

BPPV (Benign Paroxysmal Positional Vertigo)

Brief spinning spells triggered by head movement, caused by loose calcium crystals floating in the inner ear's balance canals.

THE STORY IN ONE SENTENCE

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“Tiny calcium crystals break free inside your ear and tumble into the wrong tube—so every time you tip your head, they roll and trick your brain into thinking you're spinning when you're not.”

Normal anatomy — the body's job

Your inner ear holds three semicircular canals—tiny fluid-filled loops arranged at right angles to one another, like a gyroscope—that detect rotation of your head in any direction. At the base of these canals sits a chamber called the utricle, whose floor is covered in gel studded with thousands of tiny calcium carbonate crystals called otoconia (meaning 'ear stones'). Those crystals sense gravity and straight-line movement.

BODY'S JOB

When you tilt your head or move in a straight line (forward, backward, up, down), the otoconia press down on hair cells embedded in the gel because of gravity and inertia, and those hair cells send a precise position signal to your brainstem so you know which way is up. At the same time, when you turn or spin your head, the fluid inside the three semicircular canals sloshes in the opposite direction of the movement (because of inertia), pushing against a jelly cone called the cupula that sits inside each canal. The cupula bends, bending hair cells with it, and those cells tell your brain exactly how fast and in which direction you are rotating. Your brainstem puts together the tilt messages (from the otoconia) and the spin messages (from the canals) to keep you balanced and to hold your eyes perfectly steady on a target even when your head is moving—this automatic eye-steadying reflex is called the vestibulo-ocular reflex.

1. Thousands of otoconia (tiny calcium crystals) rest on a gel layer inside the utricle, the base chamber of the inner ear.
2. When you tilt your head, gravity pulls the crystals downward, tugging the gel and bending hair cells underneath.
3. The bent hair cells fire nerve signals through the vestibular nerve to your brainstem, reporting, 'Head is tilted this much in this direction.'
4. Meanwhile, when you turn your head, the fluid inside each semicircular canal lags behind because of inertia, flowing in the opposite direction of your head's spin.
5. That fluid flow pushes the cupula (a jelly cone blocking the canal), bending it and the hair cells inside it.
6. The cupula's hair cells send rotation signals to the brainstem: 'We are spinning this fast, in this direction.'
7. Your brainstem instantly combines the tilt data (from the otoconia) and the rotation data (from the three canals) to compute your head's exact position and movement in three-dimensional space.
8. At the same time, your brainstem sends commands to your eye muscles through the vestibulo-ocular reflex so your eyes move opposite to your head's turn, keeping your gaze locked on target—that is why you can read a sign while walking or running without the world blurring.

What breaks

One or more otoconia break free from the gel pad in the utricle and float into a semicircular canal—most often the posterior (back) canal, because it hangs in the lowest position when you lie on your back. Once inside the canal, the loose crystals are heavier than the fluid around

them, so every time you tip your head in the canal's plane of movement, they roll and drag extra fluid with them. That abnormal fluid flow pushes the cupula when it should stay still, sending a false 'we are spinning' signal to your brain, even though your head only tilted or turned gently.

CLINICAL TERM

Canalithiasis (free-floating otoconia tumbling inside a semicircular canal) or, less commonly, cupulolithiasis (otoconia stuck directly onto the cupula, making it abnormally heavy and gravity-sensitive).

How the body compensates

Your brain cannot turn off or ignore the false spinning signal while the crystals are tumbling, so the a spinning sensation (vertigo) will recur every time you move into a trigger position. The body's immediate compensation is behavioral: you instinctively avoid the movements that set off the spinning. Long-term, the only reliable fix is to physically reposition the crystals out of the semicircular canal and back into the utricle (or another spot where they cannot roll freely), which stops the false signals at their source.

1. {'step': 'Positional avoidance and slower movement', 'how': 'After one or two episodes, people quickly learn which head positions trigger a spinning sensation (vertigo)—lying flat, rolling to one side (usually the affected ear down), looking up at the ceiling, or bending forward—and they begin moving more slowly, sleeping propped up on pillows, or turning their whole body instead of just their head. This minimizes the number of attacks but does not cure the condition; the crystals remain loose.'}
2. {'step': 'Increased reliance on vision and proprioception', 'how': 'Between dizzy spells, the brain compensates for the unreliable inner-ear signal by weighting visual cues (watching the horizon, focusing on stationary objects) and proprioceptive input (signals from muscles and joints about body position) more heavily. You may stand with a wider base, hold onto walls or furniture, or avoid dim lighting and uneven ground where vision and joint sense are less helpful.'}

3. {'step': 'Canalith repositioning maneuver (particle repositioning therapy)', 'how': "A clinician—doctor, physical therapist, or audiologist—guides your head and body through a precise series of positions, each held for twenty to thirty seconds, designed to use gravity to roll the loose crystals along the canal, around its arc, past the cupula, and out through the canal's opening back into the utricle. The Epley maneuver is the most widely used and studied treatment for posterior-canal BPPV (the most common type); the Semont maneuver (also called the liberatory maneuver) and the log-roll (barbecue) maneuver for horizontal-canal BPPV are alternatives. Success rates range from seventy to ninety percent after one or two sessions. Once the crystals exit the canal, the abnormal fluid movement stops and a spinning sensation (vertigo) resolves immediately or within a day or two as any residual debris clears."}
4. {'step': 'At-home repositioning (if trained) or Brandt-Daroff exercises', 'how': 'Patients can be taught to perform the Epley or half-somersault maneuver at home if symptoms recur, which is common—BPPV has a recurrence rate of about thirty to fifty percent over five years. Brandt-Daroff habituation exercises (repeated side-lying movements) are a less specific alternative that may help disperse crystals or desensitize the system, though they are less effective than targeted repositioning.'}
5. {'step': 'Natural resolution over time', 'how': 'If no repositioning is done, loose otoconia may eventually dissolve, fragment into pieces too small to cause symptoms, or clump together and stop moving freely. Symptoms often improve or disappear over weeks to months through this natural process, but they frequently return when new crystals detach.'}

Domino effect

1. Otoconia break free from the utricular macula (the gel patch in the utricle) and become loose particles floating in the inner ear. — The crystals detach because of head trauma, viral labyrinthitis (inflammation of the inner ear), natural aging (the organic matrix holding the crystals weakens, especially after age fifty), prolonged inactivity (bed rest or immobilization reduces normal crystal turnover), or with no known cause (idiopathic) degeneration (no clear cause, which is the most common scenario). Women are affected about twice as often as men, possibly due to hormonal influences on calcium metabolism and bone health.
2. The free-floating crystals drift through a small opening (the crus commune or individual canal opening) into one of the three semicircular canals, most often the posterior canal. — Gravity and head position during sleep or rest allow the loose crystals to tumble into the canal. The posterior canal is lowest when lying supine, so it collects crystals in seventy to ninety percent of cases; the horizontal (lateral) canal accounts for five to fifteen percent, and the superior (anterior) canal is rarely affected (under three percent) because it is positioned highest.

3. When you move your head into the plane of the affected canal—for example, lying down, rolling over, tipping your head back, or bending forward—the heavy otoconia sink or tumble along the canal, pulled by gravity. — Otoconia are denser than the surrounding endolymph (canal fluid), so they act like tiny weights. As they roll downward through the canal, they drag a wave of fluid with them—this is called endolymphatic flow—creating pressure that pushes the cupula at the far end of the canal.
4. The abnormal fluid wave deflects the cupula (the jelly cone that blocks the canal), bending it and the hair cells embedded in it. — Normally, the cupula only bends when the entire head rotates and inertia causes the canal's fluid to lag behind, creating relative fluid flow. In BPPV, the cupula bends during a position change (a tilt or slow movement) because the rolling crystals generate a fluid current that mimics rapid rotation—even though the head is not spinning. This is a false-positive rotation signal.
5. The bent hair cells in the cupula fire a burst of nerve impulses through the vestibular branch of cranial nerve VIII (the vestibulocochlear nerve) to the vestibular nuclei in the brainstem. — Hair cells are mechanoreceptors: when their stereocilia (tiny hair-like projections) bend in one direction, ion channels open, the cell depolarizes, and it releases neurotransmitter (glutamate) onto the vestibular nerve fiber. The brain interprets this signal as 'The head is rotating rapidly in the plane of this canal'—for the posterior canal, that means rotation as if somersaulting backward.
6. The vestibular nuclei in the brainstem instantly activate the vestibulo-ocular reflex (VOR), commanding the eye muscles to move the eyes in the opposite direction of the perceived spin to stabilize vision. — The VOR is a hardwired, automatic reflex with a three-neuron arc: vestibular nerve → vestibular nuclei → oculomotor nuclei (controlling eye muscles). When the brain believes the head is spinning, it moves the eyes the opposite way at the same speed to keep images steady on the retina. In BPPV, because the head is not actually spinning, the reflex produces involuntary eye jerking (nystagmus)—rapid, involuntary, rhythmic eye jerking. For posterior-canal BPPV, the involuntary eye jerking is typically upbeat (eyes jerk upward) and torsional (eyes rotate slightly), and it lasts ten to sixty seconds, matching the time it takes for the crystals to settle.
7. You experience intense rotational a spinning sensation (vertigo)—the sensation that you or the room is spinning or tumbling—and often nausea or even vomiting. — Your inner ear (via the false signal) says you are spinning rapidly, but your eyes (when open), proprioception (muscle and joint sensors), and your cerebellar expectation all say you are nearly still. This sensory mismatch—called sensory conflict—triggers a spinning sensation (vertigo), the illusion of motion. The vestibular nuclei also project to the chemoreceptor trigger zone and the vomiting center in the medulla, so strong vestibular stimulation or conflict commonly causes nausea and vomiting. The a spinning sensation is abrupt, severe, and can be frightening, but it is self-limited.

8. After ten to sixty seconds, the crystals settle at the lowest point in the canal and stop moving; the fluid calms, the cupula returns to neutral, the nerve signal stops, and the spinning sensation (vertigo) fades. — Once the otoconia reach the bottom of the canal and quit rolling, there is no more abnormal endolymph flow. The cupula straightens, hair cells return to their resting firing rate, the false rotation signal ends, and the vestibulo-ocular reflex stops driving the eyes. You may feel unsteady or 'off' for a few minutes to a few hours afterward—a phenomenon called post-a spinning sensation (vertigo) imbalance—but the acute spinning sensation is gone.
9. The next time you move your head into the same position, the crystals roll again and the entire cascade repeats, causing another brief spinning spell. — The crystals remain loose inside the canal; each position change that tips them will restart the chain of fluid flow → cupula deflection → false rotation signal → involuntary eye jerking (nystagmus) and a spinning sensation (vertigo). The only way to stop the cycle is to reposition the crystals out of the canal (via a canalith repositioning maneuver such as the Epley) or wait for them to dissolve or become immobilized naturally over weeks to months—but recurrence is common (thirty to fifty percent over five years) because new crystals can detach at any time.

Symptoms · what the patient feels, and why

- Sudden spinning feeling when you move your head: Tiny calcium crystals called otoconia normally sit in the utricle (a pouch in your inner ear that senses gravity). When they break loose and float into the semicircular canals (curved tubes in your ear that sense head turns), they tumble around during head movement. This makes the fluid in the canals slosh when it shouldn't, sending false spinning signals to your brain even though you're standing still.
- Dizziness triggered by rolling over in bed: Rolling over shifts your head quickly, which moves the loose crystals inside the semicircular canals. The crystals push on tiny hair cells lining the canal, making them bend and fire signals that tell your brain you're spinning. Since you're actually lying still, the mismatch creates the dizzy, spinning feeling.
- A spinning sensation (Vertigo) when looking up or bending down: Tilting your head back to look up or forward to bend down changes where gravity pulls the loose crystals in the canal. This shifts the crystals and makes the canal fluid move, triggering the hair cells to send false spinning signals to the cerebellum (the brain's balance control center at the back of your head).
- Nausea or vomiting during a spinning episode: Your inner ear tells your brain you're spinning, but your eyes see that you're not moving. This mismatch confuses the vestibular nuclei (balance centers in your brainstem) and activates the area postrema (the brainstem's vomiting trigger zone), making you feel sick to your stomach or throw up.

- Brief episodes that last less than one minute: Once you stop moving your head, the loose crystals settle to the bottom of the canal and stop tumbling. The false spinning signals stop within seconds to a minute, so the a spinning sensation (vertigo) fades quickly on its own without any treatment.
- Unsteadiness or feeling off-balance between spinning episodes: Even when the crystals aren't actively moving, your brain remembers the recent false spinning signals and stays on high alert. The cerebellum adjusts your posture and gait to be extra careful, so you may walk more slowly, feel wobbly, or avoid quick head turns.
- Rapid, jerking eye movements during the spinning (nystagmus): Your semicircular canals connect directly to your eye muscles through the vestibulo-ocular reflex (a brainstem pathway that keeps your vision steady when you move). When the loose crystals send false spinning signals, this reflex makes your eyes jerk automatically to try to track the imaginary movement. The doctor can see this eye twitch and use it to confirm BPPV and figure out which canal has the crystals.
- Sudden hearing loss or ringing in one ear during the a spinning sensation (vertigo): BPPV affects only the balance parts of your inner ear, not the hearing parts. If you lose hearing or get new ringing (tinnitus) along with a spinning sensation (vertigo), the problem is likely not loose crystals. Instead, there may be fluid pressure in the cochlea (the snail-shaped hearing organ) as in Meniere disease, or damage to the vestibulocochlear nerve (the nerve that carries both balance and hearing signals to your brain).

Focused exam

- Dix-Hallpike test triggers spinning and you see the patient's eyes jump (nystagmus) after 5-20 seconds, then it stops in under a minute: This confirms crystals in the back canal (posterior semicircular canal — the most common canal for BPPV) are loose and tumbling. The delay, the spinning-room feeling, and the fact it fades are the fingerprint of BPPV — not stroke or ear infection.
- Supine roll test (patient lies flat, you turn head side to side quickly) causes spinning and eye jumping: This tells you crystals are in the horizontal (lateral) canal instead of the back one. The treatment is different for horizontal-canal BPPV, so this test picks the right maneuver.
- Patient can walk in a straight line, tandem gait (heel-to-toe) is steady, and Romberg test is normal: BPPV spins the room only when the head moves; balance between spells is normal. If someone cannot walk or stand even when still, think cerebellum stroke or inner-ear nerve damage instead.
- Hearing is the same in both ears, and the Weber tuning-fork test does not shift to one side: BPPV does not hurt hearing. If one ear is suddenly muffled or you hear a constant ringing (tinnitus), consider Ménière disease or a tumor on the hearing nerve (acoustic neuroma).

- HINTS exam (Head Impulse, Involuntary eye jerking (Nystagmus), Test of Skew): head thrust is normal, involuntary eye jerking only happens during position change, and the cover test shows no vertical eye drift: This three-part check rules out stroke in the back of the brain (posterior circulation). An abnormal head impulse or eyes that drift up-and-down point to brainstem or cerebellum trouble, which needs imaging right away.
- No headache, no numbness or tingling, no slurred speech, no double vision, and no weakness in arms or legs: BPPV is purely a balance problem — it does not touch the rest of the nervous system. If any of these are present with a spinning sensation (vertigo), stroke or multiple sclerosis moves to the top of the list and you need brain imaging urgently.

Diagnostics · every test answers a question

- Dix-Hallpike maneuver (bedside positional test) → Are loose crystals in the posterior semicircular canal causing the spinning?
- Supine roll test (bedside positional test for horizontal canal) → Are crystals in the horizontal (lateral) canal instead of the back canal?
- Audiometry (hearing test) if hearing loss, ringing in the ears (tinnitus), or ear fullness is present → Is the inner ear itself sick (cochlea or nerve), or is this purely a crystal problem?
- Brain MRI with diffusion-weighted imaging (DWI) if HINTS exam is abnormal or patient has stroke risk factors (age > 50, diabetes, high blood pressure (hypertension), atrial fibrillation (an irregular, quivering heartbeat)) → Is there a stroke in the cerebellum or brainstem that is pretending to be BPPV?
- Orthostatic vital signs (blood pressure and pulse lying, then standing after 1–3 minutes) → Is lightheadedness from low blood volume or blood-pressure drop, not inner-ear crystals?
- Fingerstick blood glucose if confusion, sweating, or tremor accompanies dizziness → Is blood sugar dangerously low and mimicking a spinning sensation (vertigo)?
- Serum 25-hydroxyvitamin D level if BPPV recurs often → Is low vitamin D weakening the inner-ear crystals and making them break loose more easily?
- Video head-impulse test (vHIT) if the bedside head-impulse test is hard to read or if vestibulopathy is suspected → Is the inner-ear balance nerve (vestibular nerve) itself damaged, rather than just loose crystals?

Treatment logic

- Epley maneuver (canalith repositioning) for posterior-canal BPPV — a series of four head positions, each held 30–60 seconds, to roll crystals out of the canal → Crystals tumble out of the semicircular canal back into the wide vestibule (utricle — a sac where they cannot trigger spinning). About 70–80% of people are cured in one session; a second session brings cure to ~90%. Spinning stops immediately or within 24–48 hours as debris clears.

- BBQ roll (log roll) or Gufoni maneuver for horizontal (lateral) canal BPPV — rolling the patient 360° in steps, or a quick side-lying maneuver → Clears crystals from the horizontal canal, which the Epley does not reach. Success is also high (~70–90% in one to two sessions). Picks the correct physics for the canal involved.
- Vestibular rehabilitation exercises (Brandt-Daroff or Cawthorne-Cooksey home exercises) if maneuvers fail or BPPV keeps coming back → Trains the brain to ignore false spinning signals and improves balance reflexes. Reduces how often BPPV returns and shortens each episode. Helpful for people with chronic imbalance after repeated BPPV or if crystals will not stay relocated.
- Meclizine 25 mg by mouth (or dimenhydrinate 50 mg) for nausea during the maneuver or the first 24 hours after → Calms the vomit center in the brainstem (area postrema) and reduces the sick-to-your-stomach feeling that comes with spinning. Makes the patient comfortable enough to tolerate repositioning.
- Vitamin D supplementation (1,000–2,000 IU daily or higher-dose repletion if severely low) if serum 25-OH vitamin D is < 20 ng/mL and BPPV recurs often → Low vitamin D may weaken the glue (otoconia matrix protein) holding crystals in place. Repleting vitamin D can cut recurrence roughly in half in people with low levels (per multiple small trials). Safe, cheap, and targets a modifiable cause.
- Patient education: sleep semi-upright (two pillows) for 24–48 hours after the maneuver, avoid rapid head movements for a few days, and return if spinning lasts hours or hearing changes → Lets crystals settle in the vestibule and not tumble back into the canal. Reduces the chance the maneuver will fail. Empowers the patient to recognize when something more serious (stroke, Ménière) is happening.
- Surgical posterior canal plugging (rare, < 1% of cases) if BPPV is disabling and fails all maneuvers and rehab for months → Physically blocks the problem canal so crystals cannot float and cause spinning. Success rate is high (> 90%) for stopping a spinning sensation (vertigo) in intractable cases.

Medications

Meclizine · Antihistamine (H1 blocker)

Meclizine blocks histamine signals in the balance centers of your inner ear and in the part of your brainstem that triggers throwing up. When those histamine messages are turned down, your brain gets fewer spinning signals, which calms the dizzy feeling and stops the sick-to-your-stomach urge.

1. The loose calcium crystals in your semicircular canal (the curved tube in your ear that senses head turns) send confusing movement signals every time you tilt your head.

2. Those false signals travel to the vestibular nuclei in your brainstem and trigger histamine release.
3. Histamine attaches to H1 receptors and cranks up the spinning sensation and nausea.
4. Meclizine sits on those H1 receptors and blocks histamine from landing.
5. With fewer histamine signals getting through, your brain perceives less spinning.
6. The vomit center also gets fewer triggers, so you feel less nauseated.

SAFETY WATCH

Drowsiness and tiredness (very common; do not drive or use machinery until you know how it affects you) · Dry mouth and blurred vision (because it also blocks acetylcholine receptors, which control moisture and focus) · Use caution in older adults; can cause confusion, falls, or trouble urinating, especially in men with enlarged prostate · Avoid alcohol; it adds to the drowsiness and raises fall risk · Not recommended for long-term daily use; meant only for short relief during acute dizzy spells (usually a few days) · May worsen narrow-angle glaucoma (a type of eye pressure disease); tell your doctor if you have this · Generally safe in pregnancy (Category B in older FDA labeling), but always confirm with your doctor before taking any medicine while pregnant

Dimenhydrinate (Dramamine) · Antihistamine (H1 blocker; contains diphenhydramine plus 8-chlorotheophylline, a mild stimulant)

Dimenhydrinate works almost the same as meclizine: it blocks histamine signals in your inner-ear balance system and brainstem to quiet the spinning sensation and calm nausea. The drug is actually a combination of diphenhydramine (an antihistamine) and a caffeine-like molecule, but the antihistamine part does the real work for dizziness.

1. Loose calcium crystals in your semicircular canal send false spinning signals when you move your head.
2. Those signals boost histamine activity in the vestibular nuclei.
3. Histamine attaches to H1 receptors and amplifies the dizzy and nausea messages.
4. Dimenhydrinate blocks those H1 receptors, so histamine cannot attach.
5. With histamine blocked, your brain receives fewer spinning messages.
6. Nausea signals also drop, so you feel less sick.

SAFETY WATCH

Drowsiness (very common; avoid driving or operating heavy equipment) · Dry mouth, blurred vision, and constipation (anticholinergic side effects) · Confusion and increased fall risk in older adults · Do not combine with alcohol or other sedatives; they stack and can make you dangerously sleepy · Not for long-term daily use; only short-term symptom relief (a few days at most) · Can worsen narrow-angle glaucoma and urinary retention (trouble peeing) · Generally safe in pregnancy (Category B in older FDA labeling), but discuss with your doctor before use

Promethazine (Phenergan) · Antihistamine (H1 blocker) with dopamine (D2) blocking action

Promethazine blocks histamine receptors in the balance centers and also blocks dopamine receptors in the vomiting center of your brainstem. This double block makes it especially strong at stopping severe nausea and vomiting that can come with intense a spinning sensation (vertigo). It calms the spinning feeling and settles your stomach.

1. Loose crystals in your semicircular canal send abnormal spinning signals to the vestibular nuclei.
2. These signals activate both histamine and dopamine pathways, which drive a spinning sensation (vertigo) and nausea.
3. Promethazine blocks H1 histamine receptors and D2 dopamine receptors at the same time.
4. With both pathways blocked, your brain receives far fewer spinning and nausea triggers.
5. You feel less dizzy and much less likely to vomit.

SAFETY WATCH

Very sedating (often more than meclizine or dimenhydrinate); do not drive or do anything that requires alertness · Dry mouth, blurred vision, and constipation (anticholinergic effects) · Can cause severe tissue damage and gangrene if the IV injection leaks outside the vein; nurses must give it slowly and watch the site carefully · Not recommended in children under 2 years old (risk of fatal slowed breathing); use cautiously in children under 6 · Can cause restless-leg sensations or involuntary muscle movements (extrapyramidal side effects from dopamine blocking) · Avoid in older adults when possible; high risk of confusion, falls, and urinary retention · Do not use with alcohol, opioids, or other sedatives; dangerous breathing suppression can result · Pregnancy Category C (older FDA labeling; animal studies show some risk); use only if benefit clearly outweighs risk; discuss with your doctor

Red flags

- New severe headache or the worst headache of your life with the a spinning sensation (vertigo)
- Weakness, numbness, or trouble moving one side of your face, arm, or leg
- Double vision, slurred speech, or difficulty swallowing
- A spinning sensation (Vertigo) that lasts hours without stopping or keeps getting worse
- Loss of consciousness, confusion, or trouble staying awake during the spinning episode

Nursing priorities

1. Keep the patient safe from falls by staying close, using the call bell, and helping with all movement. — The sudden spinning makes balance impossible. Patients can fall and break bones or hit their head if they try to walk alone. We lower the bed, keep the path clear, and walk with them every time until the crystals are fixed and the spinning stops.
2. Help position the patient comfortably and teach them to move slowly, pausing between position changes. — Fast head movements stir up the loose crystals and make the spinning worse. Moving in stages—sit up slowly, pause, then stand—gives the crystals time to settle and reduces the intensity of each spin. Patients feel more in control and less frightened when they know how to minimize triggers.
3. Give anti-nausea medicine as ordered and offer small sips of clear fluids or bland crackers. — The brain's confusion from spinning signals often causes strong nausea and vomiting. Medicine blocks the nausea pathways in the brain. Keeping the stomach calm prevents dehydration and helps the patient feel well enough to cooperate with repositioning maneuvers that fix the problem.
4. Prepare for and assist with the Dix-Hallpike test and repositioning maneuvers like the Epley maneuver. — The Dix-Hallpike test moves the head into positions that make the crystals shift, which creates spinning and tells us exactly which ear canal the crystals are in. The Epley maneuver then rolls the head through a careful sequence that guides the crystals back to the right spot. This is the main treatment—it fixes the root cause instead of just masking symptoms.
5. Teach the patient what BPPV is, why it happens, and that it is not dangerous or a sign of stroke. — Sudden spinning is terrifying. Many patients fear they are having a stroke or something life-threatening. Explaining that loose crystals cause the spinning, that it is benign and fixable, calms fear and builds trust. Understanding also helps patients follow through with repositioning exercises and know when to return if symptoms come back.

Sources

- American Academy of Otolaryngology–Head and Neck Surgery (AAO-HNS) Clinical Practice Guideline: Benign Paroxysmal Positional Vertigo (2017)
- American Academy of Neurology
- Cochrane Database of Systematic Reviews
- UpToDate

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