

LR 07CHEATSHEET

Ménière's Disease

Recognising and managing episodic vertigo with cochlear symptoms

WHY IT MATTERS

Prevalence ~200–500 per 100,000; peak fourth to sixth decades; up to 30% develop bilateral disease over time. Average diagnostic delay 2–4 years from symptom onset. Early recognition + audiometry + referral preserves hearing, reduces attack burden, and shortens the path to definitive management. Untreated, the disease tends to a vestibular-cochlear burnout phase after 5–15 years.

BÁRÁNY 2015 CRITERIA — DEFINITE MÉNIÈRE'S

- ▶ Two or more spontaneous episodes of vertigo, each lasting 20 minutes – 12 hours.
- ▶ Audiometrically documented low- to mid-frequency SNHL (≥ 30 dB at 2 contiguous frequencies < 2 kHz) on the affected side.
- ▶ Fluctuating aural symptoms (hearing, tinnitus, fullness) in the affected ear.
- ▶ Not better accounted for by another vestibular diagnosis. (Probable: episodes 20 min – 24 h; audiometry not yet diagnostic.)

♦ Episodes shorter than 20 minutes are NOT Ménière's — reconsider BPPV or vestibular paroxysmia. Episodes longer than 12 hours suggest vestibular migraine or atypical disease — review the diagnosis.

DIFFERENTIAL — EPISODIC VERTIGO

Diagnosis	Discriminator
Ménière's	20 min – 12 h • cochlear symptoms • low-tone fluctuating SNHL on affected side
Vestibular migraine	Minutes – days • migraine features • audiogram usually normal • visual triggers
BPPV	Seconds (< 60 s) • position-triggered • +ve Dix-Hallpike or supine roll
Vestibular paroxysmia	Seconds – minutes • frequent brief attacks • carbamazepine-responsive
TIA / posterior stroke	Minutes – hours • vascular risk • focal neurology • central HINTS — do not miss
Sudden SNHL with vertigo	Hours – days • PERMANENT loss • emergency — oral steroids < 72 h, same-day ENT
Anxiety / panic	Minutes • lightheaded not vertiginous • full ENT exam normal

AUDIOMETRY — THE KEY OBJECTIVE TEST

Audiogram pattern	Interpretation
Unilateral low-tone (250 Hz – 1 kHz) SNHL	Highly suggestive of Ménière's — early disease pattern
Mid-frequency notch on affected side	Middle-stage disease, fluctuation likely
Flat or descending SNHL, severe	Late-stage or burnt-out disease
Normal audiogram	Argues against Ménière's — consider VM, PPPD, anxiety
Bilateral SNHL	Reconsider: AIED, syphilis, ototoxicity — investigate accordingly

WORK-UP — ORDER FROM PRIMARY CARE

Investigation	Indication / purpose
Pure-tone audiogram	Every suspected case — repeat during fluctuations
MRI internal auditory meatus	Unilateral SNHL — exclude vestibular schwannoma
Thyroid + autoimmune screen + treponemal serology	Bilateral disease, progressive course, or systemic features
FBE, U&E, lipids	Baseline before diuretic therapy

♦ Three-question triage — (1) How long do attacks last? (Sec = BPPV; 20 min – 12 h = Ménière's; min-days = VM.) (2) Hearing affected? (Yes, fluctuating, same ear = Ménière's.) (3) Migraine features? (Yes = VM; may co-exist with Ménière's.) Three minutes of focused history sorts the majority.

STEP 1 — LIFESTYLE & DIET (ALL PATIENTS)

- ▶ Low-salt diet — target < 2 g sodium/day. Read labels; avoid processed foods. Single most-supported lifestyle intervention.

- ▶ Reduce caffeine, alcohol, and nicotine — common precipitants. Trial complete elimination 6–8 weeks.
- ▶ Sleep hygiene + stress management — fatigue and stress are reproducible triggers; consider written prevention plan, CBT.
- ▶ Symptom and trigger diary — frequency, duration, severity. Useful for monitoring and at vestibular physician review.

STEP 2 — FIRST-LINE PHARMACOTHERAPY

Add when lifestyle alone fails (>1 disabling attack/month, work or driving impacted). Trial each agent 8–12 weeks before declaring failure. Lifestyle measures continue alongside.

Agent / Action	Regimen / Principle
Betahistine	16 mg tds (up to 48 mg tds in resistant cases). Modest evidence, few side effects.
Hydrochlorothiazide	25 mg daily, often combined with amiloride or triamterene to spare K+.
Combination	Betahistine + diuretic when monotherapy insufficient (additive evidence limited).
Acute attack — antiemetic	Prochlorperazine 12.5 mg IM / 3 mg buccal, OR promethazine 25 mg PO. Single doses.
Acute attack — duration	Suppressants <72 h ONLY. Then STOP. Chronic use delays compensation, predisposes to PPPD.
Sudden SNHL with vertigo	Oral prednisolone 1 mg/kg <72 h while arranging same-day ENT — emergency.
Monitor	Attack diary + audiogram every 6–12 months. Refer if not controlled at 3 months.

◆ Vestibular suppressants beyond 72 hours are the single commonest avoidable error in primary-care Ménière's management. Routine maintenance prochlorperazine, promethazine, or betahistine for 'cover' between attacks worsens long-term outcomes — STOP at 72 hours.

STEPS 3 & 4 — REFRACTORY DISEASE (vestibular physician)

Option	Indication	Trade-off / Notes
Intratympanic dexamethasone	Step 3 first — refractory at 3 months	Hearing-sparing • ~60–70% vertigo reduction • repeat courses common
Intratympanic gentamicin	Refractory unilateral disease, hearing on contralateral side preserved	~80% vertigo control • 20–30% hearing-loss risk • patient counselling essential
Endolymphatic sac decompression	Refractory, hearing preserved	Hearing-sparing • evidence beyond placebo contested
Vestibular nerve section / labyrinthectomy	Refractory, no serviceable hearing	Definitive vertigo control • tertiary skull-base team

Adjuncts throughout — vestibular rehabilitation when persistent unsteadiness, hearing aids when SNHL impacts function, mental health support, tinnitus management, patient education materials. Run alongside every step.

◆ Two messages at every visit — (1) Capture an audiogram BEFORE referral. (2) Start lifestyle measures TODAY (low salt, reduce caffeine and alcohol, sleep, stress). These two cut diagnostic delay and start meaningful management.

WHEN TO REFER + RED FLAGS

- ▶ Sudden permanent SNHL — same-day ENT + oral prednisolone 1 mg/kg <72 h. ED if unavailable.
- ▶ Acute focal neurology with vertigo — ED + MRI-DWI; consider posterior circulation stroke.
- ▶ Tumarkin drop attacks (sudden falls without LOC) — late, ominous; urgent vestibular physician.
- ▶ Bilateral simultaneous symptoms or rapid contralateral progression — autoimmune / syphilis screen.
- ▶ All suspected Ménière's — routine vestibular physician referral within 4–6 weeks for confirmation, audiometric staging, and longitudinal management.
- ▶ Inadequate control on lifestyle + first-line therapy at 3 months — for intratympanic options.

◆ Three rules — (1) Audiogram every suspected case. (2) Lifestyle and betahistine for everyone. (3) Refer all to a vestibular physician for confirmation and longitudinal care. Goal is control, not cure: 50–70% attack reduction is the realistic target.