Dizziness as a symptom may be caused by pathology of one or more systems. To help diagnosis, it should be classified into symptom categories of Syncope / Presyncope, Disequilibrium / Imbalance, Psychogenic or Vertigo. See Page 2 for more information points on each condition and on medication.

**Dizziness Pathway**

This guidance has been developed in collaboration with local specialists. It is intended to assist GPs in decision making and is not intended to replace clinical judgment.

**History:**

**Syncope/Presyncope** (sensation of impending loss of consciousness): cardiovascular disease, postural hypotension, arrhythmia, anaemia, murmurs, medications, vasovagal

**Dys equilibrium / Imbalance** (unsteadiness): multiple sensory deficits, peripheral neuropathy, cerebellar ataxia, presbyastasis, CVA/TIA, metabolic

**Psychogenic:** hyperventilation, anxiety, panic, somatisation

**Vertigo:** 

<table>
<thead>
<tr>
<th>Central causes</th>
<th>Peripheral causes</th>
</tr>
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<tbody>
<tr>
<td>BPPV, vestibular neuritis or labyrinthitis, Meniere’s; Vertebrabaasal CVA/TIA, migraine, MS</td>
<td>Vestibular neuronitis / labyrinthitis, Meniere’s; Vertebrabaasal CVA/TIA, migraine, MS</td>
</tr>
</tbody>
</table>

**Examination:**

Cardiovascular, Neurological (esp cranial n, nystagmus, cerebellar signs, gait), Ears, Vision, Erect and Supine BP, Dix-Hallpike test, BM glucose, Affect

**Investigations:** For Syncope/Presyncope consider FBC, U&E, Glucose, Lipids, TFTs, ECG, Echocardiogram, 24 hr tape

See explanatory video on dizziness assessment and Dix-Hallpike & Epley manoeuvres with Dr Ian Colvin

Comments & enquires relating to medication: NHS Camden Medicines Management Team mmt.camdenccg@nhs.net

Refer to current BNF or SPC for full medicines information

Clinical contact for this pathway: Dr Alex Warner, a.warner@nhs.net

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**Peripheral vestibular causes (approx 40%)**

- **BPPV**
  - Confirm by Dix-Hallpike test, treat by Epley manoeuvre or similar.
  - Supportive advice of remaining mobile to assist compensation.
  - Review patient at 2-4 weeks. Repeat once.
  - Incomplete compensation after 6 weeks
  - Refer to Audiological Medicine

- **Vestibular neuronitis / labyrinthitis**
  - Treat with vestibular sedatives if severe e.g. prochlorperazine.
  - Supportive advice of remaining mobile to assist compensation.

- **(Possible) Meniere’s disease**
  - Vestibular sedatives may be useful in acute episode
  - Advise low salt diet
  - Supportive advice of remaining mobile to assist compensation.

- **Multisensory dizziness** (up to 17% of pts)
  - Improve comorbid factors, e.g. diabetes control, visual correction

- **Psychological cause or component** (up to 26%)
  - Support / treatment for primary components of anxiety, panic disorder, avoidance, depression which make dizziness worse

**Red Flag Features**

- Sudden (sensorineural) hearing loss
- Acute onset tinnitus
- Abnormal neurological signs
- Central causes: Possible TIA/ CVA, Vascular, MS, Spinocerebellar degeneration
- Seizures
- Loss of consciousness
- Arrhythmia, Murmur requiring investigation, Diabetic peripheral neuropathy, other ‘medical’ causes

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**Other common causes**

- **Consider referral for vestibular rehabilitation**
- **Consider referral to Falls Clinic**
- **Consider need for Psychology or Psychiatry input**

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Urgent ENT Referral

Urgent

Refer appropriate specialty (Neurology, Cardiology)

Pathway updated by Alex Warner June 2015

Review due: June 2018

V1.41 Links updated Jan16
Dizziness Pathway Page 2 – Management Advice

### General Information Points

**Avoid long-term pharmacological use in dizziness or vertigo**
(e.g. prochlorperazine (stemetil), cinnarizine, anticholinergics like scopolamine); there is little evidence of clear effectiveness but they often delay central compensation and create a psychological dependence.

All patients should receive general supportive and reassurance advice as a significant proportion develop secondary avoidance behaviour. They should be advised to mobilise as much as possible as this helps them compensate quicker. Those patients at risk of developing secondary avoidance behaviour should be referred to Audiovestibular Medicine.

Multisensory dizziness is age related and due to impairment of inner ear, peripheral neuropathy, (cervical) arthritic changes, vision and hearing. It is present in up to 17% of dizzy patients.

Vertigo associated with headache may be migrainous vertigo which should be treated with migraine treatments i.e. analgesia, triptans.

Three general classes of drugs are used to suppress the vestibular system, although their effectiveness has not been reliably assessed.
- Antihistamines, eg. Cinnarizine (stugeron)
- Phenothiazines, eg. prochlorperazine (stemetil)
- Anticholinergics, eg. scopolamine

**Meniere’s disease:**
‘Primary endolympathic hydrops’ (swelling of the inner ear compartments) causing impairment of balance and hearing, with some rare secondary causes.

It is a diagnosis of exclusion made in secondary care.

4 cardinal features: usually unilateral
- Vertigo – characteristically rotatory or rocking and can be associated with nausea and vomiting
- Hearing loss - sensorineural, initially affecting the lower pitches, may fluctuate and often becomes permanent
- Tinnitus - typically of low pitch and may be associated with auditory distortion
- An aura of ‘fullness’ or pressure in the ear or the side of the head can last from 20 minutes to several hours.

Clinical course varies among individuals and over time in the same individual.

Little evidence for long-term effectiveness of a low salt diet, diuretics and betahistine (Serc), but expert opinion supports these.

Chief role of medication is to alleviate symptoms such as vertigo, nausea, and vomiting during an acute or transient dizzy episode; rarely is surgery indicated.

### Benign Paroxysmal Positional Vertigo (BPPV)

One of the most common causes of dizziness (up to 65% of vertigo)
- Severe, brief paroxysms of rotational vertigo provoked by positional changes.
- Idiopathic in 35% of cases, about 15% have a history of relatively minor prior head trauma.

The remainder is a residual effect of a variety of vestibular pathologies, most commonly Meniere’s disease (30%), but also vestibular neuronitis, ear surgery, and inner ear ischaemia.

There is a relatively straightforward confirmatory test and treatment manoeuvre for this condition, which should be attempted when the diagnosis is being considered.

**Hallpike test:** The diagnosis is confirmed by this test: The patient is rapidly lain down flat on a couch from a sitting position with head turned to the side and neck extended. After a delay, a typical torsional horizontal nystagmus is seen for up to 30 seconds. It is present in the opposite direction on sitting back up. The test is repeated on the other side. Caution should be used in patients with neck pathology.  **(Video)**

**Epley Manoeuvre:** (Particle repositioning manoeuvre) There is evidence that this is effective in up to 90% of patients in improving or resolving symptoms. Following a positive Hallpike test, the head is turned through 180 degrees in 2 x 90 degree stages with a wait of 30 seconds in between. It may be repeated at subsequent clinic visits.  **(Video)**

### Acute Vestibular Neuronitis (acute vertigo) and Labyrinthitis (vertigo with altered hearing)

Abrupt onset of severe, debilitating vertigo with associated unsteadiness, nausea and vomiting.

Patients often describe their vertigo as spinning, which increases with head movement.

On physical examination spontaneous, unidirectional, horizontal nystagmus is the most important physical finding and fast phase beat towards the side of lesion (acute phase) and towards the healthy ear (during compensation).

The patient tends to fall towards the affected side when attempting ambulation or during Romberg tests.

Some patients may develop benign paroxysmal postural vertigo (BPPV) later.

Symptoms of other diagnoses should be absent: multidirectional, non-fatiguing nystagmus suggesting vertigo of central origin; hearing loss; other cranial nerve deficits; truncal ataxia (suggests cerebellar disease or another CNS process); inflamed tympanic membrane; mastoid tenderness; high fever; nuchal rigidity.

Causes: may be viral and ischaemia of the vestibular nerve and inner ear.