Occupational disability caused by dizziness and vertigo: a register-based prospective study
Anne Kari Skøien, Kjersti Wilhemsen and Sturla Gjesdal

ABSTRACT

Background
Despite the magnitude of dizziness/vertigo in primary healthcare, prospective studies are scarce, and few studies have focused on vocational consequences. Using the International Classification of Primary Health Care (ICPC), GPs have two alternative diagnoses, H82 (vertiginous syndrome) and N17 (vertigo/dizziness), when issuing sickness certificates to these patients.

Aim
To assess the incidence of dizziness/vertigo in long-term sickness absence and to identify sociodemographic and diagnostic predictors for transition into disability pension.

Design of study
Register-based prospective study, 5-year follow-up.

Setting
All individuals in Norway eligible for sickness absence in 1997 (registered employed or unemployed).

Method
The risk of disability pension was assessed with Cox proportional hazards analysis, with medical and sociodemographic information as independent variables, stratified for sex.

Results
Six-hundred and ninety-four women and 326 men were included. Dizziness/vertigo made up 0.9% of long-term sickness absence among women and 0.7% among men. Among both women and men, 41% was certified with H82 and 59% with N17: 23% of women and 24% of men obtained a disability pension. Age was the strongest predictor for obtaining a disability pension. Subjects with only basic education had an almost doubled risk of obtaining a disability pension compared to the highest educational group. Women with H82 had significantly higher risk for obtaining a disability pension than those with N17. The difference increased after adjustment for sociodemographic variables. Sex had no effect when all other variables were controlled for.

Conclusion
Dizziness/vertigo is an infrequent cause of certified sickness absence, but long-term sickness absences with dizziness/vertigo have a considerable risk of obtaining a disability pension in the future.

Keywords
disability insurance; dizziness; health insurance; risk factors; sick leave; vertigo.

INTRODUCTION

Dizziness/vertigo challenges clinicians and researchers due to its subjective nature. Traditionally dizziness is subclassified into vertigo, presyncope, disequilibrium, and ‘other types of dizziness’. This classification was introduced 35 years ago and is still in use. Vertigo indicates vestibular disorder: benign paroxysmal positional vertigo (BPPV), vestibular neuritis, or Ménière’s disease, and has constituted 30% of cases in previous studies. It has been claimed that vertigo can easily be distinguished from other causes of dizziness.

Dizziness/vertigo is a common symptom, increasing with age, and the frequency is higher in women than men. Lifetime prevalence was estimated to be 30% in a German survey, while a study from Scotland reported 21% vertigo, 29% unsteadiness, and 13% other types of dizziness. In a sample of general practices in London, 24% reported patients with dizziness in the last month. The studies differ, with unequal populations, different case definitions, and different measures of prevalence.

Prospective studies indicate that nearly 30% of the patients have symptoms after 12–18 months; however, knowledge of the vocational consequences is scarce. In a UK survey, 23% reported symptoms of dizziness, but only 1.5% had taken days off work. Sickness absence is an important measure of ill-health and social functioning, and permanent withdrawal
from the labour market is common after longer spells of absence.\textsuperscript{21,22}

**Aims of the study**
The aims of this study were to assess the incidence
of dizziness/vertigo in long-term sickness absence in
Norway, and to identify sociodemographic and
diagnostic predictors for transition into disability
pension.

**METHOD**

**The Norwegian sickness absence benefit scheme**
All employed and registered unemployed subjects
are covered by the scheme. After 8 weeks, GPs must fill in
an ‘8 weeks’ sickness absence certificate’ that
includes a main diagnosis based on the International
Classification of Primary Care (ICPC).\textsuperscript{23,24}

**The disability pension scheme**
All legal inhabitants aged 16–66 years are covered by
the scheme. Disability pension is granted in cases of
permanent, at least 50%, incapacity for work, when all
relevant treatment and rehabilitation approaches have
been applied.

**Setting and participants**
In 1997, 920 139 women and 1 019 216 men in
Norway were eligible for sickness absence benefits.
All cases with at least 8 weeks’ sickness absence
were recorded by The National Insurance Services.
Anonymous data were transferred to a research
database established by The National Insurance
Services and Statistics Norway. Information from
patients aged below 63 years with a main diagnosis of
dizziness/vertigo were included in the study.

**Explanatory variables**
The main diagnosis for each case based on the ICPC.
The ICPC is organised in chapters corresponding to
organ systems: H includes otological and N
neurological conditions. With respect to
dizziness/vertigo, two diagnoses are available: H82
(vertiginous syndrome), and N17 (vertigo/dizziness).
Sociodemographic variables were age, sex, income
before tax in 1996, and educational level (years).

**Follow-up and endpoint**
The sample was followed from the start of the sickness
absence spell until 31 December 2002, with granting of
disability pension as the endpoint.

![Table 1. Descriptive statistics of study sample, and percentages obtaining disability pension during follow-up, according to diagnosis and sociodemographic variables.](image-url)
Survival analysis was carried out with Cox proportional hazards analysis for the full sample, and stratified for sex, with disability pension as the dependent variable. Sociodemographic variables and diagnoses were entered as explanatory variables. The hazard ratio (HR) for obtaining disability pension, with 95% confidence intervals (CI), was identified for each variable. The statistical software program SPSS (version 13.0) was used.

### RESULTS

Among all spells of long-term sickness absence in 1997, cases with dizziness/vertigo made up 0.9% of women and 0.7% of men. The descriptive statistics of the study sample are shown in Table 1; 694 women and 326 men were included, corresponding to an annual incidence for women of 7.5/10,000 at risk (vocationally active) and for men of 3.2/10,000 at risk (vocationally active). Among both women and men, 41% were certified with H82, and 59% with N17.

### Analysis

Survival analysis was carried out with Cox proportional hazards analysis for the full sample, and stratified for sex, with disability pension as the dependent variable. Sociodemographic variables and diagnoses were entered as explanatory variables. The hazard ratio (HR) for obtaining disability pension, with 95% confidence intervals (CI), was identified for each variable. The statistical software program SPSS (version 13.0) was used.

### Transition to disability pension

Disability pension was obtained by 23% of the women and 24% of the men. Among women with an H82 diagnosis, 29% (95% CI = 24 to 34) obtained disability pension versus 18% (95% CI = 15 to 22) for those with N17. There was no difference in the male groups. Disability pension rates increased linearly with age.

### DISCUSSION

**Summary of main findings**

Dizziness/vertigo is an infrequent cause of long-term sickness absence; the annual incidence for women of 7.5/10,000 at risk (vocationally active) and for men of 3.2/10,000 at risk (vocationally active). Among both sexes, 41% were diagnosed with vertigo. One-quarter of women and men obtained a disability pension. Low education was a strong predictor of obtaining a disability pension.

#### Table 2. Results of Cox regression analysis in full sample and separately for sexes: risk of transition to disability pension according to diagnosis and sociodemographic variables: n = 326 men and n = 692 women on long-term sick-leave with a diagnosis of dizziness or vertigo.

<table>
<thead>
<tr>
<th>Variables</th>
<th>All</th>
<th>Men</th>
<th>Women</th>
</tr>
</thead>
<tbody>
<tr>
<td>HR 95% CI P-value</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diagnosis</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>N17</td>
<td>1.0</td>
<td>1.0</td>
<td>1.0</td>
</tr>
<tr>
<td>H82</td>
<td>1.5</td>
<td>1.1 to 1.9</td>
<td>0.003</td>
</tr>
<tr>
<td>Age, years</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>16–39</td>
<td>1.0</td>
<td>1.0</td>
<td>1.0</td>
</tr>
<tr>
<td>40–49</td>
<td>2.7</td>
<td>1.7 to 4.2</td>
<td>0.003</td>
</tr>
<tr>
<td>50–62</td>
<td>6.6</td>
<td>4.3 to 10.1</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Education, number of years</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Academic, ≥15</td>
<td>1.0</td>
<td>1.0</td>
<td>1.0</td>
</tr>
<tr>
<td>Higher middle, 12–14</td>
<td>1.0</td>
<td>0.6 to 1.6</td>
<td>0.003</td>
</tr>
<tr>
<td>Lower middle, 10–11</td>
<td>1.6</td>
<td>1.1 to 2.5</td>
<td>0.003</td>
</tr>
<tr>
<td>Basic, 7–9</td>
<td>2.0</td>
<td>1.2 to 3.2</td>
<td>0.003</td>
</tr>
<tr>
<td>Annual income 1996, NOK</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>≥240 000</td>
<td>1.0</td>
<td>1.0</td>
<td>1.0</td>
</tr>
<tr>
<td>160 000–239 999</td>
<td>1.0</td>
<td>0.7 to 1.5</td>
<td>0.003</td>
</tr>
<tr>
<td>80 000–159 999</td>
<td>1.2</td>
<td>0.8 to 1.8</td>
<td>0.003</td>
</tr>
<tr>
<td>0–79 999</td>
<td>1.2</td>
<td>0.6 to 2.2</td>
<td>0.120</td>
</tr>
<tr>
<td>Sex</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Men</td>
<td>1.0</td>
<td>1.0</td>
<td></td>
</tr>
<tr>
<td>Women</td>
<td>1.1</td>
<td>0.8 to 1.4</td>
<td>0.670</td>
</tr>
</tbody>
</table>

HR = hazard ratio. DP = disability pension. NOK = Norwegian Kroner (1 GBP = 9.7 NOK).
disability pension, while an H82 diagnosis was a risk factor for women only. The strongest predictor was age, probably caused by increasing comorbidity, a difficult labour market, and more lenient treatment of applications with increasing age.25,26

**Strength and limitations of the study**

This is the first population-based study on occupational consequences of dizziness. Sick-leave data are regarded as reliable and objective. The ICPC is a well-known classification instrument,23,24 and confidentiality reduced the risk of ‘false’ diagnoses.27 Weaknesses of register-based studies are lack of clinical data except for diagnoses, lack of information related to work conditions, and the fact that the diagnoses cannot be validated. Since cases were identified through the ICPC codes, patients whose dizziness was linked to mental health or cardiovascular problems were not included. The baseline data were recorded in 1997. The process of application, approval and delivery from Statistics Norway meant that the data were received in late 2005. There has been no secular change since baseline. No major alteration in the rules for the sickness absence benefit scheme or disability pension has been introduced, and the ICPC is still used on the sickness certificates.

**Comparison with existing literature**

Vertigo and dizziness reflect a distinction between vestibular and non-vestibular symptoms.1,3 The possibility of differentiating between types of dizziness is disputed,1,1 although a high degree of sensitivity has been reported in identifying vertigo by history alone.38

The proportion of subjects with vertigo (41%) was slightly higher than in previous studies.2,3 In the present study, as well as in previous studies, dizziness/vertigo was more common for women than for men in all age groups.3,3,7,10,11,15,16 However, women also have higher rates of sickness absence in general,3,3,7,10,11,15,16 often explained by occupational differences.3,10,11 Less control of working conditions increases the burden on employees, especially on women in low-paid jobs.19 The present study confirmed findings of no sex difference in relation to the risk of transition from sickness absence to disability pension,2,3,5,9 implying that the threshold for taking sick leave is not lower among women than men.

Disability pension is granted when ‘all relevant treatment and rehabilitation approaches have been applied’. Treatment in primary care typically consists of reassurance and medication to relieve symptoms,3,5,9,11 even though medication is not recommended beyond the acute stage.3,5,9 Referential to vestibular rehabilitation10,20 is uncommon in primary care.17,36,41 Lack of guidelines may lead to persistent complaints with disability pension as the endpoint.25 Vestibular rehabilitation could play an important role in preventing disability if applied at an early stage.36

**Implications for future research**

Further studies should focus on GPs’ role in the management of patients with dizziness/vertigo. Attention should particularly be directed towards female patients.

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**Ethical approval**

Not applicable

**Competing interests**

The authors have stated that there are none

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**REFERENCES**


