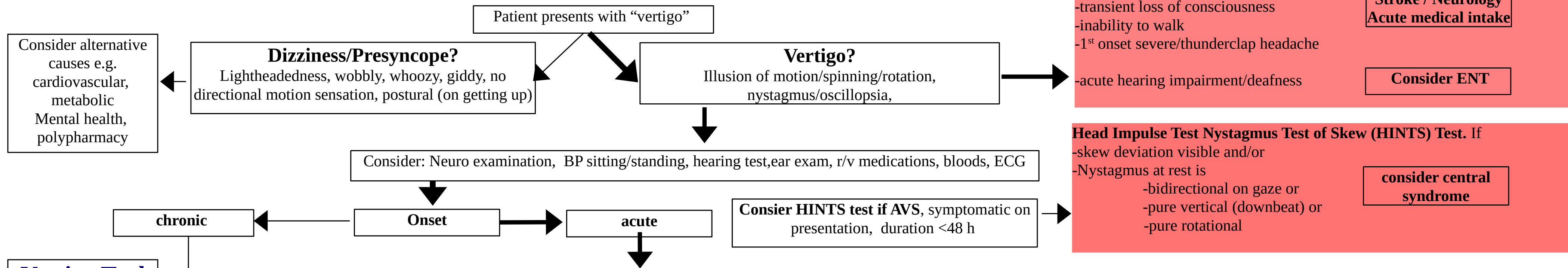
Quick reference and referral guide Vertigo



Vertigo Tool
For more information about
- differentiation
- examination
- treatment options
- patient information leaflets and weblinks

In chronic vestibular conditions commonly unspecific dizziness exists alongside vertigo

	Episodic vestibular Syndrome EVS *(most common conditions)*			Acute Vestibular Syndrome AVS *(most common conditions)*			
	BPPV	**Vestibular Migraine**	**Meniere**	**Neuronitis vestibularis**	**Labyrintitis**	**PICA stroke**	**AICA stroke**
Prevalence % of acute vertigo cases taken from chat GPT	20-30%	10-30%	5-10%	10-15% of vertigo cases		5-15% ***consider this in patients with Cardiovascular risk factors and higher age!***	
Duration/	minutes	Minutes-72 hours	hours-days	Up to 14 days		hyperacute onset, TIA? Stepwise deterioration	
Additional symptoms /bsigns	Positional provoked, Dix Hallpike +	+/-headache, hypersensitivity migraine triggers	Triad of + Tinnitus, hearing impairment, sensation of fullness of ear, fluctuating symptoms	Often previous URTI, on waking up, worse on motion, persistent	See Neuronitis PLUS hearing impairment/loss	Cranial nerve deficit severe ataxia headache	Facial palsy, Horner, sensory changes Hearing loss
Tx	Liberation /Epley manouvre see vertigo tool	Cinnarizine, Triptans Prochlorperazine +/_ Migraine Prophylaxis	Betahistine 16 mg TDS 2 months reduce caffeine and salt	Cinnarizine, Prochlorperazine in acute phase vestibular Rehabilitation		Stroke Treatment	
Referral	If ongoing for >8 weeks ENT	See headache tool gp gateway	1st episode ENT due to hearing impairment. Also ENT if relapsing and progressive hearing impairment	ENT if no improvement within 6-8 weeks	ENT for hearing impairment	Stroke/Neurology	

Chronic Vestibular Syndrome			
	Chronic or bilateral vestibulopathy	**PPPD**	**Presbyastasis, Multisensory dizziness/ chronic instability/ chronic cerebellar syndrome**
Prevalence % of acute vertigo cases taken from chat GPT	10-20%	30-40%	Different conditions, often though co-existing, 10-20% multisensory, chronic instability 20-30%, 5-10% cerebellar
Additional symptoms	Vision worse on movement, HIT positive, atactic gait, balance poor, Romberg positive.	Distractable, variable, balance test often normal, no obvious vestibular abnormalities like Nystagmus,	Visual, hearing and/or sensory impairment, multifactorial gait instability, cognitive impairment, may have cerebellar/central symptoms if previous stroke or small vessel disease
PMHx	Relapsing AVS or Meniere, exposure to ototoxic drugs?	Mental health comorbidity, often initiated by AVS	Often older age, +/-cognitive impairment, pain syndromes e.g. due to Osteoarthritis, may have had AVS, Polypharmacy, cardiovascular disease with e.g. hyper/hypotension
Tx	Remove any vestibulosuppressive/ototoxic drugs vestibular Rehabilitation	Psychotherapy, Antidepressants, phusiotherapy vestibular Rehabilitation	Balance training/falls prevention for elderly, vestibular Rehabilitation, remove vestibular suppressants, reduce polypharmacy, improve sensory imput,
Referral	community physio balance training, ENT for diagnosis and vestibular Rehabilitation	Talking Therapy, Physiotherapy for balance training ENT for diagnosis and treatment	Physiotherapy community for falls prevention/balance training. If falls occur repetitively Falls clinic, otherwise balance clinic, in stroke patients Neurorehabilitation

Created for gpgateway July/2025, Dr. Sabine Dedner GPwSI Neurology in collaboration with Dr. Emma Hoskison, Consultant ENT Surgeon, University Hospital Coventry and Warwickshir