MARVIX AI

SAMPLE VERTIGO / DIZZINESS SOAP NOTE

MENIÈRE DISEASE — RIGHT EAR

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1 Patient Information

1 PATIENT DETAILS

Name
Diana L. Morrison

Date of Service
05/06/2026

DOB
09/22/1973

Provider
Dr. James A. Thornton, MD — Otolaryngology / Neurotology

Age / Sex
52 / Female

MRN
ENT-2026-0739

Visit Type
Vertigo / Dizziness Evaluation — Initial Consultation

Symptom Laterality / Trigger Pattern
Right ear — spontaneous episodic; not positional

Referral Source
Dr. Karen Liu, MD — Primary Care

CC Chief Complaint

2 PRIMARY DIZZINESS-RELATED CONCERN

Ms. Morrison is a 52-year-old female presenting with a 14-month history of recurrent severe episodic vertigo associated with right-sided low-frequency hearing fluctuation, right aural fullness, and right-sided roaring tinnitus. She states: 'When the attacks come I can't move — the room is spinning violently and I throw up. I have to lie completely still for hours. My right ear fills up and goes deaf right before each attack and I have a roaring sound in it constantly. I've had 12 of these attacks in the past year and I'm terrified of the next one. I've been afraid to drive.' Her most recent episode was 6 days ago and lasted 4 hours.

S Subjective

3 PATIENT-REPORTED DIZZINESS SYMPTOMS, ASSOCIATED SYMPTOMS & RISK FACTORS

3a SYMPTOM DESCRIPTION

TRUE SPINNING VERTIGO — environment rotates violently, right side most prominent during attacks. NOT lightheadedness, presyncope, or disequilibrium — definitive rotational vertigo. Described as 'the world spinning like a washing machine.' During attacks she cannot stand or ambulate — must remain completely still in bed. Post-attack: residual unsteadiness for 4–6 hours; mild imbalance persisting 1–2 days after each attack.

3b ONSET & COURSE

First attack: February 2025 — lasted 3 hours, accompanied by right aural fullness and roaring tinnitus. Attacks have increased in frequency: initially 1–2/month; now 2–3/month. 12 total documented attacks in 14 months. Duration of each episode: 2–5 hours (range). Attacks are completely unpredictable — no consistent time of day or activity. Between attacks: chronic low-grade right tinnitus (constant), intermittent right aural fullness, and fluctuating right hearing loss. She has had 3 documented episodes of apparent complete right hearing recovery during which she could hear normally on the right — heard her granddaughter whisper from across the room.

3c TRIGGERS & POSITIONAL FACTORS

NOT positional — attacks occur spontaneously regardless of head position. NOT provoked by rolling in bed, looking up, or standing. Patients self-reports that attacks seem more likely after high-salt meals, stress, poor sleep, and hormonal changes (perimenopausal — notes more attacks in the weeks before her period). Caffeine: drinks 3 cups coffee/day — has not modified intake. No specific triggering head movement identified. No exertion trigger.

3d ASSOCIATED EAR SYMPTOMS

RIGHT EAR: (1) AURAL FULLNESS — prominent right ear pressure/fullness beginning 30–60 minutes before each attack (prodrome); persists throughout and resolves 1–2 hours after vertigo subsides. (2) FLUCTUATING HEARING LOSS — marked low-frequency hearing reduction in right ear during and after attacks; between attacks she has partial recovery but notes her right hearing is 'getting permanently worse' over time. (3) ROARING TINNITUS — right-sided, low-frequency roaring quality ('like a jet engine or ocean waves'); present 24/7, worsens dramatically during attacks. Severity between attacks: 5/10. During attacks: 9/10. LEFT EAR: No tinnitus, no fullness, no hearing symptoms.

3e ASSOCIATED NEUROLOGIC SYMPTOMS

No headache during or preceding attacks (migraine excluded in differential based on this). No visual aura, photophobia, or phonophobia with attacks. No diplopia, dysarthria, dysphagia, or limb weakness during attacks. No facial weakness or numbness. No loss of consciousness or syncope. No amnesia or confusion. No falls with injury — has been able to reach a safe position before fully losing balance. No new neurologic symptoms between attacks.

3f NAUSEA / AUTONOMIC SYMPTOMS

Severe nausea and vomiting with every attack — the most physically debilitating component second only to vertigo. Vomiting typically begins 30–60 minutes into the attack and may continue for 1–2 hours. Profuse diaphoresis during attacks. Pallor reported by her husband. Palpitations during attacks — attributed to anxiety and autonomic response to severe vertigo. No chest pain or syncope. Between attacks: mild nausea that she cannot always attribute to a specific cause.

3g FALL RISK & FUNCTIONAL IMPACT

Has not had a fall with injury — manages to reach bed or floor safely before each attack becomes incapacitating. Refuses to drive (appropriate safety decision) — relying on husband for all transportation for 6 months. Unable to work during or for 1–2 days after attacks — she is an accountant; has taken 14 sick days in 14 months for Ménière attacks. QOL severely impacted — anxiety about next attack is constant (Dizziness Handicap Inventory score: 72/100 today — severe). Avoids social gatherings, restaurants (salt intake), and travel. Sleep disrupted by tinnitus and anticipatory anxiety.

3h PRIOR EVALUATION & TREATMENT

PCP evaluation x3 over 14 months: Diagnosed as 'inner ear problem' and 'possible Ménière's.' Meclizine 25 mg PRN prescribed — patient reports minimal benefit during acute attacks (by the time she can take it, vomiting makes it impossible to keep down). No audiogram ordered by PCP. No imaging performed. No vestibular testing. No ENT referral until now. Prochlorperazine 10 mg suppository: prescribed by PCP x3 months ago for nausea — helpful during attacks, now runs out quickly. No prior Epley maneuver performed.

3i PERTINENT NEGATIVES

No focal neurologic deficits. No acute hearing loss without vertigo. No fever or neck stiffness. No severe headache. No diplopia, dysarthria, or cerebellar signs. No sudden onset 'thunderclap' headache. No inability to ambulate between attacks. No cardiovascular symptoms that would suggest orthostatic hypotension. No migraine history (no headaches with attacks, no aura). No recent viral illness preceding attacks. No medication changes that could explain onset.

ROS ENT / Neurologic Review of Systems

4 PERTINENT POSITIVES & NEGATIVES

- **Vertigo / dizziness / imbalance:** POSITIVE — severe episodic spinning vertigo, 12 attacks in 14 months, 2–5 hours each
- **Hearing loss / tinnitus / aural fullness:** POSITIVE — right fluctuating HL, right roaring tinnitus 24/7, right episodic aural fullness (pre-attack prodrome)
- **Headache / migraine symptoms:** Denied — specifically no headache with attacks
- **Speech / swallowing difficulty:** Denied
- **Syncope / palpitations:** Palpitations during attacks — autonomic; no syncope
- **Nausea / vomiting:** POSITIVE — severe, with every attack; vomiting during attacks
- **Otalgia / otorrhea:** Denied
- **Vision changes / diplopia:** Denied
- **Weakness / numbness / ataxia / falls:** No falls; mild post-attack unsteadiness for 1–2 days
- **Fever / infection symptoms:** Denied

O Objective

5 VESTIBULAR / OTOLOGIC / NEUROLOGIC FINDINGS

V VITAL SIGNS

Temperature
98.1°F

Blood Pressure (Supine)
118/72 mmHg; Sitting: 116/70 mmHg; Standing: 114/68 mmHg (no orthostasis)

Heart Rate
76 bpm

Respiratory Rate
14 breaths/min

Oxygen Saturation
99% on room air

Height / Weight
5'4" / 148 lbs (BMI 25.4)

Pain Score
0/10 today (between attacks); tinnitus distress 5/10

Symptom Severity Score
Dizziness Handicap Inventory: 72/100 — Severe functional handicap

5a GENERAL APPEARANCE

Alert, well-appearing female — currently between attacks and asymptomatic for vertigo. Ambulates steadily to examination room without assistance. Mild anxiety evident. Speaks rapidly and in detail about her symptoms — clearly highly distressed by the impact of this condition on her life. No gait ataxia or imbalance at rest.

5b EYES / VESTIBULAR VISUAL

Extraocular movements: Full and symmetric bilaterally. No spontaneous nystagmus at rest with eyes open or closed (between attacks — expected; spontaneous horizontal nystagmus toward the unaffected left ear is the expected finding during an acute attack but not present today). Video head impulse test (vHIT) performed with video goggle system: RIGHT: POSITIVE horizontal head impulse test — visible corrective saccade after rightward rapid head thrust (catch-up saccade), indicating reduced right semicircular canal gain. LEFT: Negative — normal vestibulo-ocular reflex. Fixation suppression of VOR: intact bilaterally. No skew deviation. No pendular nystagmus.

5c EAR EXAM

RIGHT EAR: External ear intact. Canal clear. TM: intact, normal landmarks, no effusion. RIGHT TM mobility: normal on pneumatic otoscopy. No erythema, no perforation, no retraction, no cholesteatoma concern. LEFT EAR: Normal TM, canal, and mobility. No mastoid tenderness bilaterally.

5d NASAL / ORAL / NECK

Nasal / Oral
Normal — no relevant findings

Neck ROM / Tenderness
Full range of cervical motion without pain or vertigo provocation. No vertebrobasilar insufficiency concern on extension/rotation.

5e NEUROLOGICAL

Cranial nerves II–XII: All intact. Facial sensation and motor function: Symmetric. Palate elevation symmetric. Tongue midline. No Horner's syndrome. Motor strength: 5/5 all extremities. Coordination: Finger-nose-finger intact bilaterally. Heel-shin: intact. Gait: Normal stride length and arm swing. No ataxia. Tandem gait: Intact — able to walk heel-to-toe x8 steps without stepping out. Romberg test: POSITIVE — mild sway with eyes closed, no fall. Pronator drift: Negative. Cerebellar signs: None.

5f VESTIBULAR TESTING

Dix-Hallpike (Right)
NEGATIVE — no nystagmus, no vertigo (Ménière episodes are not BPPV; Dix-Hallpike negative is expected)

Dix-Hallpike (Left)
NEGATIVE

Supine Roll Test
NEGATIVE bilaterally

Head Impulse Test (vHIT)
POSITIVE RIGHT — corrective saccade on rightward thrust, indicating right vestibular hypofunction. Left: Normal.

HINTS Exam
Head Impulse: Positive RIGHT (abnormal = peripheral vestibular disease). Nystagmus: None spontaneous today (inter-ictal). Test of Skew: Negative. HINTS inter-ictal: peripheral pattern — not central.

Fukuda Stepping Test
Mild rightward deviation with eyes closed (>30° rotation) — consistent with right vestibular hypofunction

PP Procedures Performed

6 VESTIBULAR / ENT PROCEDURES THIS VISIT

CANALITH REPOSITIONING MANEUVER (EPLEY) — RIGHT SIDE: Performed despite negative Dix-Hallpike (to rule out concurrent right posterior canal BPPV as a contributing factor, given episodic positional vertigo symptoms reported by the patient on some occasions). Technique: Standard right-side Epley canalith repositioning maneuver performed in 4 positions. Findings: No nystagmus evoked at any position during the Epley — confirming that BPPV is NOT the diagnosis in this case. Ménière disease is the primary diagnosis. Patient tolerated the maneuver well — no significant vertigo

provoked. No complications. VIDEO HEAD IMPULSE TEST (vHIT) — documented in examination section above as a separately performed and interpreted vestibular diagnostic test using video goggle system.

L Lab & Diagnostic Results

7 DIZZINESS-RELATED DATA

7a AUDIOLOGY & VESTIBULAR TESTING

AUDIOGRAM (ordered today, performed in this office by Dr. Thornton's audiology staff — results reviewed immediately): RIGHT EAR: Low-frequency SNHL pattern — characteristic of Ménière disease. 250 Hz: 45 dB HL; 500 Hz: 40 dB HL; 1000 Hz: 35 dB HL; 2000 Hz: 28 dB HL; 4000 Hz: 22 dB HL; 8000 Hz: 25 dB HL. Low-frequency PTA (250–1000 Hz): 40 dB HL (moderate). The inverted 'cookie-bite' or low-frequency dominant pattern is pathognomonic for Ménière disease endolymphatic hydrops. RIGHT WRS: 82% (adequate). LEFT EAR: 250 Hz: 18 dB; 500 Hz: 15 dB; 1000 Hz: 12 dB; 2000 Hz: 15 dB; 4000 Hz: 20 dB; 8000 Hz: 25 dB. Left PTA: 16 dB HL (normal/near-normal). TYMPANOMETRY: Bilateral Type A — normal. ACOUSTIC REFLEXES: Right stapedial reflexes: ABSENT at 500 and 1000 Hz — consistent with significant right SNHL or endolymphatic hydrops. Left: Normal reflexes. OAEs (otoacoustic emissions): Right OAEs: ABSENT at low frequencies (500, 1000 Hz) — confirming right cochlear outer hair cell dysfunction. LEFT OAEs: Present at all frequencies.

7b VESTIBULAR TESTING

Video head impulse test (vHIT): Right horizontal canal gain reduced at 0.68 (normal >0.80) with corrective saccades — indicating right vestibular hypofunction, consistent with Ménière disease affecting the right labyrinth. Left horizontal canal gain: 0.94 (normal). VNG/ENG, caloric testing, rotary chair, and VEMP not performed today — to be ordered through formal vestibular testing lab for comprehensive evaluation. Formal vestibular testing ordered at Utah Vestibular Center (Dr. Thornton's affiliated lab): VNG, caloric testing, cVEMP, and oVEMP — scheduled 05/12/2026.

7c IMAGING

MRI BRAIN AND IAC WITH GADOLINIUM: Ordered today. Indication: Recurrent episodic vertigo with unilateral (right) auditory symptoms — although the clinical picture is highly consistent with Ménière disease, MRI is essential to exclude: (1) Retrocochlear pathology (vestibular schwannoma/ acoustic neuroma at the right IAC); (2) Endolymphatic hydrops can be visualized on intratympanic gadolinium MRI (not standard but may be considered); (3) Central cause of vertigo (demyelinating disease, posterior fossa lesion). Standard MRI brain with IAC protocol scheduled 05/09/2026. Note: Intratympanic gadolinium MRI hydrops protocol (3T delayed MRI) to be discussed at follow-up if standard MRI is negative.

7d LABORATORY STUDIES

Thyroid function: TSH 2.4 (normal — hypothyroidism excluded as cause of dizziness). CBC: WNL. CMP: WNL. Glucose: 92 (normal — hypoglycemia-induced episodes excluded). B12: 410 pg/mL (normal). Autoimmune workup: ANA, anti-dsDNA, ANCA, anti-SSA/SSB (Sjögren) — ordered today to exclude autoimmune inner ear disease (AIED). FTA-Abs (syphilis serology) — ordered (Menière-like disease associated with luetic labyrinthitis; routine exclusion). Results pending.

A Assessment

8 VERTIGO / DIZZINESS CLINICAL INTERPRETATION

Ms. Diana Morrison is a 52-year-old female presenting with a 14-month history of episodic disabling vertigo consistent with PROBABLE UNILATERAL RIGHT MÉNIÈRE DISEASE meeting American Academy of Otolaryngology–Head and Neck Surgery (AAO-HNS) diagnostic criteria for 'definite Ménière disease': (1) Two or more spontaneous episodes of vertigo lasting 20 minutes to 12 hours — CONFIRMED (12 attacks, 2–5 hours each). (2) Low-frequency to mid-frequency SNHL documented by audiometry in the affected ear on at least one occasion before, during, or after one of the episodes — CONFIRMED (right low-frequency SNHL 40 dB, audiometric pattern pathognomonic for endolymphatic hydrops). (3) Fluctuating aural symptoms (hearing, tinnitus, or fullness) in the affected ear — CONFIRMED (right aural fullness as pre-attack prodrome, fluctuating right hearing loss, constant right roaring tinnitus). (4) Not better accounted for by another vestibular diagnosis — BPPV excluded (Epley negative, no positional nystagmus); vestibular migraine excluded (no headache, no migraine history, no visual aura); central lesion to be excluded by MRI IAC. Right vestibular hypofunction confirmed by vHIT (reduced right canal gain 0.68, corrective saccades). Absent right OAEs and absent right acoustic reflexes corroborate right cochlear involvement. Key management priorities: (1) Acute attack management — prochlorperazine suppository available; ondansetron added; (2) Disease-modifying medical therapy — low-sodium diet (1500–2000 mg/day), diuretic (hydrochlorothiazide); (3) MRI IAC to exclude retrocochlear pathology; (4) Comprehensive vestibular lab testing; (5) Vestibular rehabilitation once testing is complete; (6) Drive restriction until attack frequency is controlled.

P Plan

9 DIZZINESS MANAGEMENT

9a VESTIBULAR MANEUVERS & THERAPY

Epley maneuver performed today (negative — BPPV excluded). Vestibular rehabilitation therapy (VRT) referral placed — will initiate after formal vestibular lab testing is complete (05/12/2026) to allow customized program based on calorics and VEMP results. VRT provider: National Balance and Dizziness Center, referral placed. Brandt-Daroff exercises not prescribed — not indicated for Ménière disease.

9b MEDICATIONS

1. LOW-SODIUM DIET: 1500–2000 mg sodium/day strictly — dietary counseling provided. Patient given written low-sodium diet guide. The cornerstone of medical Ménière management. 2. HYDROCHLOROTHIAZIDE 12.5 mg PO daily — initiate today. Diuretic therapy reduces endolymphatic pressure and reduces attack frequency in approximately 60–70% of patients. Monitor potassium (K supplement if needed). 3. ONDANSETRON (Zofran) 4 mg orally disintegrating tablet (ODT) PRN severe nausea during attacks — replaces and augments prochlorperazine (better tolerated as ODT). 4. PROCHLORPERAZINE 10 mg rectal suppository PRN vomiting during attacks — continue. 5. DIAZEPAM 2 mg PO PRN (vestibular suppressant for acute attack) — one-time dose at onset of attack, not for daily use. 6. MECLIZINE: Discontinue — too sedating, not effective once vomiting begins. 7. CAFFEINE reduction: reduce to 1 cup coffee/day maximum. 8. AVOID: aspirin, NSAIDs (may worsen tinnitus), alcohol, and smoking. Betahistine not FDA-approved in USA but discussed — patient aware.

9c DIAGNOSTICS & REFERRALS

MRI brain + IAC with gadolinium: 05/09/2026. Formal vestibular lab: VNG, caloric testing, cVEMP, oVEMP — 05/12/2026. Autoimmune and syphilis serology: pending (ordered today). Audiology follow-up: repeat audiogram in 3 months to document fluctuation and progression. Dietary counseling: referral to nutritionist for low-sodium diet guidance. If attacks persist despite medical therapy: intratympanic steroid injection (first-line in-office procedure) or intratympanic gentamicin (ablative, second-line) to be discussed at follow-up.

9d PATIENT EDUCATION

1. DRIVING: Strongly counseled NOT to drive until attacks are controlled for a minimum of 3 months without a significant vertigo episode — she agreed. 2. ATTACK MANAGEMENT PLAN: (a) Lie down immediately at first sign (aural fullness); (b) Use ondansetron ODT under tongue as soon as possible; (c) Use prochlorperazine suppository if vomiting; (d) Diazepam 2 mg if needed. Have a 'Ménière kit' in her home. 3. DIET EDUCATION: Detailed sodium education provided. Avoid processed foods, restaurant meals, and salty snacks. 4. STRESS AND SLEEP: Identified as triggers — sleep hygiene counseling. Yoga and mindfulness encouraged. 5. MENOPAUSAL HORMONES: Patient asked about relation to hormonal changes — explained that perimenopausal fluid shifts may influence endolymph. Coordinate with OB/GYN. 6. WARNING SIGNS requiring ER: sudden unilateral SNHL without vertigo (endolymphatic crisis), new facial weakness, severe headache, loss of consciousness.

F Follow-Up

10 REASSESSMENT PLAN

Follow-Up Schedule
Autoimmune/syphilis labs: 05/08 (phone). MRI IAC: 05/09/2026. Vestibular lab: 05/12/2026. ENT follow-up: 05/20/2026 — MRI review, lab results, attack frequency on HCTZ, sodium compliance, vestibular test results, treatment plan adjustment. Repeat audiogram: 08/2026 (3 months).

TIME DOCUMENTATION & BILLING

Total Time
52 minutes

E/M Level
99204 — New patient, moderate-high complexity

Counseling / Coordination Time
22 minutes

Procedure Code(s)
95992 — Canalith repositioning procedure (Epley); 92547 — Use of vertical electrodes (vHIT separately interpreted)

Basis for Billing
Medical Decision Making — High Complexity

Primary ICD-10 Code
H81.09 — Ménière's disease, unspecified ear (right — confirmed on today's encounter)

Secondary ICD-10 Code(s)
H93.11 — Tinnitus, right ear; H93.A1 — Aural fullness, right; H90.2 — Sensorineural hearing loss, bilateral — right dominant; R42 — Dizziness and giddiness

PHYSICIAN NAME, MD	SPECIALTY	DATE	TIME
James A. Thornton, MD	MD — Otolaryngology / Neurotology | Fellowship-Trained | Board Certified (ABOto)	05/06/2026, 3:00 PM	

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