Hearing Loss Care Guide

March 2025

CALIFORNIA CORRECTIONAL HEALTH CARE SERVICES

Information contained in the Care Guide is not a substitute for a health care professional's clinical judgment. Evaluation and treatment should be tailored to the individual patient and the clinical circumstances. Furthermore, using this information will not guarantee a specific outcome for each patient. Refer to "Disclaimer Regarding Care Guides" for further clarification.

https://cchcs.ca.gov/clinical-resources/

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GOALS

- ✓ Evaluate and assess patients with suspected hearing loss using the screening hearing test(s).
- ✓ Identify the type of hearing loss.
- ✓ Order a consult with a hearing aid specialist or refer to an Ear, Nose, and Throat physician (ENT) and/or Audiologist when indicated.
- ✓ Order the hearing aid/device when the patient meets the criteria.
- ✓ Assign the appropriate Disability Placement Program (DPP) code for hearing impairment if indicated.
- ✓ Educate the patient in the expectations of using a hearing aid(s).

ALERTS

- A patient with a sudden onset of sensorineural hearing loss or fluctuating sensorineural hearing loss in one or both ears is an otologic urgency that needs to be referred to the ENT.

INTRODUCTION

Under Title II of the Americans with Disabilities Act (ADA), people with disabilities have a right to communication "as effective as" communication with others. The key to determining what aid or service is needed to communicate "effectively" is to consider the nature, length, complexity, and context of the communication, as well as the person's normal method(s) of communication. Patients with hearing impairments must have an equal opportunity to participate in any program, service, or activity provided in prison, which requires effective communication.

Hearing loss is the decreased perception of loudness and/or diminished speech intelligibility. The decrease in hearing is a common problem that everyone experiences from time to time. Diminished hearing also may occur during an ear infection. The other extreme is the permanent sensorineural hearing loss that occurs most commonly with aging but can occur with other etiologies.

According to the National Institute of Deafness and Other Communication Disorders (NIDCD), part of the National Institutes of Health, age is the strongest predictor of hearing loss among adults aged 20-69 years, with the greatest amount of hearing loss in the 60-69 age group. Men are almost twice as likely as women to have hearing loss among adults aged 20-69 years. Non-Hispanic white adults are more likely to have hearing loss than adults in other racial/ethnic groups. Non-Hispanic black adults have the lowest prevalence of hearing loss among adults aged 20-69 years (Hoffman, et al., 2016).

Arnold et al. (2019), reported hearing aid use among U.S. adults of Hispanic/Latino backgrounds is lower than that of the general U.S. population. The biggest barrier was current access to health insurance with lesser factors including low acculturation, language and economic barriers, and cultural aspects.

Several approaches can be used to screen for hearing loss, but the benefits of screening are uncertain. Patients with suspected hearing loss should undergo in-office hearing tests like the whispered voice test.

HEARING LOSS SCREENING RECOMMENDATION

The U.S. Preventive Services Task Force and the American Academy of Family Physicians concluded that the current evidence is insufficient to assess the balance of benefits and harms of screening for hearing loss in asymptomatic adults 50 years and older. There is insufficient evidence to recommend for or against screening for hearing loss in persons with unrecognized hearing loss. Clinicians should use their clinical judgment about hearing testing for patients who have symptoms of hearing loss or who have raised concerns about their hearing.

CLASSIFICATION

Hearing loss may be classified into three types:

- **Sensorineura**l: Involving the inner ear, cochlea, or the auditory nerve.
- **Conductive**: Involving any cause that in some way limits the amount of external sound from gaining access to the inner ear. Examples include cerumen impaction, middle ear fluid, or ossicular chain fixation (lack of movement of the small bones of the ear).
- **Mixed loss**: A combination of conductive and sensorineural hearing loss.

It is helpful to begin the evaluation by classifying the loss as sensorineural or conductive since this helps focus the remainder of the patient assessment. Conductive hearing loss is usually related to abnormalities of the outer or middle ear; sensorineural hearing loss is related to inner ear pathology.

Any patient complaining of hearing loss should have an entire auditory history and examination performed. Patients with sudden hearing loss require urgent referral, as treatment success is related to early treatment initiation. The American Academy of Otolaryngology-Head and Neck Surgery Foundation does not recommend ordering computed tomography of the head/brain for sudden hearing loss.

There is no universally accepted definition of hearing impairment or a universally adopted scale of hearing loss. However, some widely used descriptions are listed in the tables below.

Models for Classifying Severity of Hearing Impairment

Degree of Hearing Loss in Better Ear (dB)

Severity	Clark Model 19	Centers for Disease Control and Prevention Model 20	World Health Organization Model 21	Examples of Sounds that Can or Cannot be Heard
Normal	10 to 15	≤ 25	≤ 25	Can hear normal breathing
Slight	16 to 25	—	—	Infrequent difficulty in some situations; can hear whispering from 5 ft (1.5m) away
Mild	26 to 40	26 to 40	26 to 40	Difficulty hearing soft speech, quiet library sounds, or speech from a distance or over background noise
Moderate	41 to 55	41 to 55	41 to 60	Difficulty hearing regular speech, even at close distances, or sounds of a refrigerator
Moderately Severe	56 to 70	56 to 70	—	Extreme difficulty hearing normal conversation; can hear electric toothbrush
Severe	71 to 90	71 to 90	61 to 80	Cannot hear most conversational speech, only loud speech or sounds (e.g., an alarm clock)
Profound	≥ 91	≥ 91	≥ 81	May perceive loud sounds (e.g., factory machinery, car horn) as vibrations

Causes of Conductive Hearing Loss in Adults		
Middle Ear	**Pinna (External Auditory Canal)**	**Tympanic Membrane**
Cholesteatoma	Obstruction of External Auditory Canal by cerumen	Perforation, Tympanosclerosis
Ossicular Chain Disruption	Obstruction of External Canal by Exostoses (surfer's ear)	
Otitis Media with Effusion	Otitis Externa	
Otosclerosis		

Causes of Sensorineural Hearing Loss in Adults
Autoimmune Condition (idiopathic or part of recognized autoimmune disease)
Cerebellopontine Angle Tumor/Neoplasm
Infectious Condition (e.g., meningitis, labyrinthitis)
Ménière's Disease
Noise Exposures
Ototoxin Exposure
Presbycusis
Trauma

HEARING LOSS EVALUATION IN THE PRIMARY CARE SETTING

History

People with hearing impairment may present with self-recognized hearing loss or concerns from other members who have observed difficulty understanding everyday conversation, turning up television volume, frequently asking others to repeat things, social avoidance, and difficulty hearing with background noise. People with decreased hearing may also present with sensitivity to loud noises, tinnitus, or vertigo.

Age-related sensorineural hearing loss (e.g., presbycusis) is the most common type in adults. Presbycusis characteristically involves gradual onset of bilateral high-frequency hearing loss associated with difficulty in speech discrimination. Conversations with background noise become difficult to understand.

The primary care provider (PCP) should ask about the duration of hearing loss and whether symptoms are bilateral, fluctuating, or progressive. The evaluation should also include a neurologic review, history of diabetes mellitus, stroke, vasculitis, head or ear trauma, use of ototoxic medications, and family history of ear conditions and hearing loss.

Physical Examination

The ear should be examined for cerumen impaction, exostoses (benign growths of bone extending outwards from the surface of a bone), or other abnormalities of the external canal, in addition to perforation or retraction of, or effusion behind, the tympanic membrane.

Examination should include the cranial nerves because tumors of the auditory nerve (acoustic neuroma) and stroke may affect cranial nerves V and VII. The head and neck should be examined for masses and lymphadenitis; if present, they suggest infection or cancer.

Hearing Tests

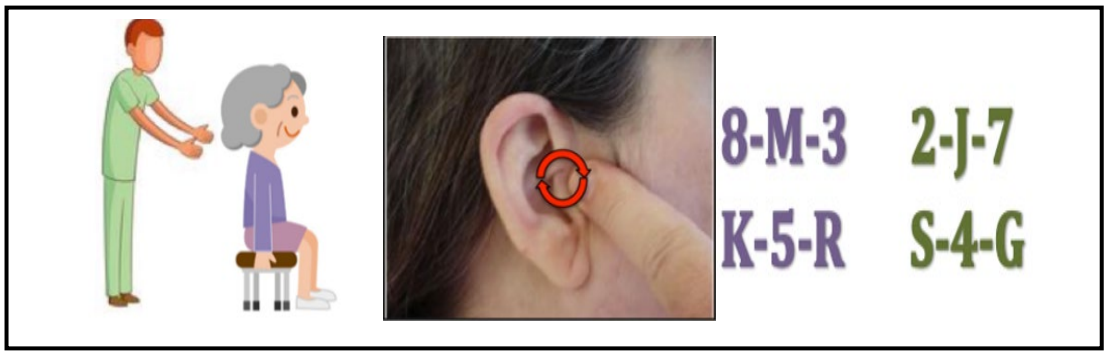
Hearing tests can be performed in the exam room and help the PCP to determine the presence and type of hearing loss.

Finger Rub Test

The finger rub test is a simple screening method for hearing loss. The PCP gently rubs their fingers together six inches from the patient's ear, one ear at a time, and asks the patient to identify where they hear the rubbing sound; a positive result is failing to identify the rub in at least three of six attempts.

Whispered Voice Test

The Whispered Voice Test is a screening hearing test used in primary care. Each ear is tested individually, starting with the better ear. The PCP stands at arm's length behind the patient (to prevent lip reading), and the patient masks hearing in one ear by occluding the ear canal and rubbing the tragus in a circular motion. The PCP whispers a short sequence of letters and numbers and asks the patient to repeat them (e.g., 8-M-3). Test the other ear in a similar manner. Ensure that the number-letter combination is different for each ear. The test is passed if all three letters and numbers are repeated correctly. If the patient fails, reattempt testing with different letter and number combinations. The patient is considered to have passed the screening test if they correctly repeat at least three out of six numbers and letters.



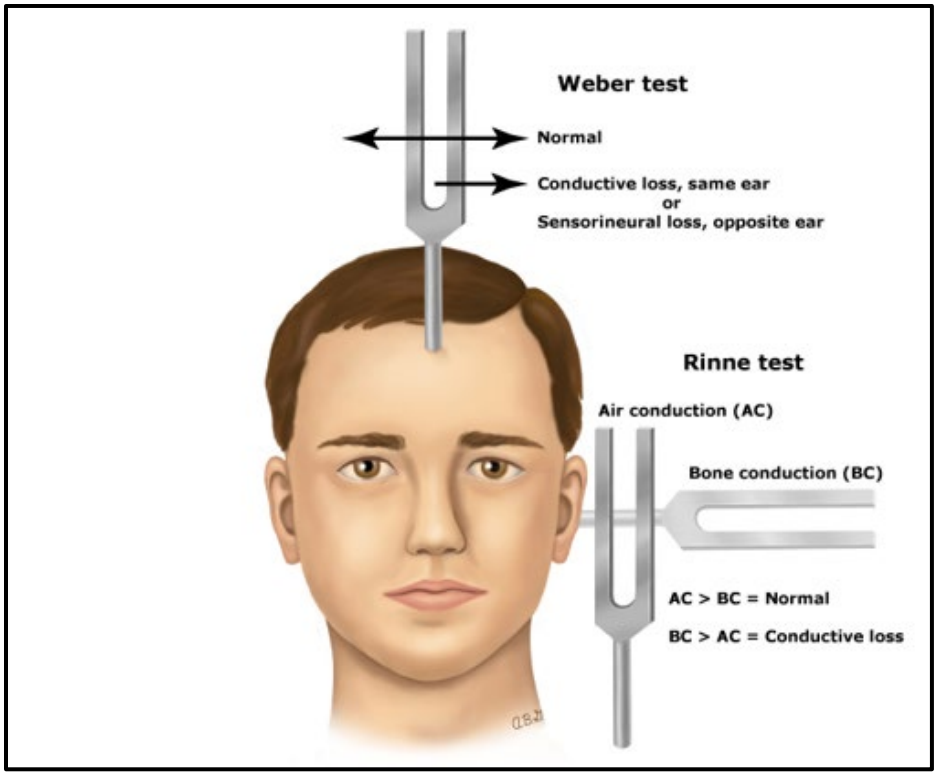
Tuning Fork Tests

The Weber and Rinne tests can help direct the remainder of the evaluation but should not be used as screening evaluations for hearing loss. The tuning fork used should be 512 hertz (Hz).

- **Weber test:** The Weber tuning fork test is performed by pressing the handle of the tuning fork to the bridge of the forehead, nose, or teeth and asking the patient if the sound is louder in one ear or the other. The sound is heard equally in both ears in patients with normal hearing or symmetric hearing loss.
- **Rinne test:** The Rinne test compares sound when the tuning fork is placed on the mastoid bone behind the ear (bone conduction) versus when the tuning fork is held near the ear (air conduction).
    - The Rinne test is considered normal when the vibrating fork near the ear is louder than when placed on the mastoid bone (air > bone conduction).
    - An abnormal result occurs when sound is at least equally loud or louder when the fork is placed on the bone as it is held next to the ear (bone > air conduction).

The Weber and Rinne tests can help distinguish conductive from sensorineural hearing loss.

- In patients complaining of a unilateral decrease in hearing, the Weber test suggests sensorineural hearing loss if the sound lateralizes (is louder) to the "good" side; conductive hearing loss is suspected if the sound lateralizes to the "bad" side. If a tuning fork is not available, having the patient hum to themselves can be a rough substitute (the patient is asked to hum and if there is lateralization of the sound toward the unaffected ear, this suggests sensorineural hearing loss. In conductive hearing loss, the sound would lateralize to the affected ear with humming).
- An abnormal Rinne test, with bone > air conduction, is consistent with conductive loss, particularly if the Weber test also lateralizes to that side.
- When the Weber test lateralizes to an ear where the Rinne is normal, the Rinne test in the opposite ear should be performed. A normal Rinne test in the contralateral ear suggests sensorineural hearing loss in this contralateral ear (i.e., the Weber lateralized to the normal ear).



Interpreting Weber and Rinne tests: Conductive versus sensorineural hearing loss

	Weber lateralizes	Rinne test
Conductive loss		
Good ear		AC > BC
Bad ear	To bad ear	BC > AC
Sensorineural loss		
Good ear	To good ear	AC > BC
Bad ear		AC > BC*

AC > BC: Air conduction better than bone conduction (normal Rinne).

BC > AC: Bone conduction better than air conduction (abnormal Rinne).

* For patients with severe sensorineural hearing loss, the patient may report BC > AC because the sound is being sensed by the "good" (contralateral) ear.

Patients with abnormal hearing tests should be referred for pure tone audiometry, in which signals are delivered through air conduction and bone conduction to assess hearing thresholds. This test not only differentiates conductive from sensorineural hearing loss, but also characterizes the pattern of hearing loss at various frequencies. A complete audiological evaluation also includes an evaluation of speech perception.

Laboratory evaluation is not indicated for primary care patients with hearing loss unless systemic illness is suspected. Imaging is not needed if the hearing loss pattern suggests presbycusis.

Differential Diagnosis

Depression and dementia should be considered in the differential diagnosis of hearing loss. Both conditions may present with the apathy, inattentiveness, and social disengagement that can occur with hearing loss.

CONSULTATION AND REFERRALS

Consultation to Hearing Aid Specialist

The PCP can order a "Consult to Hearing Aid Specialist" if the patient's hearing evaluation is abnormal and requires further hearing tests.

Hearing Aid Specialists are allied health professionals who have the training, knowledge, and experience required to address the amplification needs of individuals with hearing loss. They provide onsite services and can administer and interpret tests of auditory function (pure tone audiometry and speech tests), fit and dispense hearing instruments, and provide comprehensive post-fitting care. The CCHCS-contracted Hearing Aid Specialist is the vendor of choice and must be used for hearing aid referrals.

If the patient is a candidate for conventional hearing aid(s) after evaluation, the CCHCS contracted Hearing Aid Specialist will provide and fit the hearing aid(s) and educate the patient about the use and expectations of the hearing device(s) (see Tips for Using Your New Hearing Aids in the Patient Education).

The Hearing Aid Specialist may refer the patient to the ENT physician for possible treatment of a suspected ear condition. The ENT physician may request an Audiologist referral for further testing (e.g., Acoustic Immittance testing).

Referral to an ENT and Audiologist

Refer to the ENT physician in situations including, but not limited to:

- The patient reports a sudden onset of sensorineural hearing loss or fluctuating sensorineural hearing loss in one or both ears. This is considered an otologic urgency and needs to be seen by ENT. Sudden conductive hearing loss is not urgent and will usually self-resolve.
- Any conductive hearing loss caused by the outer ear that failed treatment or cannot be managed by the PCP (e.g., exostosis, osteoma, polyps, etc.).
- Any conductive hearing loss caused by the middle ear that failed treatment or cannot be managed by the PCP (e.g., unresolved middle ear fluid for > 6 weeks after the acute infection has been successfully treated, persistent tympanic membrane perforation, cholesteatoma, etc.).
- Unexplained sensorineural hearing loss (e.g., unilateral or asymmetric high-frequency sensorineural hearing loss).
- Congenital atresia of the ear canal in both ears.
- Suspected malingering or symptom magnification.

Refer to the Audiologist in situations including, but not limited to:

- The ENT physician requests a more comprehensive hearing test.
- Nonorganic/functional hearing loss that requires further hearing testing (e.g., Stenger test).

HEARING DEVICES

Hearing loss is measured on a scale based on the threshold of hearing. The hearing threshold is the quietest sound that can be perceived at a certain frequency. Pure tone audiometry testing is used to measure the frequency and hearing level of an individual. Frequency is measured in hertz (Hz), which are cycles per second. The most common range of frequencies tested is 250 Hz to 8000 Hz. The intensity or loudness of the sound is measured in decibels (dB) which range from -10 dB to 120 dB. A summary of the audiogram for each ear is the pure-tone average (PTA) of thresholds measured at specific frequencies. A traditional PTA measure is the speech frequency average of thresholds at 500, 1000, and 2000 Hz.

Patients with hearing levels in the PTA of 500, 1000, and 2000 Hz of 34 dB or less do not require amplification devices.

The PCP needs to have a realistic discussion with the patient about what a hearing aid can and cannot do. One common misconception is that the aid restores normal hearing. The goal of hearing amplification is not to restore normal hearing but to improve communicative ability.

Personal Sound Amplification Products (PSAPs) which include items such as the Pocketalker® are not supported by medical evidence as superior or equivalent to hearing aids. These devices are not ordered through health care but rather provided as reasonable accommodations upon request for those with confirmed hearing impairments.

Conventional Hearing Aids

Conventional Hearing Aids, also known as Air Conduction Hearing Aids, are considered medically necessary to treat mild to profound hearing loss, and they are indicated for patients with sensorineural hearing loss or mixed hearing loss.

- **Standard Hearing Aid:** Hearing aids for patients with 35 to 89 dB hearing levels in the PTA of 500, 1000, and 2000 Hz.
- **High Power Hearing Aids:** Hearing aids for patients with 90 dB or greater hearing level in the pure PTA of 500, 1000, and 2000 Hz.

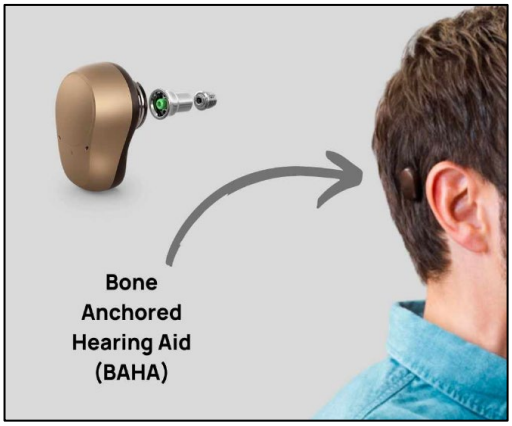
A licensed and qualified professional (e.g., Hearing Aid Specialist) should fit hearing aids to avoid problems with feedback and reliability associated with poor quality hearing aids. Hearing aids must be properly fit and digital hearing aids must be programmed appropriately. Providers must utilize the CCHCS contracted onsite hearing aid specialist for all hearing aid requests. Alternative devices must be justified through the non-formulary Durable Medical Equipment Request for Service process with a recommendation from an ENT.

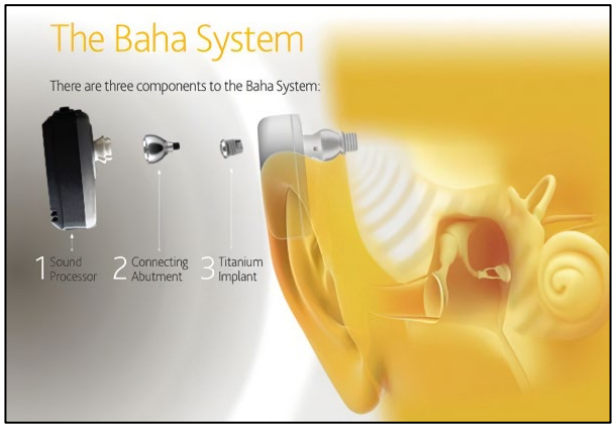
Bone Conduction Hearing Devices

Certain patients who cannot benefit from standard air conduction hearing devices may benefit from a device that transmits sound directly through the skull to the functioning cochleae. Bone conduction hearing devices are suitable for patients with conductive or mixed hearing loss who do not benefit from conventional hearing aids. For example, a patient with congenital atresia of the ear canal in both ears may be referred for evaluation for a bone conduction hearing aid.

There are two main types of bone conduction hearing systems:

- Nonsurgical bone conduction hearing aids (BCHA). BCHA doesn't require surgical implantation. This system can be held against the skull with a steel-spring headband or attached to the skin with adhesive.
- Surgically implantable bone-anchored hearing aids (BAHA). This is the most common type. The BAHA system consists of a permanent titanium fixture surgically implanted into the skull bone behind the ear and a small detachable sound processor that clips onto the fixture.



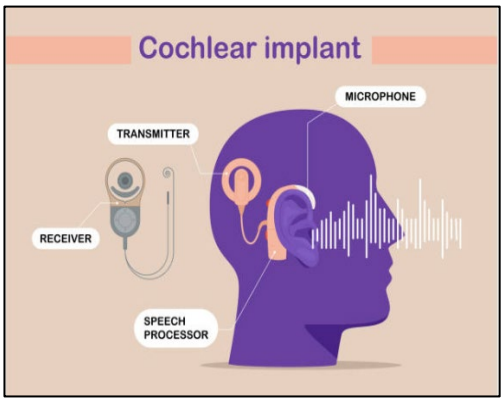


Cochlear Implants

Cochlear implants are surgically implanted prosthetic devices that use electrical stimulation to provide hearing. The cochlear implantation is considered medically necessary for the treatment of bilateral severe or profound sensorineural

hearing loss when there is reasonable expectation that a significant benefit will be achieved from the device and when the following criteria are met:

1. Patients who have 90 dB or greater hearing level in the PTA of 500, 1000, and 2000 Hz, and have speech discrimination of less than 40% in both ears should undergo speech testing with conventional hearing aids set to maximum gain and comfort after six months of conventional hearing aid usage.
2. If aided speech discrimination is less than 40% and the patient has shown limited or no benefit from conventional hearing aids, the patient should be evaluated for a cochlear implant by a licensed Audiologist with cochlear implant training and experience.



DISABILITY PLACEMENT PROGRAM (DPP) CODE FOR HEARING IMPAIRMENT

DPP is the CDCR set of plans, policies, and procedures to provide disabled incarcerated individuals equal access to programs, services, and activities. DPP programs ensure incarcerated individuals are not discriminated against due to a disability that affects a major life activity, whether or not the disability impacts placement within CDCR's prisons or requires accommodation.

The two DPP codes outlined below are used to categorize the degree of hearing impairment.

DPH Code Criteria

- The patient is deaf or severely hearing impaired and requires written notes, sign language, or lip-reading accommodation to achieve EC or receive an emergency warning.

DNH Code Criteria

- The patient has a hearing impairment and uses a hearing aid(s) in one or both ears to communicate effectively.
- If the patient has hearing loss in one ear and normal hearing in the other ear and is able to communicate effectively, the patient is neither DNH nor DPH. .

A DNH code will not impact the patient's placement. However, the placement is impacted in patients with the DPH code who require a Sign Language Interpreter (SLI) to achieve effective communication (EC). These patients will need to be placed in one of the institutions with an SLI (CCWF, CHCF, CIM, CMF, LAC, NKSP, RJD, SATF, and SQRC). DPH class members who do not need an SLI for EC can be housed at any institution, as they typically use written notes and/or lip reading to achieve EC.

If the patient meets the DNH or DPH code criteria, the PCP shall update the DPP code on the patient's 1845/7410 Powerform. In addition, the PCP shall ensure that a Hearing Disability Vest is ordered for patients who have a DNH or DPH code.

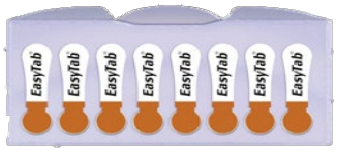
REFERENCES

1. Department of Justice nondiscrimination based on State and Local Government Services Regulations, 28 C.F.R. Part 35, § 35.160 (2005) www.ada.gov/reg2.htm.
2. ADA Requirements: Effective Communications," U.S. Department of Justice, Civil Rights Division, Disability Rights Section https://www.clearinghouse.net/detail.php?id=17014.
3. Hoffman HJ, Dobie RA, Losonczy KG, Themann CL, Flamme GA. Declining Prevalence of Hearing Loss in US Adults Aged 20 to 69 Years. JAMA Otolaryngol Head Neck Surg. 2017 Mar 1;143(3):274-285. doi: 10.1001/jamaoto.2016.3527. PMID: 27978564; PMCID: PMC5576493. Declining Prevalence of Hearing Loss in US Adults Aged 20 to 69 Years | Otolaryngology | JAMA Otolaryngology–Head & Neck Surgery | JAMA Network
4. "Evaluation of hearing loss in adults." *www.uptodate.com*, www.uptodate.com/contents/evaluation-of-hearing-loss-inadults?search=PCP%20assess%20hearing%20loss&source=search_result&selectedTitle=5%7E150&usage_type=default&display_rank=5. Accessed 29 May 2024.
5. Djalilian, Hamid R., M.D., et al., *CDCR Hearing Aids Specification*. Executive Summary. September 29, 2023.
6. Michels, Thomas C., et al. "Hearing Loss in Adults: Differential Diagnosis and Treatment." *American Family Physician*, vol. 100, no. 2, 15 July 2019, pp. 98–108, www.aafp.org/pubs/afp/issues/2019/0715/p98.html. Accessed 29 May 2024.
7. "Recommendation: Hearing Loss in Older Adults: Screening | United States Preventive Services Taskforce." https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/hearing-loss-in-older-adults-screening#fullrecommendationstart. Accessed 29 May 2024.
8. *The Whisper Test*. University of California San Francisco. Department of Medicine. Division of Geriatrics. https://geriatrics.ucsf.edu/sites/geriatrics.ucsf.edu/files/2018-06/whispertest.pdf. Accessed 29 May 2024.
9. Quick Statistics About Hearing, Balance, & Dizziness. National Institutes of Deafness and Other Communication Disorders. https://www.nidcd.nih.gov/health/statistics/quick-statistics-hearing. Accessed 23 September 2024.
10. Hearing Aid Prevalence and Factors Related to Use Among Older Adults From the Hispanic Community Health Study/Study of Latinos. National Institutes of Health. https://pubmed.ncbi.nlm.nih.gov/30998816/. Accessed 25 September 2024.

PATIENT EDUCATION

Tips for Using Your New Hearing Aids
What you Should Know

General Use



Use the correct battery size (312 Brown tab).

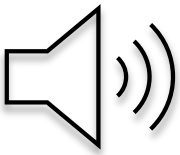
To make the battery last longer, turn off your hearing aids when not in use.

Replace dead batteries right away.

Keep hearing aids away from heat  and moisture. 

Check for wax buildup daily. Use the cleaning tool supplied if there is any evidence of wax.

Adjusting to Using Hearing Aids



Hearing Aids will NOT restore your hearing to normal levels in most cases. You should experience a lot of improvement but be realistic in your expectations.

For the first week or two, avoid loud environments. Start with quieter surroundings and gradually build up to noisier areas and more wearing time.

Remember, hearing takes place in the brain. Your brain will take several weeks to accommodate the change.

Best results will be obtained with daily use once you are accustomed to normal sounds. Wearing hearing aids only when you think you need them will not give you the best results.

Above all, be patient. If you haven't heard well in a few years, hearing aids flood your ears with sounds you didn't notice before. Background noise that most people seldom notice might seem very loud. This is because your brain has forgotten how to block background noise. People adjusting to a new hearing aid must relearn how to ignore the background noise and take it slow as their brains adjust.

Frequently Encountered Problems

You may experience some of the following problems as you adjust to wearing your new hearing aids:

My hearing aid feels uncomfortable.

Some individuals may find a hearing aid to be slightly uncomfortable at first. Ask your Hearing Aid Specialist how long you should wear your hearing aid while you are adjusting to it.

My voice sounds too loud.

Your own voice will sound different. The sounds of swallowing and chewing may also be unfamiliar. The “plugged-up” sensation that causes a hearing aid user’s voice to sound louder inside the head is called the occlusion effect, and it is very common for new hearing aid users. Check with your Hearing Aid Specialist to see if a correction is possible. Most individuals get used to these changes over time.

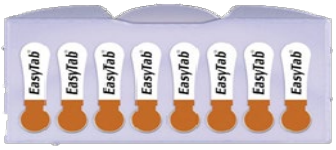
I get feedback from my hearing aid.

A whistling sound can be caused by a hearing aid that does not fit or work well or is clogged by earwax or fluid. See your Hearing Aid Specialist for adjustments.

EDUCACIÓN PARA EL PACIENTE

Consejos para utilizar sus nuevos aparatos auditivos
Lo que debe saber

Uso general



Utilice el tamaño de batería correcto (312 pestaña marrón).

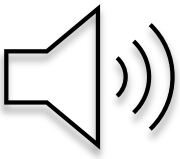
Para que la batería tenga mayor duración, apague los aparatos auditivos cuando no los utilice.

Sustituya de inmediato las baterías descargadas.

Mantenga los aparatos auditivos protegidos del calor  y la humedad. 

Compruebe a diario si se les ha acumulado cera. En caso de restos de cera, utilice la herramienta de limpieza suministrada.

Adaptarse al uso de aparatos auditivos



En la mayoría de los casos, los aparatos auditivos NO le devolverán la audición a los niveles normales. Debería experimentar una gran mejoría, pero sea realista respecto a sus expectativas.

Durante la primera o segunda semana, evite los ambientes bulliciosos. Empiece con un entorno más tranquilo y vaya aumentando gradualmente a áreas donde haya más ruido y mayor tiempo de uso.

Recuerde que la audición se produce en el cerebro. Su cerebro tardará varias semanas en adaptarse al cambio.

Los mejores resultados se obtendrán con el uso diario, una vez que se haya acostumbrado a los sonidos normales. Usar aparatos auditivos sólo cuando cree que los necesita no le brindará los mejores resultados.

Sobre todo, tenga paciencia. Si hace años que no oye bien, los aparatos auditivos inundan sus oídos de sonidos que antes no percibía. El ruido de fondo que la mayoría de las personas apenas percibe puede parecer muy elevado. Esto se debe a que su cerebro ha olvidado cómo bloquear el ruido de fondo. Las personas que se adaptan a un nuevo aparato auditivo deben volver a aprender a ignorar el ruido de fondo y tomárselo con calma mientras su cerebro se adapta.

Problemas que se experimentan con mayor frecuencia

Es posible que experimente algunos de los siguientes problemas mientras se adapta al uso de sus nuevos aparatos auditivos:

Mi aparato auditivo me resulta incómodo.

A algunas personas les resultan un poco incómodos los aparatos auditivos al principio. Pregunte a su especialista en audioprótesis cuánto tiempo debe usar el aparato auditivo mientras se adapta a él.

Mi voz suena demasiado fuerte.

Su propia voz sonará diferente. Los sonidos que se producen al tragar y masticar también pueden resultar extraños. La sensación de "tapón" que hace que la voz del usuario de aparatos auditivos suene más fuerte dentro de la cabeza se denomina efecto de oclusión, y es muy común entre las personas que recién usan aparatos auditivos. Consulte a su especialista en audioprótesis para ver si es posible una corrección. La mayoría de las personas se acostumbran a estos cambios con el paso del tiempo.

Recibo retroalimentación de mi aparato auditivo.

Si un aparato auditivo no se ajusta o no funciona bien, o si está obstruido por cerumen o líquido, puede emitir un pitido. Consulte a su especialista en audioprótesis para realizar ajustes.