MADISON NEUROLOGY · NEUROLOGY SYMPTOM GUIDE

Progressive or fluctuating hearing loss

Structured history, interpretation & clinical review

Symptom 77 of 94
Clinical educational workbook
Version 1.0 · October 2026

Not for clinical use. This guide cannot diagnose, triage, or exclude an emergency. Seek emergency care for severe, sudden, or worsening symptoms.

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> **Document purpose**
> A structured educational history and diagnostic-reasoning workbook. Treatment is outside its scope.

Scope and safe use

Progressive or fluctuating hearing loss is characterized by symmetry, course, tinnitus, vertigo, ear disease, family history, noise, and medication exposure.

Not for clinical use.
This educational workbook does not diagnose, triage, estimate probability, replace examination, or exclude an emergency. If a safety-screen answer is Yes or uncertain, follow the stated action rather than continuing routine interpretation.

How to complete the workbook

- Record the current episode and the person’s usual baseline; use a witness account for events with impaired awareness.
- Check one option per question unless a clinician documents a different combination. “Not sure” is unresolved information, not a negative answer.
- Complete the safety screen before all other sections. Record exact onset or last-known-well time for sudden deficits.
- Use Section 2 only after the form is complete. More than one pattern may be relevant; urgency takes precedence.
- Use Section 3 to plan focused examination and clinician-selected investigations. No test is automatic or universally required.

Specific escalation rule

New severe headache, new focal weakness or numbness, new speech/language difficulty, reduced consciousness, a prolonged seizure, severe breathing or swallowing difficulty, sudden visual loss, or rapidly progressive weakness requires emergency assessment. Call 911 in the United States.

Section 1: Input form

Checkbox history for Progressive or fluctuating hearing loss

1A. Immediate safety screen

Is there new face droop, one-sided weakness or numbness, difficulty speaking or understanding, double vision, or severe loss of coordination?

☐ No ☐ Yes ☐ Not sure

If Yes: Call emergency services now and record the exact time the person was last known well.

Is there new confusion, reduced consciousness, a seizure, or difficulty awakening?

☐ No ☐ Yes ☐ Not sure

If Yes: Call emergency services now. Do not leave the person alone or give food, drink, or medication by mouth.

Is there new severe breathlessness, inability to swallow saliva, blue lips, or rapidly worsening weakness?

☐ No ☐ Yes ☐ Not sure

If Yes: Call emergency services now; breathing and swallowing problems can become critical quickly.

Is there sudden loss of vision, a new missing visual field, or a painful red eye?

☐ No ☐ Yes ☐ Not sure

If Yes: Seek emergency eye or emergency-department assessment now.

> **Stop rule:** Any Yes answer triggers the action printed under that question. Any Not sure answer requires prompt in-person clarification; do not treat it as No.

1B. Timeline

How did the symptom begin?

☐ Suddenly, over seconds or minutes ☐ Over hours to days ☐ Gradually over weeks or months ☐ Longstanding or since childhood ☐ Not sure

Use the first occurrence for recurrent episodes; use the current episode for a changing symptom.

What is the overall course?

☐ One persistent episode ☐ Separate recurrent episodes ☐ Steadily worsening ☐ Fluctuating or variable ☐ Currently resolved

Has this exact pattern been assessed before?

☐ Definitely new ☐ The same pattern occurred before ☐ Present and stable for a long time ☐ Not sure

1C. Discriminating features

Which course best fits?

☐ Gradually progressive ☐ Fluctuating or recurrent ☐ Stable long-term difficulty ☐ Not sure

Are both ears affected similarly?

☐ Yes, broadly similar ☐ One ear is clearly worse ☐ Only one ear ☐ Not sure

Are there recurrent vertigo attacks, ear fullness, pain, discharge, or pulsatile noise?

☐ Vertigo attacks with fullness or fluctuating hearing ☐ Pain, discharge, or recurrent infection ☐ Pulse-synchronous sound ☐ None

Is there occupational/recreational noise, ototoxic medication, family history, or prior ear surgery?

☐ Yes ☐ No known risk ☐ Not sure

1D. Associated findings

Are there other neurological symptoms—weakness, numbness, speech change, double vision, swallowing difficulty, or severe imbalance?

☐ Yes ☐ No ☐ Not sure

Are there systemic clues—fever, weight loss, cancer, infection risk, pregnancy/postpartum status, or a new medication?

☐ Yes ☐ No ☐ Not sure

How much does this affect daily activity?

☐ Noticeable but activities continue ☐ Some activities are limited ☐ Cannot perform usual activities ☐ Not sure

1E. Clinical context

Who is being assessed?

☐ Adult or adolescent ☐ Child under 12 ☐ Adult aged 65 or older

Could a medicine, substance, withdrawal, or recent dose change be relevant?

☐ No plausible contributor ☐ Yes or possibly ☐ Not reviewed

Include sedatives, dopamine-blocking drugs, stimulants, decongestants, anticholinergics, alcohol, and non-prescribed substances when relevant.

Is there a relevant neurological, muscular, metabolic, cardiovascular, autoimmune, or sleep disorder?

☐ No known relevant condition ☐ Yes ☐ Not sure

What prior information is available?

☐ A previous examination or investigation ☐ Prior records but no clear explanation ☐ No useful prior assessment ☐ Not sure

Additional history and documentation

Record exact dates/times, witness details, relevant medication doses and changes, prior investigation reports, and the person’s baseline function.

Section 2: Interpreting the input form

Answer combinations generate a differential and an assessment pathway—not a diagnosis.

> **Precedence:** Emergency safety answers override every pattern below. Otherwise, the highest-urgency fully matched pattern takes precedence. If entries are incomplete, contradictory, or match no pattern, use the unresolved-information pathway.

Pattern 1: Fluctuating inner-ear pattern

Which course best fits? Fluctuating or recurrent
Are there recurrent vertigo attacks, ear fullness, pain, discharge, or pulsatile noise? Vertigo attacks with fullness or fluctuating hearing

Prompt clinical review pattern — Promptly

Fluctuating hearing with vertigo and fullness follows an inner-ear/vestibular assessment pathway.

Differential to review:

- Meniere-type or other fluctuating inner-ear disorder
- Age-related, noise-related, or hereditary sensorineural loss

Action: Arrange an in-person medical or neurological review promptly, usually within days. Seek sooner care if the pattern changes.

Pattern 2: Asymmetric retrocochlear pathway

Are both ears affected similarly? One ear is clearly worse / Only one ear

Prompt clinical review pattern — Promptly

Asymmetric persistent loss needs audiometric and retrocochlear evaluation.

Differential to review:

- Retrocochlear, vascular, autoimmune, or medication-related disorder
- Age-related, noise-related, or hereditary sensorineural loss

Action: Arrange an in-person medical or neurological review promptly, usually within days. Seek sooner care if the pattern changes.

Pattern 3: Chronic conductive pattern

Are there recurrent vertigo attacks, ear fullness, pain, discharge, or pulsatile noise? Pain, discharge, or recurrent infection

Prompt clinical review pattern — Promptly

Recurrent discharge or infection requires structural outer/middle-ear assessment.

Differential to review:

- Chronic conductive or middle-ear disorder

Action: Arrange an in-person medical or neurological review promptly, usually within days. Seek sooner care if the pattern changes.

Pattern 4: Symmetric exposure-related pattern

Are both ears affected similarly? Yes, broadly similar
Is there occupational/recreational noise, ototoxic medication, family history, or prior ear surgery? Yes

Structured clinical review pattern — Routine review

Symmetric gradual loss with noise, family, or drug exposure supports a structured audiologic and exposure review.

Differential to review:

- Age-related, noise-related, or hereditary sensorineural loss

Action: Arrange a routine in-person clinical review. New, severe, or worsening symptoms change this pathway.

Unresolved-information pathway: The entries need structured in-person characterization.

Prompt clinical review pattern — Promptly

Do not guess missing answers or convert uncertainty into reassurance. Document what is unknown, perform an in-person examination, clarify the timeline with a witness or records when available, and reassess if any new feature appears.

Action: Arrange an in-person medical or neurological review promptly, usually within days. Seek sooner care if the pattern changes.

Section 3: Clinical review

Diagnostic modules and focused investigation logic

The examination comes before a test list. Select investigations only after localization, urgency, comorbidity, pregnancy status, renal function, anticoagulation, and prior results have been considered.

3.1 Age-related, noise-related, or hereditary sensorineural loss

Discriminating features: Symmetric gradual loss with noise exposure, age, or family pattern and no focal ear disease.

Logical investigations: Otoscopy and formal audiometry; review noise, medication, family history, and functional impact.

3.2 Chronic conductive or middle-ear disorder

Discriminating features: Discharge, infection, perforation, otosclerosis pattern, or conductive audiometric findings.

Logical investigations: ENT examination and audiometry, with targeted imaging or other testing when indicated.

3.3 Meniere-type or other fluctuating inner-ear disorder

Discriminating features: Fluctuating hearing with episodic vertigo, tinnitus, or aural fullness.

Logical investigations: Serial audiometry and ENT/vestibular assessment; review migraine and other causes of vertigo.

3.4 Retrocochlear, vascular, autoimmune, or medication-related disorder

Discriminating features: Asymmetric/progressive loss, unilateral tinnitus, neurological findings, rapid fluctuation, or drug exposure.

Logical investigations: ENT/neurological assessment with MRI or targeted laboratory/vascular evaluation according to phenotype.

Reassessment and documentation

- If the symptom pattern changes, repeat the safety screen and timeline rather than carrying forward an earlier interpretation.
- If a test is unrevealing but the deficit persists or progresses, revisit localization and seek specialist review; a normal result does not automatically end assessment.
- If symptoms resolve, document duration, completeness of recovery, recurrence, and any residual deficit. Resolved sudden focal symptoms can still require urgent vascular assessment.
- If the history and examination conflict, obtain collateral information and in-person review rather than forcing a single diagnostic label.

Selected references

Sources provide background standards and do not replace local emergency pathways or current specialist guidance. Accessed October 2026.

1. Chandrasekhar SS, Schwartz SR, Bontempo LJ, et al.. (2019). *Clinical Practice Guideline: Sudden Hearing Loss (Update)*. https://pubmed.ncbi.nlm.nih.gov/31369359/

2. National Institute for Health and Care Excellence. (2018). *Hearing loss in adults: assessment and management (NG98)*. https://www.nice.org.uk/guidance/ng98