






Dizziness & Funny Turns

“I feel dizzy Doc”. This is often a difficult consultation for a GP registrar. Dizziness incorporates a wide range of possible causes, ranging from benign to potentially life threatening. Appropriate work-up involves comprehensive history taking and examination, followed by selective use of appropriate investigations. Dizziness is a frequent presentation in general practice, and is a common cause of falls in the elderly.

<p>TEACHING & LEARNING AREAS</p> 	<ul style="list-style-type: none"> • Common causes of dizziness in general practice • Approach to history taking and examination, especially key features to differentiate common causes • Clinical features of vertigo, giddiness, pre-syncope and disequilibrium • Red flags and serious causes not to be missed • Hallpike's and Epley manoeuvres • Indications for investigation • Indications for referral • Treatment of common causes of dizziness 						
<p>PRE-SESSION ACTIVITIES</p> 	<ul style="list-style-type: none"> • Read the FOAM4GP article on dizziness as an overview - Do Dizzy Patients Make Your Head Spin • Ask the registrar to reflect on a few patients with dizziness that they have recently seen 						
<p>TEACHING TIPS AND TRAPS</p> 	<ul style="list-style-type: none"> • The commonest causes of dizziness in general practice are benign – postural hypotension, hyperventilation, vasovagal, labyrinthitis, BPPV • Ask about prescribed and other drugs, including alcohol • Consider depression and anxiety in patients with chronic low-grade dizziness • Dizziness in children is uncommon and warrants early investigation 						
<p>RESOURCES</p> 	<table border="1"> <tbody> <tr> <td data-bbox="331 1572 434 1697">Read</td> <td data-bbox="434 1572 1487 1697"> <ul style="list-style-type: none"> • An Approach to Vertigo in General Practice – AFP article • Dizziness: A Diagnostic Approach – a good summary article in AAFP </td> </tr> <tr> <td data-bbox="331 1697 434 1796">Listen</td> <td data-bbox="434 1697 1487 1796"> Emcrit - Vertigo – good summary by Dr Scott Weingart on dizziness </td> </tr> <tr> <td data-bbox="331 1796 434 1877">Watch</td> <td data-bbox="434 1796 1487 1877"> Epley Manoeuvre - You Tube </td> </tr> </tbody> </table>	Read	<ul style="list-style-type: none"> • An Approach to Vertigo in General Practice – AFP article • Dizziness: A Diagnostic Approach – a good summary article in AAFP 	Listen	Emcrit - Vertigo – good summary by Dr Scott Weingart on dizziness	Watch	Epley Manoeuvre - You Tube
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<p>FOLLOW UP & EXTENSION ACTIVITIES</p> 	<ul style="list-style-type: none"> • Registrar to reflect on how their assessment and treatment of dizziness has changed after the teaching session • Role play the Clinical Reasoning Challenge under exam conditions • Role play a patient with an anxiety disorder presenting with dizziness 						

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Clinical Reasoning Challenge

Margie is a 53 yo woman who presents with acute dizziness, nausea and vomiting for the past 5 hours. She describes 'true vertigo', with a sense of the room spinning.

Margie smokes 15 cigarettes per day. Her BP is 140/92

On examination Margie is pale and sweaty. Margie has a left beating nystagmus which is enhanced on left gaze. The head impulse test is abnormal to the right with an abnormal corrective refixation movement. There were no other neurological signs evident. Hearing is clinically normal and otoscopy is clear.

QUESTION 1. What is the most likely clinical diagnosis on the basis of the information presented so far? Write ONE diagnosis

1 _____

QUESTION 2. What are the other possible diagnosis? List THREE differentials.

1 _____

2 _____

3 _____

QUESTION 3. What initial investigations would you request at this stage? List as many as appropriate.

1 _____

2 _____

3 _____

4 _____

5 _____

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ANSWERS

ANSWER 1

VESTIBULAR NEURITIS

This clinical syndrome is commonly thought to be related to reactivation of herpes simplex virus infection of vestibular nerve ganglion (also known as Scarpa ganglion)

ANSWER 2

A. STROKE

Stroke should be considered when there are vascular risk factors, the presence of any one of the red flags or abnormal signs on examination of the cranial nerves.

B. MENIERE DISEASE

While Meniere disease, can cause acute vertigo, it is not the likely cause in this case because:

- Attacks are brief (though the after effects of nausea, disequilibrium and ear symptoms may last hours to days)
- recurrent episodes are required to make the diagnosis
- associated ear symptoms (e.g. fluctuating low frequency sensorineural hearing loss, aural fullness and tinnitus) are usually present

C. BENIGN PAROXYSMAL POSITIONAL VERTIGO

Episodes of vertigo (BPPV) are usually provoked by a change in position of the head or change in posture.

Episodes are brief and not accompanied by vomiting and not associated with spontaneous nystagmus before provocation

D. VESTIBULAR MIGRAINE

Migraine can cause acute vertigo, however, usually there are no clinical signs and there is usually, but not invariably, significant headache present. Consider a diagnosis of migraine where there is a past or family history of migraine.

Like Meniere disease, recurrent episodes are required before a diagnosis of vestibular migraine can be made.

ANSWER 3

It is reasonable at this stage to make a clinical diagnosis of labyrinthitis and treat expectantly without the need for any investigations.