ACADEMY OF NEUROLOGIC PHYSICAL THERAPY

APTA'S UPDATED EVIDENCE-BASED CLINICAL PRACTICE GUIDELINE FOR PERIPHERALVESTIBULAR HYPOFUNCTION

GOAL:

To assist physical therapists or other qualified healthcare professionals with choosing appropriate assessments and outcome measures for the identification of impairments and activity limitations, treatment interventions and discharge decisions.

Patient Population: Patients with unilateral* or bilateral peripheral vestibular hypofunction with report of dizziness and/or vertigo, visual blurring with head movement, and/or imbalance and as confirmed with vestibular function laboratory testing (Normal saccades and smooth pursuit eye movements; Unilateral hypofunction has at least 25% reduced vestibular response to bithermal caloric irrigation on one side; Bilateral hypofunction has abnormal rotational chair gain, phase, and asymmetry).

Acute: First two weeks after the onset of symptoms; Subacute: After first two weeks and up to three months; Chronic: After three months

DECISION TO TREAT:

Strong recommendation (Level I**) that clinicians offer vestibular rehabilitation to patients with peripheral vestibular hypofunction who are experiencing symptoms.

Exclusions:
a. Those at risk for bleeding or cerebrospinal fluid leak
b. Cognitive or general mobility deficit that impedes application of treatment
c. Active Meniere's disease

DISCHARGE DECISIONS:

Moderate (Level II*) recommendation for the decision to stop rehabilitation, based on: reached plateau, symptoms resolve, normalized gait, balance, and vestibular function, choice, non-adherence, or status deteriorates.

FOR MORE DETAILED INFORMATION, PLEASE REFER TO THE ORIGINAL DOCUMENT:
https://journals.lww.com/jnpt/Abstract/9000/Vestibular_Rehabilitation_for_Peripheral.99697.aspx

***LEVEL OF EVIDENCE**

I	II	III	IV	V
High quality (≥50% critical appraisal score) diagnostic studies, prospective, or randomized controlled trial	Lesser quality (<50% critical appraisal score) diagnostic studies, prospective, or randomized controlled trial	Case-controlled or retrospective studies	Case study or case series	Expert opinion

Based on Centre for Evidence Based Medicine website: http://www.cebm.net/oxford-centre-evidence-based-medicine-levels-evidence-march-2009/

Hall CD, et al. Vestibular Rehabilitation for Peripheral Vestibular Hypofunction: An Updated Clinical Practice Guideline. JNPT. 2021; doi: 10.1097/NPT.0000000000000382

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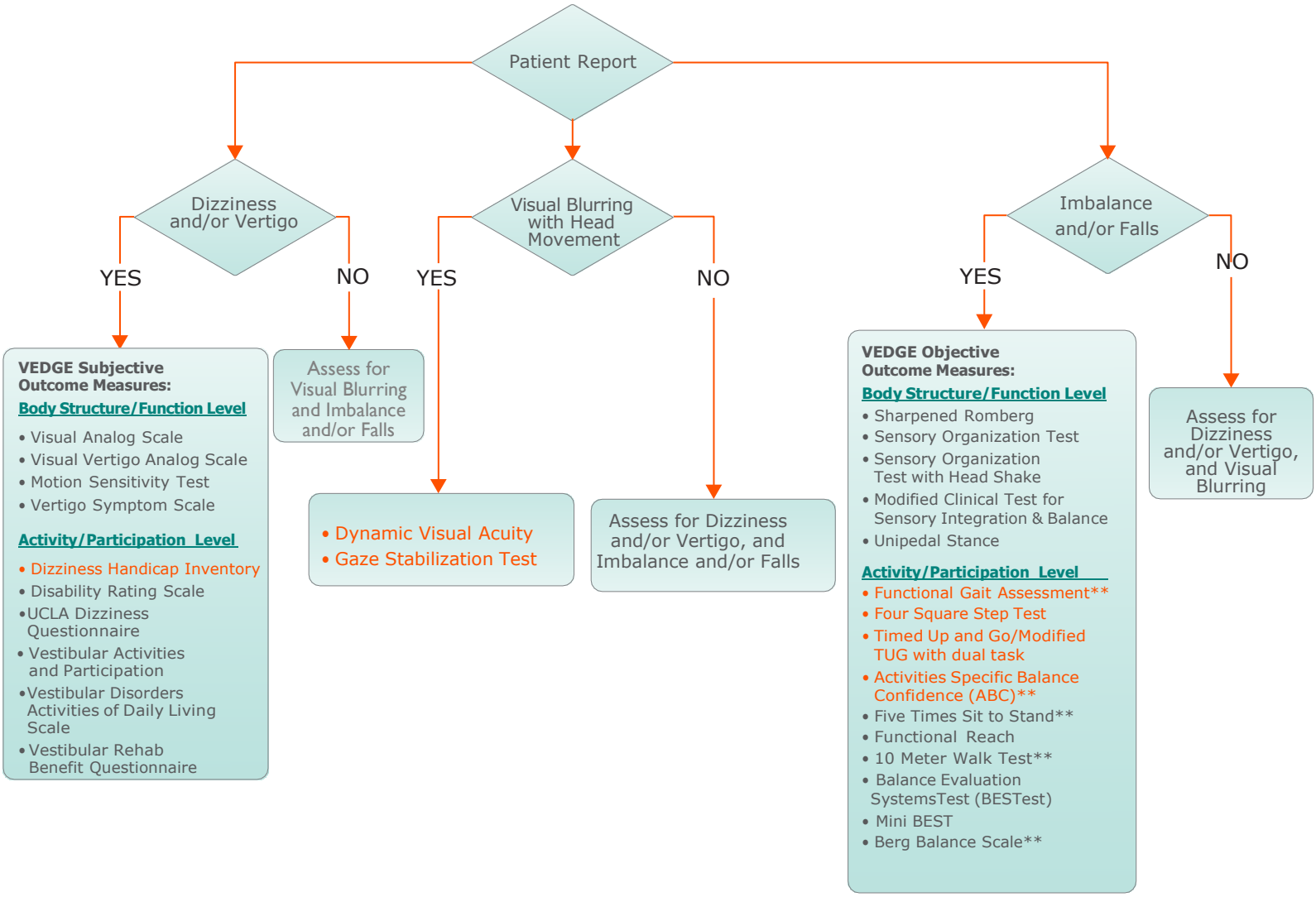
OUTCOME ASSESSMENT MEASURES BASED ON SUBJECTIVE REPORT IN PERSONS WITH PERIPHERAL VESTIBULAR HYPOFUNCTION



Algorithm depicts measures recommended by Vestibular EDGE taskforce. (http://www.neuropt.org/professional-resources/neurology-section-outcome-measures- recommendations/vestibular-disorders). Outcome measures featured in ORANGE depicts those that are highly recommended by Vestibular EDGE taskforce (Level I). **Outcome measure is also recommended in the Core Set of Outcome Measures for Adults with Neurologic Conditions Undergoing Rehabilitation Clinical Practice Guideline (Moore JL, et al. 2018).

LEVEL OF EVIDENCE**

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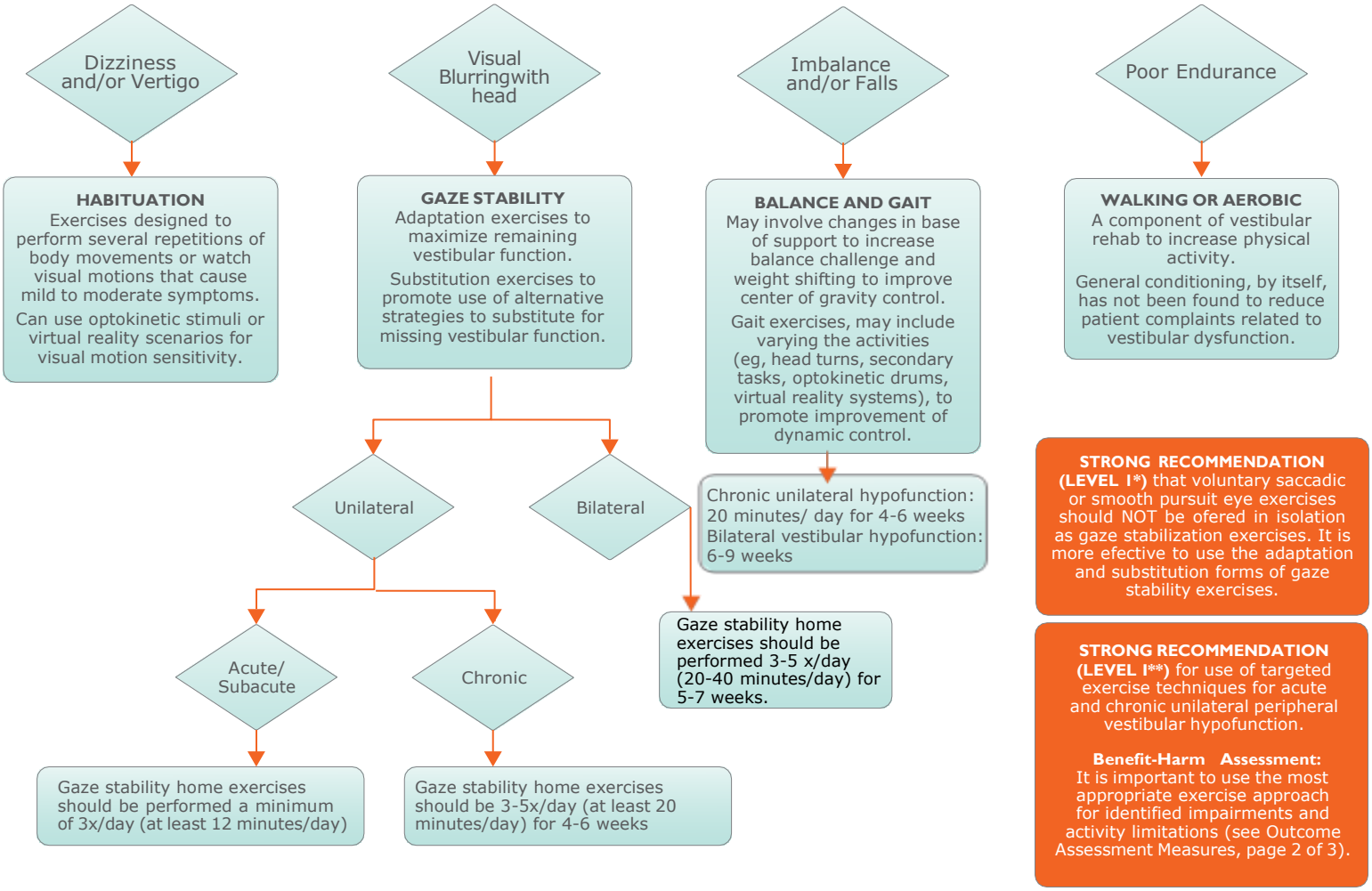
TREATMENT DECISIONS BASED ON OUTCOME ASSESSMENT MEASURES



STRONG RECOMMENDATION (LEVEL I*) that voluntary saccadic or smooth pursuit eye exercises should NOT be ofered in isolation as gaze stabilization exercises. It is more efective to use the adaptation and substitution forms of gaze stability exercises.

STRONG RECOMMENDATION (LEVEL I)** for use of targeted exercise techniques for acute and chronic unilateral peripheral vestibular hypofunction.

Benefit-Harm Assessment: It is important to use the most appropriate exercise approach for identified impairments and activity limitations (see Outcome Assessment Measures, page 2 of 3).

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