Disposition Decisions:

Safe Discharge After Dizziness in the Emergency Department

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How to Use This Review

Dizziness accounts for roughly 4–5% of emergency department visits, with most presentations driven by benign peripheral vestibular conditions — BPPV, vestibular neuritis and vestibular migraine [1,2]. A smaller subset, however, harbours life-threatening pathology including posterior-circulation stroke, cerebellar haemorrhage, basilar artery occlusion and vertebral artery dissection [3,11].

Disposition decisions in dizziness therefore carry disproportionate clinical and medicolegal weight — getting it wrong can kill [1,11]. This review sets out a structured framework for safe discharge, the red flags that mandate admission, the documentation required to defend the decision, and the outpatient pathways that support patients after discharge [1,2,9] [11].

The document follows a structured clinical format with numbered sections, integrated callout boxes for rapid reference, summary tables, and a references section. It is designed both as a learning resource and a quick-reference tool for practising clinicians.

 Key Point: *Foundational concepts and summary statements that anchor the core scientific content of each section.*

 Clinical Insight: Clinically relevant observations derived directly from the evidence — for direct application in assessment and diagnosis.

 Clinical Pearl: High-yield, memorable clinical points — the take-home messages most likely to influence management or examination performance.

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I. Introduction

Dizziness accounts for roughly 4–5% of emergency department visits, with most presentations driven by benign peripheral vestibular conditions — BPPV, vestibular neuritis and vestibular migraine [1,2]. A smaller subset, however, harbours life-threatening pathology including posterior-circulation stroke, cerebellar haemorrhage, basilar artery occlusion and vertebral artery dissection [3,11].

Disposition decisions in dizziness therefore carry disproportionate clinical and medicolegal weight — getting it wrong can kill [1,11]. This review sets out a structured framework for safe discharge, the red flags that mandate admission, the documentation required to defend the decision, and the outpatient pathways that support patients after discharge [1,2,9] [11].

The ED challenge is rapid identification of the minority of dizzy patients with serious pathology against the background of a much larger benign population [1,11]. A TiTrATE-style structured approach — Timing, Triggers, And Targeted Examination — reliably separates these groups at the bedside [2].

Disposition decisions in dizziness carry medicolegal significance [11,20]. Missed posterior-circulation stroke is the most common successful claim against ED clinicians in this presentation group, driven almost entirely by incomplete examination and inadequate documentation [11,20]. Structured documentation of what was examined, what was found, what was considered and why discharge is safe is the single most effective risk-mitigation step [11,20] [11].

 Key Point: *Most dizziness is benign and self-limited. Safe discharge requires identifying high-risk features early and ensuring appropriate follow-up.*

II. Risk Stratification: TiTrATE Approach

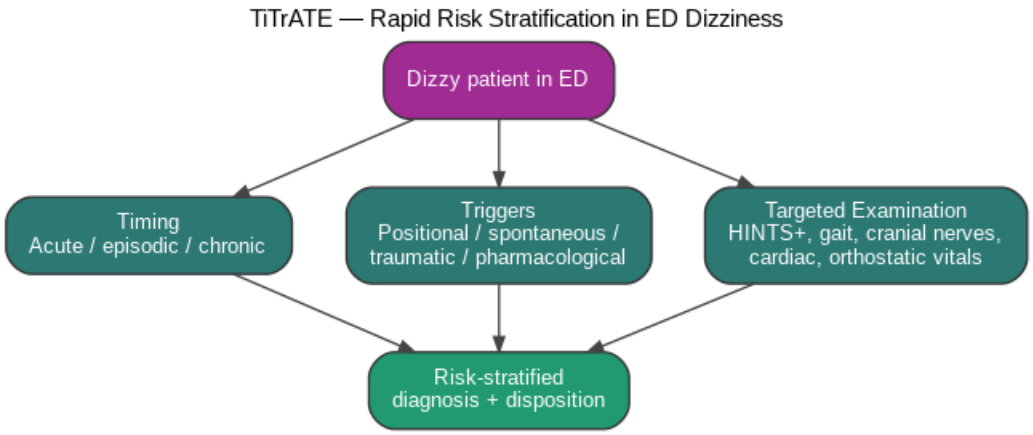

Figure 1. TiTrATE — rapid risk stratification in ED dizziness [2].

Timing, Triggers, And Targeted Examination

The TiTrATE approach — Timing, Triggers, And Targeted Examination — is the accepted structured framework for rapid risk assessment of dizziness in the ED [2]. Timing classifies the presentation as acute, episodic or chronic [2]. Triggers establish whether symptoms are provoked or spontaneous [2]. Targeted examination focuses the neurological and cardiac evaluation on the most likely category [2].

Timing

Onset timing is critical: sudden-onset sustained vertigo (acute vestibular syndrome) raises concern for vestibular neuritis or posterior-circulation stroke, whereas episodic brief positional vertigo strongly favours

BPPV, and chronic unsteadiness points to disequilibrium, PPPD or neurological disease [2,6]. Each timing category has its own red flags and workup [2,6].

Triggers

Clear triggers reduce concern for serious pathology: positional triggering points to BPPV (confirmed by Dix–Hallpike or supine roll test) [15]. Orthostatic triggering points to orthostatic hypotension or POTS [8]. Visual-motion triggering points to vestibular migraine or PPPD [6].

Absence of triggers in an acute-onset sustained vertigo raises concern for vestibular neuritis or central pathology and mandates a full HINTS+ and gait assessment [2,6]. Spontaneous continuous vertigo with any central feature should not be discharged without imaging and specialist review [6,11].

Targeted Examination

Targeted examination must include gait (tandem and unassisted), nystagmus characterisation, cranial nerves, cerebellar testing (dysmetria, dysdiadochokinesis), HINTS+ when AVS is present, orthostatic vital signs, and a 12-lead ECG [2,6,7]. Absent gait testing is a common documentation failure that undermines the whole disposition decision [6,9] [12].

 Clinical Insight: TiTrATE is a reminder: "Did this start suddenly or gradually? Are there clear triggers? What does the exam reveal?" Risk stratification takes minutes.

III. High-Risk Features

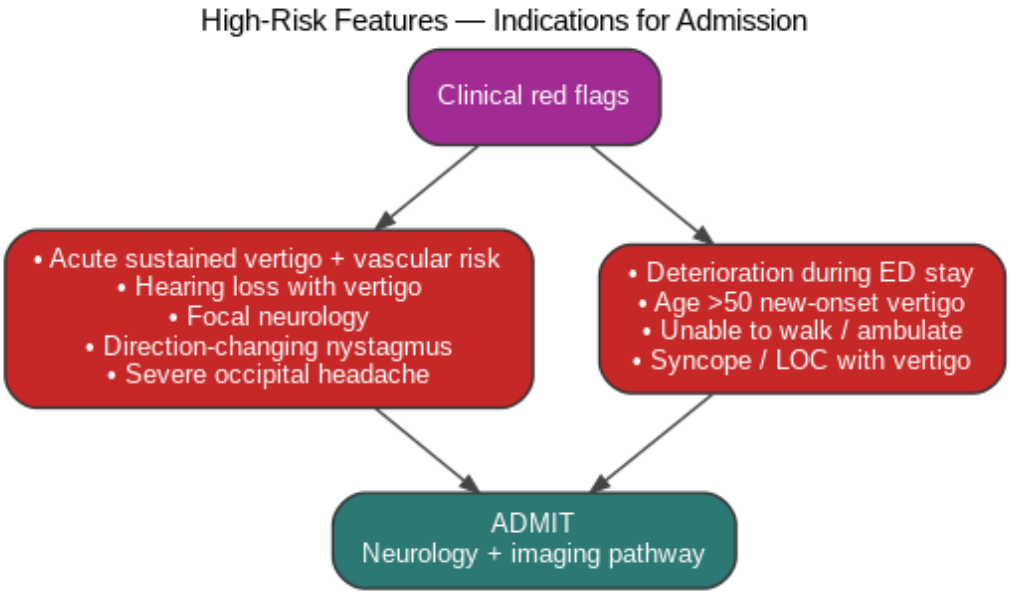

Figure 2. High-risk features — indications for admission.

Clinical Red Flags

Any of the following clinical red flags warrant admission, neuroimaging and specialist consultation [1,11]:

- **Acute-onset sustained vertigo in a patient with vascular risk factors — even when the examination looks peripheral — requires exclusion of posterior-circulation stroke before discharge [2,11,19]. HINTS+ sensitivity is operator-dependent and MRI-DWI should be obtained when there is any residual concern [2,19].**
- **Acute hearing loss with vertigo is a red flag: AICA-territory stroke, bacterial labyrinthitis and sudden sensorineural hearing loss all present this way and each requires different urgent management [3,7,16]. Imaging and ENT input are usually needed before disposition [3,7,16].**
- **Any focal neurological sign — dysarthria, facial droop, hemiparesis, sensory loss, dysphagia, diplopia, gait ataxia disproportionate to the vestibular complaint — reclassifies the patient as possible stroke and mandates full stroke pathway activation [6,11,19].**
- **Direction-changing nystagmus on eccentric gaze, vertical nystagmus or nystagmus that fails to suppress with fixation are central features and should prompt imaging and specialist review regardless of other findings [2,6].**
- **Severe occipital or generalised headache with vertigo raises concern for cerebellar haemorrhage, vertebral artery dissection, meningitis or subarachnoid haemorrhage — urgent CT followed by MRI/MRA is indicated depending on the suspected cause [3,4,13].**
- **Rapid clinical deterioration during the ED stay — new focal neurology, reduced GCS, new severe headache, new cranial nerve deficit — indicates evolving posterior-fossa pathology and requires immediate reassessment, neurosurgical/neurological escalation and repeat imaging [3,4,11].**
- **Age >50 with new-onset vertigo increases the baseline probability of stroke and reduces tolerance for diagnostic uncertainty [11,19]. In this group, the bar for discharge without imaging should be higher than in younger patients [11,19].**
- **Inability to walk or ambulate safely — particularly astasia (inability to stand unaided) — is a strong predictor of central pathology and also a practical barrier to safe discharge, requiring inpatient vestibular rehabilitation and ongoing monitoring [2,8,9].**
- **Syncope or loss of consciousness accompanying dizziness shifts the workup toward cardiac or systemic pathology and usually requires admission for telemetry, cardiology review and structural assessment [1,4,7].**

Vascular Risk Factors

Vascular risk factors — age >60, hypertension, diabetes, atrial fibrillation, prior stroke or TIA, smoking, hypercholesterolaemia — raise pre-test probability for posterior-circulation stroke and lower the threshold for imaging and specialist review in AVS [11,12]. Absence of risk factors does not exclude stroke, particularly in dissection or cardiogenic embolism in younger patients [11,13].

⚠ **Important:** Any combination of acute vertigo + vascular risk factors + focal findings = high risk. Image and admit.

IV. Safe Discharge Criteria

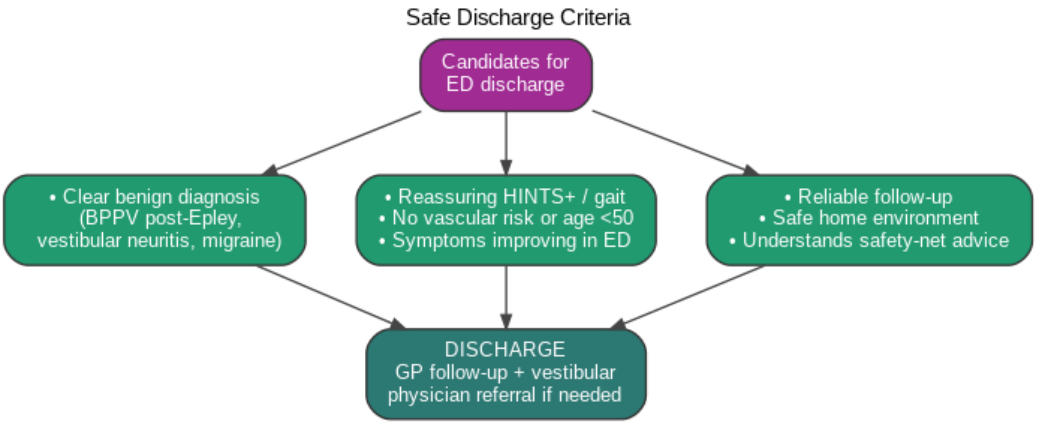

Figure 3. Safe discharge criteria.

Candidates for ED Discharge

Safe ED discharge is appropriate when the patient has a clear benign diagnosis, a reassuring examination and cardiac assessment, improvement during the ED stay, low vascular risk, reliable follow-up and a safe home environment [1,9]. Typical features include:

- **Benign examination findings — normal gait, direction-fixed horizontal nystagmus suppressed by fixation, normal cranial nerves, normal cerebellar examination, reassuring HINTS+ pattern — support a peripheral diagnosis [2,6,9].**
- **A clear diagnosis — BPPV confirmed on Dix–Hallpike and improving after canalith-repositioning, vestibular neuritis with typical HINTS pattern, vestibular migraine with prior similar episodes, or clear orthostatic cause — gives the discharge decision a defensible foundation [9,15].**
- **Symptom improvement during the ED stay — the patient feels better, can ambulate, tolerates oral intake — is an important practical safety signal and should be explicitly documented [9].**
- **Absent vascular risk factors or age <50 further reduces stroke probability and supports discharge in appropriate patients [11,12]. These features should not by themselves override genuine examination red flags, but they refine the overall risk picture [11].**
- **Reliable follow-up — the patient can contact primary care within days and is willing to return if symptoms change — is prerequisite to safe discharge [9]. Provide written safety-net advice in plain language covering the specific red flags that should trigger re-presentation [9].**
- **A safe home environment with someone available to observe and assist if required is important, particularly in older patients or those with residual unsteadiness [9,18]. Falls-risk assessment and referral for home OT input may be appropriate [18].**

Discharge Pathway Example

Example: a 35-year-old woman with two days of mild positional vertigo, no headache, able to walk, normal HINTS+, no red flags, reassuring examination and improving symptoms — with a working diagnosis of BPPV treated with Epley manoeuvre — is suitable for discharge with GP follow-up and a vestibular physiotherapy referral [9,15].

 Key Point: *Safe discharge is reasonable when exam is benign, diagnosis is clear, and there are no red flags.*

V. Documentation Standards

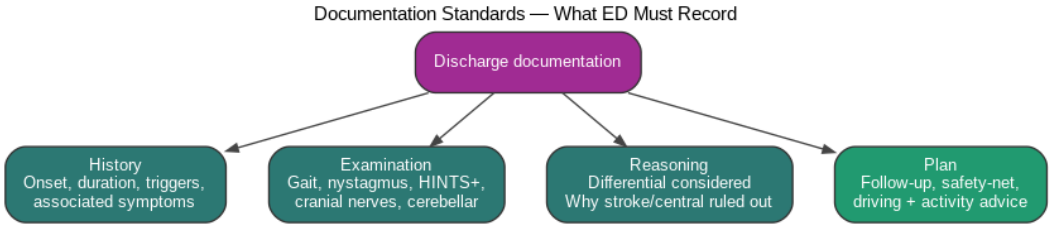

Figure 4. Documentation standards — what must be recorded.

What to Document for Safe Discharge

Clear, structured documentation is essential for both clinical continuity and medicolegal defensibility [11,20]. The absence of a documented examination finding is treated legally as the absence of the examination [11,20]. The following minimum dataset should accompany every dizziness disposition decision [11,20] [11]:

- **History — onset, duration, triggers, associated symptoms (hearing, focal neurology, headache, chest pain), prior episodes, medications and vascular risk factors [1,2,6].**
- **Examination findings — gait, nystagmus characteristics (direction, plane, amplitude, suppression by fixation), HINTS+, cranial nerves, cerebellar testing, orthostatic vitals and cardiac findings [2,6,7].**
- **HINTS results (when AVS is present) should be documented in full: 'Head impulse: negative. Nystagmus: direction-fixed left-beating. Skew: absent.' An explicit interpretation — 'peripheral pattern' or 'central pattern' — makes reasoning transparent [2,6].**
- **Differential diagnosis — what you think is happening, what you considered and why you ruled each alternative in or out [1,11]. This is the single most important documentation element for medicolegal defensibility [11,20].** [11]
- **Testing performed — ECG, imaging status, other investigations and their results [4,7,19]. A normal CT in posterior-fossa symptoms does not exclude stroke and this should be explicitly noted if imaging stops there [19].**
- **Reasoning for disposition — why you selected discharge (or admission), what safety criteria were met, what follow-up was arranged and what safety-net advice was given [1,9,11].**

 Clinical Pearl: If you chart that you considered and ruled out serious pathology, it protects you medicolegally.

VI. Discharge Advice and Driving Safety

Return Precautions

Advise patients to return immediately if they develop severe headache, new weakness, slurred speech, diplopia, facial droop, worsening or new-onset hearing loss, new unsteadiness, or any symptom they judge more severe than the current presentation [9,11]. Written instructions improve recall and adherence [9].

Driving Safety

Counsel patients on driving restrictions in line with jurisdictional guidance [9]. Patients with ongoing acute severe vertigo should not drive until symptoms have fully resolved [9]. Patients with recurrent BPPV, vestibular migraine or Ménière's should be advised not to drive during active attacks [9,15].

Activity and Vestibular Rehabilitation

Advise gradual return to normal activity [9]. Bed rest is not recommended in vestibular neuritis or BPPV because it delays central compensation and worsens outcomes — early mobilisation and vestibular rehabilitation exercises improve recovery [9,10].

 Key Point: *Discharge advice should be specific: return precautions, driving guidance, activity restrictions, and vestibular PT referral.*

VII. Outpatient Referral Pathways

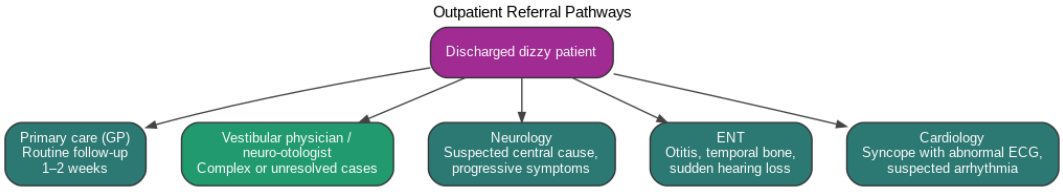

Figure 5. Outpatient referral pathways after ED discharge.

Primary Care

Most discharged dizziness patients should have primary-care follow-up within 1–2 weeks to confirm resolution, initiate further workup or refer onward [9]. A copy of the ED record should accompany the patient or be sent electronically to the GP [9].

Vestibular Physician or Neuro-Otologist

Indications for vestibular physician or neuro-otology referral include recurrent BPPV, chronic vestibular dysfunction, complex Ménière's, post-concussion vestibular syndrome, vestibular migraine refractory to first-line management, and any diagnostically unresolved case [9,15]. Early specialist involvement improves outcomes and reduces repeat ED visits [9].

Neurology

Indications for neurology referral include suspected central vestibular pathology, progressive neurological symptoms, confirmed or suspected posterior-circulation stroke or TIA, and atypical features that do not fit a clear vestibular diagnosis [6,11].

Otolaryngology

Indications for ENT referral include chronic otitis media with labyrinthitis concern, temporal bone trauma, sudden sensorineural hearing loss accompanying vertigo, and suspected perilymph fistula [7,16,17].

Cardiology

Indications for cardiology referral include syncope with abnormal ECG, suspected arrhythmia, exertional syncope, family history of sudden cardiac death, and any high-risk syncope pattern [4,7].

 Clinical Insight: Tailor referral pathway to diagnosis: BPPV → PT; vestibular neuritis → PCP + PT; syncope → cardiology.

VIII. Follow-Up Timing

Urgent Follow-Up

Patients with unresolved diagnosis or high-risk features should have urgent follow-up — within 48–72 hours — with the appropriate specialist service, and should be given clear safety-net advice for re-presentation in the interim [9,11].

Routine Follow-Up

Most patients with clear benign diagnoses can follow up routinely with primary care within 1–2 weeks [9]. Vestibular physiotherapy referral should accompany any diagnosis of vestibular neuritis, vestibular migraine, BPPV or PPPD [9,10].

Specialist Follow-Up

Patients with a clear diagnosis but significant residual symptoms — unsteadiness, persistent dizziness, oscillopsia — benefit from vestibular physiotherapy review within 2–4 weeks and specialist vestibular review if symptoms fail to resolve [9,10].

IX. Medicolegal Considerations

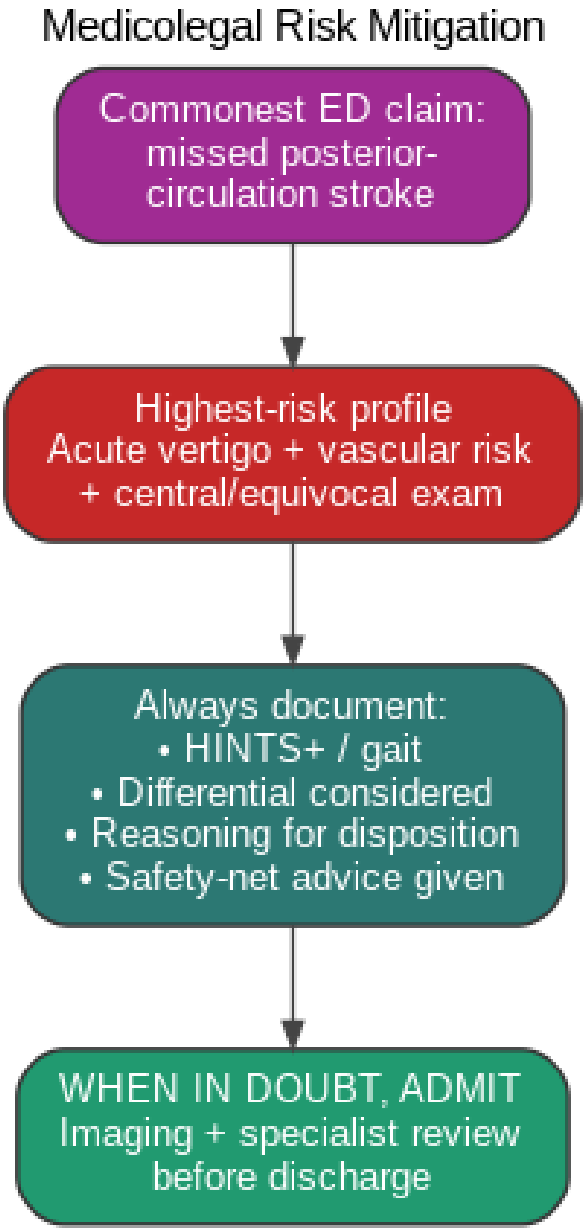

Figure 6. Medicolegal risk mitigation — the commonest claim and how to avoid it.

Missed Posterior Fossa Stroke

The most common medicolegal claim in acute vertigo is missed posterior-circulation stroke [11,20]. The classic vignette is an older patient with vascular risk factors and acute vertigo, discharged with 'vestibular neuritis' after an incomplete examination — subsequently returning with an evolving cerebellar infarct [11,20] [11].

The key risk factor pattern is acute vertigo plus vascular risk factors plus incomplete or equivocal examination [11,20]. In this population, structured HINTS+, gait testing and a low threshold for MRI-DWI are not optional — they are the standard of care [2,11,19].

Documentation and Risk Mitigation

Document thoroughly: your history, examination findings (including what was normal), the differential you considered, why each alternative was ruled in or out, the tests performed, and your reasoning for disposition [11,20]. Dictate and sign in the patient's presence where possible [11].

When in doubt, admit [11]. The combination of acute vertigo, vascular risk factors, and an equivocal examination is not the patient in whom to take the risk of discharge — even when bed pressure argues otherwise [11,19,20].

⚠ **Important:** Document your differential diagnosis and what you ruled out. This protects you medicolegally.

Table 1 summarises the disposition decision framework — admission indications, discharge criteria, and the documentation required for each [1,9,11] [12].

Clinical Scenario	Exam Findings	Imaging	Disposition
BPPV, age <50	Positive Dix-Hallpike, suppressed nystagmus	None (unless atypical)	Discharge with Epley, PT
Acute ves. neuritis, age <60	Positive HIT, normal neuro exam	CT if concern	Discharge with PT, follow-up
Acute vertigo + age >60 + HTN	Any concerning findings	CTA/MRI mandatory	Admit for imaging
Vertigo + headache + ataxia	Gait ataxia, direction-changing nystagmus	CT/MRI emergent	Admit; rule out cerebellar
Syncope + abnormal ECG	Arrhythmia or cardiac findings	Based on ECG	Admit; cardiology
Vertigo improving in ED	Benign, improving exam	None if low risk	Discharge; same-day PT

X. Conclusions

Safe discharge in dizziness requires rapid risk stratification using the TiTrATE framework, clear identification of red flags, and explicit documentation of reasoning [1,2,9]. The majority of ED dizziness presentations are benign and can be discharged safely with clear diagnosis, safety-net advice and appropriate follow-up [1,9] [2].

Most patients with benign peripheral vestibular disease — BPPV, vestibular neuritis, vestibular migraine — can be discharged with vestibular physiotherapy referral, clear written advice, and GP follow-up within 1–2 weeks [9,10,15]. Outcomes are excellent with appropriate rehabilitation [10].

High-risk features — acute sustained vertigo with vascular risk or central signs, focal neurology, severe headache, inability to walk, rapid deterioration, syncope — mandate admission, imaging and specialist review [1,11,19]. Rigorous documentation of reasoning is the single most effective medicolegal safeguard and supports clinical continuity [11,20] [11].

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