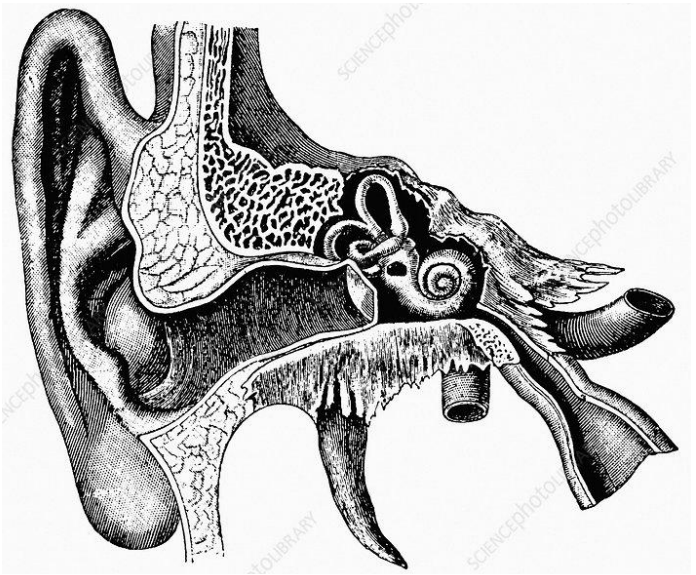
Video link

Editing file

V 1.0.1

REVEIWED BY
ABDULAZIZ ALSAIF



Audiology

A2 Presented by Dr.Murad Almamoni

Lecture Objectives:

- ★ PTA,tympanometry and impedance (speech & ABR in brief)
- ★ Vestibular tests in brief.
- ★ Identify type,degree and configuration of hearing loss.
- ★ Identify possible site of lesion for each type of hearing loss.
- ★ Determine middle ear function from Tympanometry measurement.
- ★ Understand origin,indications and clinical applications of OAE,ABR and speech audiometry.

Color Index:

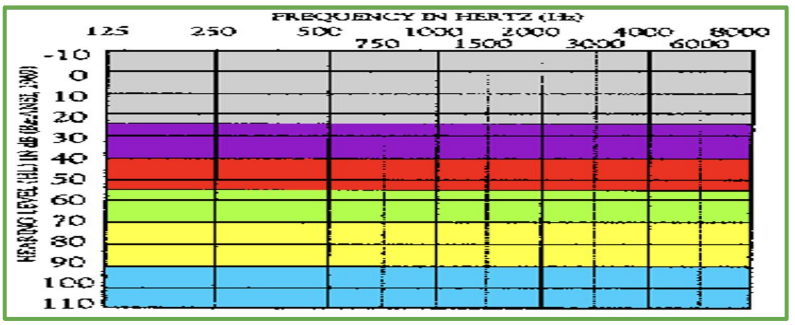
Important Original content Doctor's notes[439] Doctor's notes[441] Golden Notes Extra

Pure Tone Audiometry

- **Auditory system consists of**: 1- External ear 2- Middle ear (both are responsible for conduction of the sound) 3- Inner ear: has Cochlear part (responsible for hearing) and Vestibular part (responsible for balance), connected to each other by vestibulocochlear nerve.
- To drive the auditory system into action (hearing) it needs a sound.
- Sound is a physical stimulus, it's kind of mechanical energy that needs sound source and medium to reach the auditory system.
- The cochlea convert the mechanical energy into electrical impulses.
- The process for measuring the hearing loss is audiometry.

◀ Ranges of Hearing Loss

- -10 – 25 dB HL = Normal range.
- 26 – 40 dB HL = Mild hearing loss.
- 41 – 55 dB HL = Moderate.
- 56 – 70 dB HL = Moderately Severe.
- 71 – 90 dB HL= Severe.
- Greater than 90 dB HL = Profound



PTA (Audiogram)

Pure tone audiometry :

Play a tone and ask the patient to raise their hand if they hear it over multiple frequencies.

Air conduction : tested by using headphones. Bone conduction : tested by using oscillator "bone vibrator"

The purpose of PTA : provide a **quantitative** measurement of hearing thresholds
(" threshold"is the lowest intensity in which a patient can hear a tone 50% of the time)

- If the slope between 2 adjacent points is too big (>20 db difference) we need to test the interoctaves (e.g.between 500 & 1000).
- The decibel itself has no meaning unless we assign a reference to it known as sound pressure level (we don't use atmospheric pressure cause it's variable).

Parameters of the sound: 1- Frequency (Hz) 2- Intensity "loudness" (dB).

Audiometry results are recorded on an audiogram .

X-axis → frequency (in Hz) Tone

- Human ear can hear from 20-20000 hz but clinically we test from 250 Hz until 8000 Hz because it's the most important (useful) encompassing all the sounds we need to hear on a daily basis:
  - (include speech sounds (usually 500-2000 Hz), environmental sounds etc…), most sensitively (1000-4000 Hz)
- That's why we don't need to test higher frequencies "above 8000"(except in infection or ototoxicity because ototoxicity (causing sensorineural hearing loss) affects high frequencies first so we test extra-high frequencies in this case). (Ex: chemotherapy)

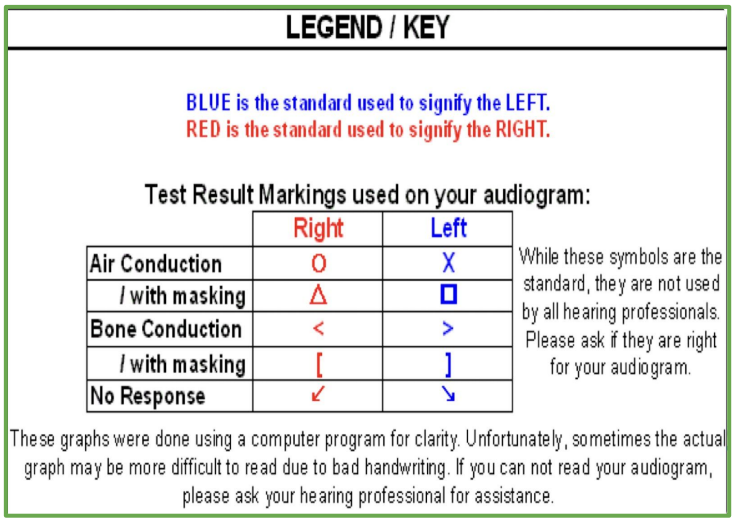
Y-axis → amplitude "intensity" (in dB) Volume at which the pt can hear the tone, it is a unit of sound pressure.

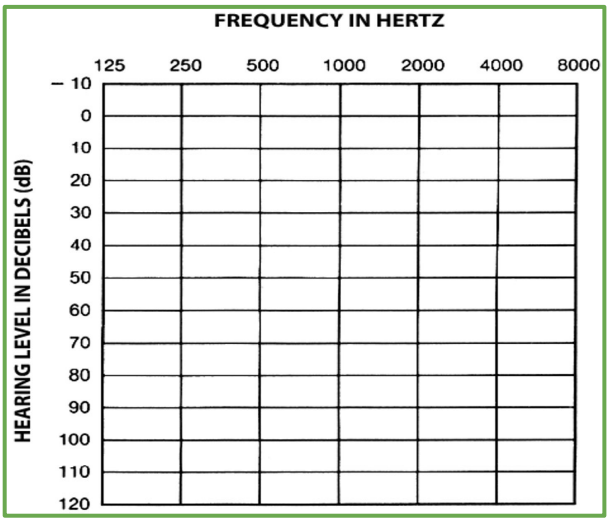
- **The 0** : Average hearing threshold "mean"
  - (measured by calculating the average of the hearing threshold of a group of people.)
- **Between -10 and 25** "the gray area" → Normal hearing
  - Anything above that is a degree of hearing loss.
- **- 10** : means the hearing pressure is better than the average of normal hearing.
  - It's a relative scale thus -ve values exist (relative to the general population).

In the exam we'll have 2-3 questions:

- MCQ: we'll be given an **audiogram** and asked to interpret it (diagnosis), we'll also be asked about middle ear assessment, type of **tympanogram**,tympanometry results, interpret results, underlying cause (pathophysiology). Doctor said he might include question about OAE & ABR.
- SAQ: we'll be given a graph (audiogram, tympanogram, ABR) and asked what is the hearing level? What could have caused this hearing loss.

Pure Tone Audiometry cont.





* Important to know symbols, and no need to know masking at your level.

1. Determine is it air or bone conduction by the symbols
    a. Air conduction: Tested by headphones
    b. Bone conduction : Tested by Placing the bone vibrator on the mastoid or the temporal bone (mastoid is used because its prominent and there isn't much tissue around it)

    *Bone conduction is better than air conduction. In PTA
2. Is the bone and air threshold within normal range ?
3. Determine type of hearing loss by : (Gap)
    a. Comparing the bone threshold to the air threshold

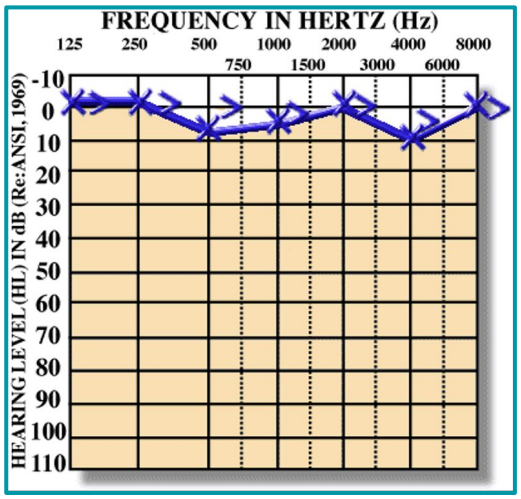
Masking is applied to the opposite ear to make sure the sound from the testing ear is not getting transmitted to the normal ear, giving a false negative (dr said we don't need to worry about this)

Ranges of hearing loss according to the site of lesion:

- Conductive hearing loss (problem in the external or middle ear).
- Sensorineural hearing loss (problem in the inner ear).
- Mixed hearings loss (both).

The lesion could be: a- Congenital. **b**-Traumatic. **c**-Inflammatory. **d**- Neoplastic.

Normal Hearing



- This is a left ear (note blue lines)
- > = Bone conduction X = Air conduction.
- **Both air and bone conduction are normal**
- If air conduction is normal then no need to test bone conduction because bone conduction is always equal or better than air conduction.
- Hyperacusis will be less than -10 dB HL → one cause is facial nerve palsy.

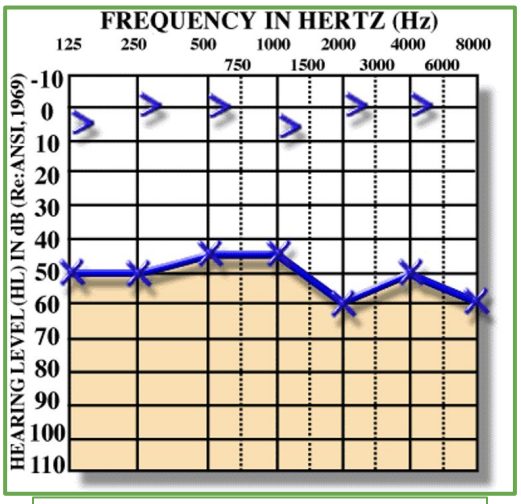
Exam questions !

An audiogram: (1 or 2 audiograms in SAQ, could be a case scenario)

1. Identify the type and degree of hearing loss
2. Where is the predicted lesion site? (example: middle ear, cochlea)
3. What is the management?

Pure Tone Audiometry cont.

◀ Ranges of Hearing Loss



Conductive Hearing Loss

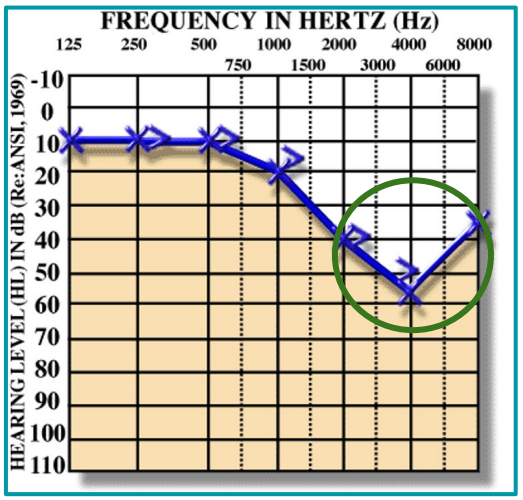
Bone conduction thresholds : Within normal range
Air conduction thresholds : Above the threshold (abnormal)
Gap between AC and BC : >10 dB

Etiology
Pathology in the conductive pathway (if there is anything in outer or middle ear) *Inner ear is normal

- Foreign body
- cholesteatoma
- Dislocation of ossicles
- Fluid accumulation
- Otitis media with effusion
- Tympanic membrane perforation
- Tumor
- Wax impaction
- **Otosclerosis:** shows Carhart's notch at around 2000 Hz

Management
Medical and surgical (release fluid from the middle ear, reconstruction of middle ear ossicles), treatment of underlying cause. Hearing aids might be needed depending on condition after treatment

*Hearing loss is usually **temporary**
Sometimes even after the threshold problem was fixed, the patient still can't understand what they are hearing. The brain just needs some time to acclimatize and reprogram itself.



Sensorineural hearing loss
High frequency and Noise-induced pattern

Bone conduction thresholds : Above the threshold (abnormal)
Air conduction thresholds : Above the threshold (abnormal)
Gap between AC and BC : <10 dB

- **Both** air and bone are **abnormal** (*more than 25 db) and there's **no gap** → **Sensorineural**.
  - A gap is (>10db)

Etiology

- **Inner ear :** (Noise exposure, labyrinthitis, cochlea fracture, Meniere's disease caused by an increase in pressure of the cochlear endolymph)
- **Nerve:** tumor (acoustic neuroma)
- **CNS :** (tumor in the pathway up to the brain, trauma)
- Otosclerosis starts conductive, then mixed, finally pure sensory neural)

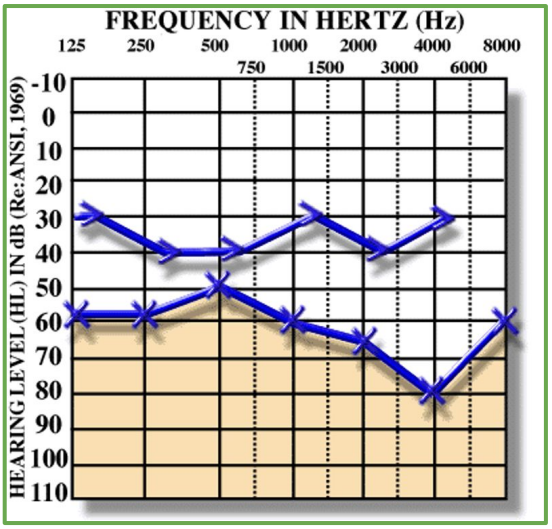
Management
Hearing aids, cochlear implant (Later)

*Hearing loss is usually **permanent** "once neurons are damaged they don't regenerate "

Noise exposure
Loud noises can cause SN hearing loss at higher frequencies without damaging the lower frequencies.

- This patient was exposed to loud noises (noises causes HL at 3000-4000 Hz range) → noises lead to a **Notched audiogram** at high frequencies (Boilermaker's notch)
- In the lower frequencies — Normal hearing. **High** frequencies — **Abnormal**.
- See the notch at high frequencies. **Notched Audiogram. (Green Circle)**
- Ask the patient in history about work: could be in airport, working factories.

Pure Tone Audiometry cont.



Mixed Hearing Loss

Bone conduction thresholds : Above the threshold (abnormal)
Air conduction thresholds : Above the threshold (abnormal)
Gap between AC and BC : More than 10 dB

Both air and bone are **abnormal** and there's difference (**gap**) between bone & air conduction is more than 10 db
→ **Mixed hearing loss.**

Etiology
Both conditions of conductive and sensorineural

Otosclerosis
- More common in females , peak age 25-35
- It can be genetic and is worsened by pregnancy.

Early :
Initially there will be a **conductive hear loss** due to the calcification preventing the stapes from moving and transmitting the sound to the inner ear.

Late :
As the disease progresses there will be **sensorineural hear loss**; due to calcification affecting the cochlear sensory cells (hair cells)

It is the fixation of the stapes
Cause calcification on the oval window and inside the cochlea itself hence becomes mixed hearing loss.

Management
1. **Hearing aids**
2. **Stapedectomy** Removal of the stapes or part of it and replacing it with an artificial device
   a. Done to delay doing the cochlear implant
3. **Cochlear implant** when hearing aid is no longer useful

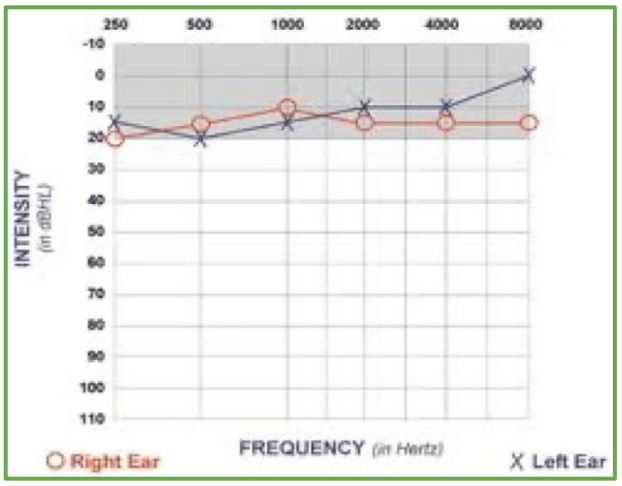
Conductive Hearing Loss	Sensorineural Hearing Loss	Mixed Hearing Loss
Air conduction is **abnormal**	Air conduction is **Abnormal**	Air conduction is **Abnormal**
Bone conduction is **normal**	Bone conduction is **Abnormal**	Bone conduction is **Abnormal**
The gap between air and bone conduction is >10 dB	The gap b/w air & bone conduction is **<10 dB**	The gap b/w air & bone **conduction is >10 dB**

Once the lesion is beyond the middle ear there's no medical tx that can be done, only one surgical tx which is implanting a hearing aid and this is indicated only for profound hearing loss.

The wear and tear that occurs the auditory system with age also leads to sensorineural hearing loss due to the outer hair cells dying and this leads to a condition called presbycusis.

The hearing loss is defined by:
- Type (conductive, sensorineural or mixed).
- Degree (mild, moderate, severe or profound).
- Configuration (in which frequency).

Pure Tone Audiometry cont.

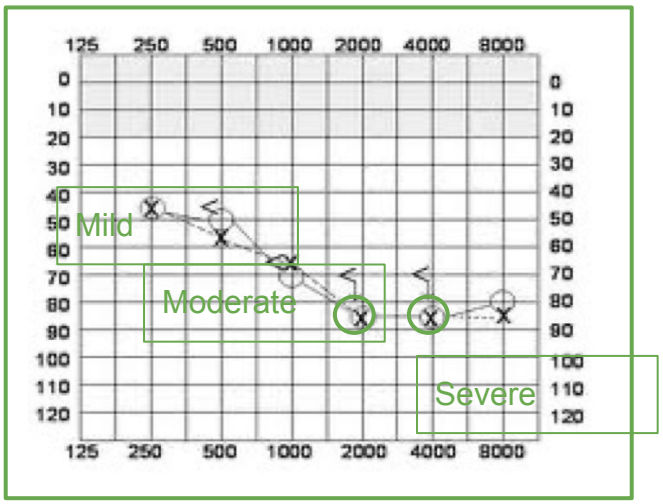


Bone conduction thresholds : Within normal range
Air conduction thresholds : Within normal range
→ **Normal** hearing.

Hearing threshold for bone is **always** equal or better than air, so if air is normal bone can't be worse. So if air conduction is normal in some or all frequencies we can just skip measuring bone conduction in those frequencies.

We only mask if we're testing above 60 intensity, as anything below 60 cannot cross to the other ear.

Usually we measure air conduction without bone conduction unless specific conditions that we have to test both (ie, third window, superior semicircular canal dehiscence



Bone conduction thresholds : Abnormal
Air conduction thresholds : Abnormal
Gap between AC and BC : < 10 dB
→ Mild sloping to severe SN hearing loss.

- Both air & air conduction abnormal + gap <10 dB
  → SN hearing loss.
- At the lower frequencies it is at the level of mild HL
- While at higher frequencies it slopes to severe HL.

Arrow : No response from the patient
Why we don't deliver a higher sound (80db) when the patient didn't respond to 70 db ?

- Because we can't produce a sound using bone vibrator with intensity more than 70db.

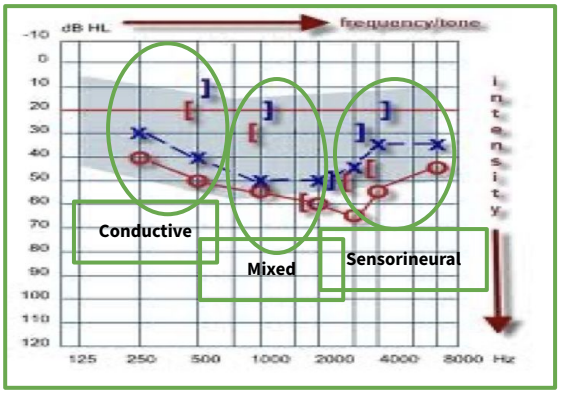
Therefore we can't know the bone hearing threshold form this audiogram (70 db is not the real threshold, the real one is probably more than 70 db).

How to determine the type of hearing loss ?
Based on this graph alone I will not be able to tell the type, we'll simply say I reached a maximum and there was no response, I need other test to determine the type by exclusion of other types

Rule out conductive hearing loss by

- **Tympanometry** (Middle ear assessment) : if there is no conductive pathology in middle and outer ear → it can't be mixed → sensorineural (by exclusion).

Pure Tone Audiometry cont.



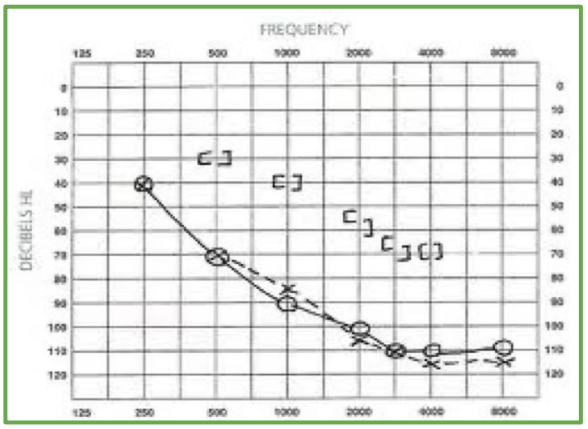
Moderate **conductive** hearing loss in **lower** frequencies
Moderate **mixed** hearing loss in **middle** frequencies
Moderate **sensorineural** hearing loss in **higher** frequencies.

Pathologies that can cause such an audiogram:

- **Otosclerosis** (ossification of the stapes, usually has to be free, but the disease calcifies the oval window with the stapes.

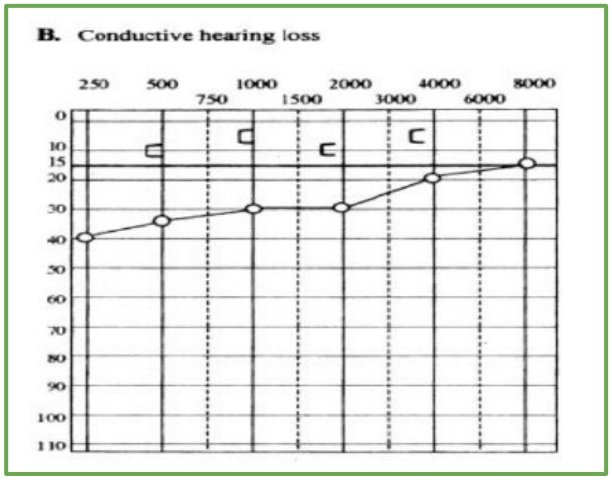
***Note** : we can have **more than one type** of hearing in the **same ear.**

- **High** frequency tones stimulate : **Basal** turn of the cochlea (in the basilar membrane "BM")
  - The basal part is less protected → so most pathologies of the **inner ear** will have abnormal hearing of **higher frequencies** like ototoxicity which is usually not discovered until it's too late if we don't test the pressure frequently.
- **Low** frequency tones stimulate : **Apical** turn of the cochlea (in the BM)
  - **Middle** ear pathologies usually affect the **lower** frequencies.
- The **degree** of hearing loss is determined by the **AIR** conduction.



Mixed Hearing Loss

Dr. : I will give you a case and a picture of an Audiogram then ask where is the possible lesion site or the diagnoses.

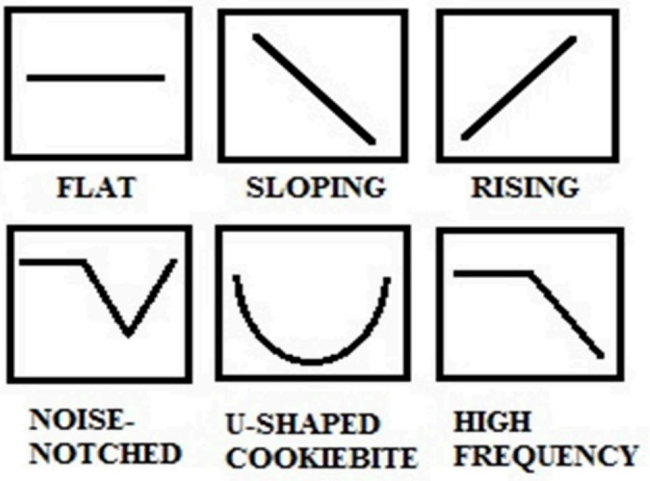


Conductive Hearing Loss

Mild to normal rising conductive hearing loss at higher Hz. This specifically can occur with middle ear effusion which affects lower Hz more than higher Hz and it's the only condition the patient has it doesn't affect the high Hz

Pure Tone Audiometry cont.

Dr skipped this slide.



The configuration of the hearing loss is a very imp aspect of the curve that should be assessed alongside the degree and type of loss, and it gives imp info on the possible cause.

Flat curve: Usually acquired by age or could be genetic

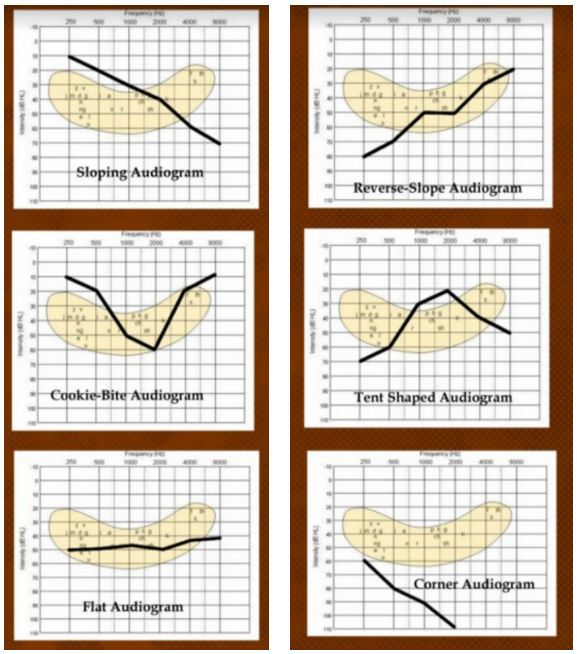
Sloping: means higher fq hearing loss is more than the lower Hz hearing loss, it's acquired by ototoxicity, prolonged noise exposure, age (age usually affects the higher freq before than lower Hz)

Rising: opposite to the sloping curve, and it means that the lower Hz are affected more than the higher, it's acquired by middle ear effusion, menière's disease, and sometimes age.

Noise-notched: Characteristic for prolonged noise exposure, so we if see a curve like this with a notch at 3000-4000 Hz think of prolonged noise exposure such as in construction workers.

U-shaped: This is really worrying as its usually related to retrocochlear lesions (brainstem or auditory nerve) such as an acoustic neuroma which is a tumor in the auditory nerve, and thus its indicated for further investigations such as an MRI, etc…

High frequency: caused by ototoxicity, age, noise.



Reverse-slope angiogram: Like the rising curve, a patient with this configuration will have a disability hearing many hz that might cause them to need a cochlear implant. There is little benefit from hearing aids

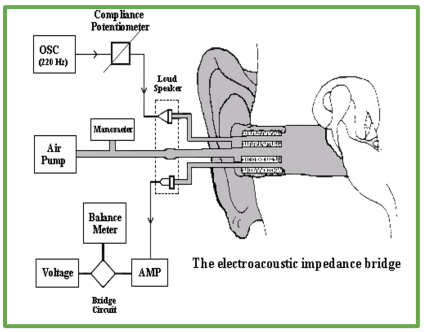
Cookie-Bite audiogram: Like the U-shaped curve, the main issue here is the patient will tell you they'll have a problem hearing when there's background noise, but when its quiet they have no problem Hearing.

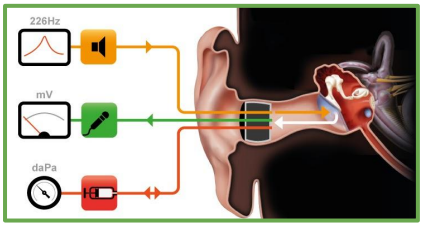
Tent ashamed audiogram: Also called the reverse Cookie-Bite, the patient loses the ability to hear very low Hz.

Flat audiogram: Not serious compared to the other configurations.

Corner audiogram: patient is only able to hear at very low Hz, these patients will only benefit from a cochlear implant.

Tympanometry





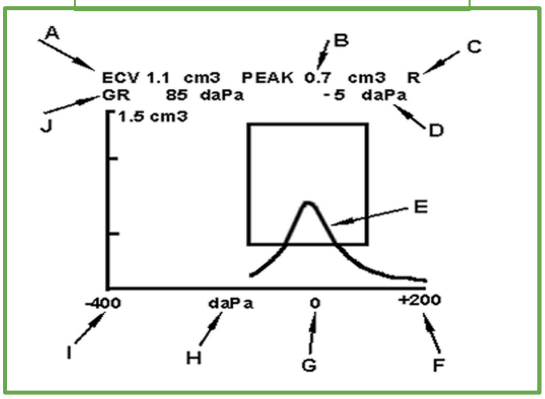
Use of tympanometry : Diagnostic tool to test middle ear function (where most pathologies occur) especially the Eustachian tube (as it functions in equilibrating the pressure between the middle air and the atmosphere. At this equilibrium state sound waves are maximally conducted through the middle ear)

Tympanometry is conducted by placing a probe into the ear canal and it'll deliver a sound with a pressure change and we assess how much of the sound goes to the system and how much reflects back and this will plot a "Tympanogram

The probe has 3 holes:

- Pump ⟶ for pressure
- Sound
- Mic ⟶ to see how much sound is reflecting back
  - More sound reflection means: more hearing loss
  - Less reflection means no or less HL

Tympanogram



Tympanogram
a graphic representation of the compliance of the tympanic membrane (TM) in response to different pressures, indicating how effectively the sound is transmitted into the middle ear
Dr: no need to memorize normal values, they'll be given in the exam.

X-axis :
Represent the pressure
Pressure difference b/w the outer side of the tympanic membrane and inside.

- When they are equal (pressure difference is 0) ⟶ best pressure for hearing (peak ⟶ maximum compliance).
- Normal range is -100 to +50

Y-axis :
Represent the compliance of the TM (flexibility of the TM when different air pressures are introduced)

- Normal range from (0.3 - 1.4 in Adults, 0.2 - 0.9 in children).
- Unit ⟶ mmho (compliance unit)

ECV : Ear Canal Volume.

- External ear canal volume (normal range ⟶ 0.6-1.5).
- Differentiate between effusion and perforation
  - **Increases** with **TM perforation** (2.0 in children and 2.5 in adults is suggestive of perforation).
  - **Decreases** with **wax impaction. (foreign body)**
  - **Normal** : **Middle ear pathology (Effusion)**

Peak :
The point where maximum amount of sound is transferred through the middle ear.
(the pressure at which there is max compliance of the TM)

- Normal range is (-100 - +50). -5 daPa (in this patient)
- GR: The gradient is how sharp the peak is.

Tympanometry cont.

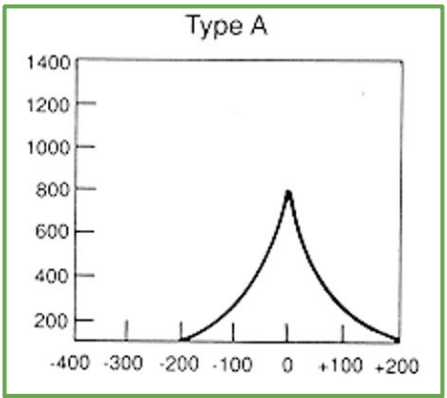
◀ Tympanometric features

- Tympanometric shapes.
- Static acoustic admittance.
- Tympanometric width (gradient).
- Tympanometric peak pressure.
- Equivalent ear canal volume.

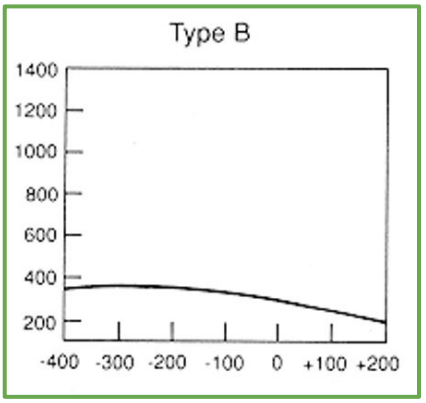
Notes:

- **Functions of the middle ear:**
  - Protection.
  - Amplification (17-20x).
- If there is no middle ear → pt will lose 50 dB of hearing → moderate conductive hearing loss (example → **Aural atresia** (congenital anomaly) where the inner ear is normal but the middle ear is ossified.
- In eustachian tube dysfunction → the compliance peak will be deviated to the negative side (left).

Exam Question !
Tympanogram with a case scenario
1. What is the type?

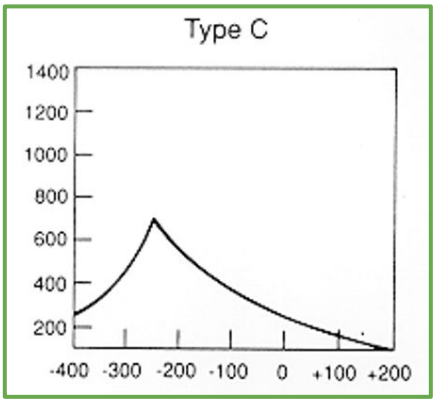


Normal
Peak between -100 & +50 daPa
(Peak within normal pressure and compliance)



Flat with no peak → either,
- **Effusion of middle ear**
- **Perforation**
- **Thick TM or patent eustachian tube.**

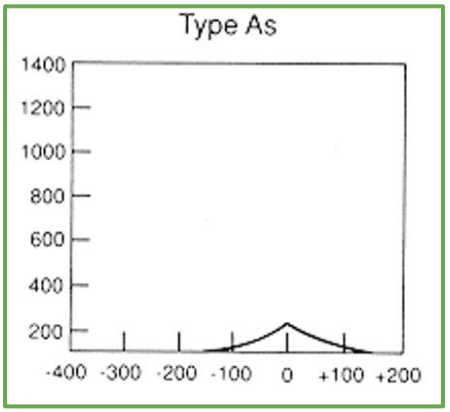
How to differentiate?
Look at **ECV**:
- High → perforation.
- Low → Wax/foreign body.
- Normal → Middle ear pathology: (Effusion)



Eustachian tube dysfunction
Peak on the negative side (around -200)
Eustachian tube inflamed and won't open causing a -ve pressure
- Painful conductive hearing loss

Seen in :
Tympanic membrane retraction due to negative pressure.

Tympanometry cont.

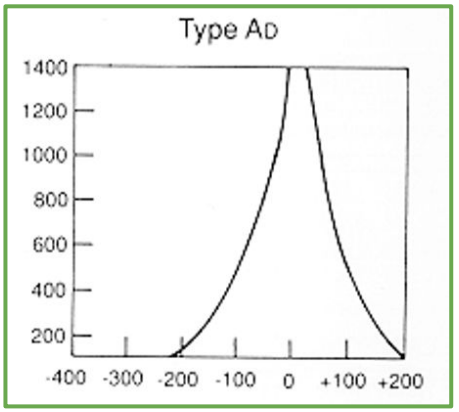


Peak : **Shallow (short)** peak. (Less compliance, stiffness)

Etiology

- Could be normal
- **Ossicular fixation**
- elderly patients (they lose elasticity of TM)
- **Otosclerosis**
  - ↓ movement of TM.
  - Conductive HL → later it becomes mixed → then pure SN HL
  - It is a congenital anomaly
  - More common in females
- Hearing aids are helpful, while we usually don't do anything unless hearing loss was profound then we implant.

A subcategory of Type A;
S: stiff / shallow
Hypo-mobile admittance (low admittance)
Seen in pt in whom the stapes has become partially immobilized



Peak : TM easily movable resulting in a **high** peak. (increased compliance)
→ Ineffective movement of the TM

Etiology

- **Dislocation of ossicles**
  - Mostly caused by accident (head trauma)
  - Multiple episodes of middle ear effusion → erosion
  - It leads to conductive hearing loss.
- **Invasive tumors could also cause it.**
- **Thin and lax tympanic membrane.**

A subcategory of Type A;
D: deep / discontinues
Hypermobile admittance (high admittance)

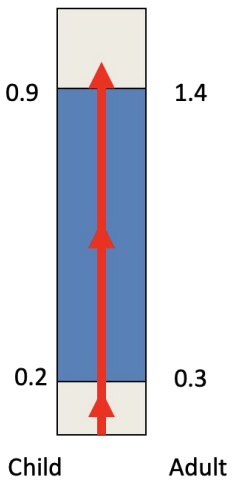
◄ Static compliance (Peak compliance)

- Acceptable Range by Age: (not needed)

	Peak Compliance (mmho or cc)	Ear Canal Volume (cc)
Mean	0.5	0.7
90% range	0.2 to 0.9	0.4 to 1.0

Adults

	Peak Compliance (mmho or cc)	Ear Canal Volume (cc)
Mean	0.8	1.1
90% range	0.3 to 1.4	0.6 to 1.5



Flaccid: disarticulation, flaccid TM, etc.

Normal mobility

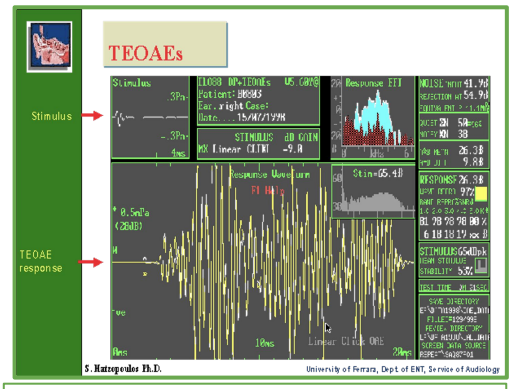
Stiff: otosclerosis fluid, tympanosclerosis, etc.

The acoustic reflex: is the contraction of the stapedius muscle elicited by the presentation of an acoustically loud sound. When either ear is presented with a loud sound, the stapedius muscles on both sides contract.

Otoacoustic Emissions

◀ Origin of OAE

- Purpose of OAE: to know the health of the OHCs + Cochlea
- Initially reported by Kemp in 1978.
- OAE are considered a by-product of sensory outer hair cells (OHCs) transduction and represent cochlear amplifier that thought to be as a result of the contraction of OHCs in synchrony with basilar membrane (BM) displacement.
- The contraction of the OHCs (movement) is then propagated outward toward the middle ear and moves the TM.
    - OHCs → basilar membrane → perilymph → oval window → middle ear → external ear to be picked up
- This in turn creates acoustic energy that is picked by the OAE probe. We put a mic behind the TM
- In order to record OAE in EAC we need to have normal middle ear function.



If waves are absent → problem of the cochlea or pathway is obstructed.

If the graph is normal then that means all the conductive pathway is normal

- If the **OHCs are intact** we can assume the **cochlea is intact too**
    - OHCs are the weakest, they're the first one to be affected in any ear pathology (Ototoxicity, infection, noise,..)
- OAE are **present** when the **OHCs are healthy.**
- OAE are **absent** when **OHCs are damaged.**
- If the **auditory nerve** or its subsequent pathway is **damaged** and **OHCs are intact → Normal OAE**, thus it differentiates between cochlear and retrocochlear causes of hearing loss.
    - (retrocochlear means beyond the cochlea into the neural pathway)

Types of OAE

- 1. Spontaneous OAE: produced without stimulus, 50% of people don't have
- 2. Evoked OAE: with stimulus
    - Transient evoked (TEOAE): produced by individual tones, usually used for for 500-4000 Hz hearing loss, most sensitive at 500-1000 Hz
    - Distortion product OAE (DPOAE): produced by two simultaneous tones, usually used for 1000-8000 Hz hearing loss. Most sensitive at 4000 Hz

Exam Questions !

- **If the OAE is Normal, what is the expected type of tympanogram ? Normal type A**
- **Type B/C tympanogram, what do expect about OAE ? OAE Should be absent**

If the lesion site is beyond the inner ear and both outer hair cells and conductive pathway were normal OAE will be produced and we may give the person being screened a pass and miss out on the lesion beyond the inner ear, which is why we need to combine OAE with an ABR to rule out auditory neuropathy spectrum disorders.

Otoacoustic Emissions

◄ Clinical applications of OAE

1. Can be used in **newborn hearing screening.** The results will indicate either fail or pass.
   Fail means that hearing thresholds are worse than 30 dB HL.
   Pass results means hearing thresholds are 30 dB HL or better. So, we can not use this tool to measure threshold of hearing.
   - TEOAE can be recorded in all non-pathologic ears that do not display hearing loss of greater than 30 dB.
   - OAE can be recorded in both adults and infants.
   - Accordingly TEOAE and DPOAE can be used to **screen for hearing loss in infants.**
   - DPOAE provide more frequency specific evaluation that TEOAE.

2. In **differential** diagnosis of hearing loss (site of lesion). This can help in differentiating **sensory** from **neural** hearing loss.

3. Monitoring of the effect of **ototoxicity or noise exposure** i.e chemotherapy monitoring (can detect it earlier than pure tone audiometry, DPOAE is used as it is most sensitive for high frequency hearing loss).

4. Although still under research: DPOAE can be used to screen for the **carriers of the recessive hearing loss genes**: many studies found that DPOAE is larger (especially at high frequencies) in carriers than in non carriers when using f2/f1 of 1.3 and low stimulus levels of 50-60 dB.

5. Testing in in **uncooperative, mentally** challenged or **sedated** individuals.

6. Can also be used to uncover malingering patients (along with ABR, see next page)

7. Alongside a tympanogram to localize a lesion causing conductive hearing loss.

◄ Clinical Limitations

- Problems because of middle ear disease.
- Not sensitive for neonates within 24 hours of birth.
- Results affected by test conditions, Noise.
- Not a test of hearing- limited application.
- False -ve results if the pathology causing the HL is beyond the cochlea (Auditory neuropathy) , need more tests (ABR)

ABR(Auditory Brainstem Response)cont.

◄ Definition

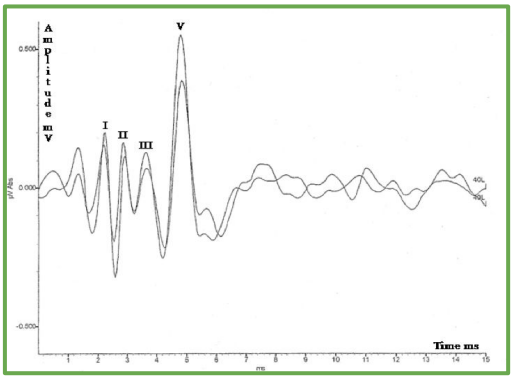
The auditory brainstem response (ABR) is an auditory evoked potential extracted from ongoing electrical activity in the brain and recorded via electrodes placed on the scalp.

- It is used to localize retrocochlear causes of hearing loss
- The process is completely objective
- Used when it is difficult to test the patient subjectively
  - (newborn, comatose, sedated, asleep, non-compliant etc).
- Screening process in newborns
  - Low-risk newborns: OAEs (if OAEs are abnormal do ABR to localize retrocochlear pathology)
  - High-risk newborns: Do OAEs and ABR together

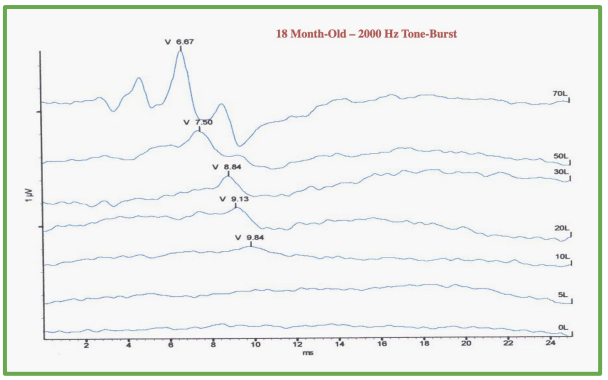
We couple ABR to OAE in screening at birth to make up for OAE limitations and to ensure we pick up any abnormalities, so when you have a normal OAE, do the ABR and it'll be abnormal in those with auditory neuropathy spectrum disorders.

- Characterized by 5-7 peaks.
- Occurs in a latency epoch of 1.4 - 8.0 ms.
- Responses are usually displayed with positive peaks reflecting neural activity towards the vertex.
- These peaks are labeled with roman numerals I through XII
- The most prominent and important waves are I, III, and V. (present in all normal ears).
- Usually 3-7 waves are present

Proposed sites of waves (**EE COLI**)
Wave I: **E**ighth cranial nerve (distal part)
Wave II: **E**ighth cranial nerve (proximal part)
Wave III: **C**ochlear nucleus
Wave IV: Superior **O**livary nucleus
Wave V: **L**ateral lemniscus
Wave VI and VII: **I**nferior colliculus



- الي بهمني اسوفه wave V وهو اعلى wave وعالبا بطلع على 5ms.
- The lowest amplitude wave V exists at → is the **hearing threshold.**
- Here we can see that wave V disappears at amplitude of 10 dB → so this is normal hearing (because hearing threshold is within the normal value of (-10 - 25 dB).
- ARB can identify the degree of hearing loss; if the ARB waves appears at 50 dB → moderate HL.
- ARB also can identify the type of Hearing loss. بدال Headphones اسجدم Bone لبوصيل الصوب.



Could come in Exam: what is the hearing threshold?

If OAE present + ABR absent → Auditory neuropathy (auditory neuropathic spectrum diseases → treatment is cochlear implant (even if the cochlea is normal)

ABR (Auditory Brainstem Response) cont.

◄ Using ABR to Estimate Hearing Thresholds

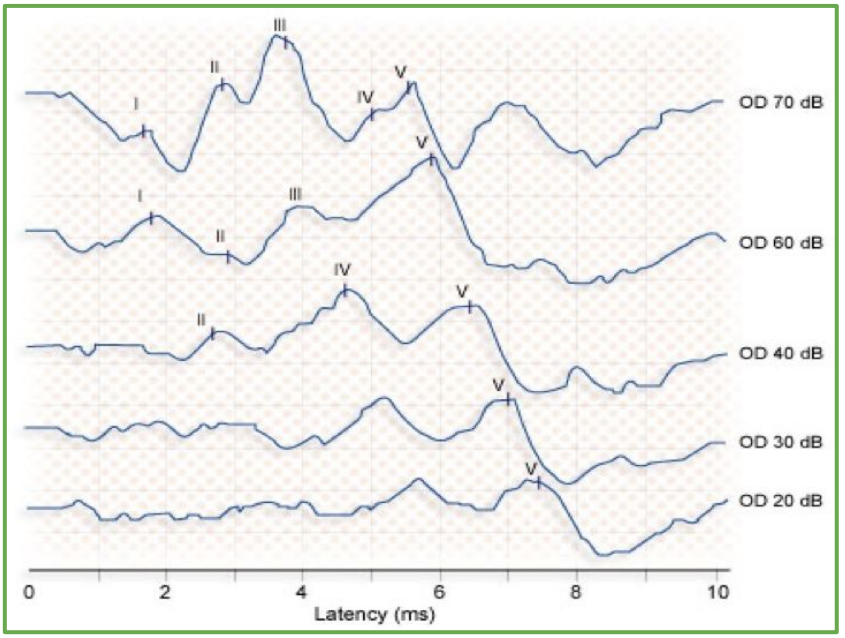
Hearing threshold: The lowest amplitude wave V exists at (Lowest sound that can provoke an electrical activity in the brain stem

- Can be obtained by progressively decreasing intensity of the stimulus (click or toneburst) and observing **wave V.**
- The **last intensity that wave V appears** at is considered its threshold.
- ABR threshold is within 10-20 dB from the subjective threshold.

Exam Question !

Graph with labeled waves (I-V), what is the threshold ?

For example in this graph it's 20dB



Lecture quiz

Q1-A 5 year old girl presented with a feeling of heaviness in the right ear for one month, The child is otherwise fine and scores good in school. The right tympanic membrane looked retracted with air bubbles seen in the middle ear. What is the most accurate diagnostic test for this condition?

A. Brainstem evoked response audiometry
B. Otoacoustic emission
C. Speech audiometry
D. Tympanometry
E. Tuning Fork tests

Q2- A 40 year old patient presented with dizziness and loss of the hearing and aural fullness.Examination showed right ear high frequency sensorineural hearing loss.Speech discrimination test and ABR showed abnormal findings.What is the most likely diagnosis?

A. Vestibular schwannoma
B. Meniere's disease
C. Chronic otitis media with effusion.
D.presbycusis
E. None of the above

Q3- A 2 year old child presented with delayed speech development. He is not responding to the sounds. He was a full-term baby with a normal APGAR score and no intensive care admission. He has a positive family history of hearing loss. Which of the following objective test should be done?

A. Tuning Fork tests
B. Video-nystagmography (VNG)
C. Pure tone audiogram(PTA)
D. Auditory brainstem response (ABR)
E. Tympanometry

Q4-78 year old male presented to the audiology clinic with long time hearing loss, he said that he can hear the people talking but can't understand the words. What do expect to see in his audiological configuration?

A. Low frequency CHL due to presbycusis
B. High frequency CHL due to presbycusis
C. High frequency SHL due to presbycusis
D. Low frequency SHL due to presbycusis

1.D
2.A
3.D
4.C

THANK YOU!

This work was done by:

Naif Alfahed
Reviewed by Abdullah AlQarni

Team Leaders:

Naif AlFahed
Nawaf AlGhamdi
Abdullah AlQarni

Special Thanks to

439 Team