Vertigo and dizziness- advice for initial management in primary care

Dept Clinical Neurosciences, NHS Lothian. 2022

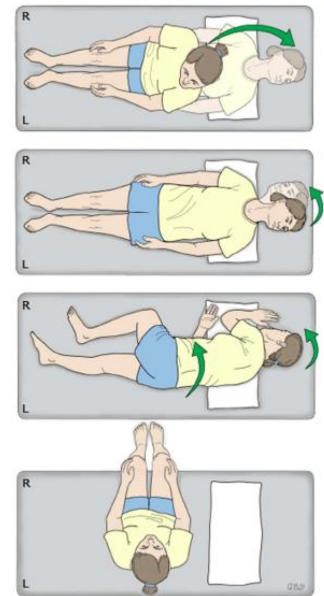
Please note this is only designed as a summary of management

Please consult BNF for contraindications, cautions, side effects, pregnancy etc. www.refhelp.scot.nhs.uk/

Dizziness - vertigo, light-headedness, presyncope, dissociation or disequilibrium?

Dizziness is a very common symptom and has a wide differential, mostly benign. The history will help distinguish what the patient means, although patience is often required. Light-headedness/presyncope = a feeling you might pass out. Dissociation = a spaced out feeling as if disconnected from your body or the world around you. Here we focus on vertigo, which is the illusion of movement and familiar to many people after drinking too much alcohol . 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/out bed/chairs/car, looking up at cupboards, hanging up washing. Common after head injury, under-recognised, but eminently treatable (not with drugs). Once you cure your first BPPV patient you will wish you learnt how to do an Epley sooner!
- **Vestibular migraine**: the only common brain cause of vertigo, attacks last hours to days, usually associated with other migrainous features but not always headache.
- **Acute vestibular syndrome (aka labyrinthitis, vestibulo-neuronitis)**; better known to GPs than hospital doctors, typically disabling vertigo lasting days, most recover fully, can occasionally recur and/or leads to PPPD (see below).
- **Persistent perceptual postural dizziness (PPPD)**: not vertigo, but may evolve after vertigo, persistent disequilibrium, the "chronic fatigue syndrome" of the brain/inner ear axis (https://www.neurosymptoms.org/en_GB/symptoms/fnd-symptoms/dizziness-including-pppd-persistent-postural-perceptual-dizziness/)
- **Meniere's disease/syndrome**: ENT classic, vertiginous episodes last hours usually with associated unilateral aural fullness/tinnitus/fluctuating hearing loss.

All other causes of isolated vertigo including central causes such as TIA, acoustic neuroma, MS are rare or very rare. Brainstem TIA and MS nearly always presents with vertigo + other brainstem/ focal symptoms.

Do they need investigation in primary care?

The most useful "investigation" is a Hallpike manoeuvre (https://www.youtube.com/watch?v=8RYB2QlO1N4) to identify BPPV. Routine blood tests and imaging are rarely helpful.

ENT or Neurology or neither?

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 https://apps.nhslothian.scot/refhelp/ENTADULT/Ear/dizziness-and-balance . There is an ENT BPPV clinic based in Audiology at Lauriston Place (Rona Russell) and there is a specialist balance dizziness ENT clinic. Central (brain) causes of vertigo other than migraine are very rare.

Vertebrobasilar insufficiency (VBI) does not exist

Very simply, this "condition" does not exist. Yes, we were taught about 'VBI' at medical school too – but they were wrong. Your brain has four arteries which stops this happening. Vertigo/dizziness with neck movement is nearly always BPPV.

Post head injury dizziness

Dizziness is a common post head injury symptom, often explained by BPPV. See also www.headinjurysymptoms.org

Treatment of vertigo

Many will require nothing more than reassurance. An Epley manoeuvre for BPPV can be curative (https://www.youtube.com/watch?v=9SLm76jQg3g). Vestibular sedatives (prochlorperazine, cinnarizine, betahistine etc) should only be used for acute vestibular syndrome, long term use is not recommended. Vestibular migraine can be hard to treat but use standard migraine treatment.

Patient information

https://www.nhsinform.scot/illnesses-and-conditions/ears-nose-and-throat/vertigo

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