

Action Statement Profile: 5

- *Quality improvement opportunity*: Identify and treat conditions that can complicate the management of ARHL
(National Quality Strategy Domain: Patient Safety, Coordination of Care)
- *Aggregate evidence quality*: Grade C, based on evidence for the effectiveness of treating these conditions and harms associated with failure to treat including a randomized trial for sudden hearing loss and numerous observational studies demonstrating treatment effect
- *Level of confidence in the evidence*: High
- *Benefits*: Identify other treatable causes of hearing loss; identify situations where hearing loss requires medical/surgical management; more appropriate referrals to specialists; increase provider awareness
- *Risks, harms, costs*: Time to see additional providers; cost of additional visits; patient anxiety
- *Benefits-harm assessment*: Preponderance of benefit over harm
- *Value judgments*: Primary care providers need better guidance on when to refer patients with hearing loss
- *Intentional vagueness*: What defines “asymmetry” and “poor” discrimination will be discussed further in the subtext
- *Role of patient preferences*: Limited
- *Exceptions*: None
- *Policy level*: Recommendation
- *Differences of opinion*: Some members of the group wanted to specify that this should be a referral to an otolaryngologist. The GDG elected to keep it slightly vague to allow for different referrals that could be appropriate based on what is available locally

Supporting Text

The purpose of this statement is to identify or refer to a clinician who can evaluate for conditions that may coexist with ARHL and complicate the identification and management of ARHL. There are 3 types of hearing loss depending on which part of the auditory anatomy is affected: conductive, sensorineural, and mixed. Mixed hearing loss includes both CHL and SNHL. The key to management of hearing loss is correcting medically treatable causes and identifying the type and cause of hearing loss that is atypical of ARHL.¹⁶⁸ ARHL should be symmetric—both ears should exhibit similar degrees of hearing loss. Additionally, poor word recognition is generally considered when the unaided monosyllabic word score is less than or equal to 60%.¹⁶⁹

CHL

First, CHL occurs when there is pathology in the EAC or middle ear that blocks conduction of sound from reaching the inner ear. Examples of EAC obstruction include

cerumen, foreign body, stenosis, and atresia. Middle ear pathologies include tympanic membrane perforation,¹⁷⁰ middle ear effusion, cholesteatoma, or ossicular discontinuity or fixation such as otosclerosis.¹⁷¹ Rarely, inner ear anomalies can cause a CHL, such as a mobile third window, as seen in superior canal dehiscence.¹⁷² All these conditions can potentially be corrected with intervention, and, therefore, should be referred to an otolaryngologist for further evaluation.¹⁶¹

SNHL

The second type of hearing loss is SNHL in which the inner ear, cochlear nerve, or higher central auditory centers are affected. ARHL is 1 example of this kind of hearing loss along with noise-induced hearing loss and idiopathic sudden SNHL (SSNHL). SSNHL, hearing loss that occurs rapidly within 72 hours, is an otologic emergency covered in an independent CPG by the AAO-HNSF.¹⁷³ Initially, patients should be educated and can be offered steroids as soon as possible.¹⁷³ For treatment failures and/or patients presenting between 2 and 6 weeks after onset, intratympanic steroid therapy should be offered. All patients should have an evaluation to rule out retrocochlear pathology such as a vestibular schwannoma or meningioma.¹⁷⁴ In addition, autoimmune inner ear disease, infections such as Lyme, syphilis, and human immunodeficiency virus can also result in SSNHL. The patient's history and physical exam may warrant further blood and lab testing and subsequent treatment.¹⁷⁵

Identification and management of hearing loss that is atypical of ARHL is just as important as identification of ARHL. ARHL should be symmetric—both ears exhibit similar degrees of hearing loss. Cases of asymmetric sensorineural hearing loss (ASNHL) warrant further evaluation. There are several definitions of ASNHL summarized in **Table 6**.¹⁷⁶

Workup of ASNHL may include radiographic imaging and directed labs. The standard work-up for a patient presenting with ASNHL often includes a MRI of the internal auditory canals to exclude retrocochlear pathology, such as a vestibular schwannoma or meningioma.¹⁸¹ If history of head trauma is elicited prior to the onset of the ASNHL, computed tomography of the temporal bone may be useful to evaluate fractures or anatomic abnormalities involving the inner ear structures.¹⁸² Serological tests should only be ordered if a condition is suspected by history.¹⁸³ Despite the extensive and costly testing algorithm available, in the majority of cases, the etiology of the ASNHL remains unclear.

Statement 6: Patient Education and Counseling

Clinicians should educate and counsel patients with hearing loss and their family/care partner(s) about the impact of hearing loss on their communication, safety, function, cognition, and quality of life.