Assessing the dizzy patient

Advice on how to treat and when to refer

Is the vertigo...

- Triggers?
- Spontaneous? If so, establish...
- Head or body movement

If vertigo lasts several minutes to hours, consider:

- Vertigo (vestibular neuritis/labyrinthitis)
- Vascular labyrinthine damage
- Hearing loss ± tinnitus
- Trigeminal neuralgia
- Certain drugs

If vertigo is...

- ...a single episode
- ...constant
- ...multiple recurrent episode lasting minutes to hours

Consider...

- Incompletely compensated (or decompensated) peripheral vestibular disorder
- Check past history of vestibular neuritis/labyrinthitis
- Trigeminal or cranial nerve disorders
- Neurological causes to exclude (neurological examination is the ‘ophthalmoscope’ technique)

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Consider:

- Head-shaking (the ophthalmoscope technique)
- Negative Hallpike: non-vestibular disorder
- Positive Hallpike: benign paroxysmal positional vertigo (BPPV)

Consider:

- Meniere’s: consider betahistine 32mg tds
- Vestibular migraine: consider diet and lifestyle modifications
- Hypertension
- Hyperlipidaemia
- Raynaud’s syndrome
- Vasovagal attacks

Consider cardiovascular causes, such as vasovagal attacks

- Review antihypertensives if orthostatic hypotension suspected
- Consider peripheral neuropathy and check for diabetic conditions in patients with impaired proprioception
- Seek ‘來mean referral’ for the other conditions

Consider psychiatric

- Vascular epilepsy is very rare. Vertigo can be the aura

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