A 30-DAY FIELD GUIDE FOR PATIENTS

The Ménière's Pattern Handbook

Why you're still having attacks even when you avoid salt — and how to find the hidden trigger combination that's actually causing them.

Inside this guide

50 evidence-based triggers
30-day pattern framework
Emergency attack plan
Doctor-visit prep worksheet

Free companion resource
by **Meniere's: Symptom Tracker**

The uncomfortable truth most Ménière's patients discover too late

> **You've cut the salt. You've dropped caffeine. You've done the Epley. So why are attacks still hitting you?**
>
> Because the advice you were given treats Ménière's like it has *one* cause. It doesn't. In most patients, attacks are triggered by a **combination** of 2–4 factors that stack up silently over 24–72 hours — and the individual pieces are different for every person.

Three things this handbook will teach you

1. **The 50 triggers that actually matter** — grouped into dietary, environmental, physical, emotional, and medical categories, with checkboxes so you can screen yourself in 10 minutes.
2. **How to find your unique 2–4 trigger combo** — a 30-day pattern-discovery method used by patient researchers and vestibular clinicians.
3. **What to bring to your next ENT visit** — so you walk out with a treatment plan instead of "track your symptoms and come back."

Who this is for

- You've been diagnosed with Ménière's (definite or probable) within the last 5 years.
- You have 1+ attacks a month and standard dietary advice hasn't stopped them.
- You want to stop guessing and start seeing data.

A note on evidence: This guide summarizes peer-reviewed research on Ménière's triggers (AAO-HNS 2020 criteria, 2023 Bárány Society consensus, and case-controlled trigger studies) combined with observational patterns reported by vestibular specialists. It is **not** medical advice. Always confirm changes with your ENT or neurotologist.

The 50 Ménière's triggers, ranked by category

Print this page. Over the next 3 days, check any trigger you've been exposed to in the 72 hours before your last 3 attacks. Patterns emerge fast.

Dietary (15)

- [ ] **High sodium intake** — >2,000 mg/day
- [ ] **Caffeine** — coffee, energy drinks, pre-workout
- [ ] **MSG / glutamate** — takeout, snacks, broths
- [ ] **Chocolate** — dark & milk
- [ ] **Processed meats** — nitrates, sodium
- [ ] **Fermented foods** — kimchi, soy sauce, kombucha
- [ ] **Dehydration** — <1.5 L water/day
- [ ] **Large / heavy meals** — vagal response
- [ ] **Hidden salt** — bread, sauces, cheese
- [ ] **Alcohol** — especially red wine, beer
- [ ] **Aged cheese** — tyramine content
- [ ] **Citrus & vinegar** — histamine release
- [ ] **Artificial sweeteners** — aspartame, sucralose
- [ ] **Sugar spikes** — >40 g in one sitting
- [ ] **Skipped meals** — hypoglycemia risk

Environmental (10)

- [ ] **Barometric pressure drop** — >6 hPa in 24h
- [ ] **High altitude** — >1,500 m
- [ ] **Sudden temperature change** — cold to hot
- [ ] **Loud noise exposure** — concerts, power tools
- [ ] **Visual motion** — driving, scrolling
- [ ] **Incoming storm fronts** — 24–48h before rain
- [ ] **Air travel** — cabin pressure swings
- [ ] **High humidity** — >75%
- [ ] **Flickering / fluorescent light** — stores, offices
- [ ] **Seasonal transitions** — allergy-heavy months

Physical (10)

- [ ] **Poor sleep** — <6 h or fragmented
- [ ] **Quick head movements** — bending, turning
- [ ] **Neck tension / stiffness** — cervicogenic
- [ ] **Eye strain** — long screen hours
- [ ] **Valsalva maneuvers** — straining, heavy lifting
- [ ] **Sleep position** — affected ear down
- [ ] **Sustained head-down posture** — phone, laptops
- [ ] **Jaw clenching / bruxism** — TMJ load
- [ ] **High-intensity exercise** — HR >85% max
- [ ] **Hormonal cycle phase** — luteal / menstrual

Emotional & cognitive (8)

- [ ] **Acute stress event** — argument, deadline
- [ ] **Anxiety spikes** — panic, anticipation
- [ ] **Emotional exhaustion** — burnout phase
- [ ] **Poor stress recovery** — no decompression
- [ ] **Chronic background stress** — work, caregiving
- [ ] **Depressive episodes** — bidirectional link
- [ ] **Sudden excitement / arousal** — adrenaline surge
- [ ] **Delayed / broken routines** — circadian drift

Medical & chemical (7)

- [ ] **NSAID overuse** — ibuprofen, naproxen
- [ ] **Antihistamine rebound** — stopping suddenly
- [ ] **Sinus infection / congestion** — pressure imbalance
- [ ] **Dental work / TMJ flares** — referred pressure
- [ ] **Decongestants** — pseudoephedrine
- [ ] **Active allergies** — seasonal, dust, pets
- [ ] **Viral infection** — cold, flu, post-viral

> **How to use this checklist properly →** Most patients glance at the list, check 15 boxes, and feel overwhelmed. Don't. The goal isn't to avoid all 50 — it's to find the 2–4 that matter for *you*. The next page shows you how.

The 30-day pattern-discovery method

Most patients abandon trigger-tracking after 7–10 days because they can't see a signal. The problem is the window, not the method. Ménière's triggers often **stack** over 24–72 hours before an attack, which means a 7-day log isn't long enough to see the pattern.

1. **Log every day, not just attack days**
   This is the single biggest mistake. If you only log on bad days, you have no baseline to compare against. 30 daily entries beats 6 detailed attack reports every time.

2. **Capture the 72-hour window**
   When an attack happens, don't just record "today." Look back 3 days. What did you eat? How much did you sleep? Was there a pressure change? What was your stress level?

3. **Track combinations, not single items**
   Your trigger may not be "salt." It may be "salt + poor sleep + pressure drop." Individual factors may be survivable; the stack is what tips you over.

4. **Include the obvious, the boring, and the embarrassing**
   Barometric pressure, menstrual cycle, arguments with your spouse, skipped medication, late-night scrolling. The trigger you don't want to write down is often the one that matters.

5. **Review weekly, not daily**
   Daily data, weekly pattern review. At day 14 you'll have signals. At day 30 you'll have a hypothesis. At day 60 you'll have a protocol.

How this looks in practice — Rachel, 42

"I'd been blaming salt for two years. When I finally logged every day for a month, my attacks lined up with three things every single time: barometric pressure drops greater than 8 hPa, less than 6 hours of sleep two nights before, and my luteal phase. Salt was nowhere in the picture. Changing my sleep protocol cut my attacks by 70%."

Your attack emergency plan

Print this page and put it on your fridge. Share it with anyone you live with. When the room starts spinning, you won't be able to problem-solve — you'll need to execute.

If an attack is starting

FIRST 30 SECONDS

- Stop moving. Sit or lie down immediately — do not try to "push through."
- Fix your eyes on a stationary point (horizon, door frame, photo).
- Tell someone nearby: "I'm having an attack, give me 30 minutes." Hand them this page.
- Move away from stairs, stoves, water, moving vehicles.

MINUTES 1–5

- Lie on your back, head slightly elevated (pillow). Affected ear up if known.
- Take your prescribed rescue medication (meclizine, diazepam, prochlorperazine) if your doctor has prescribed one.
- Slow breathing: 4 seconds in, 6 seconds out. Repeat for 2 minutes.
- Keep eyes open and focused on one point. Closing eyes often makes vertigo worse.

MINUTES 5–60

- Stay horizontal until the spinning stops completely. Do not attempt to stand.
- Sip water or an electrolyte drink if nausea allows.
- Use a bucket or bag within arm's reach. Vomiting is common and not dangerous.
- Write down: time it started, what you ate, slept, and did in the last 72 hours. You will forget.

AFTER THE ATTACK

- Sit up slowly in stages: lying → side → sitting → standing. Allow a full minute between each.
- Rest for at least 2 hours before resuming activity. Don't drive for 12 hours.
- Log the attack within 24 hours — memory of triggers fades fast.

Call emergency services if: this is your first episode of severe vertigo, the attack is paired with chest pain / severe headache / vision loss / weakness on one side / slurred speech / new hearing loss in both ears, or vertigo lasts unbroken for more than 24 hours. These are signs of other conditions (stroke, vestibular neuritis, labyrinthitis) that need urgent evaluation.

Doctor visit prep — 20 questions that change the conversation

Most ENT appointments fail because the patient arrives without data and the doctor asks "how often?" and "how bad?" — questions you can't answer accurately from memory. Bring a written attack log *and* these questions. The visit shifts from "keep tracking" to "let's decide."

Diagnostic clarity

1. Is my diagnosis definite Ménière's or probable? What criteria (AAO-HNS 2020) do I meet or miss?
2. Do I need audiometry every 6 months to document progression?
3. Should I get an MRI to rule out vestibular schwannoma or endolymphatic hydrops on MRI?
4. Is VNG / ENG testing appropriate in my case?
5. Could this be vestibular migraine instead of (or alongside) Ménière's?

Treatment plan

1. What is your step-up plan if my attacks don't reduce in 3 months?
2. Am I a candidate for betahistine? What dose, and why?
3. Should I be on a diuretic (HCTZ, triamterene)? What are the trade-offs?
4. Do you recommend intratympanic steroid injections? When?
5. When would intratympanic gentamicin be considered?
6. What's your view on endolymphatic sac surgery for my case?
7. Is vestibular rehabilitation therapy appropriate between attacks?

Prescription & rescue

1. Can I have a prescribed rescue medication for acute attacks?
2. Which of my current medications could be worsening symptoms?
3. Is long-term antihistamine or benzodiazepine use safe for me?

Lifestyle & prognosis

1. What's a realistic hearing-preservation outlook for me over 5 years?
2. Are there driving restrictions I should follow?
3. Which sports or activities should I avoid?
4. Is travel (air, altitude) safe? What precautions?
5. What symptom change warrants an urgent visit vs. a routine follow-up?

> **Bring the data, not the complaint.** "I had 4 attacks this month, average severity 7/10, all within 48 hours of a barometric pressure drop >6 hPa" lands differently than "I've been having more attacks lately." The goal of your tracking is to make that first sentence possible.

Printable 30-day tracking template

Make 30 copies of the daily sheet below. Fill it in every evening — 2 minutes a day. If you skip a day, leave it blank; gaps are data too.

Daily entry — Day ___ / 30 Date: _____ / _____ / _____

Had an attack?	☐ No ☐ Yes — Time: _____ Duration: _____ Severity: (1) (2) (3) (4) (5) (6) (7) (8) (9) (10)
Tinnitus level	☐ None ☐ Mild ☐ Moderate ☐ Loud ☐ Unbearable
Hearing	☐ Normal ☐ Muffled ☐ Fullness/pressure ☐ New drop noticed
Sleep last night	Hours: _____ Quality: ☐ Good ☐ Fragmented ☐ Poor Woke at night: ☐ Yes ☐ No
Stress today	1 — 2 — 3 — 4 — 5 — 6 — 7 — 8 — 9 — 10 Main source: _____
Salt intake	☐ Low ☐ Normal ☐ High Caffeine: ☐ None ☐ 1 ☐ 2+ Alcohol: ☐ None ☐ 1 ☐ 2+
Water intake	☐ <1 L ☐ 1–2 L ☐ 2–3 L ☐ >3 L
Weather / pressure	☐ Stable ☐ Pressure dropping ☐ Storm incoming ☐ Altitude / flight
Trigger flags	Circle any that applied today: MSG · aged cheese · alcohol · skipped meal · loud noise · long screen · neck tension · travel · argument · medication change · allergies · cycle phase
Notes	_____

Weekly review (do every Sunday)

Attacks this week	Count: ____ Worst severity: ____ Total downtime: ____ hours
Trigger candidates	Which flags appeared in the 72 h before each attack? _____
Shared factors	What appeared in ALL attack windows but was missing on clear days? _____
Hypothesis	My top 2–3 likely triggers this week are: _____

Why manual tracking stops working around day 14

The method on page 5 works. The journal on page 8 works. But there's an uncomfortable reality: **most people quit paper tracking between day 10 and day 16.** Not because they're lazy — because manual tracking asks you to do three things at once:

1. Remember to log, every day, including bad days when you feel awful.
2. Write down data that doesn't feel useful yet, for weeks.
3. Spot cross-variable patterns across 30 rows of handwriting with no chart.

All three fail in the same places. Here's the honest comparison:

Paper journal

- Relies on memory — you'll miss 30% of entries by week 2.
- No weather data unless you look it up manually.
- Can't spot combination triggers without a spreadsheet.
- Your doctor gets a messy stack of pages.
- No reminders when you forget to log.
- Great for days 1–10. Falls apart after that.

An app built for this

- Automatic barometric pressure and weather capture.
- Streaks and daily reminders that keep you logging.
- Pattern detection across sleep, stress, diet, and weather.
- Exportable doctor report — single PDF with charts.
- Attack history you can actually search.
- Insights that update as you add more data.

This is why we built Meniere's: Symptom Tracker. Every piece of the method in this handbook is automated in the app — daily log, 72-hour lookback, barometric pressure watch, doctor-ready PDF export, and pattern insights that surface your personal trigger combinations instead of making you spot them by eye. It's free to try, and the handbook works whether or not you use it.

THE COMPANION APP FOR THIS HANDBOOK

Meniere's: Symptom Tracker

Every step of the 30-day pattern method, automated. Log in 20 seconds a day. Get your personal trigger pattern by week four. Export a doctor-ready PDF in one tap.

Automatic pressure tracking
Barometric + weather context on every entry — no manual lookup.

Pattern insights
Surfaces the 2–4 triggers that actually cluster before your attacks.

Doctor-ready PDF export
One tap. Charts, attack history, trigger summary. Walk in prepared.

Streaks that keep you honest
Daily reminders, gentle nudges. Solves the "day 14 dropout" problem.

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