RCHT DIZZINESS AND VERTIGO GUIDELINE

ACUTE VERTIGO	CHRONIC VERTIGO	DIZZINESS/LIGHTHEADEDNESS (NOT TRUE VERTIGO)

CENTRAL VERTIGO

RED FLAGS:
- Brainstem stroke?
- Central cause?
- Neurological symptoms or signs esp. cerebellar
- New headache esp. occipital
- Acute deafness
- Vertical nystagmus
- If symptoms severe e.g. unable to stand, not improving within a few hours, then high index of suspicion for cerebellar pathology
- HINTS Test can help distinguish central from peripheral cause

Refer urgently or admit:
Use clinical judgement
?stroke pathway
?2WW neurology

PERIPHERAL VERTIGO

Persistant +/- nausea/vomiting not positional no neurol features	Recurrent, mins to hrs +/- nausea/vomiting Not positional +/- pre-aura +/- headaches	Recurrent, 30 mins to hours with unilateral hearing loss, tinnitus +/- aural fullness/pressure	Recurrent, positional <1 min Most 'sensitive' feature is "on turning over in bed" Such POSITIONAL vertigo is distinct from MOVEMENT PROVOKED vertigo seen in chronic states	Chronic or recurrent unsteadiness, dizziness, instability, frequently movement provoked (e.g. on mobilising and perhaps turning the head or stooping/rising without visual fixation)
horizontal nystagmus, HINTS -ve	Typically no clinical signs	May have no signs between attacks	Positional torsional nystagmus<30secs, Dix-Hallpike Test +ve	Unterbergers test deviates to one side
Acute vestibular neuronitis (vertigo only) Acute labyrinthitis (vertigo and hearing loss)	Vesibular migraine	Menieres possible	BPPV	Decompensated vestibular hypofunction or chronic instability of the elderly
Vestibular rehabilitation exercises once the acute vertigo and nystagmus settles	Manage as migraine	2 month trial betahistine 16mg TDS, low salt diet, decaffeinated drinks, no aspartane, reduce stress.	Epley Manoeuvre, or Semont manoeuvre Brandt-Daroff exercises	Vestibular rehabilitation exercises
Vestibular sedative: prochloperazine for acute attacks only (can be given IM at home, or PO)				

COMMON CONSIDERATIONS
Postural hypotension
Pre-syncope/Syncope
Arrhythmias
Polypharmacy
Multiple comorbidity
Falls
Multisensory deficit

History & Meds review
- Polypharmacy leads to falls!! Especially if >4 medications
- Drugs causing falls: TCAs (amitriptyline), antipsychotics (prochlorperazine), benzodiazepines, anticholinergics (oxybutynin), opiates
- Drugs causing orthostatic hypotension - Diuretics, CCBs, ACEi, A2RBs, alpha blockers

Investigations to consider:
- Lying/Standing BP
- Bloods: FBC (anaemia), U&Es, HbA1c if diabetic
- ECG, 24-hr ECG
- Echocardiogram

REFERRAL IF ISSUES UNRESOLVED OR CONTINUE TO BE TROUBLESOME:

>75yrs, Elder care (Falls service, advice and guidance, 'Silver Phone' 01872 252161)	60-75yrs, Multiple comorbidity, polypharmacy or 2 or more falls, refer to Elder care	<60yrs to ENT