The authors and reviewers have made every attempt to ensure the information in the Family Medicine Clinical Cards is correct – it is possible that errors may exist. Accordingly, the source references or other authorities should be consulted to aid in determining the assessment and management plan of patients. The Cards are not meant to replace customized patient assessment nor clinical judgment. They are meant to highlight key considerations in particular clinical scenarios, largely informed by relevant guidelines in effect at the time of publication. The authors cannot assume any liability for patient outcomes when these cards are used.

Canadian Family Medicine Clinical Card

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Dizziness

➢If there is clinical suspicion of an active cerebrovascular event, call EMS.

ASK: "Does it feel like either the room is spinning or that you are spinning?" and/or "Is it triggered or worsened by turning your head or rolling over in bed?"

▶ YES = VERTIGO

➢ If patient has focal neurological signs, pure vertical nystagmus, or risk factors for cerebrovascular disease, suspect a serious central cause. Consider MRI head.

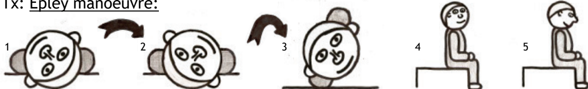
Ask about: onset, duration, nausea, vomiting, hearing loss, tinnitus, headache, aural fullness, imbalance, rash, facial paralysis, ear pain, medications

BENIGN PAROXYSMAL POSITIONAL VERTIGO (most common)

-brief, recurrent episodes (seconds to minutes), +/- nausea and vomiting

Dx: Dix-Hallpike manoeuvre: Rotate pt's head 45° to one side, lay pt supine with neck sl. extended → +ve on that side if vertigo and nystagmus elicited; if not, repeat with pt's head rotated to other side

Tx: Epley manoeuvre:



<*Pause at each position until any nystagmus approaches termination (~20s)*>

Stand at head of table, hands on pt. Reassure that nausea/vertigo is expected.

1. Lay pt supine with head over end of table. Rotate head 45° to affected side.
2. Slowly rotate pt's head to looking up and then 45° to opposite side.
3. Rotate head/body together so pt is facing downward at 135° (looking at baseboard or your shoe).
4. Sit pt up sideways, keeping their head rotated.
5. Slowly rotate pt's head so they are facing forward and tilt chin down 20°.

Vestibular Neuritis – rapid onset, severe, persistent (days), N/V, imbalance

Ménière's Disease – recurrent episodes (minutes to hours), fluctuating hearing loss, tinnitus, and sensation of aural fullness

Vestibular Toxicity – aminoglycosides, loop diuretics, ASA, NSAIDs, amiodarone, quinine, cisplatin

▶ NO = OTHER FORM OF DIZZINESS

Presyncopal Dizziness – "feels like nearly fainting or blacking out"

Initial Investigations: Hx, P/E (incl. orthostatic BP measurements), ECG

Precipitated by exertion? Palpitations/chest pain? Known structural heart dz? FmHx of sudden death? Abnormal ECG (if pt stable, fax ECG for urgent interpretation and advice)? → Yes to any. Suspect cardiac etiology. Refer to Emerg investigation, Dx, and Tx.

↓No.

Orthostatic hypotension present on P/E? → Yes. Investigate underlying etiology. New meds or alcohol? Consider CBC and electrolytes.

↘ No. Likely vasovagal/situational etiology. If recurrent episodes or pt is at risk of injury, consider referral for tilt test (+/- carotid sinus massage if >40 yo)

Disequilibrium Dizziness – "unsteadiness while walking"

Often multifactorial, common in elderly, ↑ risk of falls. Complete neuro and MSK exams to rule out peripheral neuropathy, Parkinsonism, MSK d/o, CVA, etc.

Nonspecific Dizziness – "woozy", "giddy", "light-headed"

DDx: hypoglycemic (glucose), thyroid disease (TSH), pregnancy (ß-HCG), meds, psychiatric disorders, alcohol/drugs, menstruation, previous head trauma

Key References: Epley J. The canalith repositioning procedure: for treatment of benign paroxysmal positional vertigo. *Otolaryngol Head Neck Surg*. 1992;107(3):399-404. Labuguen RH. Initial evaluation of vertigo. *Am Fam Physician* 2006;73(2):244-51. Brignole M, et al. Guidelines on management (diagnosis and treatment) of syncope – update 2004. Executive summary. *Eur Heart J*. 2004;25(22):2054-72.