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

SUGGESTED PREVISIT WORKUP

Urgent ED evaluation for possible cerebellar or brainstem stroke

MODERATE RISK

SUGGESTED CONSULTATION OR CO-MANAGEMENT

SYMPTOMS AND LABS

Dizziness with headache/migraine

EXAM:
Generally normal exam

SUGGESTED WORKUP

Non-urgent neurology consultation

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 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

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