by using direct and indirect evidence from existing randomized data. A total of 41 parallel, randomized controlled studies were included. The Epley with vestibular rehabilitation (EVR), Epley, Semont and Hybrid maneuvers were effective in eliminating nystagmus during a Dix-Hallpike test at 1 week of follow-up, among which EVR showed the best efficacy. However, at 1 month of follow-up, only the Semont and Epley maneuvers were effective in eliminating nystagmus during a Dix-Hallpike test. In the pairwise subgroup meta-analysis, for patients younger than 55 years of age, the efficacy of the Epley maneuver was comparable to that of the Semont maneuver]; for patients with a longer duration before treatment, the effect of the Epley maneuver was equivalent to that of a sham maneuver. Authors concluded that among the 12 types of PC-BPPV treatments, the Epley, Semont, EVR, and Hybrid maneuvers were effective in eliminating nystagmus during a Dix-Hallpike test for PC-BPPV at 1 week of follow-up, whereas only the Epley and Semont maneuvers were effective at 1 month of follow-up.

Concussion

Murray et al. (2017) systematically evaluated the evidence supporting the efficacy, prescription and progression patterns of vestibular rehabilitation therapy (VRT) in patients with concussion. Following a double review of abstract and full-text articles, 10 studies met the inclusion criteria: randomised controlled trial (n=2), uncontrolled studies (n=3) and case studies (n=5). 4 studies evaluated VRT as a single intervention. 6 studies incorporated VRT in multimodal interventions (including manual therapy, strength training, occupational tasks, counselling or medication). 9 studies reported improvement in outcomes but level I evidence from only 1 study was found that demonstrated increased rates of medical clearance for return to sport within 8 weeks, when VRT (combined with cervical therapy) was compared with usual care. Heterogeneity in study type and outcomes precluded meta-analysis. Habituation and adaptation exercises were employed in 8 studies and balance exercises in 9 studies. Authors concluded that the current evidence for optimal prescription and efficacy of VRT in patients with mTBI/concussion is limited. Available evidence, although weak, shows promise in this population. Further high-level studies evaluating the effects of VRT in patients with mTBI/concussion with vestibular and/or balance dysfunction are required.

Park et al. (2018) investigated whether vestibular rehabilitation therapy (VRT), rather than continued prescription of rest (cognitive and physical), reduce recovery time and persistent symptoms of dizziness, unsteadiness, and imbalance in adolescents (12-18 y) who suffer post-concussive syndrome (PCS) following a sports-related concussion. Authors noted that VRT was an effective intervention for this population. Adolescents presenting with this cluster of symptoms may also demonstrate verbal and visual memory loss linked to changes in the vestibular system post-concussion. Authors concluded that moderate evidence supports that adolescents who suffer from persistent symptoms of dizziness, unsteadiness, and imbalance following sport concussion should be evaluated more specifically and earlier for vestibular dysfunction and can benefit from participation in individualized VRT. Early evaluation and treatment may result in a reduction of time lost from sport as well as a return to their premorbid condition. For these adolescents, VRT may be more beneficial than continued physical and cognitive rest when an adolescent's symptoms last longer than 30 days. Storey et al. (2018) sought to determine whether active vestibular rehabilitation is associated with an improvement in visuovestibular signs and symptoms in children with concussion. One hundred nine children were included in the study with a mean age of 11.8 (3.4) years. Among this group, 59 (54%) were male and 48 (44%) had a sports-related concussion. Authors concluded that vestibular rehabilitation in children with concussion is associated with improvement in symptoms as well as visuovestibular performance. This active intervention may benefit children with persistent symptoms after concussion. Future prospective studies are needed to determine the efficacy and optimal postinjury timing of vestibular rehabilitation. Schlemmer et al. (2022) synthesized the best available evidence regarding the effectiveness of vestibular rehabilitation therapy (VRT) as a treatment option for adults with mTBIs. Five studies were included in the systematic review: one randomized controlled trial, two retrospective chart reviews, one pre-/post-intervention study, and one case series. Four of the five studies found VRT to be effective at reducing postconcussion symptoms after head injury. Self-reported measures were included in all studies; performance-based measures were included in four out of five studies. None of the studies reported adverse effects of intervention. Authors concluded that results suggest VRT is an effective treatment option for patients with persistent/lingering symptoms after concussion/mTBI, as demonstrated by self-reported and performance-based outcome measures.

Reid et al. (2022) investigated the effect of physical interventions (subthreshold aerobic exercise, cervical, vestibular and/or oculomotor therapies) on days to recovery and symptom scores in the management of concussion. Twelve trials met the inclusion criteria: 7 on subthreshold aerobic exercise, 1 on vestibular therapy, 1 on cervical therapy and 3 on individually tailored multimodal interventions. The trials were of fair to excellent quality on the PEDro scale. Eight trials were included in the quantitative analysis. Subthreshold aerobic exercise had a significant small to moderate effect in improving symptom scores but not in reducing days to symptom recovery in both acutely concussed individuals and those with persistent symptoms. There was limited evidence for stand-alone cervical, vestibular and oculomotor therapies. Concussed individuals with persistent symptoms (>2 weeks) were approximately 3 times more likely to have returned to sport by 8 weeks if they received individually tailored, presentation-specific multimodal interventions (cervical, vestibular and oculo-motor therapy). In addition, the multimodal interventions had a moderate effect in improving symptom scores when compared with control. Authors concluded that subthreshold aerobic exercise appears to lower symptom scores but not time to recovery in concussed individuals. Individually tailored multimodal interventions have a worthwhile effect in providing faster return to sport and clinical improvement, specifically in those with persistent symptoms.

Persistent Postural-Perceptual Dizziness (PPPD)

Persistent postural-perceptual dizziness (PPPD) is a newly defined disorder of functional dizziness that in the International Classification of Diseases in its 11th revision (ICD-11) supersedes phobic postural vertigo and chronic subjective dizziness. PPPD manifests with one or more symptoms of dizziness, unsteadiness, or non-spinning vertigo that are present on most days for three months or more and are exacerbated by upright posture, active or passive movement, and exposure to moving or complex visual stimuli. PPPD may be precipitated by conditions that disrupt balance or cause vertigo, unsteadiness, or dizziness, including peripheral or central vestibular disorders, other medical illnesses, or psychological distress. PPPD may be present alone or co-exist with other conditions. Dieterich and Staab (2017) reviewed nomenclature, clinical features, possible pathomechanisms, and comorbidities of functional dizziness. The prevalence of functional dizziness as a primary cause of vestibular symptoms amounts to 10% in neuro-otology centers. Rates of psychiatric comorbidity in patients with structural vestibular syndromes are much higher with nearly 50% and with highest rates in patients with vestibular migraine, vestibular paroxysmia, and Ménière's disease. Correct and early diagnosis of functional dizziness, as primary cause or secondary disorder after a structural vestibular syndrome, is very important to prevent further chronification and enable adequate treatment. Treatment plans that include patient education, vestibular rehabilitation, cognitive and behavioral therapies, and medications substantially reduce morbidity and offer the potential for sustained remission when applied systematically.

Popkirov et al. (2018) reviewed different treatment strategies for this common functional neurological disorder. Authors noted that an emerging understanding of the underlying pathophysiology that considers vestibular, postural, cognitive, and emotional aspects can enable patients to profit from vestibular rehabilitation, as well as cognitive-behavioral therapy (CBT). Most importantly, approaches from CBT should inform and augment physiotherapeutic techniques, and vestibular exercises or relaxation techniques can be integrated into CBT programs. They conclude that, in PPPD and related disorders, vestibular rehabilitation combined with CBT can help patients escape a cycle of maladaptive balance control, recalibrate vestibular systems, and regain independence in everyday life. Staab (2020) reports in an article on PPPD that the diagnosis is made by identifying key symptoms in patients' histories and conducting physical examinations and diagnostic testing of sufficient detail to establish PPPD as opposed to other illnesses. Ongoing research is providing insights into the pathophysiological mechanisms underlying PPPD and support for multimodality treatment plans incorporating specially adapted vestibular rehabilitation, serotonergic medications, and cognitive-behavior therapy. Cha (2021) authored an article that covered distinct causes of chronic dizziness including persistent postural perceptual dizziness, mal de débarquement syndrome, motion sickness and visually induced motion sickness, bilateral vestibulopathy, and persistent dizziness after mild concussion. Cha states that to date, none of these disorders has a cure but are considered chronic syndromes with fluctuations that are both innate and driven by environmental stressors. As such, the mainstay of therapy for chronic disorders of dizziness involves managing factors that exacerbate symptoms and adding vestibular rehabilitation or cognitive-behavioral therapy alone or in combination, as appropriate. These therapies are supplemented by serotonergic antidepressants that modulate sensory gating and reduce anxiety. Besides expectation management, ruling out concurrent disorders and recognizing behavioral and lifestyle factors that affect symptom severity are critical issues in reducing morbidity for each disorder.

Cervicogenic Dizziness

Lystad et al. (2011) performed a systematic review to determine whether manual therapy with or without VR was an effective treatment for cervicogenic dizziness. These authors cited sources indicating that the etiology of dizziness may arise from multiple sources including, but not limited to, the vestibular system. They noted that the cervical spine may also be implicated (e.g., dizziness may be associated with whiplash injuries, with a plausible mechanism related to high density of proprioceptors in upper cervical spine, acting via reflexes such as the cervico-ocular reflex that connect cervical spine receptors to head and gaze control.)

This systematic review included prospective controlled or non-controlled intervention studies involving patients with cervicogenic dizziness, defined as dizziness or imbalance related to head or neck position or movements, and utilized treatments of manual therapy (manipulation or mobilization) alone or with VR. Methodological quality was assessed using Maastricht-Amsterdam criteria (19 items) with two (2) independent reviewers and a third reviewer to settle disagreements. They found 13 studies: eight (8) single cohort (uncontrolled) studies and five (5) RCTs. Six studies used manual therapy only, seven (7) used manual therapy in conjunction with co-interventions, and none used manual therapy in conjunction with VR. Seven studies were judged low quality, five (5) moderate and one (1) good quality (meeting>80% of quality criteria). They reported that 12/13 studies showed improvement in dizziness symptoms with manual therapy. One high quality RCT on a mobilization technique known as SNAGs (sustained natural apophyseal glides) versus placebo showed better neck pain, dizziness symptoms, and DHI scores for the treatment group versus controls at six (6) and 12 weeks. Three studies reported data on adverse reactions, with two (2) RCTs reporting none, while one cohort study reported "minor adverse reactions" in 8/19 subjects.

PRACTITIONER SCOPE AND TRAINING

Practitioners should practice only in the areas in which they are competent based on their education training and experience. Levels of education, experience, and proficiency may vary among individual practitioners. It is ethically and legally incumbent on a practitioner to determine where they have the knowledge and skills necessary to perform such services.

It is best practice for the practitioner to appropriately render services to a patient only if they are trained, equally skilled, and adequately competent to deliver a service compared to others trained to perform the same procedure. If the service would be most competently delivered by another health care practitioner who has more skill and expert training, it would be best practice to refer the patient to the more expert practitioner.

Best practice can be defined as a clinical, scientific, or professional technique, method, or process that is typically evidence-based and consensus driven and is recognized by a majority of professionals in a particular field as more effective at delivering a particular outcome than any other practice (Joint Commission International Accreditation Standards for Hospitals, 2020).

Depending on the practitioner's scope of practice, training, and experience, a member's condition and/or symptoms during examination or the course of treatment may indicate the need for referral to another practitioner or even emergency care. In such cases it is prudent for the practitioner to refer the member for appropriate co-management (e.g., to their primary care physician) or if immediate emergency care is warranted, to contact 911 as appropriate. See the *Managing Medical Emergencies (CPG 159 – S)* clinical practice guideline for information.

References

Arnold SA, Stewart AM, Moor HM, Karl RC, Reneker JC. The Effectiveness of Vestibular Rehabilitation Interventions in Treating Unilateral Peripheral Vestibular Disorders: A Systematic Review. Physiother Res Int. 2017 Jul;22(3).

Bhattacharyya N, Baugh RF, Orvidas L, et al. Clinical practice guideline: Benign paroxysmal positional vertigo. Otolaryngol Head Neck Surg. 2008;139(5 Suppl 4):S47-81.

Bhattacharyya N, Gubbels SP, Schwartz SR, et al. Clinical Practice Guideline: Benign Paroxysmal Positional Vertigo (Update). Otolaryngol Head Neck Surg. 2017;156(3_suppl):S1-S47. doi:10.1177/0194599816689667

Brodovsky JR, Vnenchak MJ. Vestibular rehabilitation for unilateral peripheral vestibular dysfunction. Phys Ther. 2013;93(3):293-298.

Cha YH. Chronic Dizziness. Continuum (Minneap Minn). 2021;27(2):420-446.

Dieterich M, Staab JP. Functional dizziness: from phobic postural vertigo and chronic subjective dizziness to persistent postural-perceptual dizziness. Curr Opin Neurol. 2017;30(1):107-113.

Gupta AK, Sharma KG, Sharma P. Effect of Epley, Semont Maneuvers and Brandt-Daroff Exercise on Quality of Life in Patients with Posterior Semicircular Canal Benign Paroxysmal Positional Vertigo (PSCBPPV). Indian J Otolaryngol Head Neck Surg. 2019;71(1):99-103. doi:10.1007/s12070-018-1322-7

Hall CD, Herdman SJ, Whitney SL, Cass SP, Clendaniel RA, Fife TD, Furman JM, Getchius TS, Goebel JA, Shepard NT, Woodhouse SN. Vestibular Rehabilitation for Peripheral Vestibular Hypofunction: An Evidence-Based Clinical Practice Guideline: From The American Physical Therapy Association Neurology Section. J Neurol Phys Ther. 2016 Apr;40(2):124-55.

Hall CD, Herdman SJ, Whitney SL, et al. Vestibular Rehabilitation for Peripheral Vestibular Hypofunction: An Updated Clinical Practice Guideline From the Academy of Neurologic Physical Therapy of the American Physical Therapy Association. J Neurol Phys Ther. 2022;46(2):118-177. doi:10.1097/NPT.0000000000000382

Helminski JO, Zee DS, Janssen I, Hain TC. Effectiveness of particle repositioning maneuvers in the treatment of benign paroxysmal positional vertigo: A systematic review. Phys Ther. 2010;90(5):663-678.

Herdman SJ. Vestibular rehabilitation. Curr Opin Neurol. 2013;26(1):96-101.

Hillier SL, McDonnell M. Vestibular rehabilitation for unilateral peripheral vestibular dysfunction. Cochrane Database Syst Rev. 2011;(2):CD005397. doi(2):CD005397.

Hilton M, Pinder D. The Epley (canalith repositioning) maneuver for benign paroxysmal positional vertigo. Cochrane Database Syst Rev. 2004;(2)(2):CD003162.

Hilton MP, Pinder DK. The Epley (canalith repositioning) maneuver for benign paroxysmal positional vertigo. Cochrane Database Syst Rev. 2014 Dec 8;(12):CD003162.

Hunt WT, Zimmermann EF, Hilton MP. Modifications of the Epley (canalith repositioning) maneuver for posterior canal benign paroxysmal positional vertigo (BPPV). Cochrane Database Syst Rev. 2012;4:CD008675.

Li D, Cheng D, Yang W, et al. Current Therapies in Patients With Posterior Semicircular Canal BPPV, a Systematic Review and Network Meta-analysis. Otol Neurotol. 2022;43(4):421-428. doi:10.1097/MAO.0000000000003464

Lystad RP, Bell G, Bonnevie-Svendsen M, Carter CV. Manual therapy with and without vestibular rehabilitation for cervicogenic dizziness: A systematic review. Chiropr Man Therap. 2011;19(1):21-709X-19-21.

Maslovara S, Butkovic-Soldo S, Peric M, Pajic Matic I, Sestak A. Effect of vestibular rehabilitation on recovery rate and functioning improvement in patients with chronic unilateral vestibular hypofunction and bilateral vestibular hypofunction. NeuroRehabilitation. 2019;44(1):95-102.

McDonnell MN, Hillier SL. Vestibular rehabilitation for unilateral peripheral vestibular dysfunction. Cochrane Database Syst Rev. 2015 Jan 13;1:CD005397.

Murray DA, Meldrum D, Lennon O. Can vestibular rehabilitation exercises help patients with concussion? A systematic review of efficacy, prescription and progression patterns. Br J Sports Med. 2017;51(5):442-451.

Neuhauser HK, Lempert T. Vertigo: Epidemiologic aspects. Semin Neurol. 2009;29(5):473-481.

Oh SY, Kim JS, Choi KD, Park JY, Jeong SH, Lee SH, Lee HS, Yang TH, Kim HJ. Switch to Semont maneuver is no better than repetition of Epley maneuver in treating refractory BPPV. J Neurol. 2017 Sep;264(9):1892-1898.

Park K, Ksiazek T, Olson B. Effectiveness of Vestibular Rehabilitation Therapy for Treatment of Concussed Adolescents With Persistent Symptoms of Dizziness and Imbalance. J Sport Rehabil. 2018 Sep 1;27(5):485-490.

Popkirov S, Stone J, Holle-Lee D. Treatment of Persistent Postural-Perceptual Dizziness (PPPD) and Related Disorders. Curr Treat Options Neurol. 2018 Oct 13;20(12):50.

Power L, Murray K, Szmulewicz DJ. Characteristics of assessment and treatment in Benign Paroxysmal Positional Vertigo (BPPV). J Vestib Res. 2020;30(1):55-62.

Reid SA, Farbenblum J, McLeod S. Do physical interventions improve outcomes following concussion: a systematic review and meta-analysis?. Br J Sports Med. 2022;56(5):292-298. doi:10.1136/bjsports-2020-103470

Ricci NA, Aratani MC, Dona F, Macedo C, Caovilla HH, Gananca FF. A systematic review about the effects of the vestibular rehabilitation in middle-age and older adults. Rev Bras Fisioter. 2010;14(5):361-371.

Rodrigues DL, Ledesma ALL, Pires de Oliveira CA, Bahmad F Jr. Effect of Vestibular Exercises Associated With Repositioning Maneuvers in Patients With Benign Paroxysmal Positional Vertigo: A Randomized Controlled Clinical Trial. Otol Neurotol. 2019 Sep;40(8):e824-e829.

Schlemmer E, Nicholson N. Vestibular Rehabilitation Effectiveness for Adults With Mild Traumatic Brain Injury/Concussion: A Mini-Systematic Review. Am J Audiol. 2022;31(1):228-242. doi:10.1044/2021_AJA-21-00165

Staab JP. Persistent Postural-Perceptual Dizziness. Semin Neurol. 2020;40(1):130-137.

Storey EP, Wiebe DJ, D'Alonzo BA, Nixon-Cave K, Jackson-Coty J, Goodman AM, Grady MF, Master CL. Vestibular Rehabilitation Is Associated With Visuovestibular Improvement in Pediatric Concussion. J Neurol Phys Ther. 2018 Jul;42(3):134-141.

Tramontano M, Russo V, Spitoni GF, et al. Efficacy of Vestibular Rehabilitation in Patients With Neurologic Disorders: A Systematic Review. Arch Phys Med Rehabil. 2021;102(7):1379-1389. doi:10.1016/j.apmr.2020.11.017

Wegner I, Niesten ME, van Werkhoven CH, Grolman W. Rapid Systematic Review of the Epley Maneuver versus Vestibular Rehabilitation for Benign Paroxysmal Positional Vertigo. Otolaryngol Head Neck Surg. 2014 May 20;151(2):201-207.