

Avoiding ‘Blurry’ Hearing Aids

By Dennis A. Colucci, AuD

When fitted properly, hearing instruments can restore communication and reconnect patients with their family, friends, and environment. To maximize the outcome, I take time to choose the appropriate instruments and options, qualify the fitting with scientific measures, and ensure that the patient has adapted to the use of the devices without discomfort. I also obtain reports from the patient substantiating a significant reduction or elimination of communication stress and a sense of an improved quality of life. Finally, I make sure that the prescription and my counseling prepare the patient for auditory learning and memory changes.

Patients with hearing loss experience isolation and social deprivation. This suffering may not improve in patients who have incorrectly fitted “blurry” hearing aids. Patients can go for years trying to communicate, thinking their hearing loss is the issue, only to learn that the provider, hearing aid, and, especially, the prescription failed to meet their needs. Stress and anxiety related to amplification errors harm the patient; daily life is disrupted, learning delayed, and interpersonal situations lost, especially in the senior population.

I recently saw an 84-year-old female with mild-to-moderate, moderately sloping, bilateral, high-frequency sensorineural hearing loss. She had excellent speech discrimination in quiet, an uncomfortable loudness level measuring within normal limits, and unaided Abbreviated Profile of Hearing Aid Benefit (APHAB) scores suggesting moderate impairment. The patient had narrow 1.5-mm canals and a 90-degree angle at the first bend. There was no retention at the concha or tragus/antitragus, and the helix was small.

She had been fitted with open-mold receiver-in-canal hearing aids with domes, and had complained to her previous provider for nearly a year that the hearing aids were slipping out and she could not hear conversation. She lost three hearing aids before consulting me. I refitted her with skeleton earmolds and prescriptions that were verified with real-ear probe. Her outcome was remarkable, as she could hear in a variety of listening situations, including in background noise at her favorite restaurant. Her communication stress decreased significantly as she perceived a normalization of word clarity and sound comfort. She filed a claim with the licensing board against the previous provider and could not understand how this situation could have happened.

A second patient had premium hearing aids that were sold as offering the latest technology with superior hearing in noise. She is an 85-year-old woman who came to me for a cochlear implant evaluation because her friends with CIs could hear much better and hearing aids weren't helping her. She had a



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bilateral moderate to severe, mildly sloping, sensorineural hearing loss, with an uncomfortable loudness level measuring within normal limits, excellent discrimination in quiet, and typical Hearing in Noise Test (HINT) scores. Unaided and aided APHAB scores represented moderate impairment.

She had been fitted with receiver-in-canal hearing aids and earmolds with medium vents. She had complained to her provider for two years, who failed to improve her situation even though multiple program changes were made. Upon evaluation, the real-ear data showed peaks at 1,250 Hz and 2,800 Hz, with no other amplification to meet the patient's needs. She was refitted and provided a noise-reduction option. She quit lipreading class and remains dismayed over the entire incident.

The clinical genesis of maximizing communication is not accomplished simply with amplification that uses default programs and tweaking, but with diagnostic testing, strategic prescription writing, and a therapeutic plan that maximizes auditory performance and neuroplastic changes.

Measures to ensure the accuracy of the prescription for the patient's needs is the responsibility of the provider. The patient ultimately is not responsible for the outcome, except in over-the-counter devices and cases of noncompliance with training. Patients may have no idea what maximized hearing means until it occurs.

Ill-fitted hearing aids come in all sizes and circuits from people who manufacture devices or are licensed to fit and sell them. Blurry hearing aids not only worsen patients' social isolation and deprivation, but they also result in public confusion and distrust. [11](#)



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