A Practical Approach to

Dizziness

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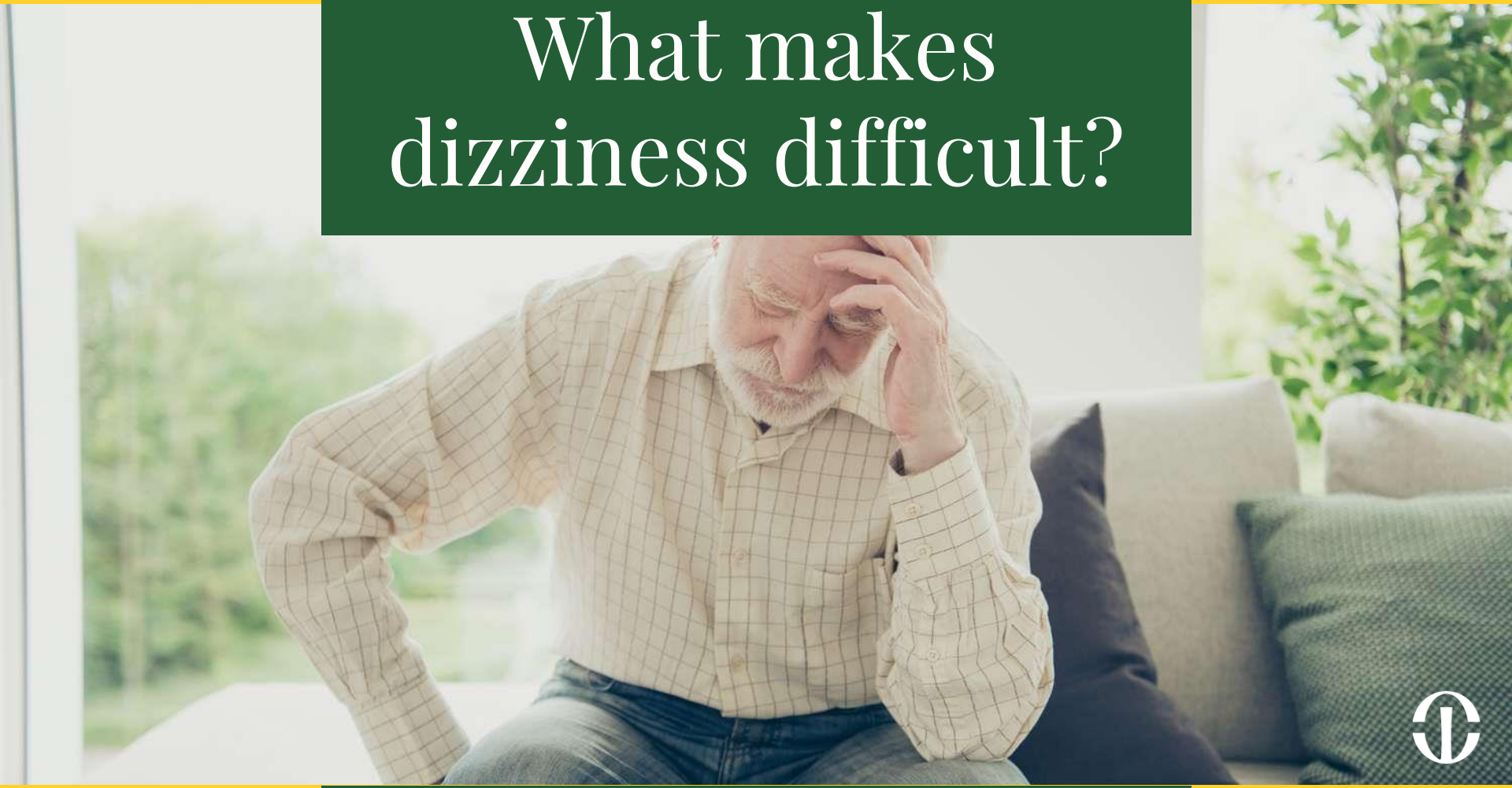
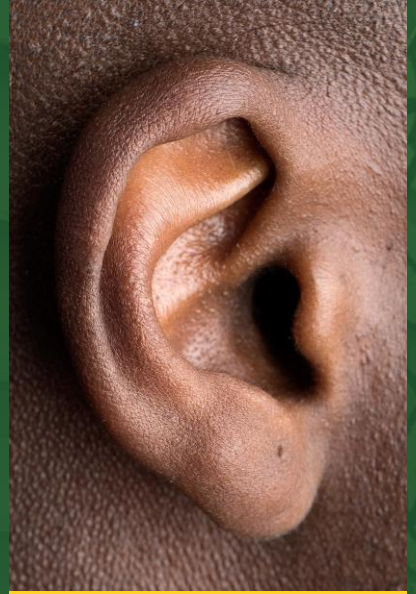
There can be few physicians so dedicated to their art that they do not experience a slight decline in spirits on learning that their patient's complaint is dizziness.

– W.B. Mathews

What makes dizziness difficult?





Many **causes** of dizziness

Limited **time** for evaluation

Desire for **immediate** relief

Difficulty **describing** symptoms

as a result...

A fraction receive a diagnosis

Most receive meclizine

Many are misled by testing

Goals

1. Recognize common **disorders** causing dizziness
2. Develop a **framework** for approaching a dizzy patient
3. Become familiar with 1st-line **treatments** for vestibular migraine

Not Goals

1. Review **all** disorders that cause dizziness
2. Understand **laboratory testing**
3. Learn the **vestibular exam**
4. Understand **surgical** treatment

History

Type & Trajectory


Is there true
acute vertigo ?

Types of Dizziness

Lightheadedness

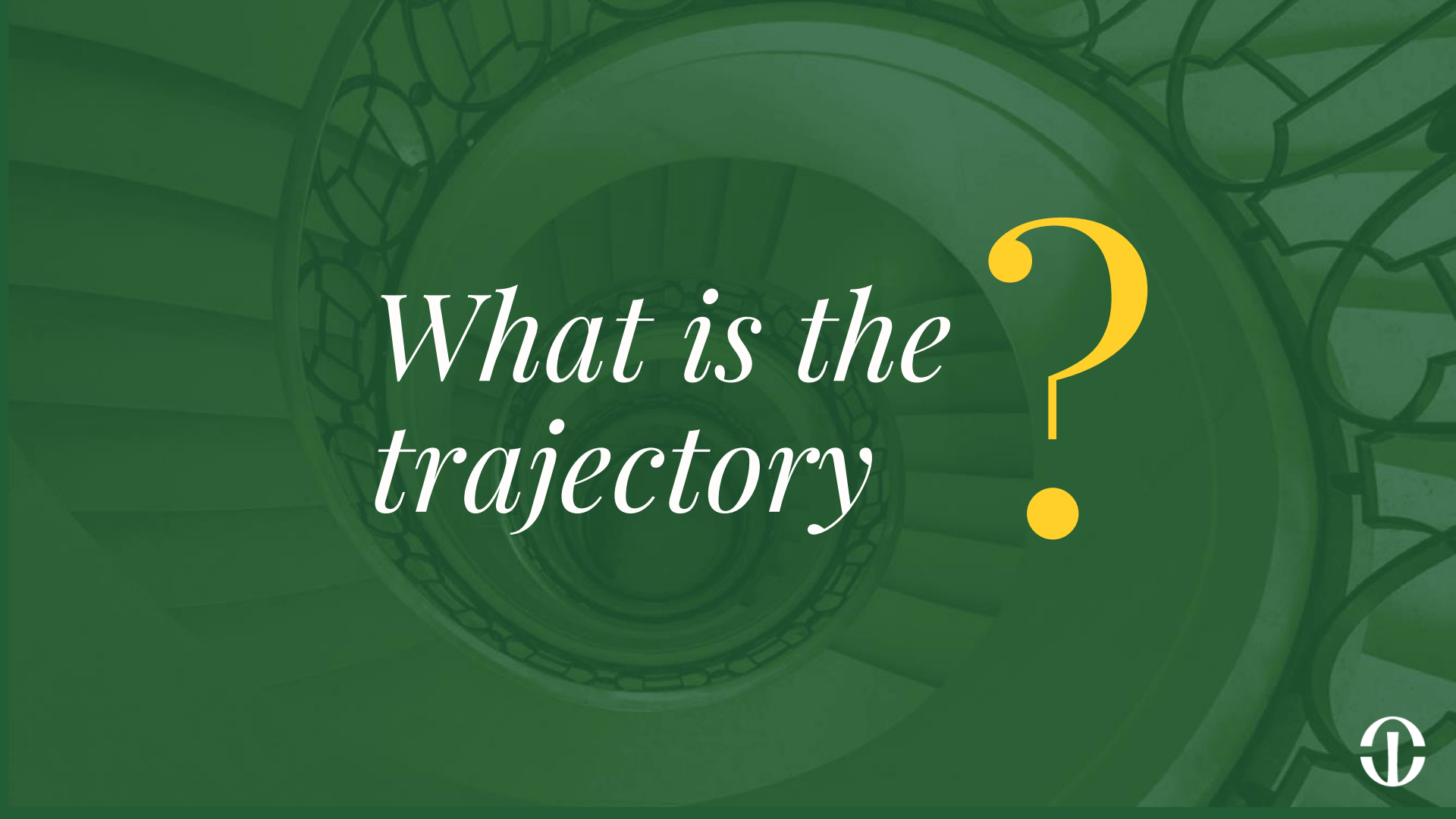
“I am going to pass out.”

Imbalance

“I am unsteady on my feet.”

True Vertigo

“The room is spinning.”


What is the trajectory ?

Trajectory of Dizziness

Vestibular neuritis

Sudden onset

BPPV

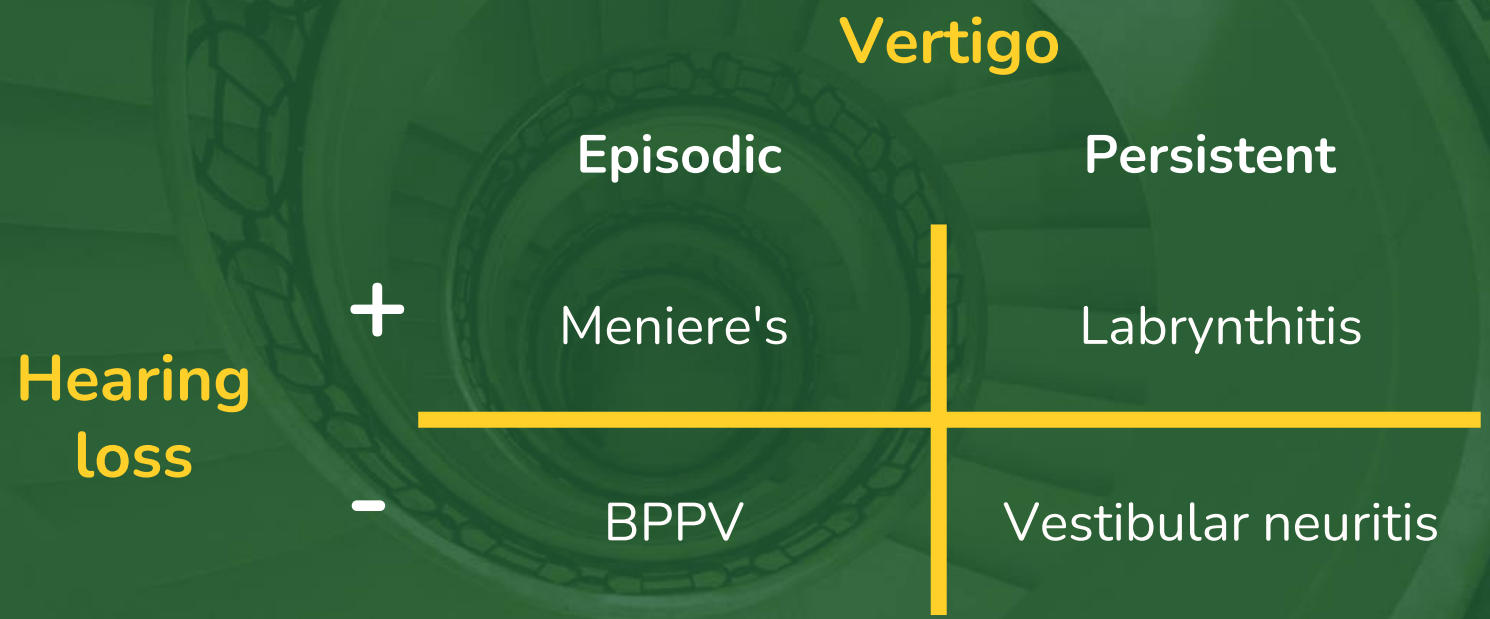
Episodic

Meniere's

Relapsing and remitting

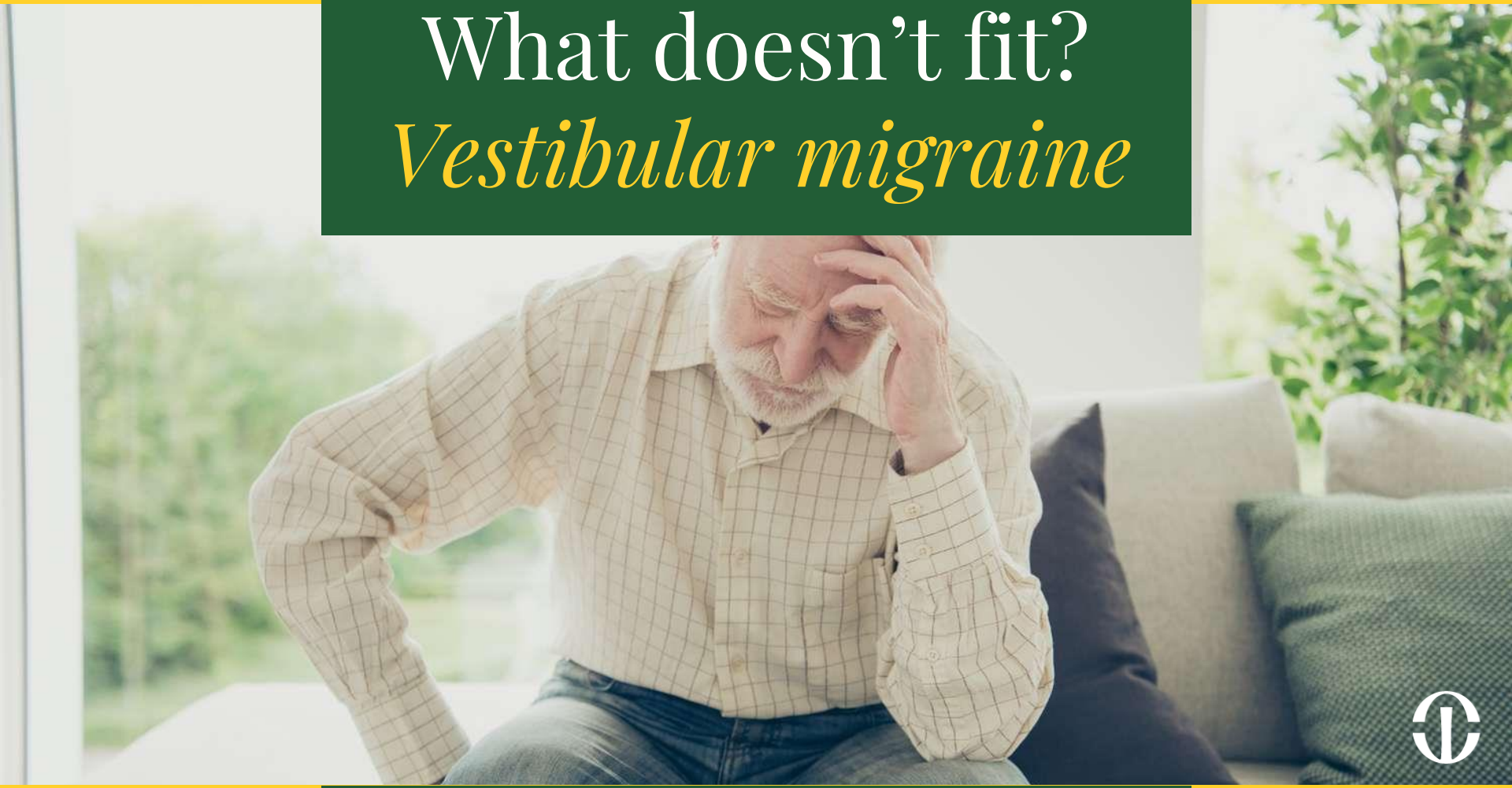

Is there
hearing loss ?

Acute Vertigo Matrix



What doesn't fit?

Vestibular migraine



What is migraine?

Conventional

- Unilateral headache
- Preceded by visual aura
- Nausea
- Needs to lie down

Modern

- Global disturbance in sensory processing
- More than a headache

ENT Manifestations of Migraine

Common

- Sinus headache
- Vertigo/dizziness/BPPV
- Facial pressure
- Atypical facial pain
- Aural pressure/otalgia
- Hyperacusis

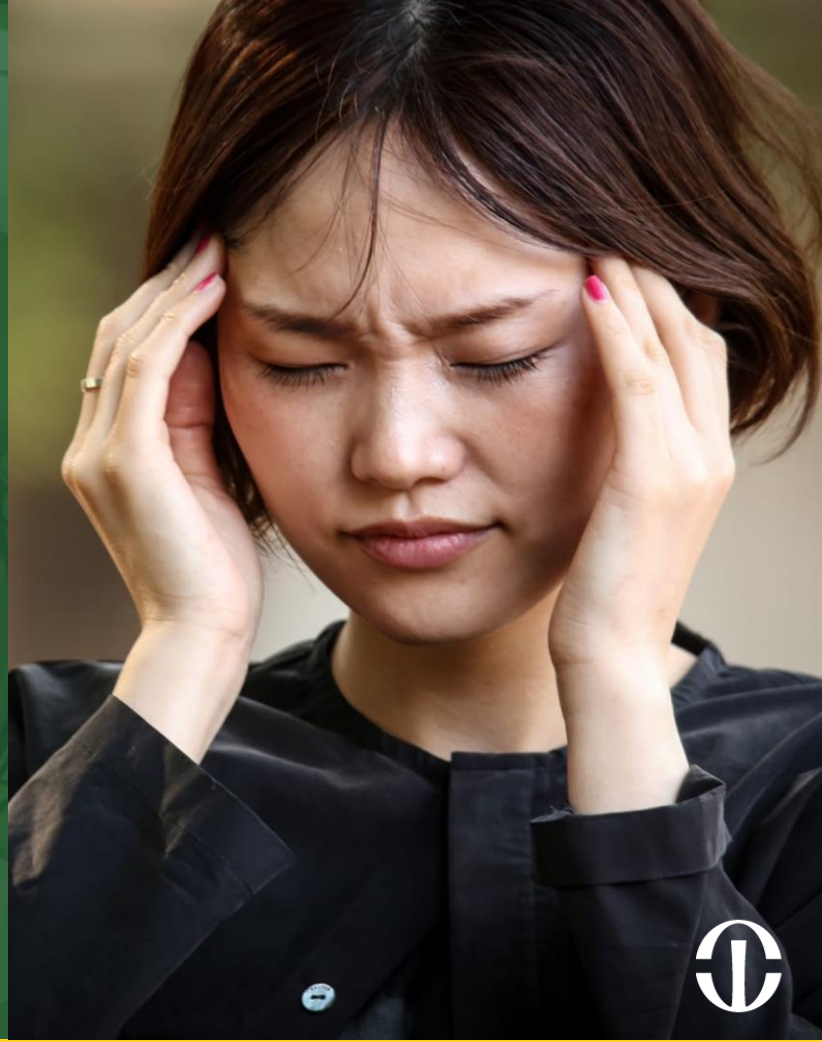
Emerging Awareness

- Recurrent BPPV
- Meniere's syndrome
- Tinnitus
- Sudden hearing loss

What is *vestibular migraine*?

Symptoms

- Spinning
- Rocking
- Disorientation in space
- Lightheadedness
- Swaying
- Disequilibrium
- Intolerance to movement



Duration

Variable:

- Seconds to days
- Months of constant disequilibrium

Triggers

- Food
- Stress
- Environment
- Menopause
- Pregnancy

Risk Factors

- Family Hx of migraine
- Personal Hx of:
  - childhood motion sickness
  - migraine as a child/adolescent
  - progressive motion intolerance

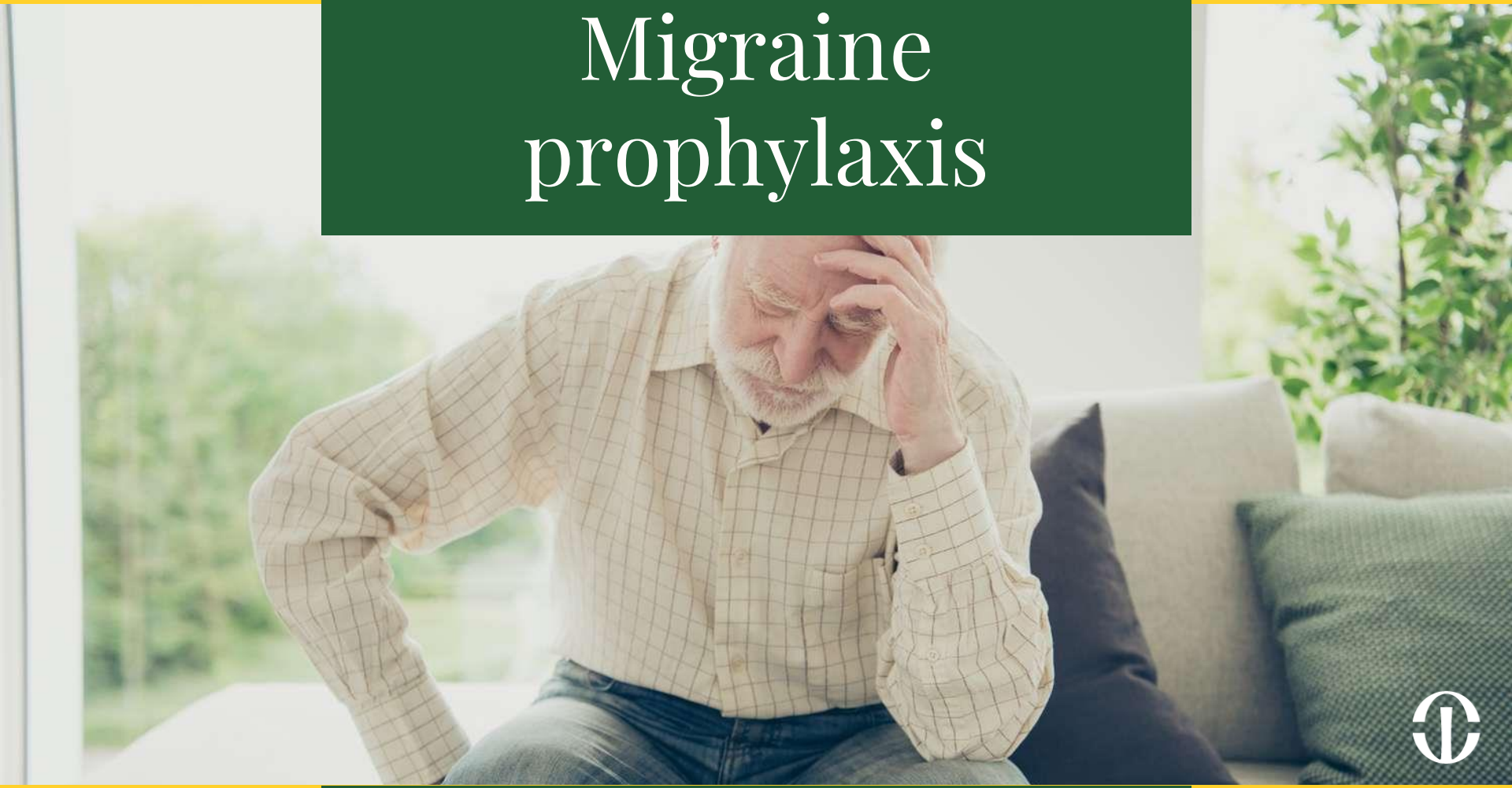
Diagnostic Criteria

Table 1: Diagnostic Criteria for Vestibular Migraine Proposed by Barany Society and the Third International Classification of Headache Disorders (ICHD-3), 2012
Definite vestibular migraine
A. At least five episodes of vestibular symptoms of moderate or severe intensity lasting 5 min to 72 h
B. Current or prior history of migraine according to the International Classification of Headache Disorders (ICHD)
C. One or more migraine features with at least 50% of the vestibular episodes. This may include migraine headache, photophobia or phonophobia, and visual aura
D. Not better accounted for by another vestibular or ICHD diagnosis
Probable vestibular migraine
a) At least five episodes of vestibular symptoms of moderate or severe intensity lasting 5 min to 72 h
b) Only one of above criteria B and C is fulfilled (i.e., migraine history or migraine features during the episode)
c) Not better accounted for by another diagnosis

Diagnosis

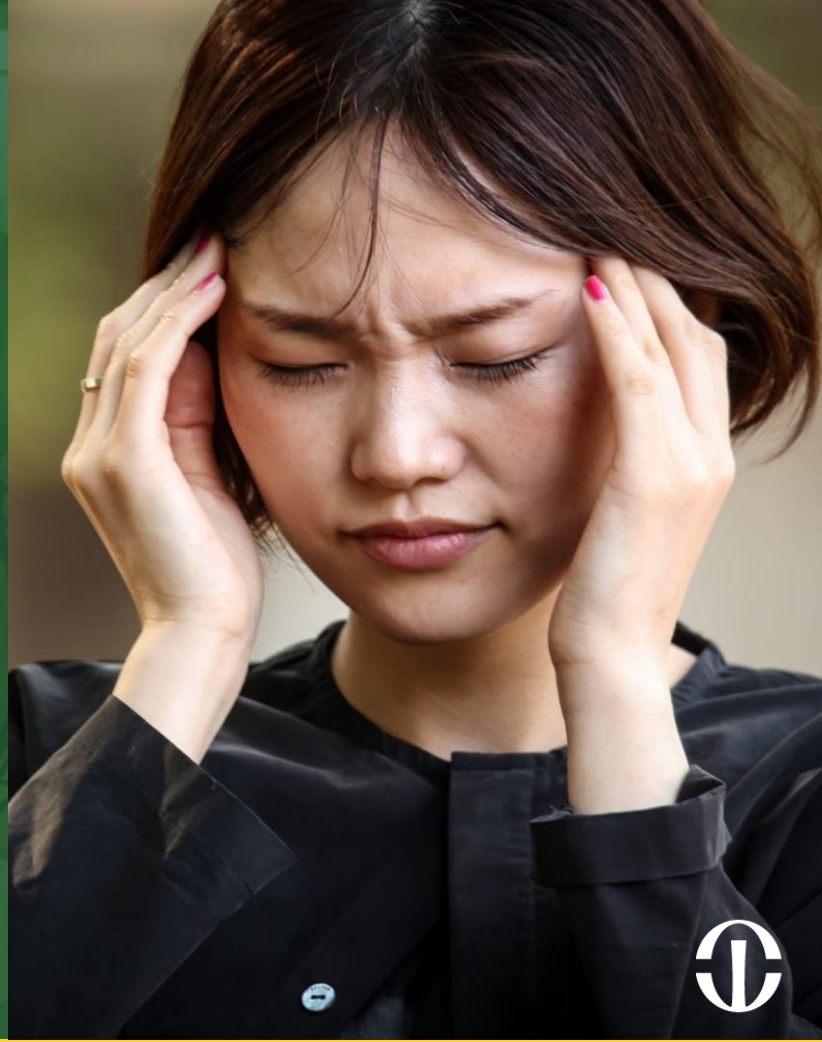
- Inclusion criteria for studies
- Do not use as exclusion criteria for treatment
- Only ½ patients have headache during vertigo spells

Migraine prophylaxis



Indications

- Frequent symptoms
- Disabling symptoms
- Too brief for abortive measures to be effective



Counseling

- Daily medication
- Usually well-tolerated
- Response takes up to 6 weeks
- Continue to identify/avoid triggers
- ↓ frequency/severity by 50-70%

Medications

Nortriptyline (tricyclic):

- Best starting medication in >50 y/o
- Start at 20mg QHS
- ↑ to 50mg QHS as needed
- SA: Dry mouth, ↑ weight
- AM sedation → dose earlier in HS

Medications

Topiramate (anticonvulsant):

- Starting medication in young women
- Start at 25mg QD → 25mg BID → 50mg BID → 75mg/100mg BID
- SA: cognitive slowing, kidney stones, ↓ weight

Medications

Propranolol (β-blocker):

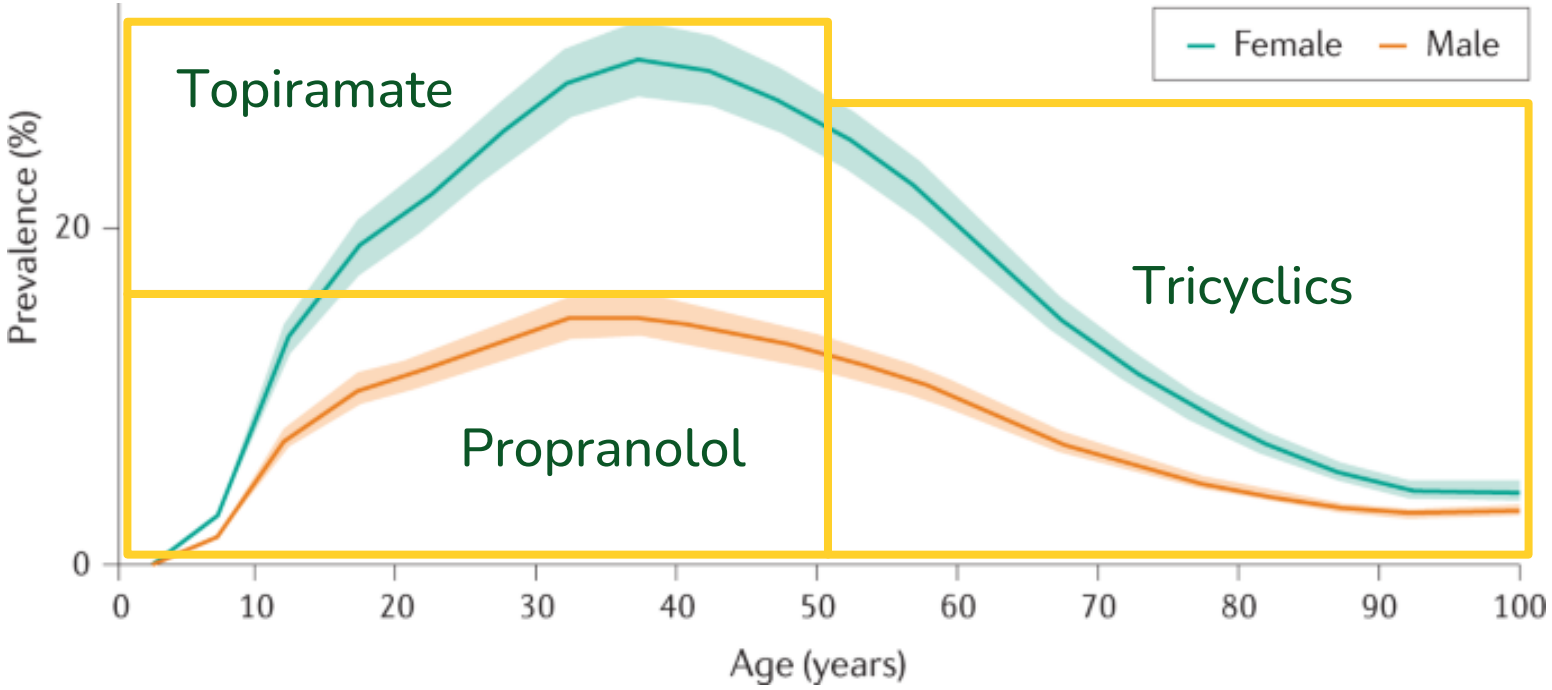
- Avoid in asthma, diabetes, low BP
- Well-tolerate in young men
- Start at 60mg QD
- ↑ to 120-180mg QD as needed
- SA: ↑ depression

Medications

Diltiazem (Ca channel blocker):

- Well-tolerated 2nd-line therapy
- Start at 120mg QD
- ↑ to 240mg QD/BID as needed
- SA: constipation, ↓ BP

First Line Agents by Age & Sex



Clinical Pearls

1. “Dizziness” is not always vertigo.
2. Ask about trajectory & hearing loss when assessing vertigo.
3. Vestibular migraine (VM) does not always involve a headache.
4. Patients who do not meet criteria for VM may still benefit from Tx.

Thank you for listening!

Questions?

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