TAKING THE HISTORY FROM A DIZZY PATIENT: WHY “WHAT DO YOU MEAN BY DIZZY?” SHOULD NOT BE THE FIRST QUESTION YOU ASK


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Introduction:

Context: Traditional teaching instructs clinicians to classify dizziness as vestibular if the patient reports vertigo, cardiovascular if the patient reports presyncope, neurologic if the patient reports disequilibrium, and psychiatric or metabolic if the patient reports non-specific symptoms. It is unknown whether patients can describe their symptom quality well enough to be classified as one of the four “types” of dizziness.

Objective: To determine whether dizzy patients can clearly, consistently, or reliably report symptom quality, and, secondarily, symptom timing or triggers.

Methods:

Design: Prospective, cross-sectional study

Setting: Two urban, academic Emergency Departments (EDs)

Patients: Adult ED patients (24x7 recruitment). Exclusions: Unable to be interviewed, risk to research assistant. Inclusions: “Dizzy, lightheaded, or off balance” ≤ 7 days, or “bothered” by same in the past. 5415 total patients, 1674 screened, 872 met inclusions, 316 completed interview.

Main Outcome Measures: Description of dizzy quality elicited by four questions in different formats (open-ended, multi-response, single-choice, directed questions). Clarity assessed qualitatively (vague, circular, etc.) and quantitatively (dizzy “type” overlaps). Consistency measured by frequency of inconsistent responses across question formats. Reliability determined by test-retest.

Results:

Clarity: Open-ended descriptions were frequently vague or circular. 62% selected >1 dizzy type on multi-response question. Consistency: On same question, 54% did not pick at least 1 type endorsed in open description. Of 218 subjects not identifying vertigo, spinning, or motion on first 3 questions, 70% endorsed “spinning or motion” on directed questioning. Reliability: Asked to choose single best descriptor, 52% picked different response on “retest” ~6min later. Relative to qualitative descriptors, reports of dizziness timing and triggers were non-overlapping, internally consistent, and reliable.

Conclusion:

Descriptions of dizzy quality are often vague and overlapping, internally inconsistent, and unreliable, casting doubt on the validity of the traditional approach to the dizzy patient. Alternative approaches, emphasizing “timing and triggers” over “type,” should be investigated.

References:


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