THE UNIVERSITY OF BRITISH COLUMBIA
Continuing Professional Development
Faculty of Medicine

UBC CPD
The Division of
Continuing Professional Development
Faculty of Medicine
City Square East Tower, 200-555 W 12th Ave
Vancouver BC Canada V5Z 3X7
ubccpd.ca

APRIL 9 WEBINAR TRANSCRIPT – RECOGNIZING AND RESPONDING TO HEARING LOSS IN ADULTS: WHAT EVERY PRIMARY CARE PROVIDER NEEDS TO KNOW

Note: Transcript may contain errors

Introduction

Good evening everybody, it's great to see you here tonight.

I am Dr. Chris Morrow, the associate Dean of UBC's

division of continuing professional development,

otherwise known as UBC CPD.

I will be your moderator tonight and I'm happy to

welcome you to this webinar, recognizing and responding

to hearing loss in adults.

What every primary care provider needs to know.

We are very lucky to be joined by a panel of experts

who will be introduced shortly.

I would like to begin by acknowledging that the land on

which UBC CPD offices are located is on the unceded

territory of the Squamish, Musqueam and Tsleil-Waututh

nations.

And in reflection, I would like to consider and I will

be listening today to the talk and think about how

these principles we learn in care ideas relate to

Indigenous peoples.

We know that Indigenous culture is a very verbal culture and as a result, we can imagine that hearing is terribly important to Indigenous people as well.
We also noticed that Indigenous children are known to have a higher incidence of early hearing loss.
So that is what I will be keeping in mind as we move forward this evening.
I would also like to recognize that all of you are joining an evening from many different places.
Full to you here.
If you like, a few more details about the webinar.
I would like to thank think UBC language scientists, the Hamber Professorship in Clinical Audiology and the Canadian Hard of Hearing Association, BC chapter 4 providing funding to support the delivery of this webinar.
We are happy to be providing live captioning for this webinar through StreamText.
If you would like live captions to accompany tonight's presentation, you can scan the QR code on the screen in front of you.
Use the direct link included in your email if you wish as well.
This is a 90 minute webinar.
There will be opportunities during tonight's session for questions at the end and we will be using this website to review your questions.
You can access the site by scanning the QR code on the screen or by going to the website and entering the

event code, audiology.

That is audiology.

There is also a direct link in the email invitation you received.

We will try to get to all of your questions and if you know how to upload by giving the thumbs-up to a question you are interested in having answered, those questions will rise to the top and I can get to those before others.

And if you are having any technical difficulties tonight, have no fear.

We are recording the entire event and you will be getting a copy of the recording at the end.

At the end of this session we would really love it if you could take a few minutes to complete the attendance evaluation form.

You can access these forms by way of the email you received for the session.

And in order for participating physicians to get your study credits, you have to complete the online attendance form.

So we've got some learning objectives.

Four of them in total.

First we will identify and implement strategies for optimal communication with patients who have hearing loss.

Next, describe the roles of primary care providers, hearing health care providers and otolaryngologist in the patient's hearing health care.

We will discuss screening for hearing loss and finally look at tools in pathways BC to support patient's hearing health.

These are disclosures from your presenters, take a moment to have a look at those.

And also we have some disclosures from our planning committee.

It is important to note there are no conflicts of interest and any financial relationships have not influenced the content of tonight's webinar.

So now I will handed off to her first professor,

Dr. Mark Hansen.

Please take it away.

Presentation: Mark Hansen

>> Hello, everyone.

My name is Mark Hansen, I'm an audiologist, retired audiologist.

And I want to start by noting that many of you likely see older clients that have hearing loss.

So I would like to present the following scenario.

A 73-year-old male patient arrives at your office with an issue that is unrelated to hearing or hearing loss.

He describes himself as active and independent.

He reports good overall health.

He has adhered to notices from his primary care provider for cancer screenings, he sees an optometrist regularly and he wears glasses.

The primary care provider has not raised the issue of

hearing screenings to date and as far as the primary care provider knows, he has not had an assessment on his hearing.

During the primary care providers assessment of this patient's complaint, the primary care provider has had to repeat their questions to him.

However, he seems to not notice this.

As a result of this interaction, the primary care provider has two concerns.

One, is the possibility of hearing loss and/or cognitive changes.

And to, the difficulty of conducting the appointment within the available time, given the added time needed for communication repairs.

And we will come back to this scenario later on.

Next slide, please.

Now that we have a picture of a typical older patient presenting possible hearing loss, let's review why hearing and hearing loss is important to address.

And on this graph, you will see the proportion of Canadian adults with measurable hearing loss.

And also the gap between those with measured hearing loss and those with self-reported hearing loss.

Noticed that the prevalence of hearing loss increases with age.

And notice the percentage gap between objectively measured hearing loss and those self-reported with hearing loss.

And that people wait an average of 7-10 years to seek

help.

Next slide, please.

The impacts of untreated hearing loss.

Social withdrawal, disengagement and loneliness.

If communication is difficult and social events, that may lead people to withdraw and ultimately disengage and feel lonely.

Cognitive decline.

It is important to notify there has not been a causative link found but the social withdrawal that I just mentioned may be an important mediating factor in all of this.

And untreated hearing loss increases the risk of falls by 1.4 times.

This is true even if the loss is unilateral or mild.

Next slide.

At this time there is no evidence that hearing aids and slow, stop reverse cognitive decline.

But there is potential for improvement in all of these areas.

Next slide.

Breaking barriers.

I have been involved in this research project, looking at the role of primary care providers in hearing health care.

Next slide.

And here are the project team leaders.

Next slide.

The project purpose is how we can support primary care

providers to ensure their patients with hearing concerns access hearing health care and commit to treatment.

Although as we have seen from the vignette presented, not all patients will present with awareness or concerns about hearing loss themselves.

Next slide.

Why primary care?

In our research, participants in the project reported that not enough focus on hearing loss by primary care providers as being a barrier to hearing health care in BC.

And this is backed by the literature that primary care providers are the first point of contact for health concerns.

Primary care providers only refer about 50% of the patients who report having hearing concerns.

They do expect primary care providers to play a role in hearing health decisions, including where to seek help, whether or not they should purchase hearing aids and so on.

And it is important to -- primary care providers are the most important social influence or with respect to patients seeking hearing help.

Next slide.

The project overview.

We are here today as a result of the whole research project which included three sources of data.

Those being a literature review, examined from around

the world, surveys of primary care providers in British Columbia, and focus groups within British Columbia.

This lead to understanding providers knowledge and attitudes on hearing health care.

Their practices and barriers and facilitators faced by primary care providers.

Which then led to educational intervention and learning objectives for primary care providers.

And formatting of the educational material.

Next slide.

Some of the main barriers for primary care providers are...

Lack of time, no or insufficient reimbursement, patients not raising hearing concerns, hearing loss not seen as a pressing issue in relation to everything else going on, lack of knowledge about how to do the screening and concerns about treatment costs for patients.

You may have experienced some of these barriers yourself.

Next slide.

This slide shows the themes of education and training coming up.

Next slide.

From the research project, read and by the primary care providers in BC have an important role in hearing health for adult patients which includes recognizing and screening for hearing loss, determining when to refer to EMT and medical follow-up and when to

recommend an audiologist for hearing assessment or intervention.

And optimized medication with patients with hearing loss.

And with that, I will handed over to Gael Hannan.

Presentation: Gael Hannan

>> Good evening!

My name is Gael Hannan and I am a person with hearing loss.

And I will be talking to you in that role tonight.

So when I am in an appointment with you, primary care provider, you may notice me staring at you.

Where that my eyes intently follow your every movement.

Or perhaps I answer inappropriately more than once.

Or I seem more anxious than the nature of my problem that I came to see you about may indicate.

And this is the point where you may ask, house for hearing?

We may say, it's fine for my age.

Or no worse than anyone else's.

Or even "it's fine, but my family may not agree".

Or even, "you know, I have been struggling a bit".

Most of us under a doctor's appointment with some degree of anxiety.

Will hurt?

What's wrong?

Having a hearing loss that has not been acknowledged adds an extra layer of anxiety because we time trying

to understand what the doctor is saying and hiding that effort, than on the actual problem that brought us here.

Communicating with hearing loss requires deep wells of energy.

It is not something we do in the background while completing another task, it is the task.

Hearing people, that is what we call you people who don't have hearing loss, you do what comes naturally.

You here.

You cannot help it.

We must work at it.

We don't want you to think that we are old.

Even if we are.

Or we are no longer as capable.

Or that we are somehow lesser then.

We don't want to have it.

And this is the stigma of hearing loss that we carry inside, unspoken but deeply felt.

People who try to hide or ignore their hearing loss have not yet connected the dots between hearing loss and health.

Your patients don't want to admit to you, let alone themselves, that their hearing has changed and that they themselves seem to have changed.

And they don't want to bother you.

They don't think it is bad enough or worthy of your time.

And they simply don't know how to self-identify or even

what to ask for.

So even though I had hearing loss for my entire life,

it took a seismic moment at the age of 42 transition

from a heart of hearing person bluffing my way through

life, to addressing hearing loss, my hearing loss in a

more positive way.

I was expecting a baby.

A baby.

For the first time, my hearing loss worried me.

What if I couldn't hear him?

What if I couldn't hear my baby burp or cry or breathe?

I couldn't bluff with my baby.

But I didn't know anyone with the lived experience to

answer my question.

So I reached out for help from the expert -- other

experts, the people who live with hearing loss.

At a conference, a woman with a baby sat down to talk

with me.

And she said, Gael, you can do this.

I felt the stigma vanished.

You know I left that conference with a new and powerful

self image as a person in charge of her own hearing

loss journey.

I was not alone.

I had the right to ask for accommodation.

I was validated.

I embraced new behaviours and healing attitudes that

transformed my conversation and kept my baby safe.

The big thing, my goal changed from wanting to hear

better, to wanting to communicate better.

I learned how to do it.

Yet my moment is probably not the norm for most people

with hearing loss.

We don't ask for help.

Living well with hearing loss isn't instinctive.

Just because we have it doesn't mean we are good at it.

If we don't learn helpful strategies in addition to

hearing aids and share our needs with other people,

they won't know what to do either.

You, your patients primary care Director can help

create similar moments for your patience by screening

and discussing possible next steps, such as referring

them to a hearing care professional or, as Mark said,

to an EMT for medical.

You are the one.

You are the one who can do this and we trust you.

But it is important that they understand that they are

not just being referred for a hearing aid.

That is what they are afraid of.

But what they need to understand is that they are being

referred for an assessment.

And if hearing loss is diagnosed, the ultimate goal is

improvement in their hearing and communication help.

This will help improve their relationships because

hearing loss takes its biggest fist to relationships

and also to activities in their lives.

They must learn how to do it.

And to do this the need to understand that their

emotion, the frustration, the shame is valid.
They need to accept the right to participate, to hear and be heard.
So ask us, how is your hearing?
Help us take that next step to a better hearing journey.
Help us to understand that hearing loss is common.
And when we gain the confidence and advocate for ourselves, we will decrease our bluffing.
Which is something that all people with hearing loss due and frequently.
We pretend we understand what is being said but we may not even have a clue.
When the conversation is difficult, when there is noise, when there's not enough light and when there are too many people in the conversation, it is so easy to slide into bluffing with that little Monalisa smile.
The nods.
Copying what other people do.
We do it all the time.
I'm a master bluffer.
I bluff my way through a wedding proposal, a marriage proposal.
Luckily I am a good speech reader.
People cannot communicate well with us if we don't express our needs.
And you, are primary care providers can enable and model good communication by facing us with face-to-face conversation.

Don't talk to the computer, don't talk to other body parts.

Wait until you can do eyeball to eyeball with us.

Speak at a regular pace and speak up -- you know all of this.

We don't need you to yell or over unknown C8, speak clearly.

Keep the office door close, well-lit, ask if anything was unclear and allow us to use speech to text on our smartphones if we are evolved enough to ask about that.

Most of this you do already.

My hearing care professionals are among my favourite people.

They help me with technology, my hearing aid, my cochlear implant and all of the other doodads like remote captioning, TV streamers, all of these things make our lives easier.

And the best of them, the best of these hearing care professionals help me recognize and deal with the very real emotion of hearing loss.

Enclosing, hearing loss impacts communication and communication is the glue that connects us to each other.

With you, are primary care provider and are hearing care professionals and our own desire to communicate better, like with hearing loss, will be immeasurably better.

And now I will pass it over to Dr. Tracy Monk.

Presentation: Tracy Monk

>> That was fantastic.

And I suddenly feel the pressures of primary care providers to do better.

And I'm glad there is a tool and pathways that can help me to better and actually, your comments are helping me to understand how I might use this care pathway and pathways to support me doing the things that I probably forget to do most of the time.

So there is a care pathway about hearing loss in pathways.

And one way to get to it, I'm on the landing page here, is to select the specialty and you can notice at the top of the pathway -- are at the top of the page showing me all of the different specialists and their wait times, is a hearing loss care pathway.

And if I open that up, it has got some quick links to audiology, clinician tools, the red flags and it has us go through the basics.

Does my patient have a hearing loss problem, does your patient answer yes or maybe two if they think they have hearing loss, of course we check for wax first.

There's also this hearing loss questionnaire that you can email to the patient from a no reply email or, I think I will suggest to my staff if they noticed that someone seems like maybe they have some hearing loss, print this and give it to them in the waiting room.

And if they score more than six on this, a referral to an audiologist is indicated.

But you can also email that to the patient or staff if they have been noticing that maybe somebody seems to have hearing problems when they are talking to them on the phone.

They could email it to the patient.

And when you go to email something from pathways, it will open up an opportunity to email it and then you will be able to -- if I went ahead and email that I could send it to one of our pathways staffed people.

I could add here is what we talked about and it will come from a no reply email so it doesn't expose your email to the recipient.

And you notice when I do that I get an opportunity to copy some text to my clipboard about the fact that I emailed that.

And I can paste it into my chart if I have my chart open or if my staff had their chart open.

Some additional things in the care pathway.

That is the hearing health, we will go back to the specialty of ENT and open up the care pathway again.

If we scroll further down, you can see that if they have sudden onset hearing loss, think about doing the Weber and Renee testing.

I always forget those and we have someone going through that later but this is a great reminder for those of us that keep forgetting which one is the Weber, which one is the Rinne and what they mean when we try to differentiate between.

And hear some of the key points that Gael made about

hearing loss and why it is important and the role of the audiologist and speaking face-to-face, minimizing background noise, rephrase misheard sentences.
And I will point out to you that pathways also in our search has a generative summary.
So I could type something like communication strategies for patients with hearing loss into the search and you will notice it gives me -- it mentions the hearing health pathway that we were just looking at.
And it says there is also referral to other services.
And so there is potential helpful advice from that as well.
And another way to get the care pathway one good ways to select the specialty, the other is just to type hearing loss in the search.
And he noticed the care pathway, with this care pathway symbol coming up to the top.
And here we are again at the hearing loss care pathway.
And there is also handouts that you can email to patients.
And I will point out that the hearing loss handout from HealthLink's multilingual.
And that one is handy to note that it will be in multiple languages for the patient.
There is also an ear wax handout, at tonight's handout and if you have a patient with unilateral facial findings, there is a link here as well on how to differentiate Bell's palsy from Ramsay Hunt.
So lots of useful things here.

I will stop and pass it over to the next presenter.

Presentation: Sukwhant Jassar

>> Thank you so much, Dr. Monk.

Hello, everyone, thank you for joining us tonight.

My name is Sukhwant Jassar and I'm a family nurse practitioner working in primary care.

So I will carry on.

We can actually go to the next slide.

Thank you.

I will carry on from the case presented earlier.

So we have a 73-year-old male presenting for his regular exam.

The primary care provider had to repeat their questions during the exam and has concerns surrounding their hearing and/or cognitive changes.

So is Dr. Hensen mentioned earlier, primary care providers, or the first point of contact for patients and play a pivotal role in screening for hearing loss.

So firstly, we would want to ask the patient if possible, family members, if they have concerns surrounding hearing.

And disclose that we have some concerns surrounding their hearing and potentially their cognition.

Next slide.

So we would then receive patient consent for further testing and start checking for simple causes of hearing loss, such as hearing impaction and reflecting on time constraints faced by primary care providers and the

value of team-based care, we can collaborate with our teams, such as involving nursing colleagues to further screen for hearing loss using tools such as the hearing loss questionnaire that is the question at that is recommended in the care pathway.

And nursing staff could also perform here flushes if the primary care provider detects impaction, followed by the hearing loss questionnaire and further use cognitive screening tools, such as the MOCA as applicable.

Next slide.

So here is the hearing loss questionnaire.

And the questionnaire recommends connecting patients to an audiologist if the patient score is equal to or greater than six.

Next slide?

However, noting what we follow the care pathway, once hearing loss is identified, the next step is to determine if the patient is presenting with red flag symptoms, in which case a referral to ENT is warranted first.

So the primary care provider would finish their subjective exam while acquiring red flag an orange leg symptoms.

It is also encouraged for primary care providers to complete the Weber and Rinne test in order to differentiate between sensory, neural and conductive hearing loss.

Next slide.

So here is a very clear illustration on completing this testing.

And Dr. Monk shared this earlier on the care pathway.

Essentially, in healthy patients without hearing loss, when performing the test, the patient's -- the patient hears a sound equally in both years, which is noted as midline.

And when completing the Rinne's test, air conduction is better than both conduction.

For a patient with conductive hearing loss in the ear, when completing the test, sound localizes to the affected ear.

And when completing the Rinne's test, bone conduction is greater than air conduction when you see the affected ear.

And for a patient with sensorineural hearing loss in one ear, when performing the Weber test, sound is heard in the unaffected ear.

And when performing the Rinne's test, it is greater than bone conduction.

Next slide.

So let's say with this case are older adult patient has a presentation of gradual onset hearing loss, there are no flags and they are scoring greater than six on the hearing loss questionnaire.

We can then suggest an exam with an audiologist for the patient and provide them with audiologist resources in their geographical area for self booking.

And the hearing lost care pathway includes a link to

the speech and hearing BC website to locate an audiologist nearby for the patient.

If there are red flags referred to ENT -- so for patient resources, the care pathway also includes links to HealthLinkBC with information on hearing loss in adults in multiple languages, a link to WorkSafe BC with information on how to prevent hearing loss in the workplace, and a link to Balance and Dizziness Canada website on tinnitus.

So now I will hand it over to Dr. Nardia Strydom.

Presentation: Nardia Strydom

>> Thank you very much.

I am a family physician here in Vancouver.

That is where I am.

And this is a really important topic.

So if we go to the how to address some of the resistance people might have when looking into and investigating their hearing loss.

I am surprised how resistant by patience and many of my friends are in trying to address this.

So what we want to do is try to understand what is going on for them and ask in very specific situations.

Some of the things I think about do you think everybody else is mumbling around you and do you find yourself at a family dinner or a restaurant missing bits of conversation?

People just sort of smile and nod their head but they are missing out on stuff and they are missing out on the banter like you are speaking too fast or are they

finding that social gatherings are getting harder to attend and because they are not as fun because they are not hearing stuff do they just not go as much?

Those are some of the things you can really try and get into with your patients and I find that is really useful to sort of really try to understand that a little bit more.

If we look at the next slide one of the other big things that you know that I hear from my patients and my friends is that hearing aids do not work and another one is they say they do not want to become dependent on their hearing aids and one of the things people commonly complain about is that when they have hearing aids and their friends have hearing aids everything is just too loud and from personal experience I agree it is.

I got hearing aids a year ago and I can tell you the very first time I went skiing with my new hearing aids I completely freaked out.

My kids were like mom, what is wrong?

The chapter, the noise of the ski and the snow was so overwhelming I kept thinking I was going too fast I was in a dangerous situation and it is different as somebody that was hearing things that were normal when I complained about like the restaurant or the eating area being too loud my daughter just smiled and said yes it is loud and here it is always loud in here you just have not been hearing it for the last probably five years so I think reassuring to patients that

hearing aids work and that they do a really good job
and that their hearing loss is a very treatable and how
much it has been improving their quality of life is
something we can really seriously take on to move
patients forward with this.
And then if we look at the next slide I think we are
counting more the cost and that is something that
patients will bring up very quickly and again a lot of
people will talk about other things that maybe cost a
lot of money.
So may be thinking about dental work that is not just
costly but super painful.
And the braces they might be advised to get so this is
a very comparable and you know I remind people that it
is also when they see an audiologist it is a
professional service and in my case I've been here for
multiple fittings and trying different hearing aids and
adjustments to get everything just right for me and so
that is absolutely worth paying for.
And then at last but not least in terms of being
connected to the right resources and pathways and there
are a list of providers there that we as care providers
can say here are three cases near you or here is
somebody here is a group of people that I can recommend
that goes a long the way all right, and now I think I
am handing over.

Presentation: Kaishan Aravinthan

>> Thank you perfect timing for the lights in the

building I am in to go out.
I'm a first year resident at UBC surgery -- surgery programme, ENT.
And then kicked in the care providers who are here for this presentation a backbone of hearing intervention
next slide, please so a little bit more I guess on the assessment side and specifically in relation to some sensory hearing loss ideology and ears are a difficult topic for everybody challenging things when it comes to assessment and diagnosis so I will try to simplify things around sudden sensory loss because this is an urgent emergency you do not want to miss the approach that I like to take is when talking to a patient and assessing them is this a sudden loss or more of a gradual loss?
More conductive versus sensory hearing loss and that is where tuning forks come in as a very important assessment.
Unilateral, bilateral, what are the other associated symptoms?
We think of those four things that gets us most of the information we require to figure out the next steps
next slide, please so I will use of vignettes here at this is relatively common presentation for us.
55 year old female presenting with hearing loss in one ear so unilateral that is acute in the last 24-48 hours some form of upper respiratory tract infection as well as tinnitus in that same year.
So here applying that principle that we discussed on

the previous side -- slide we have sudden hearing loss just effective aetiology.

We should be thinking is the sensory hearing loss?

We will use the physical exam to try to confirm the diagnosis next slide, please.

So when we look at the ear always it can be challenging to identify what is going on with the middle ear space if we are not looking in the ear all the time but if things look overall normal for a patient presenting with a sudden hearing loss again, this is not an infection, this is not a traumatic cause this is more likely sensory motor hearing loss we really want to use those tuning forks of possible this is an excellent tool for giving you a lot of information at that point of care moment.

If we are seeing air conduction and if this is still superior to bone conduction than I think there's a sensorineural hearing loss and we are more again this is sudden sensory neuron hearing loss and we work to treat this patient next slide.

There has been a couple slides on this already and it is really grate the pathway gives you a simple way to understand with the tuning forks this is a table that I have and that I used to try to simplify things the Weber is really important and when we get consults about sudden hearing loss one of the things we want to know is did you do a Weber and what year did it latter lies, if it collateralized -- lateralized.

Probably a good sign it is not sensorineural hearing

loss but the Weber is really important next slide the next topic that I know there is always lots of questions about and we get lots of questions on call about us what do we need to do for next steps and there is a lot of controversies as well as some minor shut around the options really there are three main stage options panic steroids and hyperbaric oxygen therapy you will find varying levels of evidence for the options at the primary care level or the initial point of contact it is in the oral steroids you may or may not initiate.

The interest in panic steroids is either something that ENT will initiate or may not be available depending on where you are and lots of good information on that around how to initiate that.

Next slide.

So to review, it is really important to try to keep things simple when it comes to ears and focused so ask yourself if you are worried about sensorineural hearing loss is this a sudden loss?

Is this sensorineural getting in with the tuning forks especially the Weber exam, and this is also is this correlating with the neural exam of the ear?

With those three things you will have a high degree of suspicion and we will make sure we get this patient scene by ENT if you have access to that get an audiogram of possible to confirm the diagnosis that is a huge advantage if we have that information to correlate with exam findings next slide not for the

sudden sensorineural hearing loss patient but the subacute or chronic hearing loss patients sometimes they wait for ENT is unfortunately not really ideal and in that time there are other things that we can do to help the patient out see an audiologist for alternative strategies, complementary strategies, not just hearing aids can be really useful.

The audiologist has a wealth of information to get access faster.

There are a lot of good peer support groups that patients can access and as pathways get carved out with regard to hearing loss there will be more patient care resources that can be accessed in the meantime.

And I think that is my last slide.

Q&A Period

>> Amazing and thank you to our panellists for the presentation and the discussion and then we will move onto our Q&A session so just a reminder we are using sli.do.

So that is where you can ask your questions.

I have a few questions here so I will jump to one that follows up on what you just discussed.

So the question is most sudden hearing loss is probably due to middle ear effusion or a eustachian tube dysfunction.

What is the most effective way to ensure we do not miss a sudden sensorineural hearing loss?

I know you touched on that maybe work through it again.

>> Thank you for the question.
A lot of hearing loss can be secondary to middle ear infusion but if we kind of follow that framework this kind of highlights the importance of tuning forks we should not have a tuning fork that is lateral icing away because we have a conduct -- conductive hearing loss.
So tuning forks if done correctly should point out if this is not a sensorineural hearing loss and if you were doing and otoscopies exam it is harder because of this it takes some practise but you should hopefully be able to see a middle ear effusion.
But there options if you are not 100% sure what you are looking at.
Another good point if you do not have access to tuning forks there are other things you can do.
If the patient is humming they can tell you if they are actually working on a phone, if you were talking, if you cannot see them in person if they tell you that they are hearing that louder that is not a normal finding and not a replacement for the tuning fork if not able to do tuning fork exams that is something you can do to try to test where this is lateral icing.
So most physical exam should kind of hope get -- help get you out of that situation.
>> Thank you for answering that and again just to reiterate that pathways have that information on there so if you forget that you will see that information, okay.

Maybe this one will be for our audiology colleagues what do you recommend for audiology as opposed to just asking patients to self refer for assessment they initially present with hearing loss or possible hearing loss.

>> There is certainly a distance when you ask for referral you would likely get a report back from the audiologist.

If you asked for informal referral may not get a report back from the audiologist.

>> Can you just describe the role of the audiologist? What level have they taken two before this becomes something that you would want to send to ENT?

>> Good question.

One of the biggest components of an assessment is gathering the information from the patient and that can take anywhere from you know just a few minutes to half an hour or longer.

And then of course bone conduction testing, speech testing and noise testing there is of course a lot that goes to it.

Coming out in the report that would go back and that is where you have something as a primary care provider that gives you the direction.

>> Can I ask you a question?

I have noticed that even if I have not referred the patient to the audiologist if they notice unilateral hearing loss that they send me a report even if I did not make the referral because they are concerned and

what the patient referred to ENT?
>> Sudden sensorineural hearing loss is point of origin
referred to you know immediately.
>> But if it was unilateral I would get notes like it
is asymmetrical.
>> We will stick with sudden sensorineural hearing loss
so what are they chance was sudden sensorineural
hearing loss incident also have an impaction which
maybe causing the problem how do you avoid that in that
case?
>> A lot of patients will have...
And if you have seen enough patients with a lot of the
complaints it is where for it to build up to such a
level it causes a profound level of hearing loss that
the patient notices.
We would not expect it to build up and suddenly cause
acute onset hearing loss.
Possible to have a degree of hearing loss for cleaning
gears a lot patient will say it feels better I can hear
a little bit better but they do not necessarily come in
usually saying so for the patients kind of have a lot
of cerumen many of them come in saying I cannot hear
and it ends up being we just need to assess their ear
and you realize you can't see anything with the ear and
like I can hear a little bit more so the onset would be
acute not necessarily due to that we might not be able
to examine them as well but the history of the tuning
forks still helps you decipher this.
>> Just a quick comment how safe is trying to flush

cerumen out?
>> Compared to patients using body paint and Amazon devices it is safer I think a challenge is we often advocate for the benefits of having cerumen in the ear and I think being able to educate patients on that is useful as well because there are a lot of benefits to having a reasonable amount and microbial benefits if done safely on a low-pressure higher volume as opposed to high pressure it should be fairly safe but we still see patients that have either symptomatic complication where they become very uncomfortable they become potentially litigious if there is per information -- of preparation or there are patients that get a perforation because maybe the flushing is somewhat aggressive but there are a lot of patient -- patient's who have flushing with no problem at all.
>> We will switch gears a little bit so what are some difficulties with using accessibility aids for example during clinical encounter with patients who are profoundly hearing impaired?
Even when they have hearing aids as well?
Any experience with this?
>> Absolutely I have done a lot of work with older patients in the hospital and end-of-life care and they often have an amplifier right there waiting when I have come in to see them and it works quite well so I most often always ask before I go to see somebody if they have a hearing impairment if there will be a communication issue and what devices the care team has

been using and what has worked for the patients so absolutely in my experience it works very well.

>> Excellent.

We will ask another question of our audiologists I don't know if this needs clarification, what is the quality of an audiology assessment compared to free and paid hearing tests you know the places where you can come in and get a free hearing test?

>> Are free hearing test may be...

More than likely if you see an audiologist you will get a full assessment the difference being that every hearing assessment you have to pay for the assessment that is going to be the biggest difference.

>> Thank you okay here is another one.

How solid are the links between hearing loss and dementia and which kind of dementia so where are we at with the science behind hearing loss and its connection to dementia?

>> Is that a question for me again, Mark?

>> It is for the panel or anybody who wants to take a shot at it.

>> I would reiterate there is still no positive link between dementia and hearing loss the correlation.

>> Similar to the slides that we had earlier I have not seen that either but have to talk about the social benefits and the holistic benefits of hearing amplification inpatients especially as we age.

I do not think anybody could say that there is a solid light link.

>> Can you get a trial period when purchasing hearing aids?

>> Yes all hearing aids come with a trial period. Just because they are sold with warranties... And services that come with them the dispensing of hearing aids is regulated by the College and all of the rules set up by the college.

>> We have a question here about tinnitus. We were not intending to talk about tinnitus extensively because that could be a webinar in and of itself but any comments about tinnitus and the use of hearing dates for this condition.

>> Tinnitus is a hugely prevalent concept that we see in our clients both in ontology clinics in general and ENT clinics I find that with tinnitus and watching a lot of the more experienced faculty see a lot of these patients I have learned that it is really about talking power to the patient by the time the patient sees you they have probably been told there is nothing to do a couple times and part of that empowerment is to explain the role of hearing loss in conjunction with tinnitus and explaining that the hearing aid or amplification can be a tool that may benefit and masking the tinnitus and kind of trying back to the question around trials for hearing aids theoretically they should be able to mask hearing loss and hopefully provide some benefit with regard to attendees but I would always suggest you try and see if this will provide enough of a benefit for you so definitely a role for patients to have an

audiogram showing.

>> I think you will share your screen.

>> So here we are and all you need to do is take tinnitus into the pathway and you will see, if I was looking for consultants you would see if I could do that I was looking for the diagnosis and management guidelines so click into that there is a handout from balance and dizziness Canada that is a useful dizziness handout and I often send them this one sleep apps and white noise and sound therapies if we clicked into the management the AA FP management guidelines if you go to it these are the guidelines that they do mention the use of hearing aids for sound masking.

So this is the clinician tool and the guideline if we click on that and if we want to look at the patient info items there is the handout from balance and dizziness Canada and there is the list of apps as well and again you can email it these things so this is you know this explains what it is and what the findings are and what causes it and if I had wanted to email two of them to the patient I could go to the specialty of the ENT and then go to the patient info tab and select the topic of tinnitus and then I have both of those.

And then I can combine them both into a bundle and send both of them to the patient and I could save that in the future as an email bundle about tinnitus and maybe I will show one other thing if you type patient info tinnitus into the search you will see the generative summary also takes you to that page faster if you

wanted to email multiple items I can go and now I am at the page ready to email so the generative summary if you type the words patient info before the topic that you were looking for the generative summary will take it quickly to a page are you can email multiple items.
>> We are back on sudden sensorineural hearing loss so the question is how do you obtain an urgent audiogram maybe we can expand on that question a little bit to say how quickly should the patient and the office to be moving on this and should they maybe be sending the patient for example to the emergency department or should they try to contact ENT from their office anyways I will open that up.
>> I guess you will weigh in as a primary care provider as well so did you want to go first?
>> That is a great question I was actually just thinking about that while I have been listening to everybody what would I do if the patient presented with sensorineural hearing loss in my office.
I know I would go to the pathway and look at the steroid dose sink and pat myself on the back because I did the Weber and Rinne test and then I pondered what I do an urgent referral.
That is what I feel I would do.
I would look into pathways of ENT refer ability and make sure the MOE is aware and I am a little bit OCD with these things so I would probably follow up on it on the next day and make sure that the ENT office has received the referral but then I did wonder is this a

case where I would send the patient directly to the emergency because they are going to get that connection quite quickly because I also worry about the reality of primary care patients might say I never received my employment, right?
Or lots of other various constraints and barriers so back to maybe Tracy you have your hand up.
>> I would do the same although I probably would not send them to emergency I think it is important to point out that when you look at pathways so I will just share my screen again so if sudden sensorineural hearing loss within 72 hours of urgent ENT referral is indicated so you can click here and it will take you to a prefiltered page of ENT but it says average nonurgent wait times do not let that make you think that all ENT you see with hearing loss would not see a sudden sensorineural hearing loss urgently so in a way it almost does not matter with the wait time is here because they will see sudden sensorineural hearing loss urgently and so all of them will say they have a shorter wait time for referral so I would do the same as you like make the urgent referral and then say to my staff call tomorrow to make sure that they acknowledge receipt of the referral and they would start the patient on the steroids while I was waiting that would be my usual what would you do?
>> I do not think either of those are wrong it would be interesting to know from the ENT point of view you know we have workflows and you know ENT has their workflows

and how does that work flow work best?
Because they make I do not know what you guys prefer to have it come through?
That is a city where you have ENT available through your ED but if you are working in a community that a small you might not have that.
>> I think would stop the steroids and then would have to withstand the community system.
>> Do you want us to send them to emergency or call ENT?
>> Maybe before you go I will give the emergency perspective I see a lot of people with sudden hearing loss and a lot of them have been sent in by a primary care provider basically my task is the same thing is to examine them and decide if it is sudden sensorineural I had the benefit of having immediate access with possible neurologic abnormality.
And then we decide together if we are going to start steroids or not.
>> At least here in Vancouver at Vancouver coastal sites we actually want that cola.
We have asked to be called so that we know about that referral so we can flag it.
So investigations to make sure this is not vest.
Get triage and referrals for a couple of days and huge power of referrals that happens huge burden and has potentially benefit as a long weekend a whole bunch of sudden sensorineural hearing loss is from the Friday getting ready for the Tuesday and just makes my time

window shorter so call us talk about the case because sometimes actually I find the benefit of the conversation and the story is not convincing and we can decide not to give that patient a high dose for it a longer period of time.

The second thing I would indicate for with the audiogram we try our best to use our in-hospital resources for audiogram selectively because it is a precious resource that we have from some complicated testing and in the community there are tons of audiologists who can perform high level audiogram's which are sufficient for the case.

Even if it is not the strongest story we do not really think twice and I think the audiogram is essential for us to know there is profound hearing loss there.

So that is a valuable tool for our workflow and we need to see that audiogram to see the degree and where it is before I would start with steroids.

I have the benefit I can access to audiogram's much easier.

>> Makes since it needs to be easier calling the on-call person is sometimes a challenge.

>> Can I ask from the audiology point of view is getting access like if I said you need an urgent audiogram how accessible is that for patients?

You know thinking about telling somebody go and get this right away is that something you have up your sleeve or not?

>> We would squeeze those people in to the lunch hour

or at the end of the day so that depends on the clinic completely.

But you know they are not going to be turned away.

>> Almost need on-call audiology.

>> A lot about hearing loss we would change the gears a little bit.

We're can patients who brought their hearing aids in from another country go if there are problems with their hearing aids?

>> That can be tough.

>> Sometimes there can be North American hearing aids that are different from hearing dates in Asia for instance.

So the software that you use for access and controls is it different or can be different.

>> Would it be wise for the patient to call the audiologists first and see if they know how to service that brand?

>> Absolutely.

Have that manufacturer either get the software and somehow get it I have done that occasionally but it is an issue.

I think that is likely becoming more of an issue so having the patient call ahead is beneficial but regardless of if they have hearing aids and they purchase them from elsewhere than you can see an audiologist.

>> Great, thank you.

>> Next question for the panel can the panel give any

more tips for raising the issue of hearing loss?
The patient has not brought it up and maybe is a little bit resistant?
What works well?
>> I would suggest the question how are you hearing is really.
>> And I think the other thing that really struck me from what Gail has said that will help me change the way it is not about me hearing it is about us communicating.
And I think that is so much more it is not just about the relationships you know we have so many people wanting to be more preventative in their health or have a complete physical and one of the things I'm always saying to them as well the most important thing this exercise and then what you were eating and drinking and then I say and being socially connected we know that is what helps them stay the healthiest.
The only way that we can have them be socially connected well one of the biggest ways is having them here each other and communicate so you can see it blurry vision but you do not hear it and that is so, so true so that would be something.
>> You were on mute.
>> Of my apology.
>> I think it takes time so in that first appointment when you bring it out it is not going to be that life-changing moment I think that everything that you were just saying that it will not take time because it

is resistant for deep-seated reasons and they need to take time to get over that.

I would suggest offering your clients resources and referring them to some online consumer sites, reading material I would suggest my own but there are other reading material there but this is they are resistant now they have been resistant for a long time.

For me everything changed when I realize it was about communication.

>> I would say if it is not an urgent case we can take our time bring the patient back for urgent health care conditions say can I see this again in a week or a month and we can discuss this other issue and also involve the care team there is the nursing staff so it doesn't feel like everybody is concerned about their hearing.

So make them feel comfortable to have that discussion and maybe we could have that discussion and asked them again if they feel like their hearing is impacting them in their life, rate?

And having good quality-of-life discussion.

>> Excellent okay we are doing great and thank you so much with the presentation because we are having a nice long time for questions and huge variety of question so somebody dropped the whole case there so a 92-year-old patient, legally blind and very Deaf.

Cognitively intact and lives alone.

Would have difficulty distinguishing right from left hearing aid, what would be the best hearing assistant

device for her.

Is there an interest for such patients for an assistant device?

>> I think that is a good question for anybody who wants to pitch in as well.

>> Sometimes simple is better something that the patient could attach to a television might be really useful without having to resort to hearing aids.

>> Can you describe the pocket Whit Tucker?

>> This is an amplifier and typically this is a set of headphones that the patient would wear connected by wire and the cables can be quite long so that the amplifier who has a microphone can be given to primary care provider.

Could sit in front of the patient it is really essentially a microphone that transmits that sound to a set of headphones they are simple devices they are inexpensive devices.

>> Another part is assistance and financial support in this kind of situation?

>> Assistance from Canada First Nations.

>> Provides assistants and it depends on the income level and you know patients with there are different sources.

>> Could I add one thing?

The stem of the question something else that stands out is talking about the age of the patient I think sometimes you know in health care and in general we can be a little bit ageist in deciding at a certain age

there might not be interventions that are worth it and
of course that is not true put a cochlear implant into
a patient that is a hundred years old I believe.
If the patient is healthy and a good candidate for
general anaesthetic for example and there is a real
benefit we can bring to their life there is something
that we can do and on that note if you have a patient
that is you know profoundly Deaf or has a significant
hearing loss but definitely for bilateral, referral to
the cochlear implant programme at St. Paul's Hospital
for assessment very busy and they have lots of people
to see but from what they have told me they are always
happy to see these people and people that could benefit
from cochlear implant so even if they are older there
are things we can still do even surgically to try to
improve life for these patients.
>> I do not think we can understate how impactful it is
to have this narrow down because the hearing is more
and you can see their health turn in a negative spiral
because they do not go out they do not exercise so that
is really great to hear okay.
Let's go to a very specific question, is there a
certain age group or patient care pricked her wrist
where I tumour like a brain tumor middle ear tumour are
nerve I guess should be high on the differential
diagnosis for hearing loss and the absence of
neurologic signs and symptoms?
>> When we see patients for sudden sensorineural
hearing loss and this shows that there is asymmetry so

even if they recover their hearing and there is a residual asymmetry in their hearing there is really good guide things on this put something as small as... We always are going to order an MRI for this patient to make sure that we do not miss...
But a tumour of the hearing nerve because we not infrequent are sorry, frequently, we do catch these on those MRIs and sometimes the only complaint was a very minor asymmetrical hearing loss was some tinnitus so the guidelines are very clear not many necessarily thinking about this it is so much faster means compared to MRI with most other places and I guess it gives us a good answer very quickly so when it comes back to something earlier with that unilateral hearing loss and from the audiologist because if there is that asymmetry than we want to make sure there is not these benign tumours that we are missing does not matter how big are small that differences the differences there and we should be making sure there isn't that tumour.
>> Thank you for that answer and I will combine two other questions and stick with you so are there tips to improving how you see fluid or lack thereof in the middle ear when doing an otoscopies?
And then going to bundle that with what approach to current otitis media so the patient that has recurrent the fusion -- recurrent effusion how do you diagnose that?
>> So sometimes challenging with what we are seeing doing something like when I am looking on either side I

will see if we can get the patient I will ask them how
do you get the years clear some people will talk about
how they just need to Jan either way you are going to
suffocate the space behind the tympanic membrane so it
is a good way to see is there fluid there is the ear
able to move you know it should be able to see some
movement of that eardrum if they are able to do that
and that can help you figure out what is going on in
the middle ear space and then for the chronic otitis
media was that the second question.
Okay that is slightly complicated topic but we have so
there are clear guidelines from the American Academy of
Pediatrics on this but in general we have moved a
little bit more a way from just putting tubes in if
they have fluid behind their eardrum and instead
looking at broadly is this a kid that is high risk
because they have underlining -- underlying visual
impairment, learning disability, autism, craniofacial
abnormalities, or something that makes it higher risk
are more critical that we do make sure that their
hearing is good you want to see what they are hearing
just like not just the impacted fluid but the
associated hearing loss.
And then is it just at one point or are we seeing it
again at three year, six-month interval?
It happens were a kid has fluid and we bring them to
the operating room and no longer behind their eardrum
will not put a tube and unless there is other really
encouraging factors similar for adults that are

thinking about what is the status of the nose.
Are they able to equalize their ears how long because they fluid bin there but these are the kind of patient so I think generally if this is somebody that will be a teenager and a couple months this is something you should sent to the ENT and scope their nose and decide what are the best next steps so it is a little bit of a complicated answer and there is a lot to it.
>> Have you had the hearing exam yet or not?
>> That is great totally common and now we have time for a couple more questions so any specific driving recommendations or considerations for patients with hearing loss?
What do you know about driving restrictions or driving concerns.
>> Get a license, where your glasses, where you are technology, as long as you have all of those things then there are no driving restrictions if you are wearing corrective lenses and actually I don't know if in British Columbia driver's licences indicate hearing loss.
I am a recent newcomer to the province.
But apart from that people always say that they make the best drivers because they are very alert.
We are very visual people.
And theoretically we are looking out in all direction.
When you cannot hear you know you have to keep your eye out.
I've never had an accident or a ticket.

>> So any information there as well.
>> Should not be shaking my head but the only just at age factor I think it is over 80 that drivers have to have hearing assessments.
>> So I did a quick Google search and there is no minimum hearing requirement but if you have a commercial license then you are required to have new audiology assessments for certain licences and you are right we do have physical some people over the age of 80 and actually anybody I think if you have diabetes and physical one of the questions is about hearing but it is not a reason to not be able to drive basically.
If you do have hearing aids then wear them while you are driving just like your glasses.
>> It makes good sense the car can be a pretty noisy place.
Your eyes are great.
Commercial drivers hearing the train coming across the tracks.

Outro

So we are done with the questions.
We have a few questions we did not get too I really appreciate to the audience for all of those questions and I really want to express my sincere gratitude for Mark, Nardia, Kaishan, Tracy, Suki, Gael, all up for this very stimulating webinar and thank you all for taking time out of our busy lives and from your evening especially this shows us that you care about this content and it

is very inspiring I also want to acknowledge the work with the team Allison and Caldon and the rest of the team without them this webinar would not be possible and also thank you to StreamText for the live captioning.

This webinar is accredited for 1.5 points.

If you can please take a few minutes right now before we forget to complete the attendants and evaluation forms that would be so appreciated your feedback is super valuable and you can access this by doing -- using the QR code shown on your screen and you also need to complete the evaluation form if you want the credits.

In the coming days you will be receiving a follow-up email which contains today's webinar recording and many links of the team will be including so thank you again, everybody.

I hope you have a fantastic evening and look forward to how you are finding hearing loss and looking after your patients in a different way.

So, have a great night.