Chronic dizziness: can this be psychiatric?

To the Editor—In a recent article 'Diagnosing the cause of vertigo: a practical approach',[1] Dr Lee has outlined a sound and practical approach to dealing with dizziness and vertigo. However, I would like to point out that dizziness is actually a much more common symptom than true vertigo. About 80% of complainants referring to dizziness do not have a 'spinning' sensation. In Chinese, 'dizziness' 暈眩 is a very vague and subjective term. It is therefore important to ask the patient to describe the exact feeling using words other than 'dizziness'. The meaning of 'vertigo' should be used more specifically to mean an illusion of movement (horizontal, vertical, or oblique).[2] Vague symptoms such as light-headedness, pre-syncope and dysequilibrium should be grouped into dizziness. Whilst dizziness can have various causes, vertigo commonly results from disturbance in the vestibular system. Among my patients with dizziness, about 80% actually had anxiety neurosis, phobic neurosis or depression; none had any neurological abnormality, and most had normal magnetic resonance imaging of the brain. Moreover, their symptoms were controlled with minor tranquillizers such as alprazolam. Staab[3] in 2006 reviewed 'chronic dizziness' and 'chronic subjective dizziness' (CSD). The latter syndrome was defined as persistent (>3 months) non-vertiginous dizziness, light-headedness, heavy-headedness or subjective imbalance on most days, not attributable to neurotological illness, medical conditions, or medications. Conditions easily confused with CSD include vestibular migraine, traumatic brain injury, and dysautonomia.

To avoid missing co-existing active neuro-otological causes, clinically, it is best to look for CSD versus other neuro-otologic conditions and then assess for anxiety, and not vice versa. It is particularly difficult to manage chronic dizziness in those with traumatic brain injury in whom persistent dizziness and depression are defining symptoms, along with insomnia, short-term memory loss, and headache. Such patients are often resistant to medical therapy, display poor psychosocial functioning, are less likely to return to work, and many are involved with medico-legal proceedings entailing compensation.

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Authors' reply

To the Editor—Dr Chin had given a very good supplement on common causes of dizziness while my article focused on vertigo.[1] It is a simpler classification in having two groups only (vertigo vs dizziness). However, the four different subtypes are helpful to establish a starting point for a more specific diagnostic approach, especially in the primary care setting. True vertigo points to a disturbance in the vestibular system (peripheral or central), whereas disequilibrium is mainly caused by orthopaedic, neurological, and/or sensory problems. Pre-syncope mainly relates to cardiac or vasomotor conditions. Light-headedness/dizziness can be caused by psychiatric problems or be non-specific. As pointed out by Dr Chin, chronic subjective dizziness and post-concussion syndrome are two important diagnoses to consider when facing patients with chronic dizziness. I agree with Dr Chin that a significant proportion of Chinese patients complained of dizziness rather than true vertigo. However, the prevalence of the different subtypes varies in different practices and ethnic groups.

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