Emergency Department Vertigo Assessment

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Does this dizzy patient have vertigo

It can be hard to distinguish vertigo from lightheadedness/pre-syncope from ataxia from generalized weakness or even just malaise. But sometimes it's not hard, so it's worth the time to try, because you can narrow the differential considerably. Vertigo patients should see **movement**. The room should be spinning. This is different than feeling faint, which is more common.

Does the patient have red flags for central vertigo

- Neurological symptoms or exam findings: focal motor/sensory deficit, diplopia, dysarthria, dysmetria, dysphonia, dysphagia
- vertical or multi-directional nystagmus
- prominent headache or neck pain
- cannot walk
- progressive, non-episodic course

If yes, pursue stroke

no

Does the patient have prior stroke or stroke risk factors

atrial fibrillation not on/adherent to anticoagulation, old age, smoker, diabetes, hypertension, atherosclerotic vascular disease (CAD, PAD, chronic kidney disease)

Does the patient have green flags that suggest peripheral vertigo

- brief, recurrent position-triggered symptoms
- position-triggered horizontal nystagmus
- prior congruent episodes
- ear pain or tinnitus (but not hearing loss–hearing loss may increase risk of central etiology)
- recent viral illness, ear surgery or trauma

Compare strength of central vs. peripheral vertigo features to determine need for stroke rule-out. If not sure, use shared decision-making, err on the side of rule-out

If the patient has no red flags, and has spontaneous (non-positional) nystagmus, feel free to apply HINTS testing *if you are confident you know how to do it*. Recognize that most physicians who are not very fluent in HINTS do it wrong