

Overview

This guideline addresses both acute and chronic (episodic or persistent) types of dizziness, including vertigo, in adults presenting to general practitioners or specialists.

Dizziness is a frequent reason for consultations in outpatient care. While many forms of dizziness are benign, they can appear alarming or even threatening. Not all causes can be identified, and not all types of dizziness have specific treatments available.

The most common conditions associated with dizziness, such as benign paroxysmal positional vertigo (BPPV), acute unilateral vestibulopathy (AUV), Menière's disease, and functional or cardiogenic dizziness, can often be identified in general practice. Familiarity with and skill in performing the four key vestibular system tests often allows for correct diagnosis and, in some cases, treatment. Underlying cardiovascular causes should also be considered. When central nervous system disorders, Menière's disease, or vestibular migraine are suspected, referral is usually necessary. This may also be the case in dizziness caused by cardiac factors. Rare or congenital causes of dizziness often require consultation with neurology, otolaryngology, cardiology, or (neuro)radiology. Particular caution is warranted in acute dizziness; see the section on potentially dangerous courses below. In cases of acute central dizziness, immediate hospital referral is required.

Diagnosis

The following table classifies different types of dizziness and accompanying symptoms according to various criteria and probable diagnoses. This table lists only a selection of diagnoses that are frequently encountered or should not be missed in general practice; a more complete overview can be found in Table 4.1 of the extended version.

Tab. 8.1 Selection of Common Causes of Dizziness in General Practice

Symptom duration	Triggering/Modulating/Relieving Factors	Type of Dizziness	Accompanying Symptoms	Likely Diagnosis
Seconds	Head movements relative to gravity	Spinning dizziness	Nausea, possibly vomiting	Benign paroxysmal positional vertigo (BPPV)
Seconds/Minutes		Momentary gait/stance instability, drop in blood pressure leading to syncope	Arrhythmias, near syncope	Tachy-/bradyarrhythmias
Seconds/Minutes	Standing up from lying/sitting	Lightheadedness, drop in blood pressure leading to syncope	Impending feeling of faintness upon standing	Orthostatic hypotension
Seconds/Minutes	Physical exertion	Lightheadedness, rarely syncope	Dyspnea, especially on exertion	Obstructive cardiac diseases including aortic stenosis

Symptom duration	Triggering/Modulating/Relieving Factors	Typ of Dizziness	Accompanying Symptoms	Likely Diagnosis
Minutes/Hours		Spinning or (rarely) swaying dizziness	Hearing impairment, hearing loss, tinnitus, ear pressure, possibly vomiting, possibly nystagmus	Menière's disease
Minutes/Hours		Spinning or swaying dizziness	Headache, nausea, light/noise sensitivity, history of migraine, possibly vomiting, possibly nystagmus	Vestibular migraine
Minutes/Hours		Spinning or swaying dizziness	Paralysis, speech disorders, possibly double vision or altered consciousness	Transient ischemic attack (TIA)
Minutes/Hours	Hypoglycemia in diabetes (e.g., due to fasting)	Swaying dizziness	Sweating, restlessness, cravings	Hypoglycemia
Days	Sudden onset, worsens with movement	Spinning dizziness, impaired balance and gait with a tendency to fall	Nystagmus, nausea and vomiting, visual disturbances	Acute unilateral vestibulopathy (AUV), formerly vestibular neuritis
Days		Spinning or swaying dizziness	Additional neurological symptoms	Brainstem/cerebellar infarct or hemorrhage
Months/Years	Worsens in darkness or on uneven ground	Gait instability, possibly dizziness; patient describes sensation of walking on a soft, unstable surface	Numbness or burning sensation in feet	Polyneuropathy (PNP)
Months/Years	Anxiety, sensitivity to movements, moving visual stimuli, and crowds	Dizziness, different types of dizziness including organic causes of dizziness	Situational reinforcement and avoidance behavior, anxiety disorders, panic attacks, depression	Functional dizziness

Potentially Dangerous Courses & Warning Signs

Preventable and potentially dangerous courses should always be considered, especially central causes (e.g., hemorrhages/infarcts in the brain, brainstem, and cerebellum), cardiac arrhythmias, obstructive heart disease, and infections (e.g., herpes zoster). For most forms of dizziness, characteristic symptoms and findings are often, but not always, present, allowing classification according to Table 4.1. During the medical history and physical examination, attention should be paid to possible warning signs (including nystagmus and eye position according to the so-called HINTS criteria [1], see main text).

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The **HINTS-plus** test consists of the following three sub-tests plus hearing testing:

1. Clinical head impulse test to assess the horizontal vestibulo-ocular reflex (VOR):
A normal result argues against a peripheral vestibular lesion.
2. Analysis of spontaneous nystagmus (SPN): The presence of gaze-evoked nystagmus in the opposite direction to the SPN indicates a central disorder.
3. Cover test (“Test of skew”): Vertical misalignment of one eye (“skew deviation”) observed upon removal of the cover indicates a central lesion.
4. Hearing assessment to differentiate between an AICA infarction and Menière’s disease.

Numerous **warning symptoms** can indicate a potentially dangerous course of events, especially dizziness in conjunction with

- Headache, sore throat, neck pain,
- Dysphagia, dysarthria, hoarseness,
- Diplopia, ptosis,
- Sensory loss,
- Motor deficits,
- Ataxia,
- Altered consciousness, syncope,
- Arrhythmias
- or in the context of trauma.

Warning symptoms often occur in combination, which usually facilitates a suspected diagnosis. Abnormal vital signs, such as systemic blood pressure <90 or >180 mmHg, heart rate <50 or >100 beats/min, and/or respiratory rate <5 or >20/min, should also raise concern for a dangerous but preventable course [2].

Therapy

Medications

The treatment of various forms of dizziness includes medication, physical modalities, physiotherapy, psychotherapy, and rarely, surgical interventions (see full version), depending on the underlying condition. The dosage information for medications in the guideline serves merely as an example and should not to be understood as binding; the dosage instructions issued by the respective manufacturer should always be followed. Some of the listed drugs are „off-label“ for their respective indications. The various pharmaceuticals for the treatment of dizziness can be summarized in groups known as the „Eight A’s“: antivertigo agents, anticonvulsants, antidepressants, anti-inflammatory agents, anti-Menière agents, antimigraine agents, aminopyridines (potassium channel blockers), and acetyl-DL-leucine. Sedating antivertigo agents should only be used for symptomatic relief and should generally **not be given for longer than three days**, as they can slow down central vestibular compensation and may carry addiction potential. In addition, their symptom-suppressing effects can hinder accurate diagnosis and should be considered carefully.

Tab. Medications (selection from the guideline)

Drug class	Indication	Examples of Generic Drugs and Doses
Antimigraine agents	Vestibular migraine	Paracetamol combined with prokinetics For prophylaxis: Beta-receptor blockers, such as metoprolol succinate (approx. 50–200 mg/d) Topiramate (50-150 mg/d), valproic acid (600-900 mg/d) (Caution: avoid in pregnancy). Triptans are likely to have only a limited effect, if at all
Antivertigo agents	Symptomatic relief of nausea and vomiting in acute peripheral or central vestibular disorders Prevention of nausea and vomiting during rescue maneuvers in BPPV Prevention of motion sickness Central positional emesis	Dimenhydrinate (50 mg every 4–6 h); Ondansetron (4-8 mg) Diazepam (5-10 mg every 4-8 hours) Short-term use of up to three days only!
Betahistine	Menière’s disease	Betahistine dihydrochloride (up to 48 mg/d, divided into several single doses), limited evidence to date
Corticosteroids	Acute unilateral vestibulopathy (AUV)/ vestibular neuritis	6-Methylprednisolone (100 mg/d, taper by 20 mg every 4 days)
Selective serotonin reuptake inhibitors (SSRIs)	Functional dizziness	e.g. Escitalopram (5-max. 20 mg/d)

Repositioning, Vestibular Rehabilitation, and Other Measures

In the case of BPPV, repeated repositioning maneuvers should be recommended (e.g. 9 times daily for 3 days) and, if necessary, a reassessment after approximately 14 days.

Chronic forms of dizziness, diagnosed significantly more frequently in people over 65, are also treated in general practice. These include, for example, bilateral vestibulopathy (BVP) or permanent loss of vestibular (balance) organ function, cerebral perfusion disorders and circulatory problems, as well as functional dizziness and dizziness following traumatic brain injury (TBI), regardless of age.

BVP and TBI, as well as cerebral perfusion disorders, can be improved through the prescription of vestibular rehabilitation therapy, a specialized form of physical therapy. Functional dizziness benefits from antidepressants and cognitive behavioral therapy. Cardiovascular diseases as well as metabolic disorders of various origins should be treated in primary care and, if necessary, in collaboration with a specialist.

A systematic review of all types of dizziness, including diagnostic and therapeutic measures, is provided in the full version of the S2k guideline “Dizziness in Primary Care” (2025).

Versionsnummer: 2.3
Erstveröffentlichung: 11/2015
Überarbeitung von: 02/2025
Nächste Überprüfung geplant: 02/2030

Die AWMF erfasst und publiziert die Leitlinien der Fachgesellschaften mit größtmöglicher Sorgfalt - dennoch kann die AWMF für die Richtigkeit des Inhalts keine Verantwortung übernehmen. **Insbesondere bei Dosierungsangaben sind stets die Angaben der Hersteller zu beachten!**

Autorisiert für elektronische Publikation: AWMF online