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Natural history and management of dizziness: putting evidence into practice

DIZZINESS falls into the category of undifferentiated illness, which forms a substantial part of our work in general practice. I suspect that it may not be one of the more satisfying symptoms to treat, as successful outcomes are often difficult to achieve. Two articles in this month's *BJGP* highlight the importance of this condition. They pose two specific questions: 'how common is the condition?' and 'how can optimum treatment be put into practice?'.

Yardley *et al*[1] surveyed a one-in-three sample of adult patients in four practices who completed a questionnaire exploring the presence of symptoms in the previous month. The results showed that around one in five responders had experienced dizziness during the past month; almost half of these reported some degree of handicap and approximately one-third had symptoms of dizziness over a period of five years. Around half of those with dizziness also reported symptoms of anxiety; multiple physical and psychological symptoms were associated with high levels of handicap. The frequency of dizziness seems high compared with other studies, which have shown levels of 10% for women and 6% for men, with consultation rates of 1.3 per 1000 consultations per year.[2] These differences in findings may relate to the types of questionnaire used, and it is difficult to decide which is the more accurate figure. Suffice it to say that the problem is a common one.

The unanswered question is 'what comes first?': the psychological problem or the dizziness? The extent to which an underlying propensity to anxiety predisposes a patient to dizziness is difficult to tease out, but it may be too easy to label people as 'anxious' if they consult frequently with non-specific problems.

It was somewhat surprising to discover that only one in four of the responders who experienced episodes of dizziness had received any form of treatment. Had they been dismissed as 'worried well', or had their symptoms not been taken seriously? The fact that 40% of those with dizziness and who were working reported occupational difficulties emphasized the disturbance that these patients experienced. Overall, the finding of symptomatic prevalence in the community of more than 20% and recorded annual consultation rates of less than 2% show that there is a significant number of cases where dizziness is a persistent and untreated complaint.

While the causes of dizziness are well described in standard text books, management recommendations tend to concentrate on a range of drug treatments. In practice, the extent to which drug treatments are successful is often unknown and the side-effects of many of the drugs used in caring for patients with dizziness may result in unsatisfactory outcomes.

Yardley *et al*[3] investigated the use of vestibular rehabilitation (VR) in the management of persistent dizziness where no underlying pathology is found. VR takes 30 to 40 minutes and involves eight sets of standard head and body movements performed twice daily, supplemented with training in relaxation and slow breathing. In a randomized controlled trial, the authors demonstrated significant improvements compared with controls in patients receiving VR, in terms of postural control and reports of symptoms and emotional states.

Two important findings emerge from these studies. First, dizziness is a common problem; secondly, vestibular rehabilitation is a successful method of treatment. The second finding raises questions about the application of research results to everyday practice. At a time when 'getting evidence into practice' is being actively promoted, how can the results of these projects be acted upon?

From the results described, for every thousand adult patients aged 18 to 64, there will be around 200 with reported episodes of dizziness, 100 of whom will have some degree of handicap; between 60 and 70 of these will have had a problem for more than five years. In a five-partner practice of 10 000 patients, of whom approximately 7500 will be adults, there may be 750 potential patients who will report some degree of handicap that may benefit from VR.

The next question is who is going to conduct the management programme? It is unlikely that a general practitioner can fit 30- to 40-minute sessions into routine surgeries, and, from all accounts, practice nurses are similarly stretched for time.

Acquiring skills in conducting VR does not appear to be too difficult, but the extent to which an individual practice can accommodate this method of treatment into current patterns of general practice workload is unclear. This is not the only example of a procedure that will take longer than the average 7.5 minutes consultation, and if general practitioners are going to apply new techniques then the whole method of working arrangements will need to be reappraised.

To traditionalists, the notion of 'specialization' within general practice hits a raw nerve, yet without this patients may not benefit from appropriate treatments or may join ever-lengthening queues in specialist outpatient clinics. The lessons from these studies are not merely about identifying a frequently occurring symptom and improving methods of treatment; they address the need to confront time-honoured methods of working that merely react to problems rather than create systems of optimizing care for patients with common problems.

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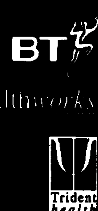

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