

Persistent Postural-Perceptual Dizziness versus Vestibular Migraine: Clinical Overlap and Diagnostic Challenges

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Abstract

Persistent postural-perceptual dizziness (PPPD) and vestibular migraine (VM) are prevalent vestibular syndromes whose overlapping manifestations often confound their clinical presentation, differential diagnosis, and management. This review focuses on their conceptual definitions, diagnostic criteria, pathophysiological models, clinical presentation, assessment approaches, treatment implications, prognosis, and future perspectives. Both syndromes are characterized by similar symptoms including dizziness, disequilibrium, motion intolerance, visual intolerance, and spatial orientation difficulties, although temporal and symptomatic patterns, precipitating factors, migraine-related associations, and responses to postural or visual stimuli may help distinguish them. The current theoretical framework highlights dysfunctions in multisensory integrative processes and central vestibular networks, although their relative contribution is different in the two disorders. Thus, diagnosis relies primarily on a detailed history, including temporal progression of symptoms, associated features, and established classification criteria, along with pertinent bedside vestibular examination and selected objective tests to exclude alternative conditions and identify concomitant syndromes. PPPD and VM often coexist and an either/or approach may be inappropriate, and an approach focused on identifying the dominant syndrome while recognizing overlapping manifestations may be more helpful to clinicians. Future studies should aim at establishing biomarkers, standardized assessment procedures, consistent terminology, and longitudinal studies to develop clinical decision-making strategies for patients with complex presentations.

Key words: persistent postural-perceptual dizziness; vestibular migraine; dizziness; vertigo; differential diagnosis; multisensory integration

1. Introduction

Persistent Postural-Perceptual Dizziness and vestibular migraine are two common vestibular syndromes that are recognized alongside a growing number of rare vestibular disorders [1]. Vestibular migraine is suspected to be among the most frequent causes of vertigo in the general population while persistent postural-perceptual dizziness is one of the most common chronic vestibular syndromes [2]. Despite the noticeable prevalence of both syndromes, the two share overlapping symptoms that lead to significant difficulties in differential diagnosis [3]. In particular, those in whom diagnosis is uncertain tend to deteriorate further, added into the worsening anxieties related to the ongoing vestibular disorder chronicity [4, 5].

It remains unclear whether persistent postural-perceptual dizziness and vestibular migraine may be entirely dissociated and hence classified as two separate syndromes, as is presently maintained by diagnostic manuals; or instead, whether a continuum exists between the two and whether the two syndromes can frequently coexist, as is pointed out by many clinical authors [6, 7].

2. Conceptual Definitions and Diagnostic Criteria

Vestibular migraine (VM) is defined as a course of vestibular symptoms (vertigo, dizziness) and migraine attacks fulfilling the criteria, parallel the temporal organization of core PPPD features and their associated conditions [8, 9]. Presentation of core symptoms, criteria, and potential signs exhibited by patients when classifying them as PPPD or VM indicates significant overlap along with a supporting history of disturbances providing further clinical evidence supporting integrated models linking both pathophysiological and diagnostic criteria [10, 11].

3. Pathophysiological Considerations

Pathophysiology models of PPPD and VM share core premises and suggest multi-sensory and network deficits influencing both generation and maintenance of symptoms [12]. Abnormalities in multi-sensory integration, especially visual-proprioceptive-vestibular, dominate current conceptualization of PPPD and emphasize particular roles of cerebellar, parietal, and frontal areas in producing vestibular percepts [7]. Proposed brain dysfunction mechanisms combine network disconnection, excessive connectivity, impaired adaptation, and competition among

primary and secondary stimuli [3]. Models account for substantial variability across patients [13].

While PPPD has no known pathophysiological underpinning, models posit chemosensory, inflammatory, and vascular elements that subtly

influence symptom characteristics, duration, and treatment responses. Supporting data are sparse; further exploration to clarify their impact is warranted [14]. Multi-sensory integration and network dysfunction theories explain VM initiation as obligatory synaptic events while considering systemic factors that sustain perturbations [15] (Figure 1).

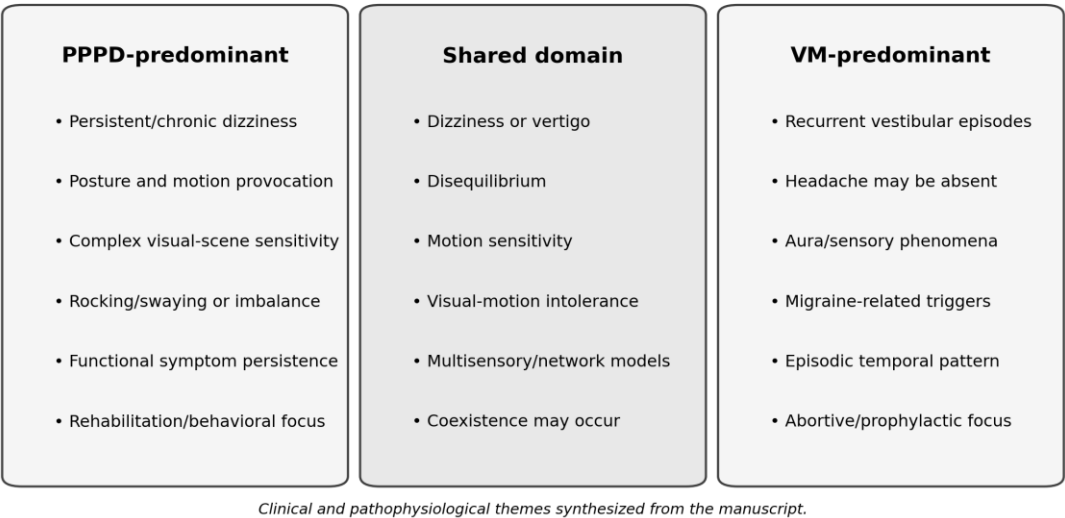


Figure 1: Clinical overlap map of PPPD and vestibular migraine.

4. Clinical Presentation and Symptomatology

At first glance, persistent postural-perceptual dizziness and vestibular migraine can appear to be two distinct entities, yet on closer inspection, they exhibit overlapping dimensions [13]. Both conditions present chronic dizziness, share numerous common features, and experience exacerbation by some of the same triggers [7]. These overlapping characteristics can create significant confusion for practitioners who may be unaware of the precise diagnostic evolution and stringent criteria required to identify vestibular migraine [15].

Dizziness associated with vestibular migraine may be isolated or accompany headache, but unilateral sensory phenomena and visual aura can also arise without headache [2]. In contrast, persistent postural-perceptual dizziness is inherently linked to vestibular dysfunction and remains ongoing, characteristically first appearing following an episode of spontaneous vertigo, motion sickness, or significant isometric exertion [1]. The diagnosis encompasses a broad spectrum of clinical manifestations, presenting a highly variable and not fully understood phenomenology [16]. Patients may experience swaying, rocking, bobbing motions, lightheadedness, faintness, imbalance, or sensation of movement [3]. Symptoms can worsen following specific head movements, complex visual motion or busy patterns, environments with high visual contrast, multitasking, or shifts between near and far visual targets [17].

5. Diagnostic Overlap: Similarities and Distinguishing Features

Management strategies for patients with vestibular migraine (VM) or persistent postural-perceptual dizziness (PPPD) are distinctly different (2). Vestibular migraine is primarily a treatable central vertiginous disorder that affects the brain’s ability to process inputs from the vestibular system and is recognised as a peripheral vestibular disturbance (18). By contrast, PPPD is regarded as a chronic functional disability, to recover there is a need for restoration of balance by re-learning vestibular cue processing, recognition of motion and incorporation of other multisensorial information [5].

Vestibular migraine may often dominate case histories [19]. The distinctions can be slight, but a few indicators can help clarify the diagnosis [20]. Common symptoms for both disorders include oscillatory or rotational, vertigo or dizziness, disorientation, intolerance of motion, change in postural stability, and visual motion intolerance [21]. Visual triggers and motion sensitivity can also be shared and PPPD and VM patients [22]. A history of migraine may be absent and symptoms worsen with menstrual cycle, postural or environmental factors, mowing, massaging, or mental health issues [23]. The duration of the symptoms can be few minutes to days, compared to PPPD, VM is more influence by postural factors and visual conflict enabling rapid identification of the patient’s diagnosis [24, 25] (Table 1).

Clinical dimension	PPPD	Vestibular migraine	Diagnostic interpretation
Temporal pattern	Persistent or chronic dizziness/unsteadiness; symptoms may remain ongoing.	Recurrent vestibular episodes with variable duration; headache may or may not accompany dizziness.	Chronology is a major differentiator, although overlap and coexistence can blur the pattern.
Prominent triggers	Postural factors, head/body motion, complex visual motion, busy patterns, and visual conflict.	Typical migraine triggers; menstrual and environmental factors may contribute; motion/visual stimuli can also worsen symptoms.	Visual and motion sensitivity are shared and should not be used alone to assign a diagnosis.

Typical symptom language	Rocking, swaying, bobbing, lightheadedness, imbalance, or a sensation of movement.	Vertigo or dizziness, disequilibrium, rotational/oscillatory sensations; migraine-related sensory symptoms may occur.	Patient wording is useful for profiling but is not by itself diagnostic.
Associated features	Functional impact and cognitive/behavioral preoccupation may become prominent in chronic illness.	Headache, visual aura, or unilateral sensory phenomena may occur, but headache can be absent.	Associated migraine features increase diagnostic support for VM; their absence does not resolve all ambiguous cases.
Mechanistic emphasis	Visuo-vestibular/proprioceptive integration, adaptation, and central vestibular network dysfunction.	Central vestibular and multisensory network dysfunction with migraine-related cortical/vascular mechanisms.	Shared network models provide a basis for clinical overlap.
Management emphasis	Vestibular rehabilitation, cognitive-behavioral/exposure approaches, and selected pharmacological options.	Acute abortive measures, prophylactic strategies, trigger avoidance, and vestibular rehabilitation.	Treatment should follow the predominant clinical phenotype when both syndromes are considered.
Diagnostic anchors	Contemporary PPPD criteria and functional/temporal clinical profiling.	Bárány Society and International Headache Society criteria.	Formal criteria should be integrated with clinical history and evaluation for coexisting disorders.

Table 1: Clinical comparison of persistent postural-perceptual dizziness and vestibular migraine.

6. Diagnostic Methodologies and Assessment Tools

Persistent Postural-Perceptual Dizziness (PPD) and Vestibular Migraine (VM) represent two common disorders with widely overlapping clinical features and, therefore, frequently ambiguous diagnoses in clinical practice [26-28]. The present study seeks to document and clarify the nature of this clinical overlap, identify potential decision-support heuristics for provisional differential diagnosis, and outline methodology and impairment markers to guide appropriate ancillary testing and subsequent management [29, 30].

The core definitions of PPD and VM, principal diagnostic criteria, and their clinically overlapping symptom domains—dizziness, vertigo, a tendency to lose balance (disequilibrium), and disturbances of vision and spatial perception—are summarized [31, 32]. Clinically distinguishing features are also reviewed, including the duration of individual symptomatic episodes, identifiable provocative triggers, the presence of associated diaphoretic or gastrointestinal autonomic symptoms, cognitive preoccupation with symptoms, and the characteristic age and sex distribution of affected individuals [33, 34].

The evolution of formally recognized diagnostic criteria for PPD and VM is traced in the context of diagnostic-ambiguity challenges, detailing contemporary criteria developed by the International Classification of Vestibular Disorders (ICVD) and the International Headache Society (IHS) that may assist clinical differentiation [34-37]. Summary comparison of current PPV and VM criteria illustrates the types of conjoined evidence required for diagnosis, the specification of provisional

and definitive characterizations, and the acknowledgement of temporal-pattern information in symptom profiled by both the ICVD/IHS criteria and the proposed alternative for PPD [38-39].

Diagnostic-criteria information is further complemented by the compilation of widely accepted methodologies and assessment tools for vestibular disorders and dizziness complaints [40-42]. The core components of history-taking, direct bedside tests, and objective, instrumented examination are presented in summary fashion, as are the comorbidities report, nonvestibular symptoms catalogue, treatment and lifestyle profiles, and lifestyle-impact strategies relevant to vestibular symptoms and motion sensitivity that encapsulate these clinical domains [43, 44].

Vigorous consideration of homologies and distinctive characteristics in the pathophysiological underpinnings of PPD and VM facilitates additional candidates for decision-support heuristics and collateral diagnostic testing [45, 46]. Theoretical mechanisms applicable to both disorders (visuovestibular incongruities, multisensory-integration irregularities, common dysregulations of central vestibular networks, and alterations in cerebrovascular excitation) are outlined alongside those pertaining exclusively to one condition (somatopathy disturbances with PPD; autoregulatory or metabolic disorders, augmented central carotid-circulation, migraine-related vascular phenomena, and cortical-excitation elevations with VM) [47,48]. Pertinent neuroimaging and neurophysiological data corroborating these mechanistic frameworks are summarized [49] (Table 2).

Assessment component	Primary purpose	Contribution to PPPD–VM differentiation
Detailed history and symptom chronology	Characterize onset, persistence versus recurrence, episode duration, precipitating events, and functional consequences.	Provides the core temporal framework for distinguishing a persistent PPPD pattern from recurrent VM while recognizing coexistence.
Trigger and provocation profile	Identify effects of posture, head/body movement, visually complex environments, visual target shifts, and migraine-related triggers.	Helps define the dominant provoking context; shared visual/motion sensitivity requires interpretation with chronology and associated features.

Associated symptom inventory	Document headache, aura/sensory phenomena, autonomic or gastrointestinal symptoms, cognitive preoccupation, and nonvestibular complaints.	Migraine-linked features support VM, whereas chronic functional and perceptual features may strengthen a PPPD profile.
Direct bedside vestibular/balance examination	Assess observable vestibular, ocular-motor, postural, and balance abnormalities and search for competing diagnoses.	May identify alternative or coexisting vestibular disorders; findings should be interpreted alongside formal criteria.
Selective instrumented vestibular testing	Objectively characterize vestibular function when clinically indicated.	Useful for identifying peripheral or other vestibular abnormalities that may precipitate, mimic, or coexist with PPPD or VM.
Neuroimaging or neurophysiological assessment	Evaluate selected patients when another neurological process is suspected and support research on central mechanisms.	May provide mechanistic or exclusionary information but is not presented in the manuscript as a stand-alone diagnostic test for either syndrome.
Quality-of-life, comorbidity and lifestyle assessment	Measure disability, visual/cognitive impact, anxiety-related burden, vitality, pain, and relevant lifestyle factors.	Clarifies disease burden and guides multidisciplinary management, particularly when symptoms persist across overlapping domains.
Formal diagnostic criteria and integrated case profile	Apply contemporary criteria and synthesize all clinical data.	Supports classification as PPPD-predominant, VM-predominant, or clinically overlapping when both sets of features are present.

Table 2: Diagnostic assessment framework for patients with possible PPPD, vestibular migraine, or an overlapping phenotype.

7. Case Profiling and Differential Diagnosis

Persistent Postural-Perceptual Dizziness (PPPD) and vestibular migraine frequently exist together, complicating the diagnostic process [50]. PPPD is defined by the International Classification of Diseases, 11th Revision (ICD-11), a necessary anchor for this discussion and the selection of pertinent case profiles [51]. This diagnostic overture, attended by interface remarks on nomenclature and usage, shape a framework where representative PPPD and vestibular migraine case profiles reveal shared attributes and discernible traits—defining distinctions whose determination guides patients to optimal therapy [52].

Criteria for diagnosing vestibular migraine are those put forth by the Bárány Society and the International Headache Society [53]. Sound and diagnostic-case anchor the ensuing review of symptoms and their evolution, serving as a reference throughout the account's diagnostic and pathophysiological opportunities [54]. The shared presence of recurring vertiginous episodes regularly precipitated by typical migraine triggers highlights the PPPD–vestibular-migraine interface and provides an illustrative venue for exploring pertinent features [55]. Detailed accounts of PPPD, vestibular migraine, and the overlap between both clusters emerge as useful companions, bolstering the exposition's state of the art [56, 57] (Figure 2).

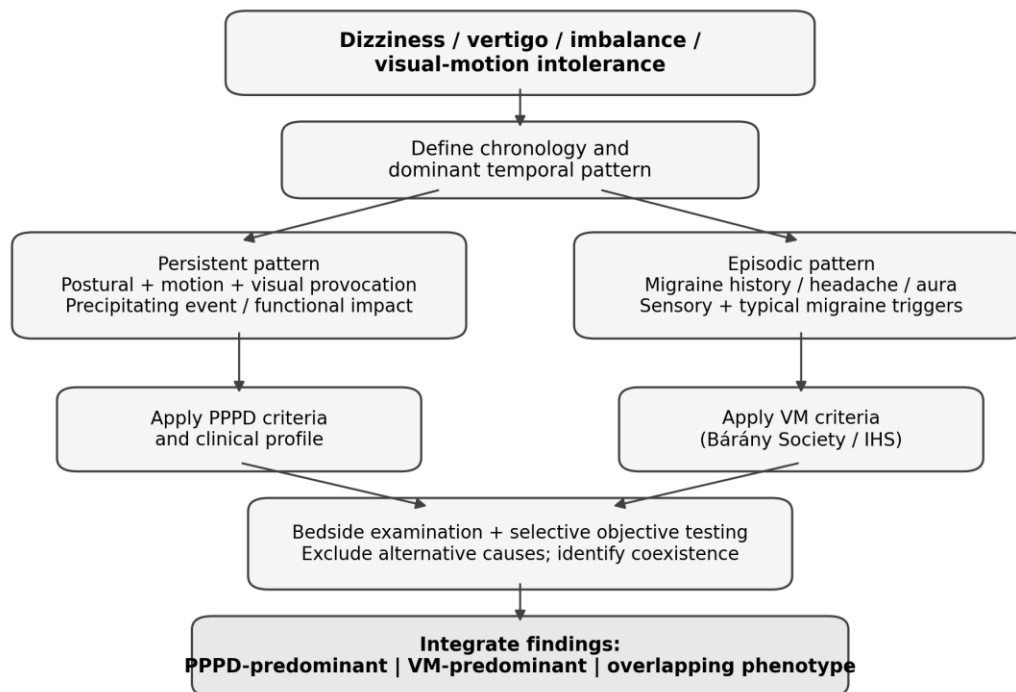


Figure 2: Stepwise clinical reasoning pathway for PPPD–vestibular migraine differentiation.

8. Implications for Management and Treatment Strategies

Diagnostic criteria and clinical profiles for persistent postural-perceptual dizziness (PPPD) and vestibular migraine indicate a spectrum of presentations. Effective management of these disorders' hinges on recognition of distinctive features [52].

Treatment options for PPPD comprise a variety of evidence-based and anecdotal approaches [58]. Recommendations supported by randomized clinical trials include the selective serotonin reuptake inhibitors sertraline and citalopram, the serotonin-norepinephrine reuptake inhibitor venlafaxine, and vestibular rehabilitation therapy [59]. Other pharmacological therapies cited in the literature include amitriptyline, clonazepam, lamotrigine, topiramate, and beta-blockers [60]. Nonpharmacological interventions encompass cognitive-behavioral therapy and exposure therapy [61]. Management typically begins with the intervention presumed to address the most prominent component; this choice may reflect the temporal evolution of symptoms or an episode-induced feature that persists [62-64].

Patients with vestibular migraine display further diagnostic variability that extends the range of potential management strategies [65]. Treatment of acute episodes often employs standard abortive measures, whereas prophylactic regimens may further include the avoidance of dietary and behavioral triggers, vestibular rehabilitation therapy, mind-body approaches, and beta-blockers [66, 67]. The lack of universally accepted criteria for the diagnosis of vestibular migraine necessitates a careful review of the clinical picture and the use of a minimum standard for securing the diagnosis [68].

9. Prognosis and Quality of Life Considerations

Long-term follow-up studies suggest a variable prognosis for both PPPD and VM, with considerable interindividual heterogeneity [69, 70]. After an acute unilaterally vestibular loss, the risk of developing persistent symptoms appears greater for patients with accompanying nausea, for those initially unable to indulge in vigorous exercise, and for visually dependent patients [71]. Reports of relapse following pharmacological therapy or superficial bilateral vestibular loss characterize VM, which, alongside partial recovery from acute symptoms, points to the possibility of a chronic stage and reinforces its classification as a recurring disorder [72, 73].

Quality-of-life assessments underscore the multifaceted impact of PPPD and VM on central dimensions such as visual and cognitive life, vitality, general health, and pain [74]. Moreover, the latter condition endorses distinct features from other vestibular syndromes. Reducing the disabling component of both syndromes requires a multidisciplinary, integrative management approach enabling various interventions—including pharmacological treatment, vestibular rehabilitation, vision therapy, and cognitive behavior therapy-targeted to restore equilibrium across the pertinent impaired domains [75-78].

10. Future Directions in Research and Clinical Practice

A need for greater understanding of both conditions within the context of clinical overlap and heightened prevalence has been highlighted [79]. The protocol for vestibular assessment in cases of PPPD warrants reassessment, particularly given the high rate of PVH among patients with PPPD [80]. A reevaluation of the appropriateness of the terminology 'PPPD' is also suggested, since the acronym implies conditionality on another vestibular diagnosis when the two conditions may exist independently [81]. While diagnostic, therapeutic, and research efforts towards both conditions remain paramount, the complementary investigation of their intersection could yield further insight into the postural control system and its interaction with migraine, vestibular disorders, and other physiological and psychological variables [82].

Development of valid biomarkers is essential to establishing more objective diagnoses within both fields [83]. Enhanced standardization of methodology, terminology, reporting, and evaluation is required to facilitate pooled analyses in observational studies and experimental investigations of both conditions [83]. Formation of international consortia to define consensus criteria of light-headedness and dizziness, these conditions lacking direct counterparts in existing classifications, is likewise advocated [84]. Standardization of clinical vignettes describing VM and PPPD in patients presenting with vertigo episodes should be prioritized to advance clarification of their specific interrelations [85]. Prioritization of all these recommended improvements is proposed for consideration in advancing both fields [59].

11. Conclusion

Overlapping features distinguish Persistent Postural-Perceptual Dizziness (PPPD) and Vestibular Migraine (VM), yet these defining characteristics overlap and may complicate management. This analysis delineates core clinical criteria, characterizes phenotypes, elucidates pathophysiological mechanisms, and summarizes contemporary diagnostic and assessment methods to inform clinical profiling and improve patient outcomes. Despite probabilistic case definitions, PPPD and VM diagnoses are often uncertain because clinical expressions overlap. The analysis narrows diagnostic ambiguity by framing overlapping presentations, clarifying differential criteria, and outlining patient-reported profiles that suggest which disorder predominates amidst concurrent features.

PPPD and VM share common precipitating factors and comorbidities, despite differences in temporal evolution and angular acceleration sensitivity [19]. Establishing a clear, precise clinical diagnosis remains critical for applying targeted management strategies. Clarity improves by assessing shared characteristics to profile patients according to predisposing factors, course of onset, concurrent entities, and responding syndromes. Available pharmacological and rehabilitative therapies for each entity can be prescribed according to the prevailing profile, and patients remain engaged in a collaborative process focused on relief from stabilizing or eliminating symptoms associated with gravity and movement.

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