EMU Looks At: Dizziness

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I have been writing EMU now for more than five years and I enjoy it- as well as receiving your comments and compliments. I even recently discovered in a desk of a fellow emergency physician every copy of EMU that has gone out - about 200 pages?? The essay part is always the most difficult, and this month is particularly so. I absolutely detest this subject. Nevertheless, it is a subject that will help people, and as such I cannot ignore it. Three articles form the basis for this essay: AEM Dec 2003, BMJ 23 Mar 2003, Laryngoscope May 2004

1. The key for all of us is to differentiate between vertigo and vertibulo-basilar insufficiency. Firstly, people with vertigo do not have syncope.
2. Ataxia is present in both but much more pronounced in central causes. The folks with vertigo can usually stand without assistance, central causes can not.
3. Central causes usually have associated neurological symptoms such as scotomata, blindness, drop attacks or dysarthria. Anyone know what it is called when you have Horner's syndrome - crossed sensory loss and vertigo? That can be a lateral medullary infarction also known as Wallenberg's syndrome.
4. Nystagmus, if peripheral, it fatigues and there is a latent period before it starts. It is never vertical.
5. Most hearing loss, tinnitus and vertigo are peripheral but a very few cases may be due to thrombosis of small branches of the internal auditory artery. But these will almost always be with associated brain stem signs
6. Vertigo that is made worse by change in position goes more with central vertigo that is brought on by change in position. It is usually peripheral Therefore the Dix Hallpike maneuver is still a useful test.
7. CT should be done for those who cannot stand, those with prolonged nystagmus and vasculopaths.
8. Keep in mind that present thought is that BPV is due to blocked flow of endolymph, (called cannalolithiasis). Vestibular neuronitis is caused by viruses and Meniere's disease is caused by excessive production of endolymph. The treatment for the first condition is physiotherapy - Eply maneuver or Semont are the best.
9. BMJ adds two very important points. If your patient develops significant symptoms with testing but does not develop vertigo he/she does not have BPV. Secondly,if there is a central lesion, the Hallpike may cause nystagmus - but it won't be latent, doesn't fatigue and doesn't cause nausea.
10. I'll add one more tip - a higher blood pressure also suggests a central cause . And do not forget to walk the patient- a wide based gait points to the cerebellum

Does this help? I hope so!