

key points

SELECTED BY

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Vertigo can be defined as an illusion or hallucination of movement. Ataxia is an abnormality of the co-ordination of muscle movement and should not be confused with vertigo. The control of balance is complicated. Vertigo can be caused by many different pathologies, some of which are potentially life threatening.

An important differentiation is whether the symptoms of vertigo originate from a central or peripheral origin. Clues to a central origin are other brainstem symptoms or signs of acute onset such as headache, deafness and other neurological findings. These patients warrant urgent referral and investigation. Red flags in patients with vertigo include: headache; neurological symptoms; and neurological signs. It is useful to categorise vertigo into acute and chronic. The former usually has a single mechanism whereas chronic dizziness is often multifactorial.

History is usually the most important part of the assessment. A number of key questions should be asked and it is vital to establish if the patient is suffering from vertigo or if they have some other complaint such as anxiety or syncope. A neurological and otological examination should be performed as appropriate to the history.

The assessment of gait and posture is crucial. If the patient has positional vertigo then a Hallpike test should be performed. Visual acuity should be checked as vision is a crucial part of the balance system. The cranial nerves should be tested in particular eye movements for any ophthalmoplegia pointing to focal cranial nerve pathology and for nystagmus. The rest of the neurological examination should exclude evidence of central disease, in particular cerebellar disease, and neuropathy. If syncope is suspected it is wise to perform an extensive systemic examination in particular lying and standing BP, and cardiovascular and respiratory system assessments.

The cause of vertigo in the elderly is often multifactorial. Decompensation from previous vestibular failure can occur through impaired vision and proprioception, and side effects from medication should also be considered. A common mistake is to prescribe vestibular sedatives such as prochlorperazine as they reduce vestibular input to the brain which in turn impairs rehabilitation.

If a specific disorder is identified then this can be managed with the appropriate treatment, e.g. the Epley manoeuvre in BPPV or betahistine in Ménière's disease. Patients with migraine should be given lifestyle advice and, if required, prophylaxis. Non-disease specific vestibular suppressants may be used for short-term symptomatic control but should be avoided in the long term as they prevent the process of compensation and are frequently a contributing factor to long-term dizziness. Vestibular rehabilitation is usually reserved for chronic dizziness as the majority of patients spontaneously compensate. Patients with chronic dizziness benefit greatly from directed exercises and support.