Table 1 Diagnostic criteria for vestibular migraine

	1. Vestibular migraine
A.	At least 5 episodes with vestibular symptoms[a] of moderate or severe intensity,[b] lasting 5 min to 72 h[c]
B.	Current or previous history of migraine with or without aura according to the International Classification of Headache Disorders (ICHD)[d]
C.	One or more migraine features with at least 50% of the vestibular episodes[e]: • Headache with at least two of the following characteristics: one-sided location, pulsating quality, moderate or severe pain intensity, aggravation by routine physical activity • Photophobia and phonophobia[f] • Visual aura[g]
D.	Not better accounted for by another vestibular or ICHD diagnosis[h]
	2. Probable vestibular migraine
A.	At least 5 episodes with vestibular symptoms[a] of moderate or severe intensity[b], lasting 5 min to 72 h[c]
B.	Only one of the Criteria B and C for vestibular migraine is fulfilled (migraine history or migraine features during the episode)
C.	Not better accounted for by another vestibular or ICHD diagnosis[h]

[a]Vestibular symptoms, as defined by the Bárány Society's Classification of Vestibular Symptoms (Bisdorff et al) and qualifying for a diagnosis of vestibular migraine, include

• Spontaneous vertigo including

- Internal vertigo, a false sensation of self-motion

- External vertigo, a false sensation that the visual surround is spinning or flowing

• Positional vertigo, occurring after a change of head position

• Visually induced vertigo, triggered by a complex or large moving visual stimulus

• Head motion-induced vertigo, occurring during head motion

• Head motion-induced dizziness with nausea. Dizziness is characterized by a sensation of disturbed spatial orientation. Other forms of dizziness are currently not included in the classification of vestibular migraine.

[b]Vestibular symptoms are rated "moderate" when they interfere with but do not prohibit daily activities and "severe" if daily activities cannot be continued.

[c]Duration of episodes is highly variable: About 30% of patients have episodes lastingminutes, 30% have attacks for hours and another 30% have attacks over several days. The remaining 10% have attacks lasting seconds only, which tend to occur repeatedly during head motion, visual stimulation, or after changes of head position. In these patients, episode duration is defined as the total period during which short attacks recur. At the other end of the spectrum, there are patients who may take 4 weeks to fully recover from an episode. However, the core episode rarely exceeds 72 hours.4–8,22

[d]Migraine categories 1.1 and 1.2 of the ICDH-2.12

[e]One symptom is sufficient during a single episode. Different symptomsmay occur during different episodes. Associated symptomsmay occur before, during, or after the vestibular symptoms.

[f]Phonophobia is defined as sound-induced discomfort. It is a transient and bilateral phenomenon that must be differentiated from recruitment, which is often unilateral and persistent. Recruitment leads to an enhanced perception and often distortion of loud sounds in an ear with decreased hearing.

[g]Visual auras are characterized by bright scintillating lights or zigzag lines, often with a scotoma that interferes with reading. Visual auras typically expand over 5 to 20 minutes and last for less than 60minutes. They are often, but not always restricted to one hemifield. Other types ofmigraine aura,

for example, somatosensory or dysphasic aura, are not included as diagnostic criteria because their phenomenology is less specific andmost patients also have visual auras.

[h]History and physical examinations do not suggest another vestibular disorder or such a disorder is considered, but ruled out by appropriate investigations; or such disorder is present as a comorbid or independent condition, but episodes can be clearly differentiated. Migraine attacks may be induced by vestibular stimulation (Murdin et al23). Therefore, the differential diagnosis should include other vestibular disorders complicated by superimposed migraine attacks.

[Reference: Thomas Lempert, MD. Vestibular Migraine. Semin Neurol 2013;33:212–218. Table.1]