Tinnitus: Update 2014

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Objective vs. Subjective Tinnitus:

OBJECTIVE TINNITUS (5%) is good....we can (often) fix it!

SUBJECTIVE TINNITUS (95%) is bad...
We (generally) cannot fix it, however,
we can usually MANAGE it
Definition (Beck, 2012):

(Subjective) Tinnitus is a PHANTOM sound or noise perceived in the ear(s) most often described as “buzzing, ringing, crickets, whistling, humming, static, hissing, high pitch tone…” which occurs in the absence of a known external stimulus. Tinnitus can be a symptom of many things.
Hyperacusis:

Over-sensitivity to certain sounds.
Difficulty tolerating everyday sounds.
Discomfort/pain caused by sound.
Misophonia:


Dislike of a specific sound.

A learned response.

An emotional reaction to sounds

(slurping, gum chewing, finger tapping....)

Abnormally strong reaction to sounds (Jastreboff, 2002)
Phonophobia (a state of mind):

A fear response caused by sound.
Anticipation that sound will be uncomfortably loud.

(Phonophobia is a sub-category of misophonia)
Residual Inhibition:

When exposed to a masking sound, the patient reports ongoing relief from their tinnitus beyond-and-after their exposure to the masker.

Residual Inhibition is an ongoing relief from tinnitus, perhaps due to efferent activity within their CNS....
How Common is Tinnitus?

50 million people in the USA with tinnitus.
10 to 20 percent “clinically significant.

Beck (Hearing Journal, June 2011) = 50 million
Kochkin, Tyler, Born (Hear Rev, Nov 2011) = 30 million
Etiology of tinnitus….

Virtually EVERY otologic disorder!
Virtually EVERY non-otologic disorder!
Pathologies Associated with Subjective Tinnitus

- Presbycusis
- Meatal Obstruction
- External Otitis with Soft Tissue Occlusion
- Primary or Secondary Cholesteatoma
- Suppurative Otitis Media
- Tympanic Membrane Perforations
- Fibrous Atresias
- Ossicular Chain Fixation
- Adhesive Fibrosis
- Otosclerosis
- Serous Effusion
- Osteomas
- Ossicular Necrosis
- Perichondritis
- Furunculosis
- Vestibular Aqueduct Disease
- Anomalies of the Jugular Bulb
- Impacted Cerumen
- Osteomas
- Bony Atresias
- Carcinoma
- Endolympathic hydrops
- Perilymph Fistulas
- Viral Diseases
- Bacterial Infections
- Ototoxic Medications
- Allergic Reactions
- Noise Damage
- Congenital Malformation
- Meningioma
- Cytomegalic Virus
- Vestibular Schwannoma
- Hemangioma
- Ossicular Chain Discontinuity

IT AINT JUST EAR ISSUES!

Tinnitus may originate from ANY and EVERY where…

Abnormal sensory interaction from multiple sources such as sensory-motor systems, cognitive and emotional networks. Gaze-evoked tinnitus, cutaneous-evoked tinnitus, finger-evoked tinnitus, tinnitus modulation by muscle contraction.

Cross-modal plasticity is as-of-yet not well understood.
Synesthesia Concepts Overview

Non-Classical Auditory Pathways are NORMALLY ACTIVE in CHILDREN.

CROSS MODAL INTERSECTIONS….

sound is affected by ELECTRICAL STIMULATION of the SOMATOSENSORY system…

INPUT FROM OTHER SENSORY SYSTEMS may provide a DIRECT SUBCORTICAL ROUTE to the AMYGDALA.

(multiple non-auditory etiologies of tinnitus…)
What we experience is not merely a product of raw sensory input, but instead reflects the combined influence of sensory factors and the internal state of the observer.
Your PATIENT is UNIQUE!!!

Their auditory ability & percept is unique.

Multiple sensory & cognitive processes impact their auditory perception.
First, tinnitus is not one thing, it’s many things. And when people say they want to cure tinnitus, it’s very much like saying you want to cure cancer or cure pain…the problem is cancer, pain, and tinnitus are not a single thing.

They each have many forms, shapes, sizes, manifestations, and perceptions—and it may very well be different in each person who perceives it—so curing it with the same treatment is indeed a noble cause and a honorable goal, but remains unlikely.
The thing we can do quite successfully most of the time is manage it.

For example, there are two components to tinnitus, the sound you hear, and the way it affects you. Two people can hear the same tinnitus sound; one may dismiss it quite readily, whereas the other person may be so severely negatively affected by the tinnitus that he/she cannot function.
Primary Impact of Tinnitus:

- hearing (39%)
- concentration (26%)
- sleep (20%)

Eggermont reports tinnitus pitch and loudness matching may vary daily in the same patient.
The perceived severity of tinnitus does not depend solely on loudness, but includes the degree of annoyance and the associated disability from tinnitus. Tinnitus patients often have higher levels of cortisol (arguably secondary to stress) and predictive factors for tinnitus include anxiety disorders and a poor sense of well-being (at tinnitus onset).

Tinnitus pitch and minimum masking level (MML) are dependent on the etiology of the tinnitus (MML is defined as the level at which tinnitus was just rendered inaudible and defined in dB SL).

405 adults, mean age of 51 yrs (range 17 to 85 yrs, 195 females, 210 males).

220 people reported bilateral tinnitus, 185 w/unilateral tinnitus.

625 ears with tinnitus.

In 512 ears, tinnitus was described as a pure-tone,

in 113 ear tinnitus was described as pulsing/popping.

For 257 patients, tiredness, alcohol consumption and silent surroundings aggravated their tinnitus, while noisy environments alleviated tinnitus complaints for 272 people.

121 people reported background noise had no impact on their tinnitus.
GROUPED according to probable tinnitus etiology:

- 11% reported acute acoustic trauma (single noise exposure).
- 13.5% reported chronic acoustic trauma (prolonged noise exposure).
- 7.5% reported more than 15 years of oral contraceptives.
- 4.1% reported Meniere’s Disease.
- 3.1% reported congenital hearing loss.
- 6.6% reported sudden sensorineural hearing loss.
- 3.1% reported dull head trauma/labyrinthine concussion.
- 8.7% reported subclinical viral labyrinthitis.
- 1% reported stroke.
- 25% reported presbycusis.
- 16.4% reported unknown etiology.
For half the group, tinnitus was sudden onset, for the other half, gradual onset.

“Tinnitus pitch was highest in subjects with acute acoustic trauma and lowest in patients with prolonged estrogen and progesterone pills utilization…”

MML values were “lowest in patients with tinnitus caused by acute acoustic trauma and congenital hearing loss…” and MML values were highest in patients with stroke and presbycusis.
Doug’s Favorite Tinnitus Measurement Device:  
Tinnitus Handicap Inventory (THI).  Newman, Jacobson and Spitzer 1996.  

**HOW TO MEASURE TINNITUS?**


25 Questions - Yes (4 points) Sometimes (2 points), No (0 points).

**TOTAL:**

0-16 Slight or no handicap  
18-36 mild handicap,  
38-56 moderate handicap,  
58-76 moderate handicap,  
78-100 catastrophic handicap.
## Tinnitus Treatments:

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<td>stress management</td>
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...and more.
We’re professionally obligated to help!

Indeed: It is unethical and immoral to tell a tinnitus patient “There is nothing that can be done for you.”
Which treatment for which patient?
Which treatment?

The one most likely to work, most of the time, for most of the patients!

Such as....
Hearing Aids.

“Scoping review” to explore the role of hearing aid amplification with regard to tinnitus management.

277 short-listed articles of which 29 (18 research studies and 11 reviews) were selected for charting...the most effective hearing aid setting for tinnitus suppression may not be the same as the one used for enhancing communication.

Further, as most hearing aids appear to be fit primarily for hearing loss (as opposed to tinnitus) & may not be set optimally for amplification of quiet environmental sounds...which are generally presumed to be important with regard to tinnitus management.
The scoping review demonstrates multiple evidence sources which support fitting hearing aids (as part of the tinnitus management program) to facilitate tinnitus management.

They conclude “the quality of evidence for the effect of hearing aids on tinnitus is not strong, (however) the weight of evidence…suggests the merit of hearing aids in tinnitus treatment.”
What does not work?

No scientific evidence to support:

Acupuncture, homeopathy,
herbal remedies, ginkgo biloba etc

PLACEBO MATTERS!!!!

Kim et al (2012) searched 14 databases to evaluate the status quo as it relates to randomized clinical trials (RCT) with regard to acupuncture used to treat tinnitus.

Nine RCTs were included, seven were "sham treatment versus acupuncture treatment."

Two of the seven suggested positive effects.

Five of the seven did not.

Based on the small numbers of patients reported, the few RCTs available, essentially poor protocols ("methodological quality was mostly poor...").

Kim et al report definitive conclusions could not be drawn and (in essence) acupuncture has not been scientifically demonstrated to be an effective treatment for tinnitus.
THINGS THAT DON’T (SEEM TO) WORK:

“The Inhibitor” (an ultrasonic tinnitus treatment device delivers a high frequency bone-conducted stimuli) produced a sound which could not be perceived by their target population (i.e., people with severe and profound hearing loss). Majority of people who tried a similar/earlier device (HiSonic) didn’t like the sensations it produced and received no relief from their tinnitus. With specific regard to The Inhibitor, Folmer reports no “well designed research studies have been conducted to establish or confirm the Inhibitor’s efficacy.”

When a variety of amplitude and frequency modulated tones were presented to patients (see Reavis et al 2012, report on the Serenade device by SoundCure by) for 3 minutes at a time, 13 of the 20 subjects were referred to as “poor responders.”

Folmer and associates report “Overstatements of a treatment’s efficacy, even in light of modest research findings, are common in this field...” They state “...well designed, placebo-controlled clinical trials should be conducted and analyzed before claims of efficacy are made...”
PLACEBO MATTERS!!!!

Dawes, Powell, and Munro (2011) investigated the impact of patient expectations with regard to hearing aid fittings. They reported 20 experienced hearing aid wearers evaluated “new” versus “conventional” hearing aid technologies. The two hearing aids were the same in different colored shells…fitted, verified to the same National Acoustics Lab (NAL) prescription. Dawes, Powell, and Munro reported each participant was fitted with both devices (new and conventional) and measures included speech-in-noise tests, sound quality ratings, and personal preference. Fifteen of the 20 subjects preferred the “new” hearing aid, five could not tell any differences, and none preferred the “conventional” fitting.

PLACEBO STILL MATTERS!!!!

Hopkins (2012) investigated...one hearing aid was described as “conventional” and the other was described as “new.” Sixteen adult hearing aid users participated. The protocol used was the same protocol used by Dawes, Powell, and Munro (see above). Hopkins reported that overall, 75 percent of the participants expressed an overall preference for the “new” hearing aid. Hopkins concluded “Placebo effects reliably impact hearing aid trials.”
What does TONAL tinnitus sound like?

195 patients evaluated.

128 males, 67 females. Mean PTA = 32 dB.

Average tinnitus pitch was 4968 Hz (std dev = 2,877 Hz).

Women Average Tinnitus Pitch = 4,264 Hz (women had more flat losses)

Men Average Tinnitus Pitch = 5,336 Hz. (men had more hi freq. NIHL)

However…

75 reported tinnitus pitch at 8000 Hz or above.

IMPLICATIONS for EXTENDED BANDWIDTHS?
It is not easy for people to characterize their tinnitus. With regard to the presentation of a 4000 Hz pure tone...34% described it as a tone, 26% a hissing sound, 18% a roaring sound and 22% described it as whistling, squeaking and more.

With regard to presentation of an 8000 Hz pure tone, 48% described it as a rushing sound, 16% said it was a beeping sound, others described it as a whistling or squeaking or other sound.
20,100 people chosen at random to receive the questionnaire.
12,166 individuals returned their questionnaire (response rate 61%).

Conclusion:
Stress management strategies should be part of hearing conservation programs - particularly for people with mild tinnitus and who experience high stress.
STRESS may be the diff bet mild and significant tinnitus.

Stress + Mild Tinnitus = SIGNIFICANT tinnitus.
CBT has TWO COMPONENTS:

1- Cognitive restructuring, to “re-conceptualize” their tinnitus into a form that does not contribute to its severity (assisting patients to think differently).

2- Behavior modification. Identifying contributory factors and finding ways to modify them through behavior alternatives.

Cognitive-behavioral therapy should produce success within 6 to 8 weeks.

1- Define T in operational terms. When does it occur? What does it impact?

2- Identify behaviors/thoughts affected by T. i.e., Fear-Anger-Suicidal?

3- List maladaptive strategies & cognitive distortions associated with T (overgeneralization, jumping to conclusions, disqualifying, catastrophizing).

4- Distinguish T experience from maladaptive behavior (refusing to socialize results from maladaptive behavior, not from T itself!)

5- Identify alternate thoughts, behaviors, & strategies to convince patient that irrational thoughts cannot persist under scrutiny.

6- Devise and rehearse strategies which can be measured. Intervention is interactive. The patient must assume responsibility for becoming an active partner in restructuring thoughts and behaviors.

7- Regularly assess success or failure of coping strategies (initial goals should be modest and easily achievable, when a strategy fails, it is a learning process of what works for the individual).
With regard to psychological interventions, CBT and Acceptance and Commitment Therapy (ACT) have been shown to reduce patient’s distress, anxiety and depression and insomnia associated with their tinnitus.

CONCLUSION:

Most people who perceive chronic tinnitus do not require any treatment interventions.

For those who do, effective and non-invasive management strategies are available…

“Our goal should be to help patients obtain relief from the condition so their quality of life improves and is not affected by the symptom…”

Tinnitus management strategies can help reduce the patient’s negative reaction to their tinnitus and reduce the amount of time they are bothered by their tinnitus. Effective tinnitus management strategies can also help the patient gain more control over their tinnitus, while reducing anxiety, depression and insomnia.
“Usual Care” (UC) versus “Specialized Care” (SC) in a randomized controlled trial. Participants initially included 492 adults (age 18 years and older) with subjective tinnitus, from 2007 to 2009.

SC was tailored to the needs of the individual based on a multi-disciplinary approach including audiologic diagnostics and counseling, hearing aids or sound generators, a tinnitus group session and an individual consultation with a psychologist.

UC consisted of much the same with regard to audiologic diagnostics and intervention (counseling, hearing aids and/or sound generator), however, additional services (if required) were delivered through a social worker, for 1 to 10 visits.

CONCLUSION:

“this economic evaluation conducted from a societal perspective (‘societal perspective’ includes health-care costs, family and patient costs, and ‘productivity’ losses) using a 1-year follow-up period, demonstrates...(SC)...multidisciplinary tinnitus treatment based on cognitive behavioral therapy is more cost effective than usual care.”
Does Counseling Work?

Authors evaluated the effectiveness of hearing aids and counseling on 29 subjects with SNHL.

NOTE - Hearing aid amplification technology changes quickly. It cannot be assumed that previous studies using older technologies yield the same results as current technologies.

CONCLUSION:

Counseling combined with hearing aids results in
twice the reduction in tinnitus handicap
as would be expected using counseling alone.
THI reductions from participants with mod-to-sev Tinn over ten weeks.

**Therapy Protocol:**

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<th>Therapy Protocol</th>
<th>THI Distress Scores</th>
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<td>Internet Based Therapy:</td>
<td>Pre = 40</td>
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<td>Post = 29</td>
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<tr>
<td>Cognitive Behav Therapy Group:</td>
<td>Pre = 44</td>
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<td>Post = 29</td>
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<tr>
<td>Control Group Discussion Forum:</td>
<td>Pre = 40</td>
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<td>Post = 37</td>
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Internet based therapy produced as positive a result as group-based cognitive behavioral therapy. Effects maintained for 6 months.
The results from this survey indicate:

60% of patients report some relief of their tinnitus when using hearing aids.

22% actually report major relief of their tinnitus when using hearing aids.

The median time spent in tinnitus counseling was 10 minutes.
Habituation therapy...uses counseling to explain that “counseling/retraining” and “sound therapy” (sound generation/enrichment) can change/reduce/eliminate the negative reaction to tinnitus. Traditionally, noise generators have been used with TRT to provide background noise. CNS is plastic and can habituate.
Long-Term Results from Tinnitus Retraining Therapy.
Bauer, Brozoski (2011): Effect of Tinnitus Retraining Therapy on the Loudness and Annoyance of Tinnitus - A Controlled Trial. Ear & Hearing

Does TRT work??? TRT & Control groups. 16 pts/group.
Both groups given sound generators and custom open, ear molds.
Both groups w/similar patterns of device use.
12 to 18 months later, both groups demonstrated improved THI scores.
TRT group - earlier habituation and more robust and clinically significant reductions in THI scores and reductions in overall rating of tinnitus awareness than the control group.
TRT offers real-although-moderate improvement in tinnitus for adults with moderate-to-severe tinnitus, in the absence of hyperacusis, significant hearing loss and/or depression.
Audiologic Tinnitus Management (ATM)....became...

Progressive Tinnitus Management (PTM)

Strong support for the efficacy of using THERAPEUTIC SOUND to manage tinnitus...The evidence DOES NOT SUPPORT any method as superior to others...RATHER, the judicious use of sound is helpful.

PTM PHILOSOPHY: Therapeutic sound provides the greatest benefit when the patient is well informed.

Cognitive Behavioral Therapy (CBT, a form of psycho-therapy) and is used in tandem with noise generators.

91 adults treated with TRT and sound generators (SG) or open-ear hearing aids (HAs).

All w/hearing loss equal to or less than 25 dB at 2000 Hz and greater than 25 dB above 2000 Hz. All w/tinn for at least six months, no ear disease, no previous TRT, and no previous hearing aids.

The tinnitus handicap inventory (THI), by Newman, Jacobson and Spitzer (1996) was used to measure tinnitus at 3 months, 6 months, and 12 months.

CONCLUSION:

TRT was equally effective with sound generators and open ear hearing aids and importantly, the net improvement from both instruments (SG and HAs) were identical and indistinguishable.

CONCLUSION: TRT with sound therapy is an effective treatment for tinnitus.

HOWEVER - the specific sound therapy instrument used (SG or HA) does not make a statistically significant difference.

**THEY DO NOT AGREE:**

1. All tinnitus patients should avoid silence
2. All silence may be bad for tinnitus patients.
3. Hearing Aid use without background sound is not beneficial.
4. Group therapy is not beneficial for tinnitus patients

**THEY STATE:**

1. Hearing aid use offers great potential for tinnitus management.
2. Group therapy is often beneficial.

48 patients in 3 groups (mixing point, total masking, counseling) evaluated pre & 1 yr post treatment w/Tinn Handicap Q (THQ). Average decrease in THQ scores: 31.6 % mixing point group, 36.4 % total masking group, 16.7% counseling group.
Shi Y, Burcheil, Anderson & Martin, Portland, Oregon

Seven patients implanted with DBS systems for movement disorders (i.e., Parkinsons) who also reported having tinnitus were interviewed about their tinnitus conditions pre and post DBS….

CONCLUSION:
Results suggest DBS of non-auditory thalamus structures may provide tinnitus relief for some patients.
Deep Brain Stimulation

(don’t try this at home)
FRACTAL TONES (Sweetow RW, Sabes JH., 2010: Effects of Acoustical Stimuli Delivered Through Hearing Aids on Tinnitus. JAAA.

Almost every technique described in the literature has worked with selected candidates. Auditory fractal tones somewhat like wind chimes.

Hypothesis - fractal tones are effective in relaxing the patient and can reduce the annoyance of tinnitus.

Half the 14 subjects reported subjective decreases with regard to annoyance from tinnitus after using the device for six months. Authors unable to determine how much of the relief came from overall amplification, versus how much came from the use of fractal tones.

CONCLUSION: Acoustic treatments for tinnitus, without the multiple benefits derived from counseling, will likely not suffice. Indeed...."tinnitus management procedures need to be supplemented with appropriate counseling."
Neuromonics Approach to Tinnitus  
(from ATA Vol 32, 2, Jun 2007)

Depends on “de-sensitization”

Uses SHOWER NOISE in music for PRE-CONDITIONING (8 weeks).

Shower noise cessation (after 8 weeks).

Tracks ONE and TWO – Baroque Music

Tracks THREE and FOUR – New Age Music

Patients use it two to four hours daily.

Retrain the brain to relegate the tinnitus to the background.
Goal - divert patient’s attention away from their tinnitus via alternative sounds, while minimizing the difference between the tinnitus and environmental sounds.

Smart phones & downloadable apps do not account for hearing loss, which many tinnitus patients have.

**RAIN noise is the preferred background noise.** Music is often too interesting (cognitively) to serve as an excellent masker, because it draws attention to itself.

Sound therapy preferences change, and having multiple options is ideal to better meet the needs of the patient across time and in multiple acoustic environments.

Tinnitus treatment methods:

“…the provision of hearing aids offers substantial benefit to a significant number of people suffering from tinnitus…”
56 patients from the Tinnitus Management Clinic at the Cleveland Clinic compared tinnitus treatments with sound generators (SGs) and Neuromonics Tinnitus Treatment (NTT) device. Comparing THI scores at baseline (pre-treatment) to 6 months post-treatment both groups (SG and NTT) demonstrated significant reduction in tinnitus and there were no differences in the SG or NTT treatment groups.

Jacobson (2012): “The cost per unit of improvement (treatment utility) on the THI (scale from 1–100) measured in “quality-adjusted life years” was $604 per point for SG treatment compared to $1771 per point for NTT.”
Conclusion:

HAs in tandem w/counseling are beneficial for tinnitus management 50-90%

Examples of successful management of the tinnitus patient facilitated through hearing aid amplification are voluminous.

Advanced hearing aids offer alternatives previously not available such as; open fits, extended bandwidth, connectivity and more....

Hearing aids are 100 percent reversible.

**Hearing aid amplification is the primary treatment for tinnitus.**

Summary:

28% of HA users had mod-to-subst red’n in Tinn w/HAs.
66% of HA users reported Tinn relief most/all of the time w/HAs. 
29% reported HAs ALLEVIATED their TINN all of the time.

Patients who had COMPREHENSIVE BEST PRACTICES applied are TWICE AS LIKELY to experience Tinn Relief.

Retrospective study of 70 patients (48 males, 22 female, mean age 55 years).

While wearing hearing aids (Oticon, Phonak or Widex) 26 patients reported their tinnitus was totally masked, 28 reported partial masking (i.e., 77 percent, or 54 of 70 reported partial or total masking) and 16 reported no masking.

Tinnitus pitch masking = 6900 Hz (average)

For the group that did not achieve masking (n=16, see above) mean tinnitus pitch = 8000 Hz

Hearing aids reduce the audibility of tinnitus and hearing aids improve the patient’s reaction to tinnitus. The authors recommend hearing aid fittings to treat tinnitus in patients with hearing loss.

Further, they note the best results are obtained when the patient has good low-frequency hearing, a strong reaction to their tinnitus and when the tinnitus pitch is perceived to be (i.e., matched) within the fitting range of the hearing aid.
Doug’s Personal Recommendations:

Rain sounds, Shower Sounds.
Excellent, Flexible, Easy-to-Use, Reliable Product.
Tinnitus Management Guidelines.
Exact Protocol TBD by Professional.
Internal Motivation matters.
Placebo matters.
Brains are plastic and they change and adapt over time.
MAY 2014: AAA Interview with Dr. DiSogra

Tinnitus, Tinnitus Cures, and OTC Tinnitus Remedies: Interview with Robert M. DiSogra, AuD

Douglas L. Beck, AuD, spoke with Dr. DiSogra about all things tinnitus, including the importance of an evaluation by a licensed health-care professional and patients’ various treatment options.

Academy: Hi, Bob. Great to speak with you!

DiSogra: Hi, Doug. Thanks. Good to speak with you, too.

Academy: Bob, I saw that you’ll be on the faculty for the 22nd Annual Tinnitus Conference held at the University of Iowa this summer addressing the efficacy and safety of OTC tinnitus relief products currently available over the counter (OTC)?

DiSogra: Yes, that’s right. It was an honor to be asked to join the meeting faculty and to present a session at this excellent meeting.

DiSogra: Exactly. I should mention that the 2014 Guest of Honor will be Anne-Mette Mohr. Doug as you know, Anne-Mette Mohr is the...
DiSogra: ….On the shelves of your pharmacy or grocery store, there are some 50 products that I’ve seen. The bottom line is these companies that market and advertise OTC tinnitus relief products have virtually no FDA oversight or approval and so as you would expect, there’s very limited science or research on their ingredients or products used in OTC products to treat or cure tinnitus. I would like to point out that of the 50 products, none are FDA approved for tinnitus relief.
DiSogra: Yes. Surprisingly, there’s a considerable amount of research on melatonin, and you’ll see that in many of these products, but the “cause-and-effect” of tinnitus relief from melatonin is not there. That is, because melatonin may help many people sleep, it may allow some tinnitus sufferers to sleep, too, and that’s great, but that’s not actually tinnitus relief, that’s sleep!
DiSogra: I agree, Doug. The first step for the tinnitus patient is an evaluation by a licensed health-care professional, and for tinnitus sufferers, who are properly evaluated, there are quite a few treatment options and as you said, Doug, the vast majority of tinnitus sufferers can be helped via professional medical and audiologic management. As long as the patient and the audiologist continue to work towards the goal, it’ll happen 9 out of 10 times.
If it looks like a duck and quacks...
That’s all folks!