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Dizziness/Vertigo: Immediate Care for Sudden Onset

WARNING: IF SYMPTOMS SUGGEST A STROKE OR MI, CALL 911.

1. **Have the patient lie down and remain still. Calm and reassure the patient.**
2. **Do not leave the patient unattended. Get help to summon a supervising clinician. The clinician will lead the care. *Use this protocol as a checklist*.**
3. **If the patient is nauseated, get waste basket.**
4. **Take blood pressure, pulse, and respiratory rate, if necessary.**
5. **If the patient complains of feeling faint or appears such, send someone for smelling salts or oxygen.**
6. **If the patient exhibits symptoms of shock, elevate the feet.**
7. **Place a cold compress on neck and cover the patient with a blanket, if necessary.**
8. **Check to see if the patient has a medical alert bracelet.**

History

- What brought on this episode?
- Is this true vertigo? Dizziness/light headedness? Pre-syncope? Dysequilibrium? Mild seizure disorder?
- Are there additional symptoms, such as nausea, diplopia, limb weakness, loss of sensation, incoherence (is patient oriented to person, place, and time?), severe headache, tinnitis, slurred speech, or balance/coordination problems? Any chest pain? Heart palpitations?
- Have there been prior episodes? How do they compare to the present one?
- Is the patient sick, recent flu, for example?
- Is the patient dehydrated or hypoglycemic (record time of last meal)?
- Review medications the patient may be taking (especially any new meds, change in dosage, "borrowing" of someone else's medication, illicit drug use). Using supplements?
- Is there a personal or family history of stroke, vascular disease, diabetes, seizures?

Evaluation

Observe carefully and record: Does the patient appear to be disoriented, uncoordinated, or exhibit symptoms of shock?

Do brief neurological evaluation

- Can patient move hands and feet?
- Is there nystagmus (fixed gaze and six cardinal fields of gaze), proper pupillary response, peripheral vision intact (unilaterally tested)?
- Proper sensation in face, hands, and feet? Any facial paralysis?
- Test grip strength, ankle strength, Babinski reflex?
- If necessary, conduct a more extensive neurological exam: for example, cerebellar tests, test hearing if Ménière's disease is suspected, test vibratory and position sense in cases of dysequilibrium.

Consider the following:

- Auscultation of the heart and carotids (especially in older patient).
- Otoscopic exam.
- Palpation of neck for spasm, rigidity.
- Having the patient slowly move the head to different positions to see if it decreases the dizzi-

ness or vertigo. When the episode resolves, consider head hanging test (Nylen-Barany Maneuver, Dix-Hallpike Maneuver) and/or neck torsion test (swivel test) during this or a subsequent visit.
- Glucose test (finger stick)

Intervention

- If the patient is dehydrated and if symptoms are more dizziness than true vertigo, consider giving fluid or juice.
- If appropriate, notify the patient's primary care giver while the patient is still in the clinic.
- If symptoms resolve or dramatically lessen, observe the patient until stabilized and then send the patient home (helping arrange for a driver if necessary).
- Tell the patient about red flags for going to the emergency room, most of which are enumerated under History, third bullet.
- If symptoms progress or are severe and show no improvement, consider calling 911.
- Record what brought on this episode, including the exact time if symptoms are severe, and place a Treatment Alert in the chart.
- Arrange for subsequent phone contact to check on patient progress.

If symptoms occur immediately after an adjustment.

- If it occurs while the patient's head is still in the practitioner's hands, carefully return the head to neutral position.
- The supervising clinician should find out what type of manual therapy was rendered.
- Do NOT adjust the patient again until the presumed side-effects resolve and a reasonable explanation has been found.
- If there is strong evidence that the symptoms were likely to be due to an unrelated cause (e.g., a displaced canalith or positional vertigo), the clinician may cautiously render appropriate spinal care.
- Under no circumstances should an intern deliver such care during this visit.
- Do not place the patient's head in significant degrees of extension and rotation.
- Take any of the other steps outlined in this document as deemed appropriate.

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