

BLASTFAX

AAP Releases Updated Position Statement on Early Hearing Loss and Detection

The American Academy of Pediatrics recently published the updated position statement on early hearing loss detection and intervention from the Joint Committee on Infant Hearing (JCIH) in its October 2007 edition of *Pediatrics* (Vol 120, Num 4, p 898-921). The following is a summary of that statement drafted by Anjali Parish, MD, FAAP & Jatinder Bhatia, MD, FAAP.

1. The definition of targeted hearing loss has been expanded from congenital permanent sensory or permanent conductive loss to include neural hearing loss in infants admitted to the NICU. As such it is recommended that NICU's and well-infant nurseries have separate hearing screening protocols. Infants in the NICU for >5 days should have auditory brainstem response (ABR) as part of their screening; the otoacoustic emission test (OAE) alone is not adequate.
2. When needed both ears should be rescreened within 1 month even if only 1 ear failed the initial test.
3. If an infant is readmitted in the first month of life (NICU or well infant), a repeat hearing screen is recommended if the admission was for conditions associated with potential hearing loss such as hyperbilirubinemia or culture positive sepsis.
4. The ABR test is recommended as part of a complete diagnostic evaluation for children <3 years of age for confirmation of permanent hearing loss. These diagnostic services should be provided by audiologists with expertise in evaluating young infants.
5. There are number of risk factors which may cause delayed-onset hearing loss including cytomegalovirus infection, neurodegenerative disorders and culture positive postnatal infections. Children who received extracorporeal membrane oxygenation (ECMO) or chemotherapy are also at risk. Infants who pass the neonatal hearing screen but have a risk factor should receive at least 1 diagnostic audiology assessment by 30 months of age. Early and more frequent assessments may be indicated according to each risk factor.
6. When amplification is needed children should be fitted within 1 month of the diagnosis of hearing loss. The selection and fitting of amplification device should be performed by an audiologist with experience in caring for young children/infants.
7. Genetics consultation should be offered to families of infants with hearing loss. Some syndromes are associated with progressive hearing loss and infants may require multiple assessments.
8. Every infant with confirmed hearing loss should be evaluated by an otolaryngologist with pediatric experience as well as have a vision assessment by an ophthalmologist with pediatric experience.
9. All infants with any degree of permanent hearing loss should be considered eligible for early intervention services.
10. Any infant who fails the speech-language portion of an objective standardized screening of global development performed in the medical home should be referred for speech-language evaluation and audiology assessment.
11. Any infant for whom there is concern regarding hearing or language development by caregiver or by the medical home should be referred for speech-language and audiology assessment.
12. The birth hospital should ensure that the hearing screening results are conveyed to the parents and the medical home. Parents should be provided with appropriate follow-up and resource information in a culturally sensitive and understandable format.
13. States should implement data systems to track and manage the quality of Early Hearing Detection and Intervention (EHDI) services and provide recommendations for improving systems of care.

For a copy of the Georgia algorithm for universal newborn hearing screening, please contact Fozia Khan Eskew at 404-881-5074 or at feskew@gaaap.org.