

Transient Ischemic Attacks Presenting with Dizziness or Vertigo



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KEYWORDS

- Posterior circulation • Transient ischemic attack • Vertebrobasilar insufficiency
- Dizziness • Vertigo • Stroke

KEY POINTS

- Transient ischemic attacks (TIAs) and strokes comprise most of the central causes of episodic vestibular syndrome.
- Dizziness with or without associated symptoms is the most common manifestation of posterior circulation TIA.
- The risk of subsequent stroke in patients who are discharged home with a diagnosis of dizziness or vertigo is low.
- Isolated dizziness as a manifestation of posterior circulation TIA is a clinical challenge because most patients are asymptomatic with only normal neurologic examination findings on presentation.
- Large artery atherosclerosis of the vertebrobasilar system is involved in one-third of posterior circulation ischemic events and carries a high early recurrent stroke risk.

CASE SCENARIO

A 65-year-old woman with a history of hypertension and hyperlipidemia presented to the emergency department with 2 episodes of transient vertigo. The first episode occurred 1 week before presentation, and she described it as unprovoked continuous vertigo with nausea that lasted for 5 minutes with subsequent complete resolution. The second episode occurred on the day of presentation and consisted of isolated vertigo associated with nausea and vomiting lasting for 15 minutes. On arrival, she had recovered to her baseline. Her blood pressure was 221/117 mm Hg and her heart rate was 96 beats per minute and regular. Her neurologic examination, including Dix-Hallpike maneuver, was normal. Routine laboratory tests were within normal

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limits. Her ABCD2 (age, blood pressure, clinical features, duration of transient ischemic attack [TIA], and presence of diabetes) score was 3. Electrocardiogram and telemetry showed normal sinus rhythm. MRI showed no evidence of acute infarct. Magnetic resonance angiography (MRA) (Fig. 1A) followed by computed tomography angiography (CTA) (see Fig. 1B, C) showed intracranial distal vertebral and midbasilar stenosis. She was subsequently admitted for close observation and further evaluation. Lipid panel showed a low-density lipoprotein (LDL) level of 182 mg/dL. Glycosylated hemoglobin (HbA1c) was 7.4%. Echocardiography showed normal ejection fraction, mild left ventricular hypertrophy, and normal left atrial size. The patient was treated with aspirin, antihypertensive medications, statin, and oral hypoglycemic agents and discharged home. One week after discharge, she presented to the emergency department with another transient episode of unprovoked isolated vertigo lasting for 2 minutes. Neurologic examination was again normal. Repeat brain MRI on admission revealed no acute infarct and MRA was unchanged. Clopidogrel was prescribed. The patient's antihypertensive regimen was adjusted and she was discharged home. At 3 months' follow-up, she reported no further events.

INTRODUCTION

TIA and strokes comprise most of the central causes of episodic vestibular syndrome, although the proportion of patients presenting with dizziness and vertigo to

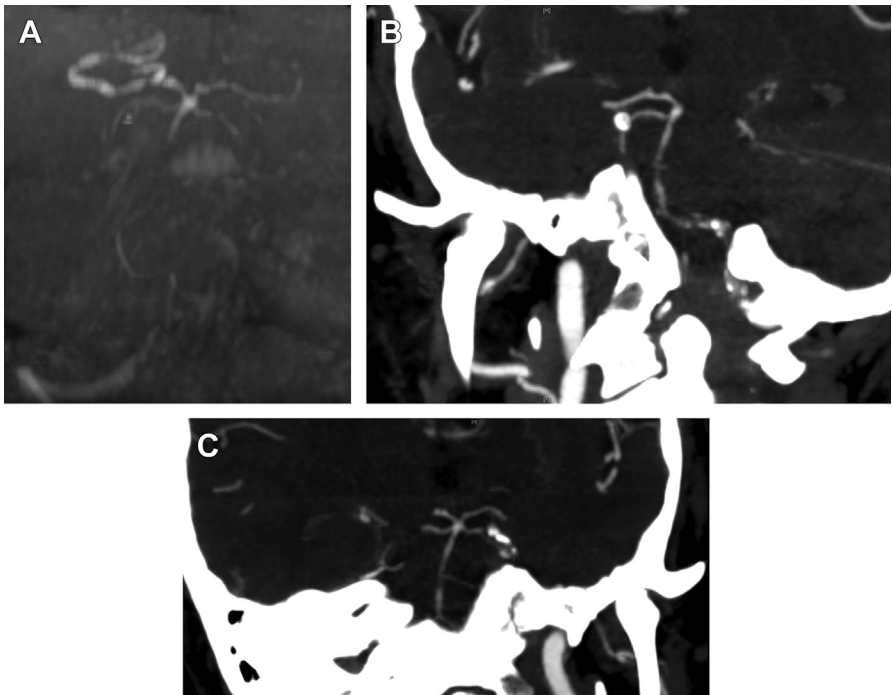


Fig. 1. (A) MRA of the head without contrast showing slow/absent flow in the basilar artery. (B) Computed tomography angiography (CTA) of the head, sagittal projection images, showing severe atherosclerosis in the left vertebral and mid-basilar artery. (C) Coronal CTA of the head showing severe midbasilar stenosis.

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