
DISORDERS

CHILDREN

Vestibular disorders in children can affect balance, vision during movement, mobility, school participation, and development

ARTICLE

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Pediatric Vestibular Disorders

Part I: Incidence & Diagnosis

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HOW COMMON ARE VESTIBULAR DISORDERS IN CHILDREN?

Vestibular problems in children are more common than many people realize. A 2023 systematic review and meta-analysis reported a pooled prevalence of vestibular dysfunction of 30.4% across included studies, although estimates vary depending on whether subjective or objective testing methods are used (Saniasiaya et al., 2023). Despite this, many affected children do not receive medical evaluation.

Diagnosing vestibular problems in children can be difficult. Younger children may not have the words to describe dizziness or blurred vision. Instead, they may cling to a caregiver, stop playing, avoid head movement, stumble often, or resist activities such as climbing or riding a bike. This contributes to under-recognition and delayed diagnosis (Fancello et al., 2021; Bhandari et al., 2023).

SIGNS THAT MAY INDICATE A VESTIBULAR PROBLEM IN YOUR CHILD

- Complaints of dizziness, spinning, or “the room is moving”
- Frequent unexplained falls or clumsiness
- Reluctance to climb, run, or play on uneven surfaces
- Blurred or jumpy vision during head movement
- Nausea or vomiting without a clear illness
- Delayed sitting, standing, or walking milestones
- Sensitivity to motion (car rides, elevators, crowds, screen time)
- Difficulty reading or keeping up with schoolwork
- Avoidance of busy visual environments (grocery stores, hallways)
- In very young children: clinging to a caregiver, refusing to stand, or falling asleep during what appears to be a dizzy spell
- Frequent headaches associated with dizziness or motion sensitivity



WHAT SYMPTOMS DO CHILDREN HAVE?

Children with vestibular disorders may report vertigo (a spinning sensation), dizziness, imbalance, or blurred/jumpy vision when moving their head. Some children do not describe dizziness clearly, but instead show fearfulness, nausea, vomiting, falls, motion sensitivity, or avoidance of movement. Others present with developmental concerns such as delayed walking, poor coordination, or difficulty keeping up with peers during play and sports (Fancello et al., 2021; Yang et al., 2023).

Vestibular dysfunction can also affect daily activities. Because the vestibular system contributes to gaze stabilization, children may have trouble seeing clearly when walking or turning their head. They may struggle with reading, schoolwork, busy visual environments, playground activities, or sports. These impacts can be especially significant in children with bilateral vestibular loss, sensorineural hearing loss, congenital infections, or chronic dizziness syndromes (Hazen & Cushing, 2021; Pinninti et al., 2021).

Vertigo lasting hours suggests acute peripheral vestibular injury and is distinct from visual vertigo (which typically does not cause prolonged spinning) or orthostatic dizziness (which occurs specifically with position changes). Careful history about onset, duration, triggers, and associated symptoms helps guide diagnosis.

DIAGNOSES ASSOCIATED WITH VESTIBULAR SYMPTOMS IN CHILDREN

A wide variety of conditions can cause vestibular symptoms in children. The following sections organize these into three broad groups: (1) episodic vestibular conditions, (2) peripheral vestibular disorders, and (3) systemic or secondary conditions associated with vestibular dysfunction.

PART A: EPISODIC VESTIBULAR CONDITIONS

Vestibular Migraine of Childhood (VMC), Probable VMC, and Recurrent Vertigo of Childhood (RVC)

Vestibular migraine of childhood (VMC) is one of the most common causes of recurrent vertigo in children. In 2021, the Barany Society and the International Headache Society published updated pediatric criteria distinguishing three related diagnoses: VMC, probable VMC (pVMC), and recurrent vertigo of childhood (RVC). These categories provide a clearer framework for children with repeated spells of vertigo, dizziness, nausea,



motion sensitivity, or imbalance, with or without typical migraine symptoms (van de Berg et al., 2021).

Diagnostic criteria for VMC require: (1) at least five episodes with moderate-to-severe vestibular symptoms lasting 5 minutes to 72 hours; (2) a current or past history of migraine; and (3) at least half of episodes associated with a migraine feature (headache, photophobia/phonophobia, or visual aura). Probable VMC requires three episodes and either a migraine history or concurrent migraine symptoms. RVC requires three historical episodes with no migraine association; children meeting RVC criteria may later develop typical migraine features (van de Berg et al., 2021; Rey-Berenguel et al., 2025).

A recent study found that applying the updated Barany criteria reduced the proportion of children without a unifying diagnosis from approximately 36% to 17%, highlighting the clinical value of these updated criteria (Rey-Berenguel et al., 2025).

Concussion and Mild Traumatic Brain Injury (mTBI)

Dizziness and balance problems are among the most common symptoms following concussion, second only to headache. Vestibular symptoms may reflect central vestibular injury, peripheral vestibular dysfunction, or both. Children and adolescents with concussion may have motion sensitivity, dizziness, unsteadiness, blurred vision, difficulty reading, or prolonged recovery (Beauchamp et al., 2023; Karl et al., 2021).

Current concussion assessment tools, including SCAT6 and the Vestibular/Ocular Motor Screening (VOMS) tool, rely heavily on balance measures and vestibular symptom reporting (Echemendia et al., 2023). Vestibular rehabilitation is supported by current evidence as an effective component of management for children with persistent post-



COMMON DIAGNOSES

DIAGNOSIS	KEY FEATURES
Vestibular Migraine of Childhood (VMC)	Recurrent vertigo/dizziness; may or may not include headache
Recurrent Vertigo of Childhood (RVC)	Repeated vertigo episodes; no migraine association (yet)
Concussion /mild TBI	Dizziness and balance problems after head injury; may be central or peripheral
Persistent Postural-Perceptual Dizziness (PPPD)	Chronic dizziness worsened by movement or busy visual environments
Vestibular Neuritis / Labyrinthitis	Sudden vertigo, nausea; often follows viral illness
Benign Paroxysmal Positional Vertigo (BPPV)	Brief positional vertigo triggered by specific head movements
Peripheral Vestibular Hypofunction	Chronic imbalance, oscillopsia; often linked to hearing loss or congenital conditions
Ototoxicity	Balance/gaze instability from medication-related inner ear damage
Sensorineural Hearing Loss (SNHL)	Vestibular loss frequently accompanies significant SNHL
Cochlear Implantation	May affect vestibular function post-surgery; monitoring recommended
Enlarged Vestibular Aqueduct (EVA)	Progressive hearing & vestibular loss; structural inner ear anomaly
Usher Syndrome (Type 1)	Genetic; combined profound hearing loss, vestibular areflexia, progressive vision loss
Congenital Cytomegalovirus (cCMV)	Common congenital infection; hearing and vestibular dysfunction
Dysautonomia / POTS	Dizziness on standing; overlap with vestibular complaints; common in adolescents
Type 1 Diabetes Mellitus	Emerging evidence of audiovestibular effects even in asymptomatic children

concussion vestibular symptoms (Tiwari et al., 2025; Zargari et al., 2023). Concussion can also result in post-traumatic BPPV or contribute to PPPD. Persistent symptoms warrant careful vestibular evaluation rather than attributing all symptoms to concussion alone (Wang et al., 2021).

Persistent Postural-Perceptual Dizziness (PPPD)

PPPD is a chronic dizziness condition characterized by persistent non-spinning dizziness, unsteadiness, or rocking sensations that worsen with upright

posture, active or passive movement, or visually complex environments. Pediatric series confirm that PPPD affects children and adolescents and can substantially interfere with school attendance, sports participation, and daily life (Wang et al., 2021; Staab, 2023).

Common triggers and comorbidities include vestibular migraine, BPPV, anxiety, prior vestibular illness, and concussion. Treatment is typically multidisciplinary and may include vestibular



rehabilitation, cognitive behavioral therapy, and in selected cases, medication. PPPD is especially important to recognize because it is treatable but may be missed when attention is focused only on structural or laboratory findings.

PART B: PERIPHERAL VESTIBULAR DISORDERS

Vestibular Neuritis and Labyrinthitis

Vestibular neuritis and labyrinthitis are inflammatory disorders of the inner ear or vestibular nerve that cause sudden-onset vertigo, nausea, vomiting, imbalance, and nystagmus (rhythmic eye movements). When hearing is also affected, the condition is called labyrinthitis. In young children, these conditions may be difficult to recognize because children may simply appear ill or refuse to move rather than reporting vertigo clearly (Fancello et al., 2021).

The most common cause is believed to be viral infection or viral reactivation. Some children experience prolonged symptoms after the initial illness. In one pediatric series, over one-third of children had prolonged vestibular symptoms warranting follow-up and referral for rehabilitation (Brodsky et al., 2016).

Benign Paroxysmal Positional Vertigo (BPPV)

BPPV causes brief episodes of intense vertigo triggered by specific head positions, such as rolling over in bed, looking up, bending over, or turning quickly. It occurs when calcium carbonate crystals (otoconia) become displaced into the fluid-filled semicircular canals of the inner ear. Although often thought of as an adult condition, BPPV also occurs in children. In one 2021 pediatric series, BPPV was identified in 10.2% of children evaluated for balance disorders (Balzanelli et al., 2021). Pediatric BPPV may differ from adult presentations in canal involvement and symptom severity (An et al., 2024). BPPV is important to recognize because it is typically treatable with repositioning maneuvers performed by a trained clinician. In children, BPPV may occur after head trauma or concussion, in association with vestibular migraine, vestibular neuritis, or hearing loss, or without an identifiable cause (Galluzzi & Garavello, 2022).

Peripheral Vestibular Hypofunction

Peripheral vestibular hypofunction occurs when the vestibular end organs or vestibular nerve do not adequately detect and transmit information about head movement. This may be unilateral (one side) or bilateral (both sides). Bilateral vestibular



hypofunction is especially important because it can lead to delayed motor milestones, poor balance, oscillopsia (bouncing or jumping vision during head movement), and reduced participation in physical activities (Hazen & Cushing, 2021; Gerdson et al., 2025).

Children with bilateral vestibular loss often do not report spinning vertigo. Instead, parents may notice delayed walking, frequent falls, difficulty navigating in the dark or on uneven surfaces, or blurred vision during movement. Because these symptoms can be subtle, vestibular hypofunction is often underdiagnosed without targeted testing.

Ototoxicity

Ototoxicity refers to inner ear damage caused by certain medications or chemicals. Because systemic exposure typically affects both sides, children may present with bilateral imbalance, gaze instability during movement, or oscillopsia rather than true spinning vertigo (Fleihan et al., 2024). Substances known to be vestibulotoxic include cisplatin and other platinum-based chemotherapy agents and aminoglycoside antibiotics.

Vestibular toxicity may be underrecognized if only hearing is monitored. Clinicians should maintain a low threshold for vestibular testing in children receiving known vestibulotoxic therapies. Notably, in 2022 the FDA approved sodium thiosulfate (Pedmark) to reduce the risk of cisplatin-associated ototoxicity in children with localized, non-metastatic solid tumors (Orasan et al., 2025).

PART C: SYSTEMIC AND SECONDARY CONDITIONS ASSOCIATED WITH VESTIBULAR DYSFUNCTION



Sensorineural Hearing Loss (SNHL)

Vestibular dysfunction is common in children with sensorineural hearing loss, especially severe to profound SNHL. The auditory and vestibular organs share anatomy within the inner ear, so conditions that affect hearing often affect balance as well. Reviews report that vestibular impairment in this population is frequent and can affect motor development, spatial skills, and balance performance (Hazen & Cushing, 2021; Gerdson et al., 2025).

Many children with SNHL do not report vertigo but instead show delayed motor milestones, poor balance, or slower gross motor development. Vestibular screening should therefore be considered as part of evaluation and follow-up for all children with significant hearing loss.

Cochlear Implantation

Cochlear implantation dramatically improves hearing outcomes in children with severe to profound SNHL, but implantation may also affect vestibular function. A 2022 systematic review and meta-analysis found significantly increased rates of abnormal vestibular testing after pediatric cochlear implantation, along with poorer balance performance compared with typical peers (Wu et al., 2022; Deng et al., 2022). These findings support vestibular assessment before and after implantation, especially in children with pre-existing balance concerns.

Enlarged Vestibular Aqueduct (EVA)

Enlarged vestibular aqueduct (EVA) is one of the most common structural inner ear abnormalities associated with childhood sensorineural hearing loss. When enlarged, the vestibular aqueduct can contribute to fluctuating or progressive SNHL, sometimes worsened by minor head impacts or increased intracranial pressure. Importantly, vestibular dysfunction is also common. Studies using comprehensive vestibular testing in children with EVA have found abnormalities across rotary chair, VEMP, video head impulse testing, and balance assessments (Zhou et al., 2023).

Children with EVA may experience hearing and vestibular symptoms that are progressive and variable over time. Because EVA is detectable on CT or MRI, vestibular evaluation should be part of the management plan for children with this diagnosis.

Usher Syndrome

Usher syndrome is the most common genetic cause of combined hearing loss and progressive vision

loss. Usher syndrome type 1 is associated with profound congenital hearing loss, absent or severely reduced vestibular function, and significantly delayed motor milestones from infancy. Children with Usher syndrome type 1 often walk later than typical peers and may have ongoing balance difficulties as vision loss progresses in adolescence (Castiglione & Moller, 2022; Amorim et al., 2024). Because Usher syndrome may first present as hearing loss or motor delay, clinicians should recognize vestibular dysfunction as a core feature and include vestibular assessment in the evaluation of these children.

Congenital Cytomegalovirus (cCMV)

Congenital cytomegalovirus is the most common congenital viral infection and a recognized cause of pediatric SNHL. Importantly, newer evidence confirms that vestibular dysfunction is also common, even in children who appear asymptomatic at birth. A 2021 study found vestibular, gaze, and balance disorders in 45% of a cohort with asymptomatic cCMV. A 2025 cohort study reported substantial vestibular impairment rates across multiple testing modalities (Pinninti et al., 2021; Malesci et al., 2025).

These findings support audiovestibular follow-up as part of developmental monitoring in all children with confirmed cCMV, regardless of initial symptom severity.

Dysautonomia and Postural Orthostatic Tachycardia Syndrome (POTS)

Not all dizziness in children is vestibular in origin. Dysautonomia, including orthostatic hypotension and POTS, can cause lightheadedness, fatigue, nausea, brain fog, exercise intolerance, and dizziness with standing – symptoms that may overlap with vestibular complaints, especially in adolescents. POTS has become increasingly recognized in pediatric populations and may be especially relevant following COVID-19 infection (Boris & Moak, 2022; Buchhorn, 2023; Drogalis-Kim et al., 2022).

For children with chronic dizziness, orthostatic symptoms should be screened alongside vestibular causes. Some children with dysautonomia also demonstrate abnormal vestibular testing, supporting the value of vestibular evaluation in this population.

Type 1 Diabetes Mellitus

Emerging evidence suggests that type 1 diabetes may affect the pediatric audiovestibular system.



A 2021 case-control study reported abnormal vestibular findings in children with type 1 diabetes, even in the absence of overt symptoms (El Shafei et al., 2021; DiLiberto et al., 2024). Although still an emerging area, this supports consideration of vestibular involvement in children with diabetes who have balance concerns or dizziness.

OTHER DIAGNOSES AND DEVELOPMENTAL RISK GROUPS

Other groups of children may also be at increased risk for vestibular problems, including children born preterm, children with global developmental delay or intellectual disability, children with Down syndrome, and children with complex neurologic or multisystem conditions. Pediatric reviews emphasize that vestibular disorders in children can arise from conditions well beyond the ear and that assessment often benefits from a multidisciplinary approach (Dasgupta et al., 2025).

WHEN TO REFER A CHILD FOR VESTIBULAR EVALUATION

- Unexplained dizziness or vertigo lasting more than a few days
- Recurrent episodes of vertigo or dizziness
- Frequent unexplained falls or significant balance problems
- Delayed gross motor milestones (sitting, standing, walking)
- Blurred or jumpy vision during head movement
- Persistent imbalance or dizziness after head injury or illness
- Diagnosed with sensorineural hearing loss, cochlear implant, cCMV, EVA, or Usher syndrome
- Receiving cisplatin or aminoglycoside therapy
- Concussion with dizziness lasting more than 2-4 weeks despite standard management
- Suspected POTS or dysautonomia with dizziness or balance concerns
- Developmental or school difficulties that may be related to balance or visual instability

SUMMARY

Vestibular disorders in children are more common than once believed and can affect balance, vision during movement, mobility, school participation, and development. A wide range of diagnoses -- from

vestibular migraine and concussion to hearing loss, congenital infections, structural inner ear anomalies, and systemic conditions -- can cause vestibular dysfunction in children. Recognizing the signs of vestibular dysfunction and understanding which diagnoses are associated with it is the first step toward appropriate testing, diagnosis, and treatment.

Part 2 of this series will address the assessment of vestibular function in children, including clinical screening tools and laboratory testing. Part 3 will address evidence-based interventions, including vestibular rehabilitation and medical management.

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