OBJECTIVES OF THIS FRAMEWORK:

(a) recommend front-line clinicians see patients with paroxysmal, positional vertigo;
(b) identify high-risk patients to be sent to the ED; and
(c) refer other patients appropriately to cardiology, neurology, ENT, or multi-disciplinary balance clinic.

STEP 1

- Brief episodes of triggered, positional vertigo/dizziness
- +/- new/adjusted medication (e.g., anti-hypertensives)
- No other symptoms

→ Prompt evaluation by **PRIMARY CARE** or **URGENT CARE**

If dizziness is accompanied by additional symptoms, refer as indicated:

Cardiorespiratory symptoms

- Loss of consciousness, syncope, pre-syncope **
- Chest pain **
- Palpitations or irregular heartbeat **
- Dyspnea (shortness of breath) **
- Uncontrolled vomiting **
- Light-headedness upon rising or after exertion
- Transient light-headedness and disequilibrium unrelated to head movement/position

< 7 days → **EMERGENCY DEPARTMENT**

> 7 days → **Internist or cardiologist**

** Red-flag symptoms should always be directed to emergency department or an urgent evaluation regardless of acute or chronic duration.

Neurological symptoms

- The D's (diplopia, dysarthria, dysphonia, dysphagia, dysmetria, drop attack) **
- Focal weakness **
- Confusion ***
- Severe headache **
- Seizure or suspected seizure **
- Loss of consciousness, syncope **
- Uncontrolled vomiting **
- Ataxia
- Dysesthesia (abnormal peripheral sensation)
- Inability to stand unassisted, falling to one side
- "Down is up" distortions (room tilt illusion)
- Constant imbalance or light-headedness
- Nystagmus visible in straight-ahead gaze (excluding positional nystagmus)

< 7 days → **EMERGENCY DEPARTMENT**

> 7 days → **Neurologist**

Otologic symptoms

- Hearing loss (sudden, persistent) **
- Uncontrolled vomiting **
- Hyperacusis (noise sensitivity)
- Tinnitus (new or worsening)
- Aural fullness
- Brief vertigo/unsteadiness provoked by cough/sneeze, straining, loud noises, especially if history of trauma

< 7 days → **EMERGENCY DEPARTMENT**

> 7 days → **E.N.T.**

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STEP 2

If management not clear from Step 1, use secondary triage protocols for the patient with episodic dizziness:

Dizziness duration	Seconds	Seconds to hours	Minutes to hours	Minutes to days	Hours to constant
Symptoms	**Symptoms provoked by:** Rolling over in bed. Getting in/out of bed. Bending. Looking upward. **Other symptoms:** Brief "room-spinning." No auditory symptoms. No other neurological symptoms. Possible nausea or vomiting.	**Symptoms provoked by:** Head movement. Busy/dark environments. Soft or uneven surfaces. History of acute event at onset. **Other symptoms:** Unsteadiness. Visual complaints when in motion (oscillopsia). +/- hearing loss or tinnitus	**Symptoms provoked by:** Spontaneous/episodic. Present at rest but may increase with head movement. **Other symptoms:** Vertigo. Hearing disturbance. Ear fullness. Tinnitus. Nausea/vomiting. Progressive fluctuating, hearing loss.	**Symptoms provoked by:** Spontaneous/episodic. Possibly increase with head movement. **Other symptoms:** Possible visual aura. Photophobia, phonophobia, environmental triggers. +/- headache.	**Symptoms provoked by:** Possible relationship with head &/or visual movement, but not necessarily. **Other symptoms:** Vague sensations of unsteadiness, dizziness or motion in the head or environment, or other*
Possible diagnosis	BPPV	Vestibular hypofunction	Meniere's disease	Vestibular migraine	Many possibilities (central, medication, multifactorial, others)
Referral	PCP manage or ENT/PT	ENT or otology/ neurotology	ENT or otology/ neurotology	Neurology or otology/ neurotology	Multidisciplinary balance clinic or otology/ neurotology

*OTHER: If symptoms are chronic and mixed/unclear, patient is best served by referral to a multidisciplinary balance center if available.

For more information about vestibular disorders, visit vestibular.org.

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