Assessing the dizzy patient Onward referral Diagnosis Treatment •Benign paroxysmal positional vertigo (BPPV). •90% of BPPV is posterior •Refer to Ears in Balance. We There are six possibilities: BPPV can arise from canalithiasis. The treatment of record the eye movement with all the posterior, anterior or horizontal choice is the Epley manoeuvre. positional testing to ensure By positional semicircular canal and can be either in the canal Brandt-Daroff's exercises are correct diagnosis and treatment. changes (canalithiasis) or cupula (cupulolithiasis). not as effective and compliance •Refer central nystagmus or See the BPPV tab on our website for detailed is poor refractory BBPV to neuro-otology differential diagnosis. See the BPPV tab on our website •Vestibular migraine (central nystagmus on for detailed treatments. •Refer to Ears in Balance to positional testing) confirm peripheral impairment and aid vestibular rehabilitation. Avoid vestibular sedatives as Incomplete compensation (or •Refer to vestibular physio (a list By head or body they can interfere with central decompensation) of peripheral impairment Triggered? can be found under resources for movement •Is there a past history of vestibular neuritis or compensation professionals on our website) Labyrinthitis? Vestibular rehabilitation Viral labyrinthine damage (vestibular neuritis) •Refer for MRI if associated Labyrinthitis (+hearing, +/- tinnitus) hearing loss/tinnitus Vertigo Vestibular sedatives can help Single episode •Neurological cause (ie. stroke) look for central •Refer to neurology if stroke or nausea and vomiting nystagmus neurological causes suspected Vestibular rehabilitation •Refer to Ears in Balance to Vestibular migraine (associated light/sound) confirm peripheral impairment sensitivity, headache, visual aura. Hx migraine. and aid vestibular rehabilitation. Duration mins to days) Spontaneous? Multiple episodes Vestibular migraine consider •Meniere's disease (associated hearing loss, •Refer to Ears in Balance to aid lifestyle modifications and tinnitus, aural fullness. Duration mins to hrs) differential diagnosis for triggering factors or Vestibular paroxysmia Meniere's disease consider diet Vestibular migraine vs Meniere's Autoimmune inner ear disease disease (eg. Documented low modification (low salt etc.) Note: Meniere's and vestibular migraine can frequency sensorineural hearing Explore symptoms of mimic each other and co-exist loss) autoimmune disease Refer to neuro-otology Constant Persistent postural-perceptual dizziness (PPPD) Neurological causes •Refer to neuro-otology for PPPD Dizziness Consider CBT for psychological •Multisensory dizziness – eg. Elderly or diabetes or overlay/chronic anxiety •Bilateral vestibular loss (falls risk) •Refer to Ears in Balance if bilateral Persistent postural-perceptual dizziness (PPPD) vestibular dysfunction suspected or to ·Hyperventilation syndrome or psychological Not constant rule out any peripheral involvement in overlay patient's symptoms Neurological causes Orthostatic hypotension Impaired proprioception **Explanatory notes:**

Vertigo: Any false sensation of movement (spinning, rocking, a feeling of being pushed or feeling the body continues to move when still etc.). Most likely a vestibular disorder.

Dizziness: Altered sensation of spatial orientation, light headedness, faintness. Does not involve a sensation of movement when still. Not necessarily due to a vestibular disorder.

Central nystagmus: One or more of the following: bidirectional (changes direction with direction of gaze); vertical (usually downbeat – a cerebellar sign); nystagmus during Hallpike testing that does not fit with BPPV (vertical, persistent etc.) See the BPPV tab for more information on BPPV diagnosis and treatment.

This flowchart has been adapted from http://www.pulsetoday.co.uk/