Edited transcript of Chat for Otology Online National Training day

**Monday 20th April 2020**

*Re: Q about HIV and SSHL*

**Delegate**: https://jamanetwork.com/journals/jamaotolaryngology/fullarticle/1655348

*Re; Acoustic shock*

**Delegate**: What is the

criteria for acoustic shock?

**Samit Ghosh**: From a med legal point of view it’s a single impulse sound above 110db

*Re: Non-organic hearing loss*

**Emma Stapleton**: I find it useful to ask the audiologist to do a Stenger test, they can do one on their audiometer

*Re: COVID, steroids and SSNHL*

**Delegate**: What is your opinion on steroid treatment for SSNHL in the COVID era?

**Simon Lloyd**: High dose oral steroids not currently recommended for SSNHL in Covid era. IT steroid has less systemic absorption and is probably preferable. No evidence base though. Given need for close proximity with patient if undertaking IT injections, appropriate PPE should be used. Also avoid fenestrated suction to minimise aerosol.

*Re: SSNHL and IT steroid regimen*

**Delegate**: Re- intratympanic steroid-which steroid do you give and how much do you give?

**Simon Lloyd**: There are two commonly used ones, Solumedrone and Dexamethasone. Solumedrone said to have better absorption but is more painful to inject. In the UK, one problem is that high dose Dex isn’t available. We only have 3.3mg/ml. Nevertheless, I currently use Dex as some of my patients haven’t tolerated the pain with Solumedrone.

**Simon Lloyd** : I give 1 injection daily for 3 days but others use different regimens

**Simon Freeman** : Agree, I use Dex for the same reasons.

**Simon Freeman** : Ideally I would do the same regimen if practical but could wait a few days between injections if no one available

**Mark Wilkie** : Profs Lloyd and Freeman, in the absence of high dose dex why not use the methylpred dose akin to the dose for Meniere’s extrapolating from the London group Lancet study?

**Simon Freeman** : I won't use methylpred since I had a pt screaming in pain afterwards!!

**Simon Freeman** : I would use IT dex up to 6 weeks after the initial SSNHL.

**Delegate**: Weekly single doses for minimum 3 weeks with weekly audios In our centre Dex comes in 6.6mg vials. That's what I use as a single dose

**Simon Lloyd** : Each vial is 2mls though

**Simon Lloyd** : You can’t normally get more than a ml in

**Delegate** : Agree...

*Re: Repeat hearing test after IT steroids*

**Delegate** : Mr Freeman, after 3 doses, when will you repeat the hearing test?

**Simon Lloyd :** ENTUK have published guidance on SSNHL although it does not specify a timescale. I use 6 weeks but tell them it is very unlikely to work after 2 weeks. I’ve sent a link to Schom so hopefully he can forward to the group.

**Simon Freeman:** At about 1 week.

*Re: Investigations for SSNHL*

Simon Freeman : MRI and syphilis testing. Basic blood tests such as FBC and U+E.

Delegate : Does anyone test for thrombophilia/prothrombotic conditions in SSNHL? Some evidence for ?microembolic events as an aetiology...

Simon Freeman : No to thrombophilia. I did my MPhil on this and the evidence was weak and we did not find an association.

Anand Kasbekar : We are doing work on this in Nottingham to pick up microembli as a LOT of these patients have SSNHL due to this. The stroke guys are aware of this as they miss

strokes also in small embolic events. If we can’t prove it with an MRI then we can’t really put them on the stroke meds. If we can see it then throbmolysis may be an option!

Anand Kasbekar : Interesting Simon!

Simon Freeman : Anand, I’m sure there are pts with vascular microembolic causes but we have no good way of identifying them at the moment.

Delegate: Interesting thanks. We had a lady diagnosed with anti-phospholipid syndrome after presenting with SSNHL, but also other features...

Simon Freeman : Although my MPil was 10 years ago so things may be changing!!

*Re: Anti-HSP70 in Autoimmune Inner Ear Disease (AIED)*

Delegate : How clinically useful are lab tests (such as western blot for anti-Hsp70 antibodies) in AIED?

Simon Freeman : I don't use western blot anti-hsp70. There seems to be some debate in literature about it's usefulness and it can be difficult to get it done.

Simon Freeman : I essentially diagnose AIED by determining if it is steroid responsive.

*Re: The East Midlands Experience for IT steroids in SSNHL, Investigations for SSNHL and AIED*

Anand Kasbekar : Methylpred 125mg/ml IT for SSNHL up

to 6 weeks post event. great weekly for up to 3 weeks ideally (due

to logistics). Not had pain as a big issue but others have. No need

for Autoimmune bloods unless family history / PMH history suggests.

Ask about systemic symptoms as this could be first presentation.

Difficulty is some AED is Not steroid responsive. There are tests

and potential treatment in the US being developed for this but will

take a while to get to us! The rheumatologists generally dont know

what to do with AED in isolated hearing loss! If there is steroid

response with increased hearing then they will consider using

steroid sparing agents medium/long term with audiogram surveillance.

They will rule out kidney and chest disease etc. Make sure they get

referred urgently especially if possibly GPA as this is life

threatening.

*Re: Advantages of Soundbridge vs BAHA vs Bonebridge*

Tom Milner : where’s the advantage of the sound

bridge over a BAHA or bone bridge device?

Delegate: Soundbridge offers ear specific

hearing whereas BAHA and bonebridge do not

Re: Audiological assessment /indications prior to CI

Delegate : What pre-op audiological asessment

is recommended ?

Simon Freeman : PTA for all (VRA for young

kids). If meet the criteria then refer to CI program where speech

testing is done for adults.

Simon Freeman : Kids just need to demonstrate not

meeting expected educational progress with HAs

Delegate : No BERA or ABR ??

Emma Stapleton : We use CERA in cases where their

audiometric thresholds may not be reliable

Simon Freeman : ABR is part of newborn hearing

screening program so definitely required in that context

Re: CI in otosclerosis

Delegate : is there a role for CI in

otosclerosis with profound deafness. what is the criteria ?

Simon Freeman : Yes definitely. If we see

some BC thresholds we might try a stapedectomy first

Simon Freeman : Most do well with CI

*Re: Pneumococcal vaccine pre-CI*

Mark Wilkie : Pneumococcal vaccine pre-op only for

those not had it or booster for all comers?

Simon Freeman : Mark: most do not need pneumococcal

booster. There is a government set protocol.

*Re: Tympanoplasty technique and materials*

Gaurav Kumar : Endoscopic surgery is suitable for

any size perforation. It depends on how you plan your flap.

Cartilage slicer does help a lot.

SM : Any preference for underlay or overlay

technique of myringoplasty?

Tom Hampton : alder hey using biodesign

Gaurav Kumar : Important point to notice is

perforation reaching anterior malleolar ligament. Anterior pull

through tend to fail. Suprior flap endoscopically gives good result

Gaurav Kumar : Endoscopic superior flap works better

in these

Delegate : How do you get round the hairs

endoscopically?

Gaurav Kumar : Trim them down before you start.

Gaurav Kumar : MRI can help when planning endoscopic

approach and preop planning if fluid in Antrum then mainly

endoscopic

Gaurav Kumar : Endoscopic with primary hearing

reconstruction

Gaurav Kumar : Endoscope will give good view of

anterior buttress

Michael Wareing : likely to have stapes should get

good result with prosthesis. actually little difference in outcomes

taking out ossicles. see my paper with Rupert Obholzer

Gaurav Kumar : Agree Mike

*Re: Case discussion*

Delegate : If the patient opted for CWD - would

you offer primary obliteration or wait before obliterating?

Gaurav Kumar : This particular case inside out with

cartilage obliteration