CG

Coral Gables Vestibular Clinic
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VertigoDx

FDA CLEARED · K260566

CLASS II

VESTIBULAR ASSESSMENT

DETAILED BPPV REPORT

Visit **06 Sept 2026 · 07:23**
Report no. **VDX-2026-00004**
Template: Detailed BPPV report

PATIENT

Margaret Ellison

DOB **14 Mar 1961**
Sex **F**
File no. **CGV-04471**
Referred by **Alan Reyes, MD (primary care)**

CLINICIAN

Sarah Whitfield, PT, DPT

Profession **Physical Therapist (PT, DPT)**
Reg. no. **FL PT 30412**
Device **SmartVertigo · iPhone 14 Pro Max**
Classifier **V4 (v24)**

HISTORY

- Onset: two weeks prior, on a Sunday.
- Trigger: turning over in bed to the right.
- Course: recurrent, most mornings since.
- Triggers: turning in bed; looking up to a high shelf; bending forward to tie shoes. Positional.
- Duration of a spell: less than a minute; first episode reported by her husband as about half a minute.
- Character: spinning.
- Nausea: present, particularly in the mornings. Vomiting: denied.
- Between spells: unsteadiness described as walking on a boat, without spinning unless the head moves.
- Hearing change, tinnitus, aural fullness: denied.
- Headache: denied. Migraine: none for twenty years (history in her thirties).
- Double vision, speech disturbance, facial/limb numbness or weakness: denied.
- Swallowing, ataxia: not documented.
- Previous episodes or treatments: none previously.
- Head trauma, recent viral illness: denied. Prolonged bed rest: not documented.
- Falls: denied; near-falls reported, now holds on to furniture.
- Medications: amlodipine 5 mg for blood pressure; vitamin D. Vestibular suppressants: one dose of cinnarizine (Stugeron) on day two, caused sedation, not repeated.
- Family history: mother had dizzy spells in her seventies, cause unknown.

Red flags — unilateral hearing loss or tinnitus: denied. New severe headache: denied. Focal or cerebellar signs: denied. Continuous non-positional vertigo: denied (symptoms occur only on head movement). Vertical or atypical nystagmus: down-beating and up-torsional nystagmus recorded on testing (see Examination). High stroke risk: not documented.

The presenting complaint was described as follows. Patient: "Two weeks ago on the Sunday. I turned over in bed towards the window, my right side, and the whole room went round. I grabbed the headboard." She described the character of the vertigo as "Spinning. Proper spinning, like a merry-go-round." Symptoms were mostly right-sided, with one or two milder left-sided episodes. On the TiTrATE framing, this is a triggered-episodic vestibular syndrome, consistent with BPPV.

MODIFYING FACTORS

- Impaired mobility or balance: reported interval unsteadiness; holds on to objects when moving.
- Central nervous system disorder: not documented.
- Lack of home support: husband present and accompanying her; daughter involved in her care.
- Increased fall risk: near-falls reported, no falls sustained.

OUTCOME MEASURES

- DHI: not administered.
- VAS vertigo: not administered.
- ABC: not administered.

EXAMINATION · 7 POSITIONS

POSITION	EYE	NYSTAGMUS	SPV	LATENCY	DURATION	CLINICIAN
Sitting	R	Down-beating 2nd opinion: No BPPV	13.7°/s	0 s	7 s	—
Lying	L	Down-beating	3.3°/s	0 s	9 s	—
Roll Left	L	Right-beating horizontal 2nd opinion: No BPPV	5.1°/s	0 s	2 s	—
Roll Right	R	Left-beating horizontal	4.2°/s	0 s	16 s	—
Dix-Hallpike Left	L	Down-beating 2nd opinion: No BPPV	20.4°/s	0 s	5 s	—
Dix-Hallpike Right	R	Down-beating	26.5°/s	1 s	12 s	—
Straight Head Hang	R	Up-torsional, counter-clockwise	12.6°/s	1 s	14 s	—

Dix-Hallpike Right — the clinician noted a delay before onset and that the nystagmus was strong with a visible torsional component; the patient's symptoms were reproduced. Patient: "Here it comes. Oh, that is horrible. The room is going over."

Straight Head Hang — the clinician noted up-beating and twisting nystagmus, counter-clockwise, with reproduction of symptoms, described as fitting the right anterior canal.

Roll Right — the patient's spinning symptoms were reproduced.

Dix-Hallpike Left — the clinician noted a small down-beating nystagmus with little subjective spinning.

OTHER EXAMINATION

Eye movements were observed under video goggles throughout positional testing, and the clinician performed a check of the eyes on sitting up after Straight Head Hang, reported as clear. Head impulse test: not documented. HINTS: not documented. Otoscopy: not documented. Cervical range: not documented. Gait and balance tests with scores: not documented.

IMPRESSION

Canal: right posterior canal and right anterior canal. Side: right. Variant: canalithiasis (posterior canal). No central red flags reported on history.

The decisive finding was the Dix-Hallpike Right, which produced a strong nystagmus (peak SPV 26.5°/s) with a 1 s latency and a 12 s duration, with reproduction of the patient's vertigo; latency with duration under 60 s supports canalithiasis of the right posterior canal. Straight Head Hang produced up-torsional counter-clockwise nystagmus (peak SPV 12.6°/s, latency 1 s, duration 14 s), which the clinician attributed to the right anterior canal. The clinician explained that crystals may occupy two canals on the same side and concluded that all findings localised to the right ear. Central causes were considered and excluded on the basis of the denied red-flag symptoms and the positional, short-lived nature of the vertigo.

TREATMENT

Right Yacovino manoeuvre · right · 1 cycle · manual · tolerated. Right Epley manoeuvre · right · 1 cycle · manual · tolerated.

The Yacovino manoeuvre was performed first for the anterior canal: head hanging back for thirty seconds, then chin brought quickly to the chest and held a further thirty seconds, then sitting up with the chin down. The patient reported brief spinning in the head-hanging position and wooziness on sitting up without room spin. The Epley manoeuvre was then performed for the right posterior canal: head turned right and lowered over the edge, where nystagmus recurred but was less than on testing; head then turned ninety degrees to the left; then rolled onto the left shoulder looking down at the floor, where the patient reported "a little swirl"; then sat up slowly with the chin down. She reported feeling "a bit floaty". No nausea or vomiting was reported during treatment. Immediate retest of Dix-Hallpike Right showed no nystagmus and no subjective spinning, and the clinician stated the manoeuvre had worked.

PLAN

- **Review** — Review 7 d — review in one week to re-check the right side.
- **Advice** — Advice — no postural restrictions: the patient may lie flat and sleep on either side; sleeping upright and avoiding movement were explained not to help.
- **Review** — Advice — if the spinning returns in the next few days, telephone the practice for repeat manoeuvre without waiting for the appointment.

Medication — no vestibular suppressants; continue the blood pressure tablet as usual.

- **Refer** — Refer if — attend the emergency department immediately for severe new headache, double vision, slurred speech, weakness or numbness, or constant rather than short-lived dizziness.
- **Advice** — Advice — remain in the waiting room for ten minutes; drive home only if steady, otherwise travel with her husband.
- **Advice** — Advice — a written summary of the findings and plan to be sent to the patient's phone.

EDUCATION AND SAFETY

The clinician explained that the symptoms were typical of BPPV, that positional testing with video goggles identifies the affected canal, and that testing and treatment would probably provoke brief dizziness, which is expected and indicates the crystals are moving. He explained that about one in three people need the manoeuvre repeated. Postural restrictions were explicitly advised against, with the explanation that the evidence shows sleeping upright makes no difference and that avoiding movement causes stiffness. A residual floaty feeling for a day or two was described as normal. Vestibular suppressants were explained to mask symptoms and delay central recalibration. Driving was addressed: the patient was asked to sit in the waiting room for ten minutes and to drive only if steady. Urgent help was advised for severe new headache, double vision, slurred speech, weakness or numbness, or continuous rather than episodic dizziness.

CODING

ICD-10 H81.11 (right) benign paroxysmal vertigo; CPT 95992 canalith repositioning procedure (from the recorded treatment)

DATA NOTES

Data note: handset item "Right Roll: Ageo HN" vs classifier "Roll Right: L HN 92%".

Data note: handset item "Right Dix Hallpike latency 16-30s" vs classifier "Dix-Hallpike Right latency 1 s".

Data note: classifier recorded down-beating nystagmus at Sitting (DBN 38%, peak SPV 13.7°/s), which the handset assessment listed as tested and clear.

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Signed electronically · 06 Sept 2026 · 07:23

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