**ENT – Dizziness**

**Patient Pathway (Adults)**

**Patient Presentation**
- **Dizziness**

**GP or practice nurse**

- When taking patient history note:
  - Age
  - Character of symptoms (e.g. illusion of movement/rotation, light-headedness, unsteadiness)
  - Time course e.g. sudden onset, short lasting, long lasting, recurring.
  - Any other associated symptoms e.g. hearing loss, tinnitus, blackouts, visual disturbance, palpitations, falls
  - Precipitating factors/provocation e.g. head movements, standing up

**Diagnostic physical examination**

**GP**

- Examination:
  - Otoscopy
  - Eye movements
  - Examination of cranial nerves
  - Cerebellar tests
  - Rhomberg’s Test
  - Blood pressure – if postural symptoms
  - Take lying and standing blood pressure
  - Dix–Hallpike test

- If patient has any of the following symptoms, refer accordingly:
  - Refer to Cardiology if there are signs of suppurative middle ear disease.
  - Auditory or vestibular symptoms are triggered by pressure changes (barotrauma or valsalva manoeuvre).

**Otherwise, Management tips on next page.**

**Refer urgently if**

- Vertigo, illusion of movement

**Non urgent ENT referral**

- Significant auditory associations present (hearing loss, tinnitus, pressure or aural fullness, particularly if asymmetrical during episodes of dizziness) and
- Vertigo, illusion of movement

**Refer to Cardiology if**

- Patient has palpitations or blackouts
- Affected by postural changes

**Refer to geriatrician or falls clinic if**

- Patient is elderly and falling and no vestibular problem has been identified

**Refer to Neurology if**

- Vertical nystagmus
- Abnormal neurological signs other than deafness/tinnitus

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Adapted from CCI ENT – Dizziness Patient Pathway, 2005
**Vertigo:** related to head movements and of short duration. Likely benign, paroxysmal positional vertigo (BPPV). Perform Dix-Hallpike test – if positive perform Epley Manoeuvre. Management is by repositioning techniques (Epley). Repeat once, if no improvement refer to ENT. Caution in the presence of cervical spine disease.

**Vestibular Neuronitis (misnamed Acute Labyrinthitis):**
*Sudden onset of very severe vertigo with nystagmus +/- nausea and vomiting:*
Acute symptoms may last up to 3 to 4 weeks, treatment includes short term anti-emetics (for one week). There is some evidence that a short course of oral steroids Prednisolone 50mg daily for 10 days, in the absence of contraindications, may help. Early return to normal activities should be encouraged. However if no subjective improvement after 4 weeks refer to ENT service. Recovery can be delayed by anxiety – every attempt should be made to address this as early as possible. There may be recurrences, usually of shorter duration and frequency, for up to 18 months after the initial event. Treatment: Vestibular Rehabilitation Therapy (VRT) which may be provided by physiotherapy department. N.B. if there is any history of unilateral hearing loss then the patient should be referred to ENT service.

**Recurrent Vertigo associated with headache, consider Migraine** – try migraine treatments
Recurrent Vertigo associated with simultaneous hearing loss/tinnitus – consider Meniere’s disease. Drug therapy includes •Prochlorperazine, •Cinnarizine •Betahistine
If no response, refer to ENT Service or consider stress/anxiety management.

**Chronic imbalance – constant dizziness:**
There is no drug therapy. Consider Vestibular Rehabilitation Therapy (VTR) and anxiety/stress management.
If required, refer for confirmation of diagnosis and reinforcement of management plan.

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Cautions: cervical spine disease

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