

Strategies for managing patients with chronic subjective dizziness

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Chronic subjective dizziness (CSD) is characterized by persistent (>3 months) dizziness, lightheadedness, or unsteadiness, without vertigo or ataxia. Symptoms often are worse in highly stimulating visual environments (eg, busy malls or grocery stores) or settings with indistinct visual orientation cues (eg, large open areas, heavy fog). Neuro-otologic examination and laboratory testing reveal no active vestibular deficits.¹

CSD is not a psychiatric illness, but exists at the interface of psychiatry and neuro-otology. For example, anxiety and depressive disorders often accompany CSD, but are not an integral part of it. Treatment outcomes are good and prognosis for full function is high.

Conditions that cause dizziness

Vertigo—a sensation of rotation or linear movement of self or surroundings—occurs in discrete attacks that typically have an acute onset and are caused by neuro-otologic conditions.² Symptoms may last for seconds (benign paroxysmal positional vertigo [BPPV]), hours (Meniere's disease), minutes to days (vestibular migraine), or weeks (vestibular neuronitis). Unsteadiness, a swaying or rocking sensation, dizziness, and a disturbed sense of spatial orientation without illusory movement may be acute, subacute, or chronic. These symptoms may accompany vertigo or occur independently.² Psychiatric disorders (panic), dysautonomias (vasovagal spells), and cardiovascular conditions (dysrhythmias) may cause episodic unsteadiness and dizziness, but not vertigo. Several illnesses can cause persistent unsteadiness and dizziness, including

bilateral peripheral vestibular deficits, central vestibular lesions (strokes), proprioceptive or visual loss (neuropathies), and generalized anxiety disorder.

Up to 30% of patients who experience episodic balance problems develop persistent unsteadiness or dizziness (ie, CSD).³ Clinical history, exam, and laboratory tests may be normal or identify previous triggering events (eg, past vestibular insults), but transient conditions cannot explain patients' persistent symptoms. Often, patients describe a transition from episodic vertigo and ataxia to chronic, often daily unsteadiness and dizziness. In this situation, the illness that started the problem often is not the one that continues to be distressing. Rather, patients develop hypersensitivity to motion stimuli (visual, vestibular, and proprioceptive inputs) and hypervigilance about motion environments that last long after the trigger event has resolved. These CSD features are thought to arise from threat-related failure of postural control systems to return to normal functioning after shifting into high-risk strategies during the acute events that disrupted balance.

5 strategies for managing CSD

1. Develop a common language among other clinicians you work with. The concept of CSD will be new to most patients and their referring clinicians, so they will need to hear about it more than once. From a neuro-otologic standpoint, make a point of separating past and present problems (ie, not the vestibular neuronitis, BPPV, etc., that the patient previously had, but the CSD they presently have). From a psy-

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Pharmacotherapy, VBRT, and CBT help provide good treatment outcomes for CSD patients

chological standpoint, talk in behavioral terms—hypersensitivity to motion, hypervigilance about motion environments, use of safety maneuvers (eg, touching a wall when walking), and avoiding situations that provoke dizziness. These are reflexive, fear-driven symptoms, but patients understand them better in terms of dizziness and unsteadiness.

2. Keep in mind that dizziness is the chief complaint. As patients go from primary care to otolaryngology, audiology, vestibular rehabilitation, and psychiatry, the problem is dizziness. You may find anxiety or depression along the way, but dizziness comes first for these patients.

3. Educate patients and referring physicians. Give patients and their referring physicians materials that define CSD and its differential diagnosis.³ Check off patients' symptoms in the diagnostic list and circle their medical comorbidities, if present. For psychiatrists, this is a good point to start discussing behavioral morbidity and treatment.

4. Screen for coexisting medical-psychiatric diagnoses (eg, Meniere's disease, panic disorder) or primarily psychiatric problems (conversion disorder). In addition to the otologic exam for vestibular diseases, patients should be screened for migraine, traumatic brain injury, dysautonomia, and dysrhythmias. Ask patients to complete symptom self-reports, including the Patient Health Questionnaire-9 (for depression) and Generalized Anxiety Disorder-7 (for anxiety).

5. Treat the patient's primary problem (eg, CSD, vertigo, ataxia, or headache) first. If headache and balance symptoms are intertwined, use venlafaxine or combine a selec-

tive serotonin reuptake inhibitor (SSRI) with a separate migraine prophylactic agent.

Treatment options

Treatment outcomes are good and prognosis for full function is high when using the following options:

Pharmacotherapy. Five open-label studies found SSRIs are effective for CSD even for patients without psychiatric comorbidity.³ Use a "start low, go slow" strategy to avoid aggravating symptoms. Final doses usually are in the lower half of the therapeutic range. Full treatment response may take 8 to 12 weeks. Vestibular suppressants such as meclizine work reasonably well for acute vertigo, but have no role in treating CSD.

Vestibular and balance rehabilitation therapy (VBRT) is an exercise program performed at home by patients but overseen by specially trained physical therapists. It is an excellent habituation/desensitization program that can be integrated with medication and psychotherapy. All patients with CSD should undergo VBRT.

Cognitive-behavioral therapy may be helpful for treating psychiatric morbidity (anxiety, depression, phobic avoidance) in patients with CSD, but it appears to be less effective for physical symptoms of dizziness.³

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