**Vestibular Sensation of movement (rocking, floating, tilting, swaying, spinning, oscillations)?**

- Assess for Fear of Falling (Consider CDC Steadi Algorithm*)

**Consider Cardiac workup:**
- Orthostatic VS
- Medication review
- EKG

***A single episode of syncope does not require neurology work up***

**Unspecified**
- Age Related? Polypharmacy?
- Multifactorial?
- Anxiety?
- Functional disorders?

**Classify Syndrome Based on Temporal Profile:**

- **First, acute, continuous (never stops) dizziness or vertigo; building over minutes to hours** (See page 2)
- **Recurrent, spontaneous (no positional or other clear triggers), dizziness or vertigo** (See page 3)
- **Recurrent, positional or triggered, dizziness or vertigo** (see page 4)
- **Chronic dizziness (present >50% of the time for >3 months)** (See page 5)

CT head is never appropriate for dizziness evaluation in the outpatient setting

First, acute, continuous dizziness or vertigo never stops, building over minutes to hours

Any significant vascular risk factors, recent trauma or focal neurologic deficit?

Yes

Consider sending to ED for acute evaluation and imaging

No

Sudden, Unilateral New Hearing Loss?

Yes

Consider labyrinthitis
Consider URGENT referral to ENT and audiology

No

Consider vestibular neuritis
1. Consider starting steroid taper 1 mg/kg over 2 weeks
2. Consider referral to physical therapy for vestibular rehabilitation

CT Head is never appropriate for dizziness evaluation in the outpatient setting
Recurrent, spontaneous dizziness or vertigo no positional or other clear triggers

Any unilateral hearing loss, ear fullness or roaring tinnitus only during dizziness?

Any headache, light, sound, smell sensitivity? Any history of migraine remotely?

Consider Meniere’s Disease and referral to ENT with audiogram prior to evaluation

Consider vestibular migraine and treat empirically for migraine headaches even in absence of current migraine headaches

1. Acute: triptans, anti-emetics, anti-inflammatories no more than 10 days/month
2. Ask patient to keep symptom diary
3. Evaluate lifestyle triggers (sleep, exercise, hydration, stress)
4. Consider chronic migraine if >15 days of symptoms per month and consider preventive treatment (refer to migraine pathway)
5. Refer to headache pathway for when imaging is appropriate

Adequate response to treatment?

Continue medical management; no imaging or specialty referral necessary

Consider econsult or referral to neurology if no response in 2-3 months

CT Head is never appropriate for dizziness evaluation in the outpatient setting
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Currently symptomatic?

Yes

Perform Dix-Hallpike evaluation of both right and left sides to evaluate for posterior canal benign paroxysmal positional vertigo

Symptoms triggered?

Yes

1. Perform Epley maneuver for that side
2. No restrictions in activity following repositioning

No

Consider providing home handout on BPPV and Dix Hallpike

Consider referral to physical therapy for vestibular therapy

No

1. Let patient know they may perform 1-2x time daily in the morning at home until symptoms resolve
2. Imaging is not necessary

1. Let patient know they may perform 1-2x time daily in the morning at home until symptoms resolve
2. Imaging is not necessary

Symptoms triggered?
Chronic, persistent dizziness
Present >50% of the time for >3 months

Stable or Progressive?

Progressive

Unilateral hearing loss?

Yes

Is there oscillopsia (vision/world shaking ONLY with head movement)?

Yes

Consider referral to ENT and audiology for vestibular evaluation

No

Consider referral to Neurology

Stable

1. Are there no falls or injuries related to the feeling of chronic dizziness?
2. Symptom worsening when:
   - Standing upright and unsupported?
   - In complex visual environments (grocery store aisles, wallpaper)?
   - In stressful situations?

Consider Persistent Postural Perceptual Dizziness (PPPD)
1. Consider giving patient handout *
2. Consider empiric treatment with SSRI (Sertraline up to 100 mg or Escitalopram up to 20 mg) or SNRI (Venlafaxine SR 75-225 mg)
3. Consider referral to physical therapy for vestibular rehabilitation
4. If no response, consider neurology e-consult for dizziness

Consider referral to Neurology

CT Head is never appropriate for dizziness evaluation in the outpatient setting


** BMJ article 2018 https://jn.bmj.com/content/18/1/5 (Popkirov S, Staab JP, Stone J. Persistent postural-perceptual dizziness (PPPD): a common, characteristic and treatable cause of chronic dizziness. Practical Neurology 2018;18:5-13.)