The diagnosis and management of acute vertigo

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Objectives

• To define dizziness and vertigo
• To understand the common causes of vertigo
• To undertake a relevant examination in the dizzy patient
• To identify the key clinical differentiators of peripheral vs central vertigo
Doctor, I’m dizzy...

This is the doctor!
ACUTE VERTIGO

- Suspected Vestibular Neuritis/ Labyrinthitis

- Onset within two weeks

- No other acute neurology

Please contact during Office Hours:

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If after hours, and not being admitted to the medical assessment unit, phone:

Dr Diego Kaski    07880 726 240    until 10pm
Diagnoses in A&E for Possible Vestibular Neuritis (12 months)

<table>
<thead>
<tr>
<th>Neuro-otology Diagnosis</th>
<th>n</th>
<th>%</th>
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</thead>
<tbody>
<tr>
<td>1- <strong>BPPV</strong> – usual ‘posterior canal’ type</td>
<td>29</td>
<td>32</td>
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<tr>
<td>2- Vestibular Neuritis / Labyrinthitis</td>
<td>14</td>
<td>16</td>
</tr>
<tr>
<td>3- Vestibular Migraine</td>
<td>12</td>
<td>13</td>
</tr>
<tr>
<td>4- Postural hypotension</td>
<td>11</td>
<td>12</td>
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<tr>
<td>5- Sepsis</td>
<td>4</td>
<td>4</td>
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<tr>
<td>6- Stroke or Vascular Brainstem events</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>7- <strong>BPPV</strong> – ‘horizontal canal’</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Meniere’s disease</td>
<td>0</td>
<td>0</td>
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<tr>
<td><strong>TOTAL</strong></td>
<td>90</td>
<td>100%</td>
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Symptoms

• Vertigo: Illusion of movement rotational or ‘true vertigo’ “like a merry-go-round”

• Dizziness, giddiness, unsteadiness, light-headedness, imbalance…even headache!

• Nystagmus = involuntary eye oscillation
Vestibular Disorders
BPPV

Brief attacks of vertigo (<30 seconds) provoked
Triggers: turning in bed, lying down, head extension, or bending over

Symptomatic episodes for weeks to months, asymptomatic intervals for months to years

Dix-Hallpike

Treatment Epley’s or Semont maneouvre
Semont repositioning manoeuvre for right sided BPPV
Acute VN
21/09/2010
Vestibular neuritis

• Sudden, unilateral vestibular loss (vertigo, nausea, unsteadiness, nystagmus)
• Hearing spared
• No CNS symptoms or findings
• Viral ‘flavour’: after URTI; mini-epidemics
• Recovery days to weeks
Treatment

• Cinnarazine
• Stemetil Not longer than 3 days!
• Prochloperazine

Explain diagnosis
Encourage mobility
Vestibular physiotherapy
Central or peripheral?
Who needs a scan?

Vertigo with normal Hallpike and:

cranial nerve or limb signs

New onset headache

Acute hearing loss

Intact head impulse test
Migraine

• History of migraine
• Migraine symptoms during vertigo attack
• Hearing usually spared
• Response to conventional treatment
**Vestibular migraine**

**Panel: Diagnostic criteria for vestibular migraine**

Patients need to meet all four of the following criteria:

- At least five episodes with vestibular symptoms* of moderate or severe intensity† lasting between 5 min and 72 h
- Present migraine or previous history of migraine with or without aura according to the International Classification of Headache Disorders
- One or more migraine features with at least 50% of the vestibular episodes
  - Headache with at least two of the following characteristics: one-sided location, pulsating quality, moderate or severe pain intensity, aggravation by routine physical activity
  - Photophobia and phonophobia
  - Visual aura
  - Not explained by another vestibular disorder
Oscillopsia with positional changes
(central positional nystagmus)

• No latency
• No habituation
• No (little) fatiguability
HINTS

Head Impulse test
Direction changing Nystagmus
Skew deviation

HINTS plus

100% sensitivity and 96% specificity for stroke with acute prolonged vertigo >24 hours and one vascular risk factor

Initial diffusion-weighted MRIs were normal in 12%.

HINTS may not be sufficiently robust to detect an AICA infarction because the HIT is mostly positive in this disorder.

HINTS plus incorporates bedside hearing test and head-shaking

To ‘v’ or not to ‘v’

NOT ALL ‘DIZZIES’ ARE VESTIBULAR

* Arrhythmias
* Presyncopal episodes
* Orthostatic hypotension
* Anaemia
* Hypoglycaemia
* Psychological
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Further information

WORKSHOP

10th May 2017

London Transport Museum
Covent Garden Piazza
London WC2E 7BB

The dizzy patient can be challenging, however most patients with vertigo can be successfully diagnosed and treated in the emergency department, stroke unit, and general practice.

This 1 day interactive course will support healthcare professionals to effectively diagnose and manage dizziness across a range of clinical settings.

The course includes short, focused talks and hands-on practical workshops delivered by a distinguished faculty of international experts in the field, including Dr Diego Kaski, Prof. Adolfo Bronstein and Prof. Linda Luxon.

Registration - £250  CPD Points - 8

For more information and to register visit dizzinessandbalanceworkshop.co.uk or use your mobile to scan this code.

Alternatively contact Karen at: kmac@interacoustics.com

Sponsored by interacoustics