When Conditions Overlap: PPPD, Vestibular Migraine, and Other Comorbidities

These are some of the questions from the 2026 Life Rebalanced Live virtual conference, answered by VeDA volunteers who are vestibular healthcare professionals. Disclaimer: This is not intended as medical advice. Please talk to your healthcare provider before making changes to your treatment plan.

Q: Is it important to know when you are having a vestibular migraine or just a regular migraine attack with vestibular symptoms?

A: Yes. Determining the medication ordered by your care provider reflects the presentation of symptoms, their duration, and frequency. When trying to decide what medication to take for attacks, it is best determined by your care provider and your history., Kelly Amspacher, MSN

Q: How is it that so many doctors and specialist doctors are unaware of chronic Vestibular migraine and PPPD? Shouldn't neurologists and ENT's be educated on these conditions?

A: VM and PPPD are relatively new diagnoses, and unfortunately, it can take a long time for curricula to change. Dizziness doesn't belong to any one particular specialty, as it can be a symptom of many different disorders, so it can be difficult to find a specialist. One of VeDA's missions is to provide education for health care providers in ENT, neurology, primary care, and more- we recognize the importance and urgency of this., Maria Machala, NP

Q: Can anyone explain the micro-dosing of certain medications to treat chronic dizziness, such as SRNIs, for people who are very sensitive to medication,

where you open the capsule and take a certain number of beads and add more gradually?

A: Multidisciplinary teamwork and self-advocacy make for the best medication plan. Dr. Beh commented that he starts medications at the lowest dose and slowly increases the dose to reflect the effect on signs/symptoms in addition to tolerance of medication., Kelly Amspacher, MSN

Q: Is it possible to have vestibular migraine, PPPD, and BPPV, and could they get worse with stressful situations? I have a weakness in my left ear that has caused my BPPV, but I have symptoms of the others as well.

A: Yes — it's possible to have vestibular migraine, PPPD, and BPPV at the same time. They're different conditions, but they can overlap and feed into each other, especially when the system is already stressed. And yes, symptoms from all three can feel worse during stressful situations because stress increases the overall load on the nervous system., Kathleen Stross, DPT, CHC

Q: When we are having our menstrual cycle, why do our symptoms ramp up? My dizziness and/or vertigo get worse. What is the connection?

A: Hormones/endocrinology can be a part of the attack occurrence. Endocrinological testing may shed light on the diagnosis and treatment plan. , Kelly Amspacher, MSN

Here is an article that explains the impact of hormones on vestibular function: https://vestibular.org/article/coping-support/living-with-a-vestibular-disorder/hormones/, Cynthia Ryan

Q: What are the differences between PPPD and VM, and what are their commonalities?

A: VM and PPPD both share sensitivity to motion and visual triggers. PPPD is often triggered by VM, but it can happen in the absence of migraine as well. Currently, no criteria have been established for chronic VM, but there is debate on whether PPPD is a form of chronic migraine. , Maria Machala, NP

Q: Even my ear specialist was baffled as to how I could have chronic episodes of vertigo-related symptoms due to moderate vestibular neuritis in my left ear, while also showing signs of vestibular migraines. He expected my system to have only had one single episode and corrected itself. But I have ongoing episodes that last for months. How do we identify the true source to know what to treat?

A: Vestibular migraine causes intermittent episodes — symptoms come and go, often in waves. A person may feel mostly normal between attacks, then suddenly have dizziness, visual motion sensitivity, or imbalance that flares and settles again. Vestibular neuritis, once past the acute phase, leaves chronic but stable symptoms — a steady baseline of imbalance or motion sensitivity that doesn't fluctuate dramatically day-to-day. It's more like a constant "off" feeling that slowly improves over time as the brain compensates., Kathleen Stross, DPT, PhD, CHC

Q: How can I tell if my symptoms are coming from Meniere's or Vestibular Migraines? Is it typical to have recurrent ear infections three years following my original diagnosis? Do tubes work to alleviate those symptoms?

A: Meniere's and vestibular migraine can feel very similar, so it's not always possible to tell which one is causing symptoms in the moment. Meniere's tends to involve fluctuating hearing, fullness, and true spinning attacks, while VM can cause dizziness, pressure, and sensory sensitivity without changes in hearing. Many

people have both, and the symptoms can overlap. Recurrent ear infections years after diagnosis aren't typical for Meniere's itself, but they can happen for unrelated reasons. Ear tubes may help with pressure or drainage issues, but they don't treat Meniere's or vestibular migraine directly. A clinician can help sort out whether the infections are a separate issue or part of a bigger pattern., Kathleen Stross, DPT, PhD, CHC

Q: Does anybody else have visual snow syndrome from these conditions? I'm not sure if it's from VM or PPPD, and it would be nice to know which one is causing the visual snow. I also get after images.

A: Visual snow is a neurological visual phenomenon where you see static-like dots, after-images, or flickering across your visual field. It can show up in people with vestibular migraine or PPPD, but it isn't caused by one specific condition — it's more about how sensitive the visual and migraine pathways in the brain have become.

While people with VM or PPPD report visual snow–type symptoms, it's not possible to say which diagnosis is causing it in any one person. After-images can happen for the same reason: the visual system is overstimulated and slow to "reset." It's frustrating, but it's a known pattern in sensory-sensitive conditions., Kathleen Stross, DPT, PhD, CHC

Q: Have you looked at the combination of vestibular deficit and dysautonomia?

A: There's not much research here, but it appears that vestibular disorders and dysautonomia might occur together more often than chance, because the vestibular and autonomic systems share pathways in the brainstem. But there's also symptom overlap, since both conditions can cause dizziness, lightheadedness, nausea, and fatigue. So when someone has both, it's not always clear which system is driving which symptom. The important thing is recognizing that these conditions can interact and amplify each other, and supporting both usually gives people the most stability., Kathleen Stross, DPT, PhD, CHC

Q: Do you feel that stress within the body and vestibular issues, such as BPPC and VM, go hand in hand? It seems in my case that they feed off each other. When I say stress, I mean stressing the body due to diet/lifestyle/ or changes within your day-to-day life.

A: Yes, Dr. Beh explained that stress is a significant trigger and can be a cause for PPPD. Here is an article with some stress management techniques: https://vestibular.org/article/coping-support/living-with-a-vestibular-disorder/stress-management/., Cynthia Ryan

Q: Can you give any advice on the dizzy fatigue cycle and how to deal with this?

A: The dizzy–fatigue cycle is common in vestibular conditions. When you're dizzy, your brain works harder to stabilize vision, posture, and balance. That extra effort uses more energy, which leads to fatigue. Then fatigue makes the system less efficient, which increases dizziness — and the cycle continues. A helpful way to interrupt it is to reduce the overall load on the system rather than trying to push through it. That can look like:

- Pacing — shorter activity periods with planned rest before symptoms escalate
- Gentle, predictable movement — enough to keep the system engaged without overwhelming it
- Supporting the basics — hydration, steady meals, sleep routines
- Letting the nervous system settle — grounding, breath pacing, or anything that signals safety

The goal isn't to eliminate dizziness or fatigue in the moment, but to prevent the cycle from spiraling. Small, consistent adjustments usually give the system more stability over time., Kathleen Stross, DPT, PhD, CHC

Here's a link to an infographic. https://1drv.ms/b/c/f4c2304f808ab86c/IQDS-zEoiljURqDb_-MoBIrgAX4vCkXyVZPJsSdtMlXknys?e=WdyS8d, © 2026 Kathleen Stross · kathleenstross.com

Q: How does low vision, legal blindness, or other visual impairments impact vestibular disorders?

A: Low vision or legal blindness can affect vestibular disorders differently depending on how the vision loss happened. If vision is lost suddenly and someone was relying on it to compensate for a vestibular problem, balance can get much harder because a major stabilizing system is gone. But when vision has been reduced gradually over the years, the brain often shifts to using somatosensation and proprioception instead, so losing the remaining vision may not cause a big change. The key is supporting the systems you do have, building confidence with movement, and adapting strategies to your specific pattern of vision and vestibular function., Kathleen Stross, DPT, PhD, CHC

Q: How do we cope when we have a handful of vestibular disorders on top of chronic fatigue, chronic migraines, and fibromyalgia? It seems like the symptoms overlap each other so much. How do doctors (knowing full well that most can't) find an effective treatment for us? Where can we research medically sound information to build our own treatment plan? We all know there is no magic pill.

A: Managing several vestibular disorders on top of chronic fatigue, migraine, or fibromyalgia is incredibly tough, and the symptoms do overlap in ways that even doctors can't always separate. These conditions all stress the nervous system, so they tend to amplify each other.

There's no single pill, but people do make progress by focusing on lowering the overall load on the system — pacing, sleep support, gentle movement, stress

reduction, and vestibular rehab when it's appropriate. The goal is to find patterns in what helps and what flares you, not to identify the exact source of every symptom.

For solid information, stick with reputable vestibular organizations and major medical centers. Building a personalized plan from trustworthy sources is often the most effective path when things are complex., Kathleen Stross, DPT, PhD, CHC

Q: Could you talk about the relationship between vestibular migraine and chronic congenital third nerve palsy? Sometimes I'm dizzy, other times I just can't see straight.

A: Yes, that would be frustrating. And you can tell the difference between those two things. Here's how they are related. Vestibular migraine and congenital third nerve palsy can overlap because they both affect how the brain manages visual input. The palsy creates a long-standing alignment issue, and the brain usually adapts — but when migraine flares, that compensation can break down. That's why some days feel "dizzy" and other days feel more like "I just can't get my eyes to work together." The VM can certainly interfere with your ability to adapt or compensate for your 3rd nerve palsy., Kathleen Stross, DPT, PhD, CHC

Q: Can you discuss the impact of weather on vestibular conditions?

A: A drop in barometric pressure has been shown to trigger both migraine and Meniere's disease. , Maria Machala, NP

Here is an article that discusses the connection between weather and vestibular symptoms: https://vestibular.org/article/coping-support/living-with-a-vestibular-disorder/environmental-influences/, Cynthia Ryan

Q: If the panelist were with a patient in a mall, grocery store, or park and they start to get symptoms while walking, what would be their strategies at that moment they would offer? Can they share an example of this scenario?

Here's a video link for supermarket syndrome, https://youtu.be/O5GN33n9ixk?si=mEz6MUX8t_QkI2CQ, and one for people who are WITH someone with vestibular symptoms. https://youtu.be/CxKURi-P5Nk?si=wd4y5LNym4EqW8c5

The person with you can stand behind you and put their hands on your shoulders, or their elbows on your shoulders, and the palms of their hands flat on your head and gently press down, while you breathe, relax, and get grounded. Practice grounding strategies as described here.

https://youtu.be/t2ZiQ-3iTss?si=iSzr3E5TYvBwtEhv, Kathleen Stross, DPT, PhD, CHC

Q: In terms of PPPD, do you believe the Balance Belt developed in the Netherlands will offer relief, and how?

A: The BalanceBelt is primarily for people with hypofunction, meaning their inner ear isn't working, causing severe imbalance. It sends haptic signals telling you if you are leaning or about to fall, so you can correct yourself, Cynthia Ryan

Q: How can the neurologist determine which vestibular condition you have?

A: Dr. Beh described that taking a comprehensive medical history is an important first step. Dr. Steenerson described collecting information on the timing and triggers of symptoms. Some vestibular tests can support this information. Here is an article that describes this: https://vestibular.org/article/diagnosis-treatment/diagnosis/, Cynthia Ryan

Q: How long does the damage from vestibular neuritis last?

A: The damage to the nerve can be permanent, but typically compensation happens after a few months. Persistent dizziness is typically PPPD, and having vestibular neuritis puts you at risk for BPPV., Maria Machala, NP

Q: Can you comment on whether diet makes a difference?

A: Diet can affect vestibular migraine and Meniere's disease. Different foods affect different people. You can learn more about that here: https://vestibular.org/article/coping-support/living-with-a-vestibular-disorder/dietary-considerations/., Cynthia Ryan

Q: Can BPPV attacks be caused by persistent and uncontrolled vestibular migraine episodes?

A: BPPV is a mechanical problem and is not caused by VM, but the VM symptoms can feel like intermittent vertigo symptoms in BPPV, but are not necessarily provoked by a specific position or accompanied by predictable patterns of abnormal eye movements. If you can repeatedly provoke the symptoms with a movement or position, your care provider can discern if it's BPPV or not., Kathleen Stross, DPT, PhD, CHC

Q: Please discuss central nervous system fatigue. What causes it, and what can I do to minimize CNS fatigue?

A: When the vestibular system is working harder to stabilize vision, posture, and balance, the whole nervous system burns more energy. That creates fatigue that isn't "tiredness" — it's system overload.

Fatigue reduces efficiency → dizziness increases

THE CYCLE:

- Dizziness increases demand
- Demand increases fatigue
- Fatigue reduces processing efficiency
- Reduced efficiency increases dizziness

This is the core of nervous system fatigue in vestibular disorders.

The best way to reduce the overload and NS fatigue?

pacing

predictable movement

hydration + steady meals

consistent sleep

grounding + breath pacing

reducing sensory load

avoiding rapid physiological shifts

Develop a toolbox of strategies that work for you., Kathleen Stross, DPT, PhD, CHC

Q: People talk about having recurrent BPPV", but by definition, BPPV can't be recurrent if it's resolved with the maneuvers, right?

A: BPPV can be recurring. Yes, canalith repositioning maneuvers are the way to treat BPPV each time it occurs. People with BPPV may also feel residual symptoms between episodes., Cynthia Ryan

Q: Is there a link between PPPD and dementia?

A: There is no evidence that PPPD increases the risk of dementia. PPPD is a functional vestibular-brain interaction disorder, not a degenerative one. It changes how the brain processes motion, balance, and threat signals, but it does not cause structural damage or progressive cognitive decline like dementia. They can feel the same sometimes because people with PPPD often experience:

- brain fog
- slowed processing
- difficulty concentrating
- sensory overload
- fatigue that makes thinking harder

These symptoms can feel like cognitive decline, but they come from nervous system overload, not neurodegeneration.

When the brain is working overtime to stabilize balance and vision, it has fewer resources left for memory, attention, and executive function. That's why PPPD can mimic cognitive symptoms — but it doesn't cause dementia., Kathleen Stross, DPT, PhD, CHC

Q: What is the maximum amount of caffeine that Dr. Beh mentioned?

A: People are affected differently by caffeine. You could try cutting it out for 1-2 months and seeing if there is a difference- sometimes energy levels actually improve/stabilize with cutting out caffeine. PT should be done for at least 3 months., Maria Machala, NP

Q: Is weather a factor in both 3PD & VM?

A: This is different for everyone. Here is an article on how weather can affect vestibular symptoms: https://vestibular.org/article/coping-support/living-with-a-vestibular-disorder/environmental-influences/., Cynthia Ryan

Q: Are women more affected by vestibular illness than men?

A: There are some vestibular disorders where research indicates that women are more affected than men., Cynthia Ryan

Q: Have the panelists seen cases of PPPD patients fully recovering? If yes, was vestibular therapy a big piece of the recovery? Or what was the most helpful?

A: Yes, full resolution of PPPD is possible. Physical therapy with a therapist familiar and experienced with PPPD is necessary, but the combination of physical therapy, cognitive behavioral therapy, and medication (SSRI or SNRI) seems to be the most effective., Maria Machala, NP

Q: Other than diet changes, is there a medication to help reduce MD symptoms?

A: Diuretics such as Dyazide or Diamox. Betahistine may also be helpful. Steroid injections in the ear. For acute events, vestibular suppressants such as meclizine or a benzodiazepine can be effective, along with nausea medication. If there is underlying migraine, migraine medication may help as well. Also, lifestyle changes such as managing stress, good sleep hygiene, etc., Maria Machala, NP