DISP
CHEAT SHEET

Disposition in Dizziness

Safe Discharge vs Admission Decision

▸ The core question

Is this dizziness peripheral (safe to discharge) or central (requires imaging and admission)?
Misdiagnosis of posterior fossa stroke as vestibular neuritis accounts for up to 35% of missed strokes in ED.

Syndrome Classification — First Step

Syndrome	Definition	Key Risk
AVS (Acute Vestibular Syndrome)	Continuous vertigo + nystagmus at rest + gait instability + N&V — lasting hours to days	Posterior fossa stroke / vestibular neuritis
EVS — Triggered (t-EVS)	Recurrent brief vertigo triggered by position change (BPPV pattern)	Central positional vertigo (rare) — if nystagmus atypical
EVS — Spontaneous (s-EVS)	Recurrent spontaneous discrete episodes without clear trigger	TIA, Meniere's disease, vestibular migraine
Chronic Vestibular Syndrome	Persistent dizziness greater than 1 month	PPPD, bilateral vestibulopathy, mass lesion

Must-Not-Miss Diagnoses

Diagnosis	Key Pointer	Immediate Action
Posterior fossa stroke	Normal HIT in AVS; direction-changing nystagmus; skew deviation	Stroke protocol; MRI DWI; admit
Cerebellar haemorrhage	Severe ataxia; headache; hypertension	Urgent CT head; neurosurgery
Posterior circulation TIA	Transient episode + vascular risk factors + resolved	Admit; dual antiplatelet; MRI + MRA; echo
Basilar artery occlusion	Progressive brainstem signs; depressed consciousness	Immediate stroke activation; thrombectomy window
Wernicke encephalopathy	Alcohol/malnutrition; ophthalmoplegia; confusion	IV thiamine 500 mg before any glucose
Cerebellar abscess	Fever; immunocompromised; recent ear infection	CT/MRI; neurosurgical consult; antibiotics

Safe Discharge Criteria

▸ All criteria must be met for safe discharge

1. Full peripheral HINTS in AVS (abnormal HIT + unidirectional nystagmus + no skew).
2. Confident clinical diagnosis: BPPV resolved after Epley, or known vestibular migraine/Meniere's pattern.
3. No new neurological signs or symptoms.
4. Patient can walk safely (with or without assistance).
5. Adequate home support; able to return if worsening.
6. Clear return-to-ED criteria provided verbally and in writing.

Disposition in Dizziness — *continued*

Admission Criteria

Criterion	Rationale
Central HINTS pattern (any one sign)	Posterior fossa stroke until proven otherwise — MRI DWI needed
New neurological deficit (any)	Central pathology; imaging and neurology input required
Unable to walk or stand	Safety risk; may indicate cerebellar stroke
Severe uncontrolled N&V	IV hydration; symptom control; observation
High-risk TIA features (ABCD2 over 3)	Stroke risk in next 48 h — inpatient workup
Syncope or presyncope component	Cardiac cause must be excluded; monitoring required
First presentation with hearing loss + vertigo	Labyrinthine infarct must be excluded; stroke workup
Diagnostic uncertainty after full assessment	Observation, senior review, delayed MRI at 24–48 h

Discharge Documentation Essentials

Document	Required Detail
Syndrome classification	AVS / triggered EVS / spontaneous EVS — not just "dizziness"
HINTS result (if AVS)	Record each component: H result, nystagmus direction, skew present/absent
Neurological exam	Cranial nerves, cerebellar signs, gait, Romberg — must be documented
Vascular risk factors	Screened and recorded; implications addressed
Working diagnosis	Specific (vestibular neuritis, BPPV type, vestibular migraine) — not "vertigo"
Discharge instructions	Written; includes return criteria; follow-up arranged

Return to ED Criteria — Give to Every Patient

▸ Written return precautions must address

New or worsening headache.
Double vision, facial drooping, arm or leg weakness, slurred speech.
Unable to walk or stand since discharge.
Symptoms dramatically worsening rather than gradually improving.
New hearing loss.
Symptoms not improving within 72 hours (vestibular neuritis expected to improve slowly).

Follow-Up Referral Guide

Diagnosis	Refer To	Urgency
Vestibular neuritis	GP + vestibular physiotherapy	Within 1–2 weeks
BPPV (resolved)	GP; vestibular physio if recurs	Routine
BPPV (unresolved)	Vestibular physiotherapy	Within 1 week
Vestibular migraine	Neurology or vestibular physician	Within 4 weeks
Probable Meniere's disease	ENT or vestibular physician + audiologist	Within 2 weeks
Post-stroke dizziness	Stroke neurology + vestibular rehab	As per stroke pathway