Vertigo and dizziness

– advice for initial management in primary care

Centre for Sustainable Delivery

NHS SCOTLAND

Introduction

This Fact Sheet provides information on how to treat patients with vertigo and dizziness in different situations and circumstances.

Dizziness – vertigo, light-headedness, presyncope or dysequilibrium?

Dizziness is a very common symptom patients may experience and has varying levels of indicators, which are mostly benign. Patient history will help distinguish the cause, but patience and thorough examination are often required.

Dizziness can present itself in the following ways:

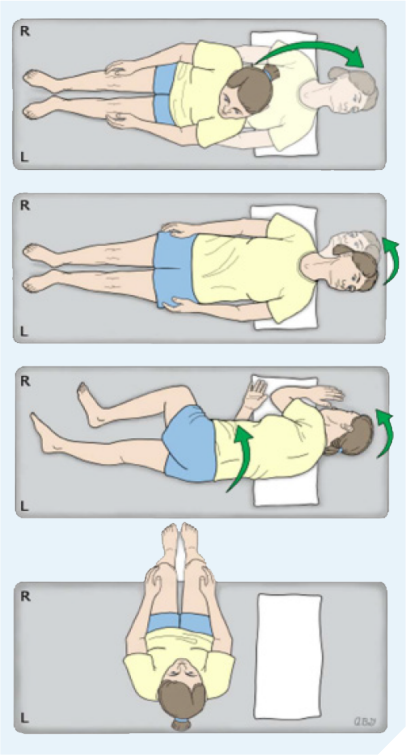
- Lightheadedness/presyncope: a feeling you might pass out.
- Dissociation: a spaced out feeling as if disconnected from your body or the world around you.

Vertigo – the illusion of movement

Vertigo arises from lesions of either the inner ear (vestibular apparatus) or the brain, although the former is far more common.

Common causes of vertigo (in order of frequency)

- Benign paroxysmal positional vertigo (BPPV): short lasting (seconds) bursts of vertigo with movement, typically rolling over in bed, getting in and out of bed, chairs, car, looking up at cupboards, hanging up washing. It is common after head injury and under-recognised, but is highly treatable without drugs. The picture examples on the right demonstrates the Epley manoeuvre, which is used to cure BPPV.
- Vestibular migraine: the only common brain cause of vertigo. Attacks can last from a few hours to several day. This is usually associated with other migrainous features, but not always headache.
- Acute vestibular syndrome (aka labyrinthitis, vestibulo-neuronitis): typically disabling vertigo lasts a few days. Most people recover fully, but it can occasionally recur and/or leads to PPPD (see below).
- Persistent Perceptual Postural Dizziness (PPPD): This is not vertigo, but it may evolve after having vertigo, persistent disequilibrium - the “chronic fatigue syndrome” of the brain/inner ear axis. More information: **www.neurosymptoms.org/en_GB/symptoms/fnd-symptoms/dizziness-including-pppd-persistent-postural-perceptual-dizziness/**
- Meniere’s disease/syndrome: vertiginous episodes which last hours, usually with associated unilateral aural fullness/tinnitus/fluctuating hearing loss.



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All other causes of isolated vertigo, including central causes such as Transient Ischaemic Attack (TIA), acoustic neuroma, Multiple Sclerosis (MS), are rare or very rare. People with Brainstem TIA and MS nearly always present with vertigo and other brainstem / focal symptoms.

Do patients need investigation in primary care?

The most useful investigation is a Hallpike manoeuvre, which can be viewed on this link to identify BPPV: **www.youtube.com/watch?v=8RYB2QIO1N4**. Routine blood tests and imaging are rarely helpful.

Do patients need Ear Nose and Throat (ENT), Neurology assessment?

Most people with vertigo do not need secondary care assessment. If you suspect the lesion is in the vestibular apparatus, ENT is the best route. Central brain causes of vertigo other than migraine are rare.

Vertebrobasilar insufficiency (VBI) does not exist
This "condition" does not exist. While VBI was taught at medical school, the teaching was erroneous. Your brain has 4 arteries which stops this happening. Vertigo/dizziness with neck movement is almost always BPPV.

Post head injury dizziness
Dizziness is a common post head injury symptom and is often explained by BPPV. See also: **www.headinjurysymptoms.org**

Treatment of vertigo
Many people will require nothing more than reassurance, while an Epley manoeuvre for BPPV can be curative.
www.youtube.com/watch?v=9SLm76jQg3g

Vestibular sedatives (prochlorperazine, cinnarizine, betahistine etc) should only be used for acute vestibular syndrome as long-term use is not recommended. Vestibular migraine can be hard to treat, but standard migraine treatment is to be used.

Patient information
www.nhsinform.scot/illnesses-and-conditions/ears-nose-and-throat/vertigo

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