include nonvestibular imbalance, gait disorders (e.g., loss of proprioception from sensory neuropathy, parkinsonism), and anxiety.

When evaluating patients with dizziness, questions to consider include the following: (1) Is it dangerous (e.g., arrhythmia, transient ischemic attack/stroke)? (2) Is it vestibular? (3) If vestibular, is it peripheral or central? A careful history and examination often provide sufficient information to answer these questions and determine whether additional studies or referral to a specialist is necessary.

## APPROACH TO THE PATIENT

# Dizziness

### HISTORY

When a patient presents with dizziness, the first step is to delineate more precisely the nature of the symptom. In the case of vestibular disorders, the physical symptoms depend on whether the lesion is unilateral or bilateral, and whether it is acute or chronic. Vertigo, an illusion of self or environmental motion, implies an acute asymmetry of vestibular inputs from the two labyrinths or in their central pathways. Symmetric bilateral vestibular hypofunction causes imbalance but no vertigo. Because of the ambiguity in patients' descriptions of their symptoms, diagnosis based simply on symptom characteristics is typically unreliable. Thus the history should focus closely on other features, including whether this is the first attack, the duration of this and any prior episodes, provoking factors, and accompanying symptoms.

Dizziness can be divided into episodes that last for seconds, minutes, hours, or days. Common causes of brief dizziness (seconds) include benign paroxysmal positional vertigo (BPPV) and orthostatic hypotension, both of which typically are provoked by changes in head and/or body position relative to gravity. Attacks of vestibular migraine and Ménière's disease often last hours. When episodes are of intermediate duration (minutes),