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Clinical Implications for Pediatric Bimodal Fittings

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Clinical Implications for Pediatric Bimodal Fittings

Audiology On-Line
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Lisa S. Davidson, PhD

Agenda

- Terminology/Patient Characteristics
- Benefits of Acoustic Hearing
- Considerations in Pediatric Bimodal Fitting
- Clinical Implications for Bimodal Fittings
- Case Study
Participant Outcomes

1) Participants will be able to summarize research findings related to how acoustic hearing may facilitate spoken language development for pediatric CI recipients.
2) Participants will be able to summarize fitting strategies related to fitting bimodal devices.
3) Participants will be able to describe outcome measures to assess bimodal benefit for pediatric CI recipients

Terminology/Patient Characteristics
BIMODAL DEVICES

Guidelines for CI Candidacy

Adults:
- ≤ 50% Sentences aided in ear to be implanted
- ≤ 60% Sentences best-aided

Children:
- < 2 yrs old: profound range for thresholds
- > 2 yrs old: ≤ 30% LNT, or MLNT, best-aided
Pediatric CI Candidacy

- Age at implantation (12 months)
- Consideration of children with more residual hearing at both ears (≥ 2 years old)
- Consideration of children with asymmetric hearing loss (≥ 2 years old)
- Poor audibility in high frequency range

Example Audiograms for Some Non-traditional Pediatric Bimodal Recipients

Increased Number of Bimodal Recipients as CI Candidacy Expands

- Numbers of bimodal recipients have increased (2002: 10% were bimodal users (Tyler et al.) 2009: ~30% (Fitzpatrick et al.) 2010: >50% with aidable hearing in non-CI ear (Dorman & Gifford):
  - Greater level of residual hearing/speech recognition at non-implanted ear (Fitzpatrick et al 2009; Gifford et al., 2010; Sampaio et al., 2011; Mowry et al., 2012.)
  - Non-traditional candidates with asymmetric hearing profiles (Firszt et al., 2012; Cadieux et al., 2013)

Unaided Audiometric Threshold Profiles at HA Ear for Bimodal Recipients

Davidson et al., 2015
Benefits of Combining Acoustic and Electric Hearing

- Benefits (compared to unilateral CI use) for adults and children may include: speech perception in quiet and noise, localization, speech quality, music appreciation/recognition & ease of listening
- A period of HA use, prior to receiving a 2nd CI, may facilitate spoken language and literacy skills in pediatric CI recipients (Nittroer & Chapman, 2009; Nittroer et al., 2012; Nittroer et al., 2014)
- Benefits may vary across individuals and conditions

(See review from Ching et al. 2007; Sammeth et al. 2011; & Schafer et al., 2011 )

What Are the Possible Mechanisms Underlying Bimodal Benefit?

Low Frequency Acoustic Cues (F0, F1, F2)
- Allow CI listeners to segregate speech when competing talkers present
- Improve performance by providing phonetic information (i.e. voicing and manner)
- Improve performance by providing phonetic cues for lexical boundaries and prosodic information

Ching et al., 2005; Mok et al., 2006; Brown and Bacon, 2009 & 2010; Spitzer et al., 2009; Cullington et al., 2010
What are the contributions of Acoustic and Electric Hearing?

Hearing Aid
- Supra-Segmental Cues (voice pitch (F0)/voicing and manner cues)
- Music appreciation
- Perception in noise

Cochlear Implant
- Segmental Cues (phoneme perception/high frequency audibility/place cues)
- Speech intelligibility

(Ching, 2011; McDermott, 2011; Sheffield & Zeng, 2012)

Speech Perception

Two main areas of speech perception:
- Segmental Perception: “what is said”
  - vowels and consonants; words; sentences
- Suprasegmental Perception: “how something is said” or “who said it”
  - prosody, intonation, stress; talker characteristics
    (emotion, gender, age, accent, etc.)

Both types of perception are necessary for effective spoken communication and spoken language development (Abercrombie, 1967; Pisoni, 1997)
Possible Bimodal Benefits for Spoken Language Development

How might a HA (combined with a CI) facilitate spoken language development—especially in the first year(s) of life?

- Good perception of the Fundamental Frequency, \( F_0 \), of voiced speech is considered important:
  - especially for *infants*, to segment speech and learn lexical boundaries (i.e., words) – possibly via the exaggerated prosody of infant-directed speech
  - to learn talkers’ voices, which may interact with word-learning
  - to segregate voices when competing talkers’ speech is present
  - to perceive indexical properties of talkers (e.g., gender, emotion)

  [Above may be considered suprasegmental speech perception]
  - to understand semantic “tone”, for tonal languages

- HAs (depending on listener’s level of hearing) convey \( F_0 \) information better than CIs

Chung et al., 2009; Mile et al., 2006; Brown and Mason, 2006 & 2010; Litton et al., 2009; Cullington et al., 2010;xffdıktan et al., 2010; Grant, 1987; Melt & Patel, 2007; Carol & Zing, 1995; Perfuswave et al., 2011; Libby & Knowles, 2012
Considerations for Fitting Bimodal Devices

Challenges for Bimodal Device Fitting

- Mismatches in pitch, timing and loudness across CI and HA
- Mismatches in gain and compression characteristics across commercial CI and HA systems

*Obstacles to bimodal fitting related to current commercial CI and HA systems (For a review see Francart & McDermott, 2013)*
Optimizing Bimodal Fittings

- Studies’ results support the coordinated fitting of a hearing aid (HA) and cochlear implant (CI) for bimodal use (CI + HA at non-implanted ear) that emphasizes balanced **loudness** across the two ears/devices (Blamey et al., 2000; Ching et al., 2001; Ching et al., 2007)
  - No widely established fitting protocols for balancing loudness/audibility across CI and HA, although some published protocols include:
    - Loudness matching task used to balance loudness of three warble-tone stimuli centered at 500 Hz, 1000 Hz & 2000 Hz (presented at 65 dB SPL) across CI and HA ears for 16 pediatric bimodal recipients. Modifications to HA made to NAL-RP gain/output targets (Ching et al., 2001).
    - Loudness scaling task (7-point scale from “not heard” to “too loud”) using narrowband stimuli at 500 Hz, 1000 Hz, 2000 Hz and 4000 Hz was administered in CI alone and HA alone condition to pediatric and adult bimodal recipients. Adjustments to devices made based on loudness scaling. Pediatric recipients had HA set to DSL output targets (Kellmann et al., 2009).
    - Loudness matching task using broadband, live voice or calibrated running speech across CI and HA ears for adult bimodal recipients. Changes to HA made to gain/outputs set to various fitting targets (Mok et al., 2006; Veugen et al., 2016).

Some Recommendations for Adjusting Bimodal Fit for Loudness

- Balance comfort/loudness of input levels of speech from soft to loud across devices using:
  - Live voice speech presentation
  - Calibrated running speech @ ~65 dB SPL, ~70 dB SPL, ~80 dB SPL
  - Environmental sounds at various levels
- Adjust Global Map C/M levels or volume, adjust output of hearing aid, evaluate compression characteristics of each device, evaluate frequency-specific C levels, output etc.
Some Optimization Recommendations

- Bimodal Hearing Aid Fitting Guidelines: Oticon White Paper 2015 - Carisa Reyes/ Boys Town National Research Hospital

Optimizing Bimodal Fittings

- What is the best frequency response for the HA? Results vary across studies, individuals and outcome measures!
  - Do we deliver low frequencies to the HA and high frequencies to the CI? Or do we provide BOTH devices with the widest frequency range? (Vermiere et al., 2008; Simpson et al., 2009; Zhang et al, 2010)
  - Should we restrict HA gain to regions that have more residual hearing or to low frequency regions? (Mok et al., 2006, 2010; Potts et al., 2009; Neuman & Svirsky, 2013, Davidson et al., 2015; Messersmith et al, 2015)
  - Should we consider Frequency transposition/compression for HA? Or could this processing interfere with CI processing? (Gifford et al., 2007; McDermott & Henshall, 2010; Park et al., 2012; Perreau et al., 2013)
Bimodal Fitting Options
Wideband Fitting   Restricted Fitting

Individual Differences across HA fittings for Bimodal Performance (compare to CI-only scores)

Individual Word Recognition Scores (in quiet) for three CI+HA conditions compared to CI-alone scores (Davidson et al., 2015)
What should we do clinically?

- Consider a variety of HA responses (i.e., restricted and NLFC) in addition to the traditional wideband frequency response for HA settings used in bimodal fittings

- Optimize HA for individual differences and preferences

- Consider a variety of outcome measures

- Consider measuring dead regions to determine “aidable” hearing (Zhang et al., 2014) – may be questionable for pediatric population

- Consider bilateral CI’s when most outcome measures fail to produce a bimodal benefit, despite the clinician’s best attempt at optimizing the bimodal fitting

Bimodal Devices on Children: A Survey of Clinician Fitting Practices in North America

Knowledge Implementation in Pediatric Audiology Group (KIPA)

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DISCLOSURES

■ THIS PROJECT HAS RECEIVED SUPPORT FROM OTICON A/S

■ DAVE GORDEY AND KAMILA ANGELO ARE EMPLOYEES OF OTICON A/S

KIPA BIMODAL SURVEY (2016)

■ A web-based survey was sent out to approximately 300 clinicians, and 85 responded.

■ The survey was posted on the ACI blog; and distributed to pediatric clinics and hospitals identified from cochlear implant manufacturer websites and hearing aid manufacturers in the United States and Canada.

■ Survey questions requested information about clinical practices when fitting cochlear implants, hearing aids and bimodal devices in children.
COCHLEAR IMPLANTS: VERIFICATION

- Unlike hearing aids, cochlear implants lack standardized verification procedures.
- Other than speech discrimination testing, the use of verification/outcome testing is highly variable and measures were not age-dependent.

SUMMARIZING SURVEY RESULTS

- Compared to hearing aids, the verification and outcome measures used for cochlear implants are highly variable. Only half of the participants report that they fit both hearing aids and cochlear implants, which makes coordinated hearing care for children using bimodal devices challenging.
- Due to the lack of evidence-based fitting protocols for bimodal devices, the majority of clinicians use their own, internally-developed fitting protocol/guideline, or do not use a systematic protocol/guideline at all.
Recommendations for Hearing Aid Use for Bimodal Fittings

- Consistent hearing aid use should be implemented prior to CI/s
- Hearing aid use after unilateral CI surgery and prior to initial activation is strongly encouraged
- Continued hearing aid use AFTER initial activation is strongly encouraged

Outcomes and Evaluation
What are the clinical issues related to evaluating bimodal benefit?

- How do we best evaluate the effects of bimodal devices using clinically available tests and procedures?
- How do we evaluate very young children?
- When do we consider bilateral implants and is there a degree of hearing associated with this decision?

Validating Bimodal Fit

- Aided thresholds for FM tones or Ling Sounds to compare audibility across devices
- Aided speech testing (binaural & monaural)
  - Speech Perception in quiet (50 and 60 dB SPL)
  - Speech Perception in noise
  - Note that HA-only testing may not be possible; a less difficult test may be needed (good to have baseline)
  - Most important to determine whether bimodal perception is not degraded compared to CI alone
Speech Perception Outcomes

- Improvements in device technology necessitate an ever expanding speech perception test battery
- Speech perception outcomes must be interpreted in the context of linguistic, cognitive and developmental level of the child
- Speech perception outcomes should reflect real world listening environments and be replicated in a clinical setting
- A variety of outcome measures should be used to assess benefit (i.e., localization, talker discrimination, perception in quiet and noise, subjective reports)

Pediatric Speech Perception Recommendations

### Outcome Measures for Evaluation

**Clinical Measures**
- Word and Sentence Recognition in quiet and noise (segmental perception)
- Subjective reports (questionnaires and patient report)
- Very young children may be limited to detection tasks (i.e., Ling Sounds, aided responses) and parent/educator reports and observation

**Research Measures**
- Music perception
- Localization
- Suprasegmental Speech Perception (emotion identification, stress discrimination and talker discrimination)

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**Clinical Standard of Care is to Fit BOTH ears**

- Normal Hearing
  [All acoustic hearing]
  - Bilateral Hearing Aids (HA)
  - Bimodal Devices
  - Bilateral Cochlear Implants (CI)

- More Hearing Loss
  [All electric hearing]
When should we move from bimodal to bilateral devices?

- Speech perception results show no/minimal bimodal benefit; however
  - Bimodal benefit may be affected by test sensitivity and may vary across test measures
  - As CI-alone performance improves bimodal benefit may appear diminished
  - Speech perception results and subjective reports may differ
- Child resists wearing hearing aid and/or reports distortion with hearing aid
  - Discussion of clarity vs. quality should be considered for some children
  - Motivation is key issue for successful transition for older children

Bimodal vs. Bilateral CIs


Issues to consider

- Is there an optimal period for receiving bilateral CIs?
- Can bimodal device use prevent binaural auditory deprivation (caused by unilateral CI use)?
- What degree of residual hearing at the HA ear is beneficial?

*(Chadha et al., 2011; Gordon et al., 2011)*

Bimodal to Bilateral Case Study
Case Study

Passed NBHS (Newborn Hearing Screening)

Diagnosed with severe - profound hearing loss at age 3, fit with hearing aids at that time and enrolled at CID

Age at Bimodal Testing: 7

Right CI - 1st - April 2008 (age 4)

Left CI - 2nd - August 2011 (age 8)

Graduated CID and entered mainstream Summer 2013

Unaided Thresholds
Bimodal and Bilateral Scores

Scores with bimodal devices from 2011

Scores with 2 CIs from 2013

In summary, performance with 2 CIs is no worse than bimodal and for some outcomes measures may be better. However cannot rule out effects of maturation.

Case Study: Localization

<table>
<thead>
<tr>
<th>Time 1</th>
<th>Time 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>HA alone (L)</td>
<td>error = 49.8, slope = 0.02</td>
</tr>
<tr>
<td>CI alone (R)</td>
<td>error = 46.5, slope = 0.06</td>
</tr>
<tr>
<td>CI and HA</td>
<td>error = 44.8, slope = 0.12</td>
</tr>
<tr>
<td>CI-2 alone (L)</td>
<td>error = 56.1, slope = 0.18</td>
</tr>
<tr>
<td>CI-1 alone (R)</td>
<td>error = 51.8, slope = 0.16</td>
</tr>
<tr>
<td>Bilateral CIs</td>
<td>error = 19.1, slope = 1.02</td>
</tr>
</tbody>
</table>
Conclusions

- Bilateral device use should be standard for Pediatric CI recipients (Bimodal or Bilateral CIs)
- Bimodal Fittings should optimized for individual performance and preference
- A variety of outcome measures should be considered when evaluating benefits

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Thank You

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References


