CLINICAL GUIDELINES

Dizziness Guideline Emergency Department, Glasgow Royal Infirmary

A guideline is intended to assist healthcare professionals in the choice of disease-specific treatments.

Clinical judgement should be exercised on the applicability of any guideline, influenced by individual patient characteristics. Clinicians should be mindful of the potential for harmful polypharmacy and increased susceptibility to adverse drug reactions in patients with multiple morbidities or frailty.

If, after discussion with the patient or carer, there are good reasons for not following a guideline, it is good practice to record these and communicate them to others involved in the care of the patient.

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Important Note:

The Intranet version of this document is the only version that is maintained.
Any printed copies should therefore be viewed as 'Uncontrolled' and as such, may not necessarily contain the latest updates and amendments.

GRI Emergency Department: DIZZINESS GUIDELINE

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(adapted with permission from the 2013 CEM CPD Lecture: *Does this dizzy patient have a Stroke*? Dr Ajay Bhalla. Consultant Stroke Physician. Guys & St Thomas')

CLARIFY WHAT PATIENT MEANS BY DIZZINESS – Vertigo, Presyncope, Imbalance or Non-specific dizziness?

History

- Age > 50 years
- Prior history of stroke/TIA
- Cerebrovascular risk factors
- Recent head or neck injury
- Onset - speed and timing
- Duration and time course < 1 minute or ≥ day(s)
- Positional or sustained
- Nausea and vomiting (50%)
- Headache (30%)
- Hearing loss
- Focal neurological symptoms
- Provocation factors
- Previous episodes?

Must have thorough neuro Examination focusing on

- Eye movements
- Visual fields
- Speech
- Limb power and sensation
- Limb co-ordination
- Hallpike Manoeuvre
- Gait Assessment
- Otoscope
- Clinical assessment of hearing

Rotatory Vertigo?

NO

- Presyncope
- Disequilibrium
- Lightheadedness

Yes

RED FLAGS SUGGESTING BRAINSTEM STROKE OR OTHER CENTRAL CAUSE

- Any central neurological symptoms or signs
  - Diplopia, hemianopia, facial weakness, dysphagia, dysphonia, limb weakness, hemisensory loss or ataxia
- New type or new onset of headache (occipital)
  - Common in stroke
  - Posterior circulatory (40%)
  - Think about vertebral dissection with Head/Neck injury (Discuss with senior. CT Angiogram)
  - Vestibular Migraine (diagnosis of exclusion)
- Acute deafness (Sudden onset with vertigo suggestive of ischaemia of labyrinth or AICA occlusion)
- Vertical nystagmus

YES

URGENT CT & REFERRAL

No

DO CONFIRMATORY TESTS "RULE IN" BPPV (HALPIKE) OR ACUTE VESTIBULAR NEURITIS (HEAD THRUST TEST)

YES		*NO*	
Positional Vertigo and torsional nystagmus fatigues in 30 seconds (+ve Hallpike Manoeuvre) **BPPV**	Sustained vertigo and horizontal nystagmus. Not positional. "Head Thrust Test" shows failure of Vestibular Ocular Reflex **Acute Vestibular Neuritis (labyrinthitis)**	Consider **Vestibular Migraine** (and treat and refer) if vertigo plus migraine is recurrent and examination is normal	Transient unilateral hearing loss or Tinnitus, and previous episodes of dizziness Consider **Meniere's Disease** and routine referral via GP

HEAD THRUST TEST