Reviewer's report

Title: Long-term symptoms in dizzy patients examined in a university clinic

Version: 1 Date: 19 January 2009

Reviewer: Lucy Yardley

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Although this paper simply reports a follow-up of a patient cohort, the results are of some interest to researchers and clinicians working in the field. However, in the present form some of the findings are difficult to interpret, and suggestions that may help to improve the interpretation are made below.

Major compulsory revisions

In a couple of places the discussion and abstract need to emphasise main findings to a greater extent compared with follow-up analyses. For example, it is important to first note that significant anxiety-related symptoms were present in the sample at follow-up before presenting the (somewhat less important) finding that dizziness symptoms were more severe than anxiety-related symptoms. Similarly, the bivariate regression analyses should take precedence over the multivariate ones - the authors should give prominence to ALL the variables that predicted symptoms, not just those that took precedence in the multivariate analyses (since the fact that only some are significant in multivariate analysis is generally just due to multicollinearity and is often not clinically important). So, for example, all the variables that were significant predictors in Table 3 should be mentioned as predictors in the abstract.

It is not clear to me why the cervicogenic group was chosen as the reference group in the multivariate analyses, and this seems a choice that is difficult to justify. Surely it would make more sense to choose the non-otogenic group as they should theoretically be more different from those who have organic diagnoses? Or one could make an argument for choosing Meniere's disease as a reference as they are arguable the group with the most severe otological disease.

It is premature from this paper to conclude that early referral to specialists is necessary - certainly the results suggest that early, active management is necessary, but there is some evidence that this can be provided successfully using vestibular rehabilitation in primary care.

Minor essential revisions

Abstract and elsewhere - it is important to make clear to the reader exactly what the anxiety-related symptom scale measures (i.e. that it includes autonomic symptoms secondary to dizziness as well as symptoms of somatic anxiety), and it should not be referred to as simply 'anxiety' as it is possible for someone to
score highly on this scale and have low levels of anxiety, if they have a lot of autonomic symptoms.

p. 4, 2nd para., line 1 - the proportion of patients with dizziness referred to specialist care probably varies widely between different countries (e.g. my impression is that it is much higher in Germany than the UK), and this needs to be briefly considered here, and what countries were investigated in the specific studies cited should be stated (with rate for each country if any differences found).

p. 5 last two lines - the precise wording of the questions used to assess current state of dizziness and spells of dizziness should be given, as this can strongly affect the findings, and these are new unvalidated questions - and the first one plays an essential role in the analysis.

p. 9 I am sure that the finding that symptom severity was unrelated to diagnosis will be surprising to some, and so VSS scores for the whole sample by diagnosis should be reported - particularly since the current subdivision of scores reported in Table 2 is based on a single, unvalidated item. It is also essential to report the proportion who were dizzy/not as a function of diagnosis (even though this can be calculated by the reader) - this could be done simply by having a column of n and % in Table 2 instead of just giving the n in brackets.

p.13, 3rd para. It would be helpful to also consider the opposite direction of association between neck pain and anxiety-related symptoms - i.e. those with high levels of somatic anxiety are more likely to complain of all types of minor symptoms (including neck pain).

p.21 Table 3 - the confidence interval figures given for the VSS-A for BPPV seem wrong (they do not include the OR!).

Discretionary revisions

p. 7 3rd para - the VSS scales were dichotomised before being entered into the regression, but of course this means that the analysis does not take account of the severity of symptoms, only the presence/absence of clinically significant symptoms. It might be useful to examine whether using the whole range of these scales influences the results.

Level of interest: An article whose findings are important to those with closely related research interests

Quality of written English: Acceptable

Statistical review: No, the manuscript does not need to be seen by a statistician.

Declaration of competing interests:
I declare that I have no competing interests