WHY IT MATTERS

Dizziness affects 30% of community-dwelling adults over 65 and over 50% beyond age 80. It is a multifactorial geriatric syndrome — older patients average 3.5 contributing causes. Each contributor adds risk additively; identifying and trimming each one reduces dizziness and falls more than any single intervention. A 10-minute bedside set + a structured medication review is curative or substantially improves outcomes in over 60% of cases — far more than any single drug or intervention.

THE SIX CONTRIBUTING SYSTEMS — LOOK FOR EACH

System	What to look for	Common drivers
Vestibular	Presbyvestibulopathy, BPPV, bilateral vestibular hypofunction	VOR loss; head-position triggers; oscillopsia
Cardiovascular	Orthostatic & postprandial hypotension, arrhythmia, AS	Antihypertensives; volume loss; vasovagal
Visual	Cataract, AMD, low contrast sensitivity, bifocal lenses	Annual eye review; single-vision lenses for stairs
Proprioceptive	Diabetic neuropathy, cervical spondylosis, sarcopenia	Foot screen; lower-limb strength; resistance training
Central	Cerebral small-vessel, lacunar, NPH, Parkinson disease	Cognitive screen; gait apraxia; medication review
Medication	Anticholinergics, sedatives, suppressants, antihypertensives	Beers / STOPP-START; deprescribe in priority order

THE BEDSIDE 10-MINUTE WORK-UP — SIX DOMAINS

Method (six domains, ~10 min)

1. Gait + tandem 3 steps; aid use, turn quality, stance width.
2. Oculomotor: HINTS only if active vertigo; head impulse alone otherwise.
3. Dix-Hallpike on every older faller (supine roll if Dix-Hallpike negative).
4. Orthostatic BP: supine 5 min, then 1 + 3 min standing; drop ≥ 20/10.
5. Lower limb + cognition: proprioception, sit-to-stand × 5, Mini-Cog.
6. Hearing screen: whispered voice or finger-rub each ear; ask about asymmetry.

Common pitfalls

- Skipping Dix-Hallpike unless patient volunteers head-position triggers.
- Single 1-min orthostatic reading misses delayed (3-min) OH.
- HINTS in non-acute / non-vertiginous patients (uninterpretable).
- Calling tandem-stand "normal" without 10-second hold.
- Forgetting to ask "what have you stopped doing because of dizziness?"

♦ Pearl: BPPV is present in 9% of community fallers and up to 40% of injured fallers. Two-thirds have not connected dizziness to head-position triggers. Dix-Hallpike on every older faller — high-yield, treatable, missed daily.

HISTORY CUES POINTING TO MULTIFACTORIAL DIZZINESS

Patient says...

"Unsteady on uneven ground, worse in dim light or on grass."
"Lightheaded when I get out of bed or stand up from a chair."
"Dizzy after a hot shower or about half an hour after a big meal."
"I've stopped going to the shops, the gym, or driving on my own."
"I had to grab the rail / kitchen bench / wall again last week."
"I have to think about my feet now — I never used to."
"It's worse in supermarkets — the lights, the aisles, the lines."

Always ask

- Falls in 12 months — number, mechanism, injury, fear of falling.
- Postural triggers: out of bed → standing → after meals or hot showers.
- Head-position triggers: rolling over, looking up, lying flat for dentist.
- Every medication + recent dose change (incl. OTC, sleep aids, antihistamines).
- Hearing change, asymmetry, tinnitus; functional impact — what has stopped?
- Visual environments: supermarkets, scrolling screens, patterned carpets.
- Cognitive concern: any recent change in memory, attention, or word-finding.

HIGH-RISK MEDICATIONS — STOP / SWITCH / REDUCE

Class	Examples	Action
Antihypertensives	Alpha-blockers, diuretics, ACE-I, ARB	Liberalise BP target for frailty; deprescribe alpha-blockers + diuretics first
Benzodiazepines / Z-drugs	Diazepam, temazepam, zopiclone	Slow taper over 8–12 weeks; CBT-I
Anticholinergics	Oxybutynin, amitriptyline, sedating antihistamines	Calculate ACB burden; substitute lower-burden alternatives
Opioids	Codeine, tramadol, oxycodone	Lowest effective dose; reassess every visit
Tricyclics	Amitriptyline, dothiepin, nortriptyline	Switch to SSRI / mirtazapine
Antipsychotics	Risperidone, olanzapine	Avoid in dementia; if used: lowest dose, time-limited
Vestibular suppressants	Prochlorperazine, promethazine, betahistine (chronic)	Limit to 48–72 h; never long-term
Other sedatives	Pregabalin, gabapentin, sedating analgesics	Review indication; trial dose reduction

♦ **Pearl: Each medication beyond five doubles falls risk. Beers + STOPP/START tools structure deprescribing. Biggest yields: alpha-blockers, benzodiazepines, anticholinergics, tricyclics, prolonged vestibular suppressants.**

MANAGEMENT — MULTIDOMAIN, ALWAYS

Step 1: Treat what you find

- Vestibular rehab — gaze-stabilisation, balance, habituation; 12 wk supervised.
- BPPV: Epley with foam wedge for cervical spondylosis; refer if technique limited.
- Strength + balance: Otago programme, supervised Tai Chi.
- Vision: annual review; single-vision lenses for stairs; cataract surgery.
- Vitamin D + footwear (closed-heel, low-rise, non-slip).

Step 2: Trim contributors

- Deprescribe in priority order — alpha-blockers, benzos, anticholinergics first.
- Liberalise antihypertensive targets for frailty; deprescribe one agent at a time.
- Orthostatic measures: slow rises, leg crossing, abdominal binding, raise HOB 10–20°.
- Compression to mid-thigh if tolerated; salt + fluid where safe.
- OT home hazard review: rugs, lighting, bathroom rails, stair contrast.

RED FLAGS — REFER OR ED

Immediate (ED / urgent)

- New focal neurology with vertigo — posterior stroke.
- Sudden hearing loss with vertigo — SSNHL emergency, oral steroids <72 h.
- New severe headache with dizziness — central pathology.
- Drop attacks (Tumarkin / vertebrobasilar).
- Sudden orthostatic syncope — exclude bleed, sepsis, autonomic failure.

Routine referral

- Vestibular physician: presbyvestibulopathy, bilateral hypofunction, refractory BPPV.
- Recurrent falls (≥2 in 12 m) with vestibular component → vestibular physician + falls clinic.
- Diagnostic uncertainty after multidomain workup.
- Persistent symptomatic OH despite deprescribing → autonomic clinic.

PUTTING IT TOGETHER — THE 15-MINUTE GP CONSULT

In the room (~15 min)

1. TiTrATE history + falls + postural + head-position + medications.
2. Bedside 6-domain set in 10 minutes.
3. Falls screen: TUG, tandem stand 10 s, sit-to-stand × 30 s.
4. List contributors; rank by modifiability; frame the plan.
5. Patient line: "many small causes, each treated in parallel."

After the visit

- Bloods (FBC, EUC, glucose, HbA1c, B12, TSH, 25-OH D); ECG if relevant.
- Vestibular function testing if presbyvestibulopathy / BVH suspected.
- OT home review for high-risk fallers; physio for vestibular rehab + Otago.
- Review at 4–6 weeks: re-screen, recheck orthostatic, reassess meds.

♦ **Important: Avoid prochlorperazine, promethazine, betahistine, and benzodiazepines for chronic dizziness in older adults — they suppress central compensation, increase falls, and worsen cognition. Acute use 48–72 h only.**