Vale of York
Clinical Commissioning Group

Referral Support Service

ENT

ENT10
Dizziness and Vertigo
(incl. BPPV - benign positional paroxysmal vertigo)

Definition

True rotational vertigo is due to problems in the labyrinth, peripheral lesions in the acoustic nerve (CN VIII) directly or its central pathways or nuclei further up in the brain. There is normally associated ataxia and nystagmus and patients feel as if the room is spinning or rotating around them. These are patients to refer to the ENT balance clinic, whereas the following "conditions" rarely benefit from this service.

"Dizziness" is a common and, in many cases, temporary, self-resolving perception of "unsteadiness" to varying degrees, which may be unpleasant or interfering with the patient's life and function. It is usually not caused by primary ENT related conditions.

Pre-syncope is "light-headedness" with near-faints, usually due to postural hypotension (iatrogenic through medication, cardiac arrhythmias or vaso-vagal attacks / poor vaso-vagal response-capacity of a patient). More worrying possible cardio-vascular features include actual falls or black-outs, sweating, or flushing. Don't forget abnormal vaso-motor responses due to metabolic disorders (Thyroid, Diabetes, Addisons etc.) or dehydration and shock.

Disequilibrium is a more vague general unsteadiness when walking, which can feel like significant imbalance with associated fear of falls. It often affects elderly due to impaired vision, musculo-skeletal weakness or progressive peripheral neuropathy etc.

A proportion (up to 20%) of dizziness patients have multifactorial causes, and some (up to 10%) could be due to mental health (e.g. anxiety, somatisation) issues.

Exclude Red Flag Symptoms

Potential red flags include cerebellar signs (Dysdiadochokinesis, Past-pointing, generalised Limb/trunk/gait ataxia, dysarthria, abnormal (i.e. vertical or unusual) nystagmus - refer via Stroke pathway or to Neurology as appropriate), acute systemic upset, new headaches etc.

General Points

The key of distinguishing the different conditions described under "definitions" above lies in taking a good, detailed enough history. Patients may find it difficult to describe their symptoms clearly and "dizzy" can mean a lot of different experiences for different people, so, some specific guiding questions can be helpful in the consultation (e.g. "what happens with your "dizziness", when you turn over in bed?").

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Possible causes for peripheral vertigo:

BPPV: Sudden onset, **positional** (when moving body or head)**. Lasts for seconds at a time, certainly < 1 minute overall** (when keeping still). No hearing loss or tinnitus. Typically fatiguable nystagmus to the affected side, either spontaneous or at Hallpike-Dix manoeuvre (always do this, if practical).

Vestibular neuronitis / acute labyrinthitis: sudden onset without warning or apparent trigger. Can last hours or days, occasionally up to two weeks. Risk of recurrence within following 18 months. No hearing loss or tinnitus. Nystagmus present as well as possibly disabling nausea and sickness.

Meniere's disease: sudden onset, no apparent trigger. Can last hours or days (not weeks). The patient usually feels better the day after an attack than the day before. Recurrence is common. **Intermittent or progressive hearing loss, fluctuating tinnitus, pressure sensation** in affected ear (usually unilateral) with nystagmus, nausea and vomiting. This is overall a rare condition.

Acoustic neuroma: slow onset with progressive unilateral tinnitus and hearing loss, usually no other symptoms (if so suspect possible other brain tumour).

Iatrogenic (medication) induced: acute or slow onset, usually intermittent depending on medication use, often partial adaptation with time, hearing loss and tinnitus less common (most likely with NSAIDs), can cause nausea and vomiting.

Central vertigo (brain stem etc.) has often a sudden onset as well, can be of variable duration (depending on the underlying cause), does not affect hearing and does not produce tinnitus. You would expect additional and quite obvious symptoms such as marked ataxia or dysarthria. This could be due to progressive neurological conditions (MS, Parkinson's etc.).

A significant proportion of referrals to ENT for “dizziness” turn out to be **vestibular migraines**. These commonly have visual, auditory or limb symptoms, consistent with features of a migraine aura. However, not all have a headache. There can be overlapping similarities to BPPV and Meniere's Disease (but the latter is a rare condition). A progressive hearing loss is pretty much an exclusion criterion for vestibular migraines. Vestibular migraines typically occur intermittently and can cause un-wellness and unsteadiness for days, or even weeks afterwards. 50% of known migraine headache sufferers may have rotational vertigo symptoms for minutes or several hours, and there can be nystagmus during attacks.

The main thing is to think of it as a possible diagnosis in the “dizzy patient” and ask for aura symptoms, photophobia etc.

Helpful guide to assessing a “dizzy patient”: please click here

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Management

Do a medication review to ensure no medication-induced dizziness such as postural hypotension.

In sudden, acute and debilitating vertigo consider a medical admission in the first place to ensure that central causes / acute cardio-vascular events can be excluded in the first place.

Vestibular migraines: think of it as a possible and common differential diagnosis with intermittent onset. Apart from symptomatic treatment during attacks, consider prophylactic treatment with beta-blockers, or low-dose Amitriptyline etc., which can be very effective and prevent the need for a referral to ENT.

BPPV:

- Epley's Manoeuvre can be performed in surgery, but warn patient they may not be able to drive afterwards. To view a demonstration, please click here
- Brandt Daroff self-help exercises please click here
- Use of vestibular sedatives / stabilisers (e.g. **Buccastem**) should be reserved for severe cases and for short duration of use only e.g. 3-5 days, as it actually delays recovery.
- Refractory Cases or if significant diagnostic uncertainty and unusual features: refer to the Balance Clinic

Acute Labyrinthitis: Symptomatic treatment with antiemetics and vestibular stabilisers (**prochlorperazine** 5mg tds orally, only short term (one week). Alternatively: **betahistine** 16mg tds longer-term (> 1 month) and for prevention of regular recurrence in some patients.

Meniere's disease: Advice, short term symptomatic treatment if needed; refer if recurrent or progressive symptoms.

Central vertigo: refer to neurology.

Consider a referral of all non-vestibular or mixed cases to physiotherapy / OT / the Falls Service in the first place, particularly elderly and perhaps somewhat frail patients. The ENT balance clinic would be of limited value initially for them.

Information to include in referral letter:

- Clear points in history as described and highlighted above (duration, hearing, tinnitus, triggers, nausea, check for possible migrainous aura, other symptoms)
- List any medications tried (eg. Prochlorperazine or Betahistine)
- Preliminary diagnosis or why uncertainty remains
- Sitting **and** standing Blood pressure
- Confirm regular pulse
- General hearing issues
- Normal ear canal (no signs of cholesteatoma or trauma)
- No (new) visual deficits

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- Presence or absence of spontaneous nystagmus (if horizonal and fatigable consider BPPV)
- Findings during bilateral Hallpike-Dix manoeuvres
- Romberg test

Investigations prior to referral:

- Usually none specific

Patient information leaflets/ PDAs

- Benign Paroxysmal Positional Vertigo Leaflet
- Vertigo and how to treat it Leaflet

References

- Vestibular migraines: https://www.entandaudiologynews.com/features/ent-features/post/migraine-related-vertigo