DIZZINESS/VERTIGO REFERRAL GUIDELINE

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HIGH RISK

SUGGESTED EMERGENT CONSULTATION

SYMPTOMS AND LABS

Acute spontaneous, non-positional vertigo with inability to walk and brainstem deficits (e.g. dysphagia, dysarthria, diplopia, unilateral incoordination, unilateral weakness or numbness), mechanism or symptoms to suggest vertebral dissection (e.g. neck/eye pain; rapid, repeated or prolonged hyperextension of neck)

EXAM:

Non-fatigable nystagmus, ataxia, CN palsies

MODERATE RISK

SUGGESTED CONSULTATION OR CO-MANAGEMENT

SYMPTOMS AND LABS

Dizziness with headache/migraine

EXAM:

Generally normal exam

LOW RISK

SUGGESTED ROUTINE CARE

SYMPTOMS AND LABS

Pre-syncope without peripheral neuropathy; benign positional vertigo, medication side effects, hyperventilation syndrome, Meniere's disease, acoustic neuroma (hearing loss, tinnitus)

EXAM:

Orthostasis, fatigable and provoked nystagmus (if BPPV)

SUGGESTED PREVISIT WORKUP

Urgent ED evaluation for possible cerebellar or brainstem stroke

SUGGESTED WORKUP

Non-urgent neurology consultation

SUGGESTED MANAGEMENT

If pre-syncope, consider cardiology evaluation and discontinue any causative medications.

If suspect BPPV or Meniere's, consider ENT evaluation.

If chronic dizziness not responsive to therapies, consider neuro-otology referral to Mass Eye and Ear

If acoustic neuroma, MRI w/ and w/o gad and neurosurgery consultation

CLINICAL PEARLS

- Etiology of dizziness in population based studies include: 40% peripheral vestibulopathy, 25% other (e.g. syncope, disequilibrium, medication side effects, TBI, hypoglycemia, vision/hearing/sensory loss), 15% psychiatric and 10% central brainstem/vestibular lesion, 10% undetermined
- If suspect benign paroxysmal positional vertigo (BPPV) due to provoked, brief vertigo and nystagmus, consider ENT evaluation and vestibular therapy.

Maine Medical
PARTNERS

Reviewed by Megan Selvitelli, MD

These clinical practice guidelines describe generally recommended evidence-based interventions for the evaluation, diagnosis and treatment of specific diseases or conditions. The guidelines are: (i) not considered to be entirely inclusive or exclusive of all methods of reasonable care that can obtain or produce the same results, and are not a statement of the standard of medical care; (ii) based on information available at the time and may not reflect the most current evidenced-based literature available at subsequent times; and (iii) not intended to substitute for the independent professional judgment of the responsible clinician(s). No set of guidelines can address the individual variation among patients or their unique needs, nor the combination of resources available to a particular community, provider or healthcare professional. Deviations from clinical practice guidelines thus may be appropriate based upon the specific patient circumstances.

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