WHY IT MATTERS

OH affects 6-10% of community adults, 20-30% of those over 75, >50% of nursing-home residents. Independent predictor of falls, fracture, cognitive decline, and mortality. In Australian GP cohorts >1 in 5 dizzy patients have OH or a clinically significant medication-induced postural drop. A 5-minute bedside test plus a structured medication review is curative in 30-40% of cases.

THE FIVE ORTHOSTATIC SYNDROMES - THE STAND TEST DEFINES THEM

Syndrome	Definition (vs supine baseline)	Typical context
Initial OH	SBP fall >40 / DBP fall >20 mmHg in <30 s; recovers by 60 s	Young; rapid risers; dehydration
Classical OH	Sustained SBP fall >=20 / DBP fall >=10 mmHg in 1-3 min	Older; medication; volume loss
Delayed OH	Drop appears only after 3 min standing	Elderly; early autonomic dysfunction
Neurogenic OH	Profound BP fall WITHOUT compensatory HR rise	Parkinsonism, MSA, diabetes, amyloid
POTS	HR rise >=30 bpm (>=40 if <19y) in 10 min, BP preserved	Adolescents, young women; post-viral

THE ACTIVE STAND TEST - HOW TO DO IT IN 10 MINUTES

Method

1. Supine 5 min in a quiet room - record baseline BP & HR.
2. Patient stands actively (not assisted) - feet uncrossed.
3. Record BP & HR at 1, 3, 5, and 10 minutes.
4. Document symptoms timed against each reading.
5. Sit immediately if presyncopal - terminate test.

Common errors

- Single 1-min reading misses initial AND delayed OH.
- Sitting up (passive) blunts gravitational stress.
- Ignoring symptoms with preserved BP - HR rise still matters.
- Failing to bring meds to the visit for review.

♦ **Pearl:** A normal 1-min reading does NOT exclude OH. Approximately 20-30% of older adults with symptomatic orthostatic intolerance have only initial or delayed OH.

HISTORY CUES THAT POINT TO ORTHOSTATIC CAUSE

Patient says...

"Lightheaded when I stand up or get out of bed."
"Worse first thing in the morning / after meals / hot showers."
"Vision blurs or greys out for a few seconds."
"Coathanger ache - back of neck and shoulders on standing."
"Better when I sit or lie down."

Always ask

- All current medications - prescribed AND OTC (including sildenafil, nitrates).
- Recent dose changes / new agent / dose escalation.
- Falls - even one fall in 12 months.
- Fluid and salt intake; alcohol use.
- Past history: diabetes, Parkinsonism, autonomic neuropathy.

HIGH-RISK MEDICATIONS - STOP / SWITCH / REDUCE

Class	Examples	Action
Alpha-blockers	Tamsulosin, prazosin, doxazosin	Substitute / nocturnal dose / 5-ARI for BPH
ACE-I / ARB	Perindopril, ramipril, telmisartan	Halve dose; review BP target in elderly
Diuretics	Frusemide, indapamide, hydrochlorothiazide	Reduce/stop if no clear indication
Beta-blockers	Metoprolol, atenolol, bisoprolol	Substitute (CCB) where indication permits
Antidepressants	TCAs > SNRIs > SSRIs	Switch from TCA; SSRI usually OK
Antipsychotics	Risperidone, olanzapine, clozapine	Lowest effective dose; falls-risk MDT
Anti-Parkinson	L-dopa, dopamine agonists	Coordinate with neurology; do not stop abruptly
Opioids/sedatives	Tramadol, morphine, benzodiazepines	Deprescribe where possible
PDE-5 / Nitrates	Sildenafil, GTN	Educate; avoid combination

♦ **Pearl:** For every dizzy patient on antihypertensives, ask: what is the evidence-based BP target for THIS patient? In a frail 85-year-old, 140/90 is supported by SPRINT-MIND and HYVET.

MANAGEMENT - NON-PHARM FIRST, ALWAYS

Step 1: Non-pharmacological

- Fluid 2-3 L/day; salt 6-10 g/day (caution: HF / HTN / CKD).
- Compression: thigh-high stockings (>=20-30 mmHg) +/- abdominal binder.
- Slow rising: sit 30 s before standing; flex calves first.
- Counter-manoeuvres: leg cross, squat, toe raise, abdominal contraction.
- Head-up tilt of bed 10-20 degrees overnight.
- Avoid hot baths, large meals, alcohol, prolonged still standing.
- Graded recumbent exercise (cycling, rowing, swimming).

Step 2: First-line drugs (after 4-6 weeks)

MIDODRINE 2.5 mg TDS -> target 5-10 mg TDS. Avoid within 4 h of bed.

FLUDROCORTISONE 0.05 mg mane -> 0.1-0.2 mg. Watch K+, oedema, supine HTN.

Both: start low, titrate over 2-4 weeks.

Combination if monotherapy fails - check supine BP each visit.

Step 3: droxidopa, pyridostigmine, atomoxetine via autonomic clinic.

RED FLAGS - REFER OR ED

Immediate (ED / cardiology)

- Syncope with injury or exertional syncope.
- Family history sudden cardiac death.
- Chest pain, palpitations, dyspnoea, focal neurology.
- Supine HTN >180/110 with neurogenic OH.
- Suspected arrhythmia or structural cardiac cause.

Routine referral

- Vestibular physician: overlap with BPPV, VM, PPPD, POTS; uncertain dx.
- Cardiology / autonomic clinic: POTS, refractory neurogenic OH, HUTT.
- Geriatrician / falls clinic: frail elderly, polypharmacy, recurrent falls.
- Movement disorders: suspected MSA, Parkinsonian autonomic failure.

PUTTING IT TOGETHER - THE 15-MINUTE GP CONSULT

In the room

1. History: onset, triggers, falls, ALL medications.
2. Active stand test: 1, 3, 5, 10 min - record symptoms.
3. Cardiac and bedside vestibular screen.
4. Identify culprit drugs - structured medication review.
5. Initiate non-pharmacological measures + patient handout.

After the visit

- Bloods: FBC, EUC, glucose, HbA1c, B12, TSH.
- ECG if palpitations / syncope / structural concern.
- 24-hr ABPM if non-dipper or supine HTN suspected.
- Review at 4 weeks: stand test, symptoms, falls.
- If lifestyle alone fails - midodrine OR fludrocortisone.

♦ **Important:** Vestibular suppressants (prochlorperazine, betahistine, cinnarizine, benzodiazepines) are NOT appropriate for orthostatic dizziness - they worsen postural BP control and increase falls risk.