Vertigo
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Useful reading


A 60 year old woman reports sudden dizziness when she arises from bed. She feels nauseous and had been vomiting. She recently had a severe cold. Her vomiting has settled, but she is dizzy on turning her head to the right. She is frightened to leave her house.

What issues you should cover

Taking a history—Dizziness means different things to different patients. Elicit a precise description of her symptoms by providing alternatives: Does the room spin around (vertigo)? Do you feel unsteady (dysequilibrium)? Do you feel lightheaded?

- Vertigo is an illusion of movement, often horizontal and rotatory. Associated nausea and vomiting indicate a peripheral rather than central cause. Studies show that about a third of cases of dizziness are vertigo.
- Dysequilibrium, which occurs when the brain receives inadequate information about the body’s position from the somatosensory, visual, and vestibular systems, may result from peripheral neurophy, eye disease, or peripheral vestibular disorders.
- Presyncope is caused by cardiovascular disorders reducing cerebral perfusion.
- Lightheadedness is non-specific and hard to diagnose; it may result from panic attacks with hyperventilation.

Examination—Include cranial nerves, in particular funduscopy for papilloedema or optic atrophy (II), eye movements (III, IV, and VI), corneal reflex (V), and facial movement (VII). Nystagmus is common in acute vertigo. Check cerebellar function (past pointing, facial movement (VII). Nystagmus is common in acute vertigo. Check cerebellar function (past pointing, dysdiadochokinaesia). Testing vibration sense (a 128 Hz tuning fork on the ankle) is useful for screening for peripheral nerve function, so may need specific treatment. Balance rehabilitation exercises promote central compensation and help resolve persistent dysequilibrium. Dysequilibrium due to Meniere’s disease or BPPV may not respond, as it is not possible to habituate to fluctuating vestibular function, so may need specific treatment. Balance rehabilitation is important in elderly people, in whom dizziness is invariably multifactorial.
- Refer her to an ear, nose, and throat specialist if she has hearing loss or recurrent or persistent vertigo with peripheral vestibular characteristics or if otoscopy findings are abnormal.

What you should do

- Explanation and reassurance are important, as anxiety exacerbates vertigo. Persistent dysequilibrium should be overcome by central adaptation, but anxiety may prevent the required level of activity.
- Drugs that sedate the vestibular-brainstem axis, such as prochlorperazine, relieve symptoms. Sublingual preparations help when vertigo is severe. Avoid prolonged use, as they prevent central compensation.
- Betalastine may improve perfusion of the labyrinth and is used prophylactically in Meniere’s disease. There is little evidence of its efficacy.
- The Epley manoeuvre usually resolves BPPV (see the BPPV section at www.dizziness-and-balance.com). A recent Cochrane review confirmed its efficacy. Untreated BPPV usually settles within months.
- The Cawthorne-Cooksey and other vestibular rehabilitation exercises promote central compensation and help resolve persistent dysequilibrium. Dysequilibrium due to Meniere’s disease or BPPV may not respond, as it is not possible to habituate to fluctuating vestibular function, so may need specific treatment. Balance rehabilitation is important in elderly people, in whom dizziness is invariably multifactorial.
- Refer her to an ear, nose, and throat specialist if she has hearing loss or recurrent or persistent vertigo with peripheral vestibular characteristics or if otoscopy findings are abnormal.

Common causes of vertigo

<table>
<thead>
<tr>
<th>Condition</th>
<th>Description and time course</th>
<th>Tinnitus</th>
<th>Hearing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Benign paroxysmal positional vertigo</td>
<td>Vertigo associated with head turning or rolling over in bed. Often accompanied by nausea and vomiting. Resolves over days but is followed by dysequilibrium. There may be a history of head injury.</td>
<td>None</td>
<td>Not affected</td>
</tr>
<tr>
<td>Meniere’s disease</td>
<td>Triad of vertigo, tinnitus, and hearing loss, often associated with a pressure sensation in affected ear. Attacks last from 1 to 24 hours but are often followed by persistent dysequilibrium</td>
<td>Present; often worsens over time</td>
<td>Hearing loss comes and goes at first but is eventually permanent</td>
</tr>
<tr>
<td>Vestibular neuritis (often misdiagnosed as labyrinthitis)</td>
<td>Recurrent vertigo attacks lasting hours or days. Followed by dysequilibrium, while central compensation occurs. A preceding viral illness is common</td>
<td>None</td>
<td>Not affected</td>
</tr>
</tbody>
</table>

This is part of a series of occasional articles on common problems in primary care