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 audiologist. 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 vertigo, where the patient is very imbalanced requires urgent transfer to the nearest Emergency Department (suggestive of vestibular neuritis (labyrinthitis) or stroke)

**Primary care management**

<table>
<thead>
<tr>
<th>Management</th>
<th>Rationale / Detail</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exclude orthostatic/postural hypotension</td>
<td>Standing and lying blood pressure</td>
</tr>
<tr>
<td>Consider migraine and treat if appropriate, eg:</td>
<td>Migraine is the second most common cause of vertigo, and can be managed by the GP</td>
</tr>
<tr>
<td>• Pizotifen 0.5mg to 1mg orally, at night, up to 3mg daily</td>
<td>For patients with a limited range of neck movement or general mobility issues, consider a modified Hallpike</td>
</tr>
<tr>
<td>• Propanolol 40mg orally, 2-3 times daily, up to 320mg</td>
<td>A positive Hallpike test demonstrating clockwise rotational nystagmus identifies BPPV</td>
</tr>
<tr>
<td>• Verapamil (sustained release) 160 or 180mg orally, once daily, up to 320 or 360mg daily</td>
<td>A positive Head Impulse Test demonstrates an inability to maintain visual fixation on a target and implies a peripheral vestibulopathy</td>
</tr>
</tbody>
</table>

Perform two simple tests (in the GPs rooms) to assist determining the likely cause of the patient’s vertigo:

- Hallpike Test
- Head Impulse Test
<table>
<thead>
<tr>
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<tbody>
<tr>
<td>If the Hallpike Test is positive:</td>
<td></td>
</tr>
<tr>
<td>• 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</td>
<td>• BPPV can be diagnosed and treated in the GPs rooms (or by an appropriate physiotherapist)</td>
</tr>
<tr>
<td>• Treat using particle repositioning manoeuvres eg the Epley Manoeuvre</td>
<td>• Although the vertigo has a short duration, the patient may complain of hours of symptoms because they may feel unwell afterward (eg. nausea, disequilibrium)</td>
</tr>
<tr>
<td>• Home Epley Manoeuvre , where appropriate, for patient to perform themselves</td>
<td>• Note which positional changes induce the vertigo (eg. rolling to the side in bed)</td>
</tr>
<tr>
<td>• Consider referral to a community Vestibular Physiotherapy or Falls Clinic, especially for patients with a limited range of neck movement or general mobility issues</td>
<td>• The Epley Manoeuvre, performed on the affected side, has an 80% success rate for symptom resolution on first treatment</td>
</tr>
<tr>
<td>• Provide Patient Info Leaflet on BPPV</td>
<td></td>
</tr>
</tbody>
</table>

If the Head Impulse Test is positive:

- In a setting of acute, constant rotary vertigo for > 24 hours, consider vestibular neuritis

Refer to Vestibular Neuritis in the ENT Referral Guidelines.

Non-specific dizziness/disequilibrium

- Avoid sedatives & 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 RHH

- 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 (greater than 3 treatments)
  - Symptoms not resolved after seeing Vestibular Physiotherapist
  - Co-morbid vestibular or otological conditions
  - Patients where particle repositioning is not advised due to limited range of movement in the neck, or due to general mobility issues that cannot be managed by the Vestibular Physiotherapist
  - Patients with suspected Migraine who have not responded to a trial of 2 or more different migraine prophylactic agents (please refer to Neurology)
  - Anyone in whom the diagnosis is unclear

Information to include on the referral letter

- Copy of recent audiogram, if available
- Description of quality, onset and duration of vertigo including 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

ENT Clinic contact details

Address: Wellington Clinics, Level 11, 42 Argyle Street, Hobart, Tas. 7000
Phone: 6166 0050
Fax: 6234 9454
To contact ENT Registrar on-call phone RHH Switch on 6166 8308

Acknowledgement to the Royal Victorian Eye & Ear Hospital Primary Care Referral Guidelines
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