GPSA
GENERAL PRACTICE SUPERVISION AUSTRALIA

Dizziness

"*I feel dizzy Doc*". Managing the dizzy patient is often a difficult consultation for a GP registrar. Dizziness is a frequent presentation in general practice, and is a common cause of falls in the elderly. Dizziness has 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. It is a classic undifferentiated presentation and a good topic for supervisors to discuss the management of uncertainty.

TEACHING AND LEARNING AREAS		• Common causes of dizziness in general practice • Approach to history taking and examination - the TiTrATE approach • Red flags and serious causes not to be missed • Approach to examination, inlcuding the Dix-Hallpike manoeuvre and HINTS examination • Indications for investigation • Treatment of common causes of dizziness, including the Epley manoeuvre • Indications for referral and local pathways
PRE- SESSION ACTIVITIES		• Read the FOAM4GP article on dizziness as an overview - Do Dizzy Patients Make Your Head Spin
TEACHING TIPS AND TRAPS		• The most common 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 • Peripheral causes of vertigo are commonly associated with nausea, vomiting and hearing loss • Hearing loss is a feature of labyrinthitis and Meniere's disease • Vertigo is an uncommon presentation of CVA (but consider vertebrobasilar CVA in patients with risk factors) • Dizziness in children is uncommon and warrants early investigation • Laboratory testing and imaging are usually not recommended when no neurologic abnormality is found on examination
RESOURCES	**Read**	• An Approach to Vertigo in General Practice – 2016 AFP article • Dizziness: An approach to evaluation and management – 2017 AAFP article
	Listen	• Dizziness and vertigo podcast
	Watch	• A basic, simplified approach to the dizzy patient
FOLLOW UP & EXTENSION ACTIVITIES		• Registrar to undertake clinical reasoning challenge and discuss with supervisor

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Clinical Reasoning Challenge

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

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

On examination Margie is pale and sweaty. She has a left beating nystagmus which is enhanced on left gaze. There are no other neurological signs evident. Hearing is clinically normal and otoscopy is clear.

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

1 _____

QUESTION 2. What are the MOST IMPORTANT other causes to consider? List THREE MOST IMPORTANT differential diagnoses.

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

QUESTION 1

What is the SINGLE most likely clinical diagnosis on the basis of the information presented so far?

Vestibular neuronitis.
Labyrinthitis has a similar presentation but is usually accompanied by hearing loss

QUESTION 2

What are the MOST IMPORTANT other causes to consider?

- Vertebro-basilar CVA

  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.

- 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

- 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

- Vestibular migraine

  Migraine can cause acute vertigo, however, usually there are no clinical signs and there is usually, but not invariably, headache present. Consider a diagnosis of migraine where there is a past or family history of migraine. Like Meniere's disease, recurrent episodes are required before a diagnosis of vestibular migraine can be made.

QUESTION 3

What initial investigations would you request at this stage?

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

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