Primary Care Management Guidelines

Dizziness

These guidelines are to assist GPs to monitor and manage their patients in a primary care setting until clinical thresholds indicate that tertiary care is required. The clinical thresholds are defined in the guidelines, and may require diagnostic support from a local optometrist or ophthalmologist. Providing a detailed diagnostic report will assist with the triage of your referral into the most appropriate clinic, within clinically appropriate timeframes.

Urgent Referral

Sudden onset debilitating, constant, rotatory vertigo, where the patient is very imbalanced requires urgent transfer to the nearest Emergency Department (suggestive of vestibular neuronitis (labyrinthitis) or stroke).

Primary Care Management

Management	Rationale / Detail
Exclude orthostatic/postural hypotension	Standing and lying blood pressure
Consider migraine and treat if appropriate with one of: • Pizotifen 0.5mg to 1mg orally, at night, up to 3mg daily • Propanalol 40mg orally, 2 -3 times daily, up to 320mg (avoid in asthmatics) • Verapamil (sustained release) 160 or 180mg orally, once daily, up to 320 or 360mg daily	Migraine is the second most common cause of vertigo, and can be managed by the GP Refer to "Therapeutic Guidelines: Neurology" listed under 'More Information'.

Perform two simple tests (in the GPs rooms) to assist determine the likely causes of the patient's vertigo: • Hallpike test • Head Impulse test •	For patients with a limited range of neck movement or general mobility issues, consider a modified Hallpike A positive Hallpike test demonstrates a rotational nystagmus. Note whether the left or right side is affected A positive Head Impulse Test demonstrates an inability to maintain visual fixation on a target.
If Hallpike test is positive: • Consider Benign Paroxysmal Positional Vertigo (BPPV) which typically lasts 10- 30 seconds, is induced with particular changes in head position and can result in movement limiting behaviour • Treat using particle repositioning manoeuvres eg the Epley Manoeuvre • Home Epley Manoeuvre, where appropriate, for patient to perform themselves • Consider referral to a community Vestibular Physiotherapy or Falls and Balance Clinic, especially for patients with a limited range of neck movement or general mobility issues • Provide Patient Info Leaflet on BPPV	• BPPV can be diagnosed and treated in the GPs rooms (or by an appropriate physiotherapist) • Although the vertigo has a short duration, the patient may complain of hours of symptoms because they may feel unwell afterward (eg, nausea, disequilibrium) • Note which positional changes induce the vertigo (e.g. rolling to the left or the right in bed) • The Epley Manoeuvre, performed on the affected side, has an 80% success rate for symptom resolution
If the Head Impulse test is positive: • In a setting of acute, constant rotary vertigo for > 24 hours, consider Vestibular Neuronitis.	• Refer to Vestibular Neuronitis in the ENT Referral Guidelines.

Non-specific dizziness/disequilibrium • Sedative & vestibular suppressants (e.g. stemetil, diazepam) may exacerbate presentation • DEXA bone density scan and bone protection medication (calcium & vitamin D at a minimum) • Specialist referral as appropriate: consider geriatrician, ophthalmologist (if visual component suspected e.g. cataracts), neurologist (if neurological component suspected e.g. peripheral neuropathy)	Nonspecific unsteadiness, particularly in the elderly may represent multi-sensory disequilibrium, often with more than one aetiology (e.g. vision, peripheral sensation, vestibular hypofunction, hypothyroidism)

When to refer to the Eye and Ear

Suspected BPPV:

- Positive Hallpike test – characteristic nystagmus that MUST be seen (not simply patient's report of dizziness on testing).
- Refractory to repeated Epley manoeuvres (over 3 days).
- Symptoms not resolved after seeing Vestibular Physiotherapist or Falls and Balance Clinic.
- Co-morbid vestibular or ontological conditions.
- Patients where particle repositioning is not advised due to limited range of movement in the neck, or due to general mobility issues that can't be > Last updated 10042015 managed by the Vestibular Physiotherapist.
- Patients with suspected Migraine who have not responded to a trial of 2 different migraine prophylactic agents.
- Anyone in whom the diagnosis is unclear.

Information to include on the referral letter

- When referring to the Balance Disorders and Ataxia Service, please ensure medical referral letters or forms are addressed to A Neurologist at the Balance Disorders and Ataxia Clinic, for Medicare purposes.
- Copy of recent audiogram, if available.

- Description of quality, onset and duration of vertigo including its frequency, if episodic.
- Description of functional impact of vertigo.
- Description of any associated otological/neurological symptoms.
- Have any previous investigations been performed regarding the vertigo? Attach results.
- Any treatments (medication/other) previously tried, duration of trial and effect.
- Has a previous diagnosis been made for the cause of the vertigo? By whom? Attach correspondence.

More information

Return to our Primary Care Management Guidelines
Go to our Referral Guidelines
How to perform the Hallpike manoeuvre, Head Impulse Test and Epley Manoeuvre
Neurology Expert Group. Therapeutic guidelines: neurology. Version 4. Melbourne: Therapeutic Guidelines Limited; 2011 – the section on vestibular disorders contains succinct and useful information on how to diagnose and manage vestibular disorders