

The pandemic urges us to take actions on hearing loss

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The COVID-19 pandemic has drastically changed the way we communicate. Social distancing and face masks distort both verbal and nonverbal cues, affecting our speech comprehension. Even the normal hearing population experienced difficulties with their communication and social interactions. For the hearing impaired, the struggle got even worse. Confronted with these new communication challenges many realised the true value of their hearing, and importance of preserving it. As Otolaryngologists and Audiologists we should take this momentum of increased public awareness, not only to highlight subjects such as prevention of noise-induced hearing loss, but also to optimize our clinical workflows, to guarantee high quality care for all of our patients. This is particularly important for our pediatric population, as appropriate and timely hearing rehabilitation are essential for the development of their auditory pathway. Inappropriate management and system delays within health care processes can have harmful effects on their development and be determinative for their future.

An evaluation of pediatric cochlear implant care throughout Europe revealed substantial differences in age at cochlear implantation between countries and centers (1, 2). Identifying potential barriers to early pediatric cochlear implantation and optimizing workflows can significantly reduce unnecessary delays, resulting in more children treated within their sensitive period of development (2, 3). The use of perioperative protocols does not only facilitate timely diagnosis and treatment, but also ensures adequate rehabilitation and optimal functioning of the implants.

In this edition of the B-ENT, Mertens et al. presented the results of a multi-center evaluation on minimal outcome measurements (MOM) for pediatric cochlear implantation (4). In this consensus paper, by the international HEARRING group, the members have formulated key evaluations required to guarantee adequate postoperative evaluations and fitting for children with cochlear implants. The proposed MOM test battery provides an evidence-based guidance for choosing age appropriate evaluations for infants and children of all ages.

Their final minimal test battery includes parental questionnaires like the Categories of Auditory Perception Scale (CAP) and LittleEars, speech perception testing in quiet and noise, as well as evaluations of language and mental development. Besides its clinical value, wide acceptance and use of the MOM test battery can facilitate international multi-center evaluations and benchmarking to improve our patient care.

Incorporating such protocols in our daily clinical practice, does not automatically guarantee success, and does not replace the individualized treatment each child deserves. Protocols are particularly useful to ensure everyone receives the appropriate care and attention, and to avoid children falling through the cracks of the medical system. On the other hand, protocols and guidelines, should not raise new barriers. The additional costs and resources required to comply with specific guidelines, should not limit the accessibility to cochlear implants and hearing aids, especially in low resource health care systems. Protocols, like the MOM, should be used in such a way that they help clinicians to establish their own clinical protocols, based on their local situations, resources and preferences. Only then, we can provide optimal care to all children, who not only struggle with their hearing during this pandemic, but also during the rest of their lives.

References

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