LR 01
CHEAT SHEET

Taking a Dizziness History

A structured clinical approach for general clinicians

▸ Why history alone matters

History alone correctly classifies dizziness in 70–75% of patients. Targeted exam adds 10–15%. Imaging, audiometry, and vestibular testing contribute in a minority of cases.

TiTrATE — The Framework

- **Ti — Timing.** Episodic or continuous? Per-episode duration? Onset and time course?
- **Tr — Triggers.** What reliably brings it on? Positional, orthostatic, visual, Valsalva, migrainous?
- **A — Associated symptoms.** Hearing, neurological, migraine, autonomic.
- **T — Targeted examination.** HINTS+, Dix-Hallpike, orthostatic vitals, focused neuro.
- **E — Evaluation.** Imaging, audiometry, vestibular testing — only where history + exam indicate.

▸ Abandon "What kind of dizziness?"

Symptom-type categorisation (vertigo / pre-syncope / disequilibrium / lightheadedness) is unreliable — patients change their description between visits, and symptom quality correlates poorly with cause. Start with timing, then triggers.

Timing — Per-episode duration → differential

Duration of each episode	Think of
Seconds (<1 min)	BPPV • Superior canal dehiscence • Vestibular paroxysmia
Minutes (5–60 min)	Vestibular migraine • TIA
Hours (20 min – several hr)	Ménière's disease • Vestibular migraine
Days (continuous >24 h)	Vestibular neuritis / labyrinthitis • Posterior circulation stroke
Weeks – months continuous	PPPD • Bilateral vestibular loss • Cerebellar disease

Triggers — Ask specifically

- **Positional.** Rolling over, lying flat, looking up, bending forward → BPPV until proven otherwise. Do Dix-Hallpike same visit.
- **Orthostatic.** Standing from sitting/lying → orthostatic hypotension, autonomic failure, POTS. Active stand test.
- **Visual.** Supermarket aisles, screens, crowds, patterned floors, highway driving → PPPD or vestibular migraine (high specificity).
- **Valsalva / loud sound.** Superior canal dehiscence; perilymph fistula.
- **Migrainous.** Sleep deprivation, hormonal cycle, stress, specific foods → vestibular migraine.
- **Exertion / head movement.** Bilateral vestibular loss; rarely exercise-induced vertigo.

Taking a Dizziness History — *Diagnostic Categories, Red Flags & Referral*

Associated Symptoms — What narrows the differential

Symptom cluster	Suggests
Hearing loss / fullness / tinnitus (episodic)	Ménière's disease
Acute unilateral SNHL + vertigo	Labyrinthitis • AICA stroke • Vestibular schwannoma (rare acute)
Headache, photophobia, phonophobia, aura	Vestibular migraine
Diplopia, dysarthria, limb weakness, ataxia	Posterior circulation stroke / TIA
Nausea, vomiting, sweating, pallor on standing	Orthostatic / autonomic dizziness
Chronic unsteadiness worse with visual motion	PPPD • Vestibular migraine

The Four Diagnostic Categories (Timing × Trigger)

AVS — Acute Vestibular Syndrome
Continuous vertigo, days
Vestibular neuritis / labyrinthitis; posterior circulation stroke (up to 25%)

s-EVS — Spontaneous Episodic
Episodic, no trigger
Vestibular migraine; Ménière's disease; TIA

t-EVS — Triggered Episodic
Episodic, clear trigger
BPPV (most common); orthostatic hypotension; superior canal dehiscence

Chronic
>3 months, non-episodic
PPPD; bilateral vestibular loss; cerebellar disease

Red Flags — Refer / Investigate Urgently

▸ Central features — urgent

- Direction-changing, vertical or torsional nystagmus • Normal head impulse in acute vertigo • Skew deviation on cover test
- New severe headache ("thunderclap") • Diplopia, dysarthria, dysmetria, hemiparesis, sensory disturbance
- Inability to stand / walk disproportionate to vertigo • Isolated vertigo with vascular risk factors (ABCD2 ≥4)
- Acute vertigo with new ipsilateral deafness → AICA stroke until proven otherwise

▸ Ear / audiology emergencies

- Sudden SNHL (>30 dB over 3 frequencies within 72 h) ± vertigo → same-day ENT; oral prednisolone 1 mg/kg within 72 h.

When to Refer a Vestibular Physician

- **Diagnostic uncertainty** after structured history + bedside exam.
- **Recurrent / resistant BPPV** — >3 episodes/year, failed 2 Epleys, atypical nystagmus, or associated hearing change.
- **Suspected Ménière's** — for confirmation (audiometry, VFTs) and longitudinal management.
- **Vestibular migraine** — frequent episodes despite trigger management; considering prophylaxis.
- **Chronic dizziness >3 months** without clear structural cause — suspect PPPD; VR + SSRI + CBT.
- **Post-concussive dizziness >4 weeks** — often multiple overlapping mechanisms.
- **Falls with vestibular component** or suspected bilateral vestibular hypofunction (presbyvestibulopathy).