Conflict of interest disclosure statement

- Otologist Neurotologist at QE11 HSC
- No private interests to declare.

HOW TO ‘SURVIVE’ THE DIZZY PATIENT
(WITHOUT GOING CRAZY YOURSELF!)

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Keep it simple
Consider

- Practical, clinical approach
- History is KING

*****Don’t Panic!*****

- Almost all vertigo is not urgent.
- It is better to wait to establish a pattern of vertigo that will lead to a more accurate diagnosis than to jump to a premature conclusion.

*****Don’t Panic!*****

- Look for the worrisome symptoms and signs and act on them.
- If you can’t figure out a diagnosis with this approach, almost everyone else is also guessing!

Remember you can always live to fight another day......
How I do it

Vertigo Clinic
- Dedicated clinic
- Time to listen
- Pre-consultation Questionnaire

Ahhhhh! my lovely questionnaire……..

What is Dizziness?
An illusion of movement of self or environment
Description in patient’s own words

Hallmarks of vestibular vertigo

True sense of rotation

Worse with head movement
Unable to walk (Ataxia)

Vegetative symptoms

Significance of True Spinning
- Almost all true spinning is vestibular
- All vestibular is not true spinning

True Spinning
- To and fro rocking

Vestibular etiology
- Lightheadedness
- Ataxia

Timing

How long does the feeling of dizziness last?
- Constant
- Now & then
- Lasting seconds to minutes
- Lasting minutes to hours
- Lasting hours to days
- Lasting days to weeks
Duration of Dizziness

- Seconds to minutes:
- Minutes to hours:
- Days:
- Constant, no improvement:

Associated features & accentuating factors

Do any of the following make your dizziness worse?
- Rising to an upright position
- Lying down
- Turning onto one side
- Looking up
- Bending down
- Staring
- Loud noise
- Menstrual cycle

Regarding your dizziness, do you recognise or experience any of the following?
- Family history of Meniere’s Disease
- Pressure or fullness in your ears
- Change in your hearing
- Tinnitus (noises in your ears)
- Headache
- Visual disturbance
- The need to avoid bright lights
- When sickness is relieved
Worrisome Features

- Diplopia, Dysarthria, Dysphagia
- Drooping of face
- Difficulty moving one side/limb
- Dysaesthesia one side/limb
- Disturbance of bowel or bladder function
- ‘Donk’ - true loss of consciousness
- Dysrhythmia

All the “D’s”

- Double vision
- Drooping of the face
- Difficulty with swallowing
- Blurred speech
- Keatiness of limbs
- Tingling or numbness
- Confusion
- Incontinence of urine / faeces

Comorbidity & Psychosocial stuff

Finally some general questions about your health and habits...

- Do you have Heart Disease?
- Do you have Kidney Disease?
- Do you have Diabetes?
- Do you take prescription medications?
- Do you smoke?
- Do you regularly drink alcohol?
- Do you drive a motor vehicle?
- Do you wear spectacles or contact lenses?

Common Clinical Syndromes
Don’t beat yourself up!

- The terms that we use reflect just one attempt to put a name to the patterns we see.
- There are limitations to our understanding.

Don’t beat yourself up!

- Don’t be confused by jargon.
- Describe the symptoms as simply as you can.

Common Clinical Syndromes

- Benign Paroxysmal Positional Vertigo (BPPV)
- Acute vestibular failure
- Recurrent Vestibulopathy
- Meniere’s Disease
- Migraine associated vertigo
- Bilateral vestibular loss

Good to know

<table>
<thead>
<tr>
<th>Duration of vertigo</th>
<th>With Hearing Loss</th>
<th>Without Hearing Loss</th>
</tr>
</thead>
<tbody>
<tr>
<td>Secs - mins</td>
<td></td>
<td>BPPV</td>
</tr>
<tr>
<td>Mins - hours</td>
<td>Meniere’s Disease</td>
<td>RV, MAV</td>
</tr>
<tr>
<td>Hours - days</td>
<td>‘Labyrinthitis’</td>
<td>Vestibular Neuronitis</td>
</tr>
<tr>
<td></td>
<td>(SSHL &amp; vertigo)</td>
<td></td>
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</tbody>
</table>
Benign Paroxysmal Positional Vertigo

- Common
- Vertigo for seconds
- Triggered by head movements
  - Looking up, rolling over, bending over
- Theories
  - Canalolithiasis vs Cupulolithiasis
- Free-floating particles
- Post. canal most commonly involved

Particle repositioning manoeuvre (Epley)

- Explanation
- Begin with Dix-Hallpike (diagnostic)
- Features of BPPV
  - Latency, limited, fatigues, reverses
- Go into Epley (therapeutic)
Menieres Disease

- It is actually quite RARE
- Try not to jump to the diagnosis

- Recurrent attacks of vertigo lasting hours
- Associated tinnitus, hearing loss, aural pressure
- Pathological correlate – endolymphatic hydrops?
Therapy
- Confounded by the placebo response
- Step-ladder approach
- Try to avoid ablation if possible
- Range of options

Names for Vertigo with Migraine
- Migraine Associated Dizziness
- Basilar Artery Migraine
- Basilar Migraine
- Episodic Giddiness in Migraine
- Benign Recurrent Vertigo
- Vestibular Migraine
  - Migraine Related Vestibulopathy
  - Migraine Related Dizziness

Ototoxicity
- Usually aminoglycosides
  - Many other possibilities
- Complain of oscillopscia
- May be unilateral
- Therapeutic applications

Named syndromes may co-exist
- More than one type?
  - E.g. Vestibular Neuronitis followed by BPPV
- Be clear about the first & last episode
- How often, how long, how changing
**Most Excellent rules of thumb**

- If symptoms more prominent than signs: Most likely vestibular
- If signs more prominent than symptoms: Most likely central

If can't get diagnosis in first 5 minutes, then very likely there isn't one

Bizarre history needs signs, otherwise usually not organically diagnosable cause

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**Exam**

- General Exam:
  - Affect, exaggerated gait
- Otologic Exam:
  - Tuning Fork Tests
  - PTA / Speech audio
  - Hyracussis, Recruitment
  - Otoscopy
  - Fistula test / Tullio phenomenon

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**Oculomotor Exam**

- Spontaneous nystagmus in light, gaze evoked, vertical nystagmus, bizarre nystagmus
- Smooth pursuit
- Saccades
- VOR cancellation
Neurologic Testing

- Cerebellar
  - Finger-Nose
  - Rapid alternating hand movements
  - VOR cancellation
  - Heel-Shin
- Cranial Nerves
- Proprioception lower limbs

Vestibular Exam

- Dix-Hallpike
- Sudden Head Thrust
- Head Shake Nystagmus
- Spontaneous nystagmus
- Gait tests

Sudden Head Thrust Test ("Halmagyi" test)

- Described by Halmagyi and Curthoys 1988

Head Thrust to one side (active or passive)

- Sudden
- High Velocity
- High Acceleration
Special Tests

- Hyperventilation
- Oscillopsia
- Valsalva
- BP lying and sitting

Investigating the Vestibular System

- Seldom necessary
- Medico-legal clarification
- Malingering / bizarre
- Baseline prior to treatment / surgery
- Follow-up after treatment

Investigating the Vestibular System

- Caloric testing with ENG (VNG)
- Rotation Chair Testing
- Posturography
  - Standing sway measured with a force plate
- MRI with gadolinium contrast

Another time
Summing Up

*** Remember ***
- You are seeing just one window in time
- “Dizzy Diaries” may be useful
- Direct the patient to be vigilant
- Offer review and support.

Be understanding
- Acknowledge the psychological morbidity associated with vertigo
- Exclude sinister pathology…… and more importantly tell the patient you have done so
- Show empathy

Thanks for you attention
Links

- Vertigo questionnaire
- Dizzy diary
- Today's Lecture notes

- [http://otolaryngology.medicine.dal.ca](http://otolaryngology.medicine.dal.ca)
- [EDUCATION](http://otolaryngology.medicine.dal.ca)

Therapy

- Sero
- Anti-migraine therapy
- The evidence

http://ear-lab.medicine.dal.ca
http://otolaryngology.medicine.dal.ca