SoundingBoard

December 2021

Workplace Wellbeing

Exostosis

Hearing Implants

Meet Your Directors

Hearing Services Update

The Official Magazine of
Hearing Aid Audiology Society
of Australia Ltd

ABN 67 626 701 559

HAASA

LABORAMUS UT AUDIATIS

Your referral could be life-changing

> *The most frequently asked question I get is, 'how do I know when I should refer a patient for an implant?' Now we're giving evidence-based advice built on really good data to help separate candidates from non-candidates.*

Dr. Terry Zwolan, Ph.D. Director of Audiology at Hearing First (USA)

Hear from Dr. Terry Zwolan as she shares her 30+ years' experience of treating patients with sensorineural hearing loss, and her 60/60 referral guidelines on the **Hearing Health Today** podcast.

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Interested in learning more about the 60/60 referral guidelines? Scan the QR code and join one of our endorsed webinars on this topic.

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Inside this Issue

Board Report

A roller coaster ride is the only way to describe this year! Particularly for those living in Melbourne and Sydney, but for all of you, all around the country who have missed being able to see family and friends. We hope you have weathered the storm! We look forward to 2022 being a better year.

We at HAASA, have missed our face to face contact with members although we did manage to squeeze in a First Aid CPED day in Sydney between lockdowns. This was an excellent day where, not only did we learn very valuable first aid skills but we got to see our colleagues and friends. It reminds us how important that is. The current, but necessary, online trend, is a poor second to actually being with each other!

HAASA has scheduled a CPED day in Sydney for Friday 18th March 2022. Our AGM will be held at the conclusion of the CPED day. For those of you that are finishing their supervision period and considering sitting their examination we are able to run exams the following day. We have also scheduled the 101 Cerumen Removal course for 12th March in Sydney and will call for expressions of interest soon. This has proven to be very popular in the past.

We have had a few enquiries from members about a potential HAASA conference in 2022. HAASA's current CPED cycle finishes 30th June 2023 so we will make a decision about a pre June 2023 conference in the new year. There will not be a HAASA conference in 2022 but there will be a CPED DAY in March and November 2022.

Your Directors have had a busy year, not only juggling their own work, businesses and families through the pandemic and long lockdowns but also keeping on top of committees and meetings to ensure HAASA members have a voice. Thank you to Helen for representing us with the Hearing Health Sector Alliance, Glen and Lyndon for their work with the Business Review Reference Group and Helen and Lyndon on the Practitioner Professional Body Group overseeing our Memorandum of Understanding with the Hearing Services Program.

Speaking of our MOU, an important part of keeping in line with other Professional Bodies is membership of the Ethics Review Committee. HAASA is in discussions to join this group and there are benefits for members who may have an ethical dilemma in that they can seek expert advice from this group. Take a look at their website https://auderc.org.au and let us know what you think.

We really need more help in the form of extra Directors, using the theory "many hands make light work". Each person brings their own unique set of skills to this volunteer role. You will find a position description further through this magazine but don't let that put you off. It is just a guide as many people don't know what is involved in the role. We need a variety of skills. It is such a great opportunity to protect your future, be involved in change and make suggestions to improve HAASA itself. We have two directors that have been on and off (mostly on) filling this role for 12 and 20 plus years each. Whilst this has been satisfying, and an honour, they would really like to pass the batten in the near future. Please consider stepping up to ensure HAASA has a great future!

We would like to acknowledge the work Daniel Fechner did during his time as a Director. He was responsible for bringing HAASA into the 21st century with the office going almost completely paperless. He has also streamlined the examination process. Daniel's likeable, honest and courteous manner was a joy to all! Daniel resigned his position this year due to business and family commitments and he said it was a "very difficult decision to make". Due to his passion for the education of Audiometrists, he will maintain a presence on the examination committee. Many thanks Daniel. We miss your humour and your wisdom.

We strongly encourage members to write some articles or give us some topics that we can pursue for future magazines. Our next publication will be 15th March 2022. Suitable articles written by members will attract CPED points.

We wish to advise that our office will be closed from 23rd December until 10th January, however if there are any urgent issues you can contact any director via email haasa@haasa.org.au

In conclusion, we would like to thank all members for their loyalty and wish you a very Merry Christmas and Happy and Healthy New Year. We look forward to seeing you in 2022!

Best wishes

Gary, Glen, Helen, Lyndon and Kerrie

ADVERTORIAL

Your referral could be life-changing

Dr. Terry Zwolan, who has been an audiologist for more than 30 years, and is a founding member of the American Cochlear Implant Alliance (ACIA), recently published a study that evaluated when to refer adults for cochlear implant candidacy assessment. We interviewed Dr. Zwolan to learn more about the study findings and what this means for clinicians in Australia.

What prompted you to conduct this study?
Professionals across the state of Michigan would frequently ask, "how do I know when it is best to refer someone for a cochlear implant evaluation?" Recognising the importance of this question, we decided to look at the data from our candidacy evaluations to come up with an answer that was evidence-based. We also looked very closely at the audiograms that were sent to us by referral sources, which encouraged us to focus on measures that they are actively using in clinical care.

What surprised you most about the outcome of this study?
We were quite surprised that the number 60 was an important number both in regard to the pure tone average and the unaided word recognition score. 92.3% of patients who met traditional candidacy had a better ear unaided word recognition score that was less than 60%. Similarly, 95% of our patients had a better ear PTA (average of thresholds at 0.5, 1, and 2 kHz) that was greater than 60 dB HL. We were pleased with the numbers because we feel the 60/60 is easy to remember.

How does 60/60 apply in Australia considering differences in speech testing and candidacy criteria?
Word recognition scores are commonly used in the US for speech testing whereas phoneme scores are commonly used in Australia. Considering this difference and the candidacy criteria, a reasonable adaptation would be using aided phoneme scores instead of unaided word recognition scores.

Why is it important that clinicians use the criteria?
Many patients who are candidates for a cochlear implant are not being referred and hence whose hearing loss is not being treated optimally. Research (and my personal experience) has shown that patients' chances of a good outcome are significantly better if they receive the device before the loss of all functional auditory skills. We are hopeful that the simplicity of the 60/60 guideline will simplify the identification process. Although meeting the 60/60 does not guarantee a patient will meet indications for a traditional cochlear implant, there is a very good chance they may, and it provides the clinician with information that supports such an important referral.

How can clinicians use the criteria to improve patient outcomes?
If a patient meets these criteria, there is a high likelihood that they will qualify for a cochlear implant. Those who did not qualify, left the appointment informed and knowledgeable about cochlear implants. Many of them returned to their dispensing audiologists to seek new hearing aids, and others returned later for a re-evaluation that indicated they were candidates. No referral is a bad referral, and people who ultimately receive a cochlear implant are so grateful to the person who referred them. Many of the patients continue to use a hearing aid in their contralateral ear in conjunction with their cochlear implant. This has provided an exciting opportunity for the cochlear implant clinics to partner with dispensing audiologists to maximise patient outcomes.

When to consider a cochlear implant for your client*

If your client meets ONE or more of the screening criteria below in EITHER ear, consider referring for a cochlear implant evaluation to determine candidacy.

Daily Interactions

Client experiences any of the following with hearing aids:

- Struggling to hear on the phone
- Having difficulty understanding unfamiliar speakers
- Withdrawing from social events
- Often needing others to repeat themselves

Audibility

≥ 60 dB[1]

Pure Tone Average (0.5, 1, 2 kHz)

Speech Understanding

≤ 60 %[2]

Aided Phoneme Score (conversational levels)

For more information: hearinghelp@cochlear.com 1800 872 212

*This provides a recommendation only of when an adult may be referred for a cochlear implant evaluation but does not guarantee candidacy based on indications (Only for adults).

1. Zwolan TA, Schvartz-Leyzac KC, Pleasant T. Development of a 60/60 Guideline for Referring Adults for a Traditional Cochlear Implant Candidacy Evaluation. OtolNeurotol. 2020 Aug;41(7):895-900.
2. Leigh JR, Moran M, Hollow R, Dowell RC. Evidence-based criteria for recommending cochlear implants for postlingually deafened adults. Int J Audiol. 2016;55 Suppl 2:S3-8

Hearing Services Program News

Transition Period and Support

To support Service Providers (providers) in implementing the voucher, maintenance and client review changes to the Hearing Services Program (Program) a transition period is in effect until 1 January 2022.

To ensure COVID safe delivery of services, during the transition period, the program will allow:

- Verbal consent/agreement for all forms/quotes that require a client signature, including Maintenance Agreements with documentation of the verbal consent/agreement details on the client record;
- Documenting the details of a lost device, on the client record rather than requiring a Statutory Declaration signed by the client; and
- Completion of ambient noise level testing and equipment calibration where it is safe to do so and permitted within the relevant jurisdiction/s

The Program recognises the importance of continuing some service items through telehealth (refer Provider Factsheet on website). Please be mindful of the COVID-19 rules in place in your state or territory.

From 1 January 2022, providers must have updated policies, procedures, and documents to ensure they comply with the new legislative changes to vouchers, maintenance, and revalidation service that came into effect on 1 July 2021. A reminder of the changes can be found on the programs website.

Hearing Services Program Review

On 30 September 2021, the Hon Dr David Gillespie MP, Minister for Regional Health announced the release of the *Report of the Independent Review of the Hearing Services Program* (the Review).

The year-long Review was led by Professor Michael Woods and Dr Zena Burgess and was the first of its kind since the inception of the Program in 1997 and makes 22 recommendations aimed at optimising hearing outcomes for clients including through improving the equity, effectiveness, governance and sustainability of the Program while building on key priorities from the *Hearing Health Roadmap*.

We would like to take this opportunity to thank all stakeholders for their contribution throughout the Review and encourage you to continue to be involved throughout the implementation phase. The final report can be found at https://www.health.gov.au/resources/publications/report-of-the-independent-review-of-the-hearing-services-program. All contact should be directed to the Hearing Review inbox hearing-review@health.gov.au.

Hearing Services Online Portal Redevelopment

Development work is underway for a new Hearing Services Online Portal (portal).

We are aiming for the new portal to give better functionality and make it easier for providers to provide services under the program. We expect the new portal will be available in mid-2022. Until then, it is business as usual for the current portal while the new portal is completed.

(continued next page)

As part of this work, have established a Business Reference Group (BRG) to understand the needs of our stakeholders. This is building on the existing user testing groups, and has representation from small, medium, large, urban and rural/remote providers and manufacturers and software vendors. The BRG will provide input through the transition period and portal redevelopment, ensuring that it meets our user's needs.

Self-Assessment Tool Reminder

As part of the Service Provider Contract requirements, providers complete an annual self-assessment to review their policies and processes to support program compliance. Usually held in September/October annually, the 2021 SAT will be undertaken in November 2021 and will focus on the program changes that took effect on 1 July 2021. This will assist providers to check in on their transition to the new arrangements. A CSPN will be released prior to the Self-Assessment Tool release and providers will have until 30 November 2021 to complete the self-assessment.

Compliance Update

As part of the review of compliance activities, the program has released the 2021 Compliance Update. The update is available on the program website and outlines the compliance priorities for 2021-22, key issues being identified and information to help prevent non-compliance.

Recent audits of Revalidated Service Item Claims have identified a large number of claims with

- insufficient evidence to support the revalidation
- refitting claims that do not meet ECR requirements
- evidence on client files that does not match the Revalidation Request
- Revalidation Requests submitted after the Refitting has been completed.

Providers are reminded that where claims do not meet requirements reimbursement will be required.

New evidence proves:

Oticon More 1 outperforms top competitors

in complex, real-life environments

More speech
Better access to speech coming from around the wearer

More sounds
Access to more of the relevant sounds in the sound scene

Faster adaptation
More rapid adjustment to changes in the sound scene

Higher fidelity
Better preserved sounds with more contrast and details

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Amazing new test results against two top competitors show that Oticon More™ gives better access to speech **at the same time** as giving the brain faster access to more of the meaningful surrounding sounds, in higher fidelity*.

These results confirm the effectiveness of Oticon's fundamentally new approach to sound processing: to give the brain more sound, not less!

So when research showed the brain needs access to the full sound scene in order to work in a natural way**, our response was to make a new generation of brain-friendly hearing aids: Oticon More.

Learn more at **oticon.com.au/professionals/more-evidence**

* Santurette et al. (2021)
** O'Sullivan et al. (2019); Puvvada & Simon (2017); Man & Ng (2020)

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HELP !
Directors needed for HAASA

Would you like to have your voice heard?

Are you passionate about your industry?

Why not help your colleagues forge ahead with HAASA?

We have room for more Directors and some fresh faces would be very good for HAASA's future.

A Directors term is usually for two years. Some old hands have already been doing this for a lot longer than that.

The future is in your hands.

If you would like more information please contact helen@haasa.org.au.

Position Description
Director
June 2020

Purpose

The Director's role is to oversee the management of the Hearing Aid Audiology Society of Australia Ltd.

Responsibilities

- Ensure compliance with Directors' duties in accordance with the Corporations Act (Cth) 2001
- Develop and execute HAASA's business strategies
- Attend monthly online Board meetings and action any agreed tasks
- Attend face to face Board meetings usually held biannually and action any agreed tasks
- Attend HAASA continuing education and development days, usually held biannually
- Attend HAASA conferences, usually held biennially
- Represent HAASA in discussions and actions with third parties, as agreed by the Board
- Approve actions and communications proposed by the Executive Board Administration Officer
- Approve banking transactions if required
- Monitor HAASA email communications between the Executive Board Administration Officer and the Board

Essential criteria:

- Extensive business or Audiometry Experience
- Computer Literacy - MS Office, Outlook
- Ability to read and interpret financial statements
- Strong communications skills
- Ability to travel
- High-level strategic, analytical and problem-solving skills

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Edge Mode

With just a double tap, instantly conducts an AI-based analysis of the listening environments and makes smart, immediate adjustments

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Detects when a hearing aid wearer falls and sends an alert message to selected contacts

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Tracks daily steps, measures movement and monitors more vigorous physical activity

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Planning the next CPED

Please save the date **Friday 18th March 2022**

The next Continuing Professional Education and Development day is currently being planned. More information will follow.

Cerumen 101 Course for HAASA members will be held on the **12th March 2022** at Macquarie University Sydney.

Places are limited so please watch for the email from HAASA seeking your registration.

CPED Reminder

Education is a key part of HAASA's mandate

A reminder - our current CPED cycle runs for two years from 1 July 2021 to 30 June 2023. We have relaxed some of the caps on different activities due to unpredictability of events in the current climate.

Points required:
50 points per cycle for Full and Fellow Members
30 points per cycle for Associate Members

Student members' coursework is sufficient to meet CPED requirements.

Members are expected to keep records including evidence (eg Certificates of Attendance) of their accrued points.

Random audits of records are conducted each year in accordance with HAASA's CPED Rules.

Our CPED Return Form may assist in organising CPED records. It is recommended to keep an electronic copy on your desktop and fill it in as you do each CPED activity this can save some stress at the end of the cycle.

There are lots of types of events and activities that attract CPED points. More detail is available on our website. Note that some categories have caps on the number of points that can be accrued for that type of activity, and some temporary relaxation of category caps is in place to allow for COVID-19.

Members that join during a CPED cycle are able to pro-rate their points.

Excess CPED points cannot be transferred to the next CPED cycle as we want to ensure our members' learning material is as up to date as possible.

Members experiencing extended periods of illness or taking parental leave may apply for an adjustment to the points required in a CPED Cycle. The member should provide a letter to the Board from a medical practitioner stating the relevant period for adjustment. Upon approval, the member may then adjust the points required as a percentage of the whole CPED Cycle. For example, if the member is ill for 3 months of a 12 month cycle, he/she would only be required to collect 75% of the normal points.

A CPED Return Form must be submitted by 30 June 2023.

If you need any assistance with CPED, please get in touch.

Get to know your Directors

Gary Stevenson is our newest appointed Director starting in November 2021.

Born in Edinburgh, he grew up in South Africa then returned to Scotland.

He started as a Registered Hearing Aid Audiologist in the U.K. in 2004, working throughout Scotland. Gary spent the last 12 years in Manchester, England, prior to starting with an Independent in Cairns over 3 years ago. He works with Connect in Cairns Queensland.

Gary loves to travel, meet all sorts of new people and have an overall lust for life itself.

He is looking forward to being involved with HAASA and the new challenges and learnings that lie ahead. We welcome Gary and encourage members to do the same.

HAASA's Directors are Audiometrists who voluntarily donate their time to run HAASA and support their members.

Workplace wellbeing

What this fact sheet covers:

- Why worry about workplace mental health and wellbeing?
- Top ten factors involved with workplace mental health
- Practical strategies to increase workplace wellbeing
- How to find a job that suits you

Why worry about workplace mental health and wellbeing? As you are reading this, one in six Australian workers will be experiencing a mental illness. Many others will be experiencing the initial signs of mental illness including insomnia, worry and fatigue.

Depression and anxiety are now the leading cause of long-term sickness absence in the developed world. They are also associated with presenteeism, where an employee remains at work despite their condition causing significantly reduced productivity. In Australia alone, poor mental health at work is estimated to cost the economy over $12 billion each year, including over $200 million worth of workers compensation claims.

While the dollar values are striking, there is a significant human cost as well. We know that meaningful employment is integral to recovery from mental illness, yet there is a tendency for these individuals to be marginalised from the workforce. In reality, research shows that the majority of mental illness seen in the workforce is treatable, and possibly even preventable.

From an organisational perspective addressing mental health in the workplace can increase productivity, and employee engagement. For the individual, it means a healthy, balanced life and psychological wellbeing. The benefits of a mentally health workforce are crystal clear. “A mentally healthy workplace is one in which risk factors are acknowledged and addressed, and protective factors are fostered and maximised.”

The top 10 factors involved with workplace mental health

Research has shown that there are a number of factors that need to be addressed to achieve a mentally healthy workforce.

1. Demand and Control

Jobs that are characterised by high emotional and/or cognitive demands have a higher rate of sickness absence due to mental illness. This is particularly the case when the role involves a high job demand (eg time pressure) but low job control (eg low-decision making capacity). Typical examples of these workforces include teachers, nurses, lawyers and industrial Workers

2. Opportunity and security

Roles involving variety, task identity, significance and appropriate feedback are more likely to be associated with higher levels of workplace wellbeing. Job insecurity, lack of appropriate resources, lack of learning opportunity and a disproportionate pressure to perform are associated with poor workplace mental health.

3. Trauma

Occupations with regular exposure to traumatic events have an increased risk of mental health problems including depression and post traumatic stress disorder (PTSD). This includes police officers, paramedics, fire fighters, military personnel, medical staff and journalists. A recent review estimated that 1 in 10 emergency workers currently suffer from symptoms of PTSD.

4. Relationships with colleagues and managers

Team relationships, and the focus on relationships placed by leadership, affect individual mental health outcomes. In many occupations, interpersonal relations are the most frequent source of workplace problems and stress, particularly if indicative of workplace bullying. Social support in the workplace, as well as perceived support from the organisation as a whole, appears to have a protective effect against mental health difficulties.

5. Leadership training

Managers and supervisors play a clear role in the welfare of staff. The actions and opinions of someone in a leadership role can have a potent influence on a staff member at risk of mental illness. Research shows that managers provided with mental health training feel more confident in discussing mental health matters and have staff that display reduced psychological distress. Additionally, an inspiring, motivated and caring leadership style has been associated with enhanced mental wellbeing.

6. Organisational change

Common organisational activities such as restructuring and downsizing can result in increased job strain and insecurity. Research shows that even those staff members who were not at risk of job loss experienced increased rate of mental illness, sickness absence and disability. Humanising an organisation and planning how any changes take place can provide a level of support resulting in improved job satisfaction and mood.

7. Recognition and rewards

Recognition and reward in a work environment refers to appropriate acknowledgement and gratitude of an employee's efforts in a fair and timely manner. Two major research reviews have suggested that an imbalance between effort and reward results in an increased risk of mental disorder. Additionally, these factors may indicate a disconnect between organisational culture and employee expectations.

8. Safety and environment

A mentally healthy workplace provides a both a physically and psychological safe climate for employees. This includes a commitment to stress management, addressing of environmental triggers such as poor lighting or noise exposure, and participation of all levels of management to the development of safety frameworks.

9. Stigma

Mental illness remains the most stigmatised group of disorders in the workplace. Employers frequently state they would not employ someone with a known mental disorder and employees will not risk disclosing any mental challenges. A responsible workplace should make every effort to reduce stigma and encourage help-seeking and support.

10. Worklife balance

Even with an understanding and proactive employer, individual employees may experience personal crises that will impact their productivity and ability to remain at work. Life experiences such as marital distress, financial strain or dependent children can exacerbate work stress and result in strain, illness and sickness absence. In addition, other issues such as substance misuse, poor diet and limited exercise may be directly related to the organisation culture as well as personal choices. Research has shown that job satisfaction, organisational support and resilience training can have a protective effect on individuals at risk.

Practical strategies to increase workplace wellbeing

A recent research review has identified a number of interventions that are effective in reducing significant mental illness in the workplace. These include the following.

1. Increasing employee control through implementation of multi-level working committees and greater employee input into work hours and location
2. Consider workplace health promotion strategies that include both physical activity incentives and mental health awareness and education. Programs that involve cognitive behaviour therapy and relaxation training are been shown to have an effect in previous studies.
3. Implement resilience training for high risk occupations such as those exposed to significant levels of trauma or stress
4. In-house workplace counselling may be of benefit, as is the provision of formal return to work programs.
5. Provision of peer support schemes or other ways to ensure staff are able to seek help early if needed.

How to find a job that suits you

When looking for a new job or as part of your current work, remain independent of it, and try to become part of something worthwhile that is larger than yourself. This helps keep a sense of perspective.

Achieve balance and peace of mind via things such as: • Meditation and other techniques • Getting involved in a hobby/interest • Listening to music • Sleeping well • Eating well • Using exercise as a stress release • Taking things in moderation • Avoiding the use of alcohol to 'wind down' • Recognising the importance of worklife balance prevent relapse.

ENT UPDATE

NEW SERIES

FIGURE 1: Otoscopic view of the right ear demonstrating severe exostoses.

FIGURE 2: Otoscopic view of the left ear showing a small attic osteoma obscuring the view of the roof of the ear.

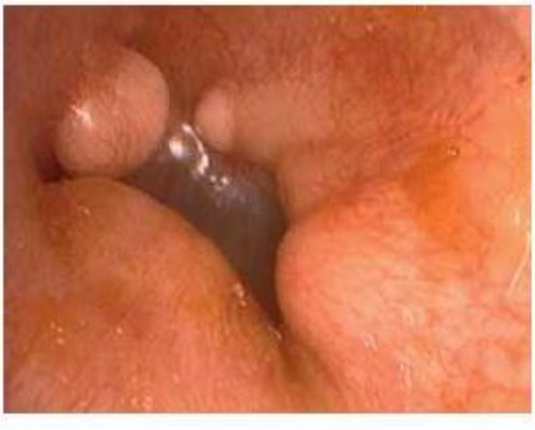


FIGURE 3: Otoscopic view of the left ear demonstrating the typical multiple, bony lesions that are covered with thin medial canal skin. This thin medial canal skin lacks any glandular elements.

FIGURE 4: Otoscopic view of an adenocarcinoma of the external auditory canal glandular tissue. This patient presented with hearing loss and a mass that appeared like either a lateral osteoma or exostosis. Careful palpation revealed a firm mass, which would be suspicious of cancer.

EAR EXOSTOSIS

This abnormal bone growth within the ear canal — common in swimmers, scuba divers and surfers — gives way to its name 'surfer's ear'.

DR NIRMAL PATEL

Case study

A 45-YEAR old male surfer presents with ear pain. On questioning, the patient says he has been a long-time sea swimmer and surfer. The patient complains that for the past few years, when he gets water in his ears, he has difficulty getting rid of the water. On examination, you note multiple, variably sized skin-covered masses in the ear canal (see figure 1).

You are unable to see the tympanic membrane. You suspect a diagnosis of ear exostosis (also known as 'surfer's ear') with a mild secondary otitis externa.

Definition and history

External ear exostosis is a hyperostotic outgrowth of the bony ear canal, histologically comprised of broad-based lamellar bone. These lesions tend to occur in swimmers, surfers and scuba divers, and it is thought cold water

may cause inflammation and increased vascularity, producing the bone growth.
With ongoing cold-water stimulation, the disease process may progress, initially causing water trapping. With consistent water trapping and subsequent hydration of ear canal skin, otitis externa becomes more common.
Finally, with end-stage disease, complete external ear canal occlusion occurs, with subsequent maximal (up to 60dB) conductive hearing loss.
Osteomas of the ear differ from exostoses because they are usually unilateral and along suture lines, often obscuring a view of the attic of the ear (see figure 2).

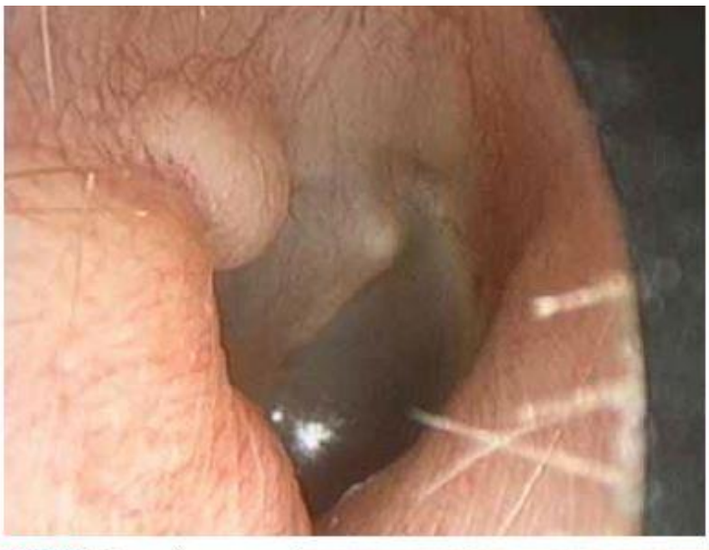


FIGURE 5: Otoscopic view of the right ear with mild exostoses.

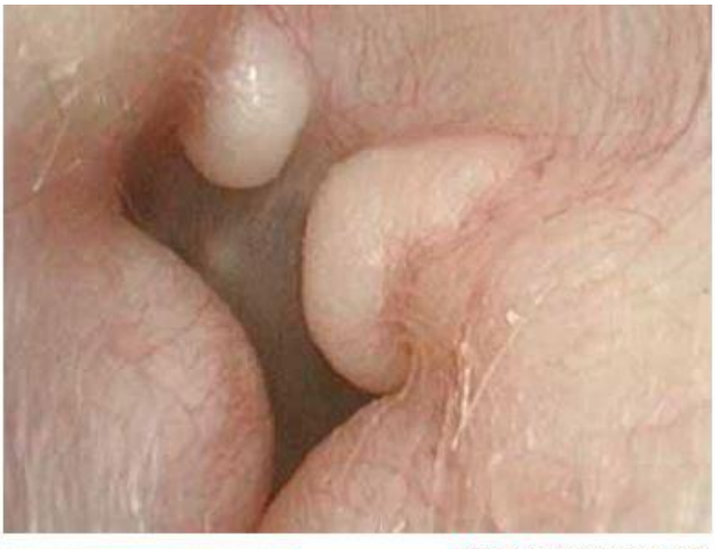


FIGURE 6: Otoscopic view of the left ear with moderate exostoses. Note that this patient should still have normal hearing. If they are complaining of hearing loss, then other causes, such as otosclerosis, should be investigated.

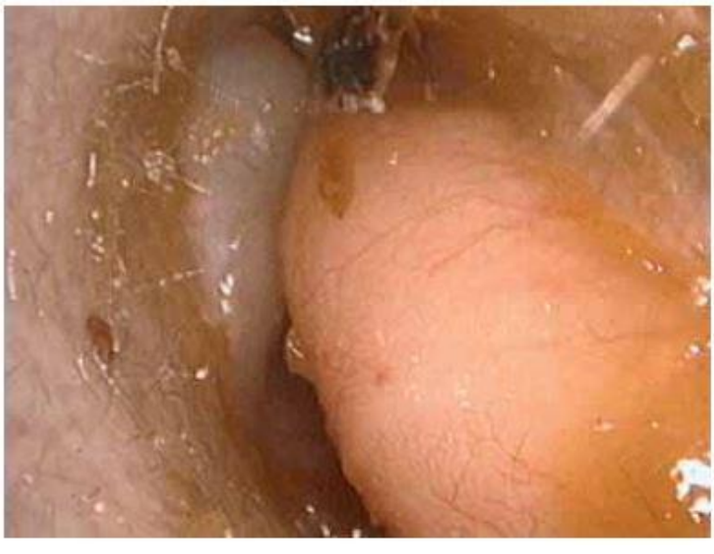


FIGURE 7: Otoscopic view of the right ear with severe exostoses showing complete canal occlusion. This patient would be an ideal candidate for corrective surgery called exostectomy.

Diagnosis basics

The diagnosis is made on otoscopic inspection and occasionally requires very gentle palpation with a blunt -tipped wax curette to exclude soft tissue masses.
The bony growths are typically multiple, medial in the external canal and are usually covered by the thin skin of the medial external auditory canal (figure 3).
Exostoses are graded into mild (figure 5), moderate (figure 6) and severe (figure 7), depending on the degree of external occlusion.
When lesions are lateral, covered in the thicker lateral (glandular) skin of the external auditory canal (figure 4), or where doubt exists about the diagnosis, palpation of the mass can be performed.
The patient should be warned about the manipulation, and under direct vision (with a bright light) a blunt-tipped wax curette may be used very gently to palpate. Bony growths are rock hard.
The clinician should suspect more sinister lesions if the mass is either soft or firm. After visual inspection, clinical testing of hearing is performed including free field and tuning fork tests.
If the tympanic membrane can be visualised, then hearing is usually normal. If the patient is complaining of hearing loss and the tympanic membrane can be seen (figures 5 and 6), if there is complete occlusion (figure 7) or the tuning forks are suggestive of a hearing loss, then an audiogram should be organised prior to referral.
With exostoses being a common diagnosis along the Australian coast, the presence of dual pathology (such as otosclerosis, a relatively common cause of conductive hearing loss in the young) should be considered.

Differential diagnoses

Skin-covered ear canal masses that are bony hard

• Exostosis

• Osteoma

• Fibrous dysplasia

• Paget's disease

Skin-covered external ear canal masses that are not bony hard

Arising from the external ear:

• Squamous cell/glandular cell carcinoma

• Benign glandular tumours

• First branchial arch anomaly cysts

Arising from the middle ear/ mastoid:

• Congenital cholesteatoma

• Other destructive lesions of the temporal bone — eg, paraganglioma

• Facial nerve tumours

Arising from adjacent structures:

• Temporomandibular joint herniation

• Meningocoele/meningoencephalocoele

• Middle cranial fossa meningioma

Management

Water protection

The affected ear needs to be kept dry and water exposure avoided, including the use of ear plugs when swimming.

Treating water trapping

Aquaear (acetic acid and isopropyl alcohol-based drop) is used after water exposure to dry and acidify the ear canal. This reduces the chance of water trapping and subsequent ear infection.

Treating otitis externa

• *Bacterial ototopical antibiotics*, such as Sofradex or Ciproxin HC, should be used as first-line treatment.

• *Analgesia* — often strong analgesia is required to control the pain of otitis externa.

• *Wicking* — if there is considerable pus discharging from the ear, wicking this away with a dry tissue is recommended before inserting the ear drops.

• *Oral antibiotics*, such as cephalexin, are reserved for when there is considerable periotic oedema and spread of infection to the adjacent tissues.

Exostectomy

Exostectomy is the surgical correction of ear canal exostoses.

It is indicated for:

• Recurrent water trapping or ear infections in the setting of exostosis.

- Hearing loss due to complete ear canal occlusion.

The operation is typically performed as a day surgery procedure under general anaesthesia, with about 3-5 days off work.
Ear canal skin takes some time to heal and the patient can expect to be out of the water for 8-12 weeks.
A post-auricular or through-the-ear canal incision is used and the skin from over the exostoses is dissected laterally to leave exposed bone.
Using various drill sizes, the exostoses are removed to reveal 100% of the ear drum. The skin is returned back to its original position and the wounds closed.
The head bandage is removed within 24 hours and the bandaids covering the subcutaneous stitching are removed in 10-14 days.

When to refer

• Symptomatic exostoses — recurrent infections, water trapping or complete canal occlusion.

• Suspicion of tumour — soft/firm, lateral mass, thick sebaceous skin covered (figure 4).

• Hearing loss disproportionate to appearance of exostoses, that is, you can see the ear drum but the patient is complaining of hearing loss (figures 5 and 6). ●

Dr Patel is a clinical associate professor of surgery and director of the Kolling Deafness Research Centre, Royal North Shore Hospital, University of Sydney.

Red flags

• Lateral canal masses covered with thick, glandular external canal skin.

• Soft or firm, but not hard, masses.

• Hearing loss disproportionate to the degree of exostosis may indicate a second cause of hearing loss

Implants Check List

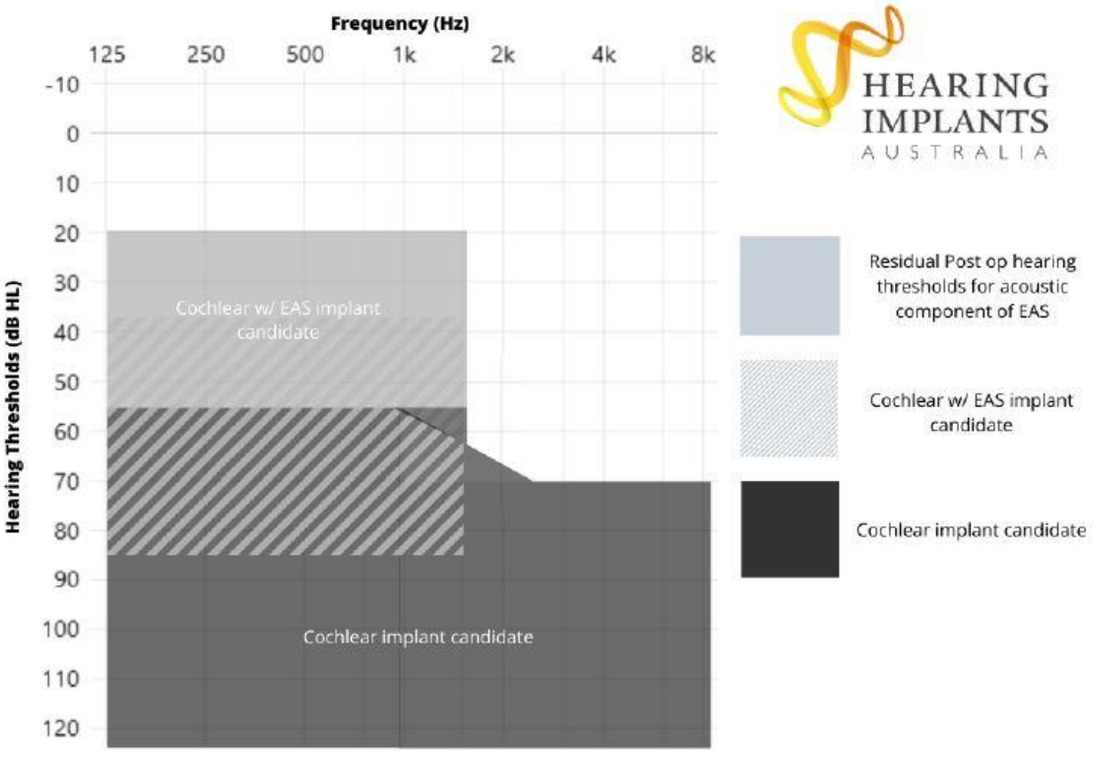
Cochlear Implant Candidacy Considerations for Adults

A cochlear implant may provide significant improvements in hearing and speech perception compared to appropriately fitted hearing aids. They can also provide significant improvements in functional hearing and quality of life.

The following checklist has been developed as a patient management tool to help you determine when a cochlear implant candidacy assessment is warranted. If **two or more** of the following questions regarding functional hearing are yes, a cochlear implant referral is appropriate.

- ☐ Does the patient have a moderate to profound hearing loss in either ear?
- ☐ Does the patient have a ski-slope sensorineural hearing loss with poor word recognition test results?
- ☐ Does the patient have a word recognition score poorer than 65% in either ear?
- ☐ Does the patient's aided hearing loss significantly impact daily interactions either socially or professionally?
- ☐ Does the patient have difficulty following a conversation in noisy situations while wearing appropriately fitted hearing aids?
- ☐ Does the patient have difficulty communicating on the telephone while wearing appropriately hearing aids?
- ☐ Is the patient dissatisfied with their current use of hearing aids?
- ☐ Does the patient have difficulty communicating with one or more people when background noise is present?
- ☐ Does the patient have difficulty in situations when lip reading is unavailable?
- ☐ Does the patient often ask people to repeat themselves?
- ☐ Is the patient withdrawing socially because the effort of listening has become overwhelming and/or frustrating?

Cochlear Implant and Electro-Acoustic Stimulation Audiological Indications



Happiness

What this fact sheet covers:

- What is happiness?
- The science of happiness
- Life in the fast lane: time, money and happiness
- Can we change our level of happiness?

What is happiness?

The term happiness captures a huge variety of positive emotional responses, including such things as cheerfulness, serenity, optimism, and joy. Throughout history, philosophers, religious writers and poets have pondered on the meaning of happiness and how it might be achieved. More recently, scientists, psychologists and even politicians, have joined the pursuit.

Psychologists have found it useful to distinguish between a hedonic and an eudaimonic states of happiness. A hedonic state is a transitory state of pleasure, while a eudaimonic state is one associated with ongoing wellbeing, engagement and contentment. Eudaimonia is based on Aristotle's notion of the 'good life'.

Sociologist Corey Keyes argues that wellbeing is more than just the absence of persistent negative emotions. His concept of 'flourishers' describes people who have high life satisfaction and/or enduring positive mood plus at least six of the following eudaimonic qualities:

- contributing to society
- social integration
- wide range of social groups
- accepting others
- self-acceptance
- mastery over their environment
- positive relationships with others
- autonomy
- personal growth
- purpose in life

The science of happiness

Happiness and evolution

Barbara Fredrickson from the University of Michigan claims that positive emotions have a grand purpose in evolution. Positive emotional mindsets widen our range of thoughts and actions, fostering play, exploration and creativity. We become open to new ideas and new experiences. These states then help us create lasting personal resources, such as social connections and knowledge. We can draw on those resources during trying times.

Happiness and the brain

Neuroscientist Richard Davidson measured electrical activity in the prefrontal cortex area of the brain. He found that the left side is activated when people are feeling happy and that the balance of activity between right and left moves as mood changes. He studied the brain activity of Tibetan monks whose meditation training resulted in extremely high activity on the left side. In fact, Matthieu Ricard, a Buddhist monk and translator to the Dalai Lama, has been dubbed 'the happiest man in the world'. The activity in his left prefrontal cortex was the highest ever measured.

It's not just highly trained Buddhist monks who benefit from meditation. Davidson gave meditation therapy to a group of highly stressed unhappy employees with high levels of right brain activity. Meditation increased activity in their left prefrontal cortex, employees felt happier and they reported renewed enthusiasm. Techniques such as meditation, relaxation, yoga and mindfulness therapy can boost activity in the left side of your prefrontal cortex leading to increased wellbeing.

Happiness and our genes

David Lykken, from the University of Minnesota, studied the role of genes in determining satisfaction in life. He gathered information on 4000 sets of twins and found that about 50% of one's satisfaction with life comes from genetic predisposition. However, neuroscientists have learnt that the brain is highly plastic and can rewire and change itself in response to life experiences.

Health and happiness

Numerous studies have shown that eudaimonic happiness is associated with longer life and superior health. In one study, monitoring 1,300 men over 10 years, Laura Kubzansky found that optimists had half the rate of heart disease. This research has shown that happy people are better at health maintenance, such as spending more time exercising and having routine check ups.

Memories and happiness

Daniel Kahneman, from Princeton University, studies what makes experiences pleasant or unpleasant. When thinking about happiness, he says that it is important to recognise that life is a long series of moments. In any of those moments there is a lot going on and you could stop and ask, what is happening right now? We all have mental, physical and emotional activity at each of those points in time. However, almost all those moments are lost to us forever.

We selectively keep memories and certain moments count more than others. We tend to hold onto beginnings, peak moments, and endings. For example, a parent might remember with great pleasure the day their child scored their first goal at sport. They'll have forgotten the early start, the driving back and forth and the uneventful evening that accompanied that event.

Life in the fast lane: time, money and happiness

Research has shown that there is no significant relationship between how much money a person makes and how happy they are. For example, Ed Diener, a psychologist at the University of Illinois, interviewed members of the Forbes 400 (the richest Americans), and found that they were only a tiny bit happier than the rest of the population.

Kasser and Ryan discovered that people for whom money, success, fame and good looks are especially important are less satisfied than those who strive for good relationships with others, develop their talents and are active in social causes.

Researchers Brickman and Campbell studied a process called adaptation. They found that when we want something and then attain it, we don't seem to be any better off. They called this the hedonic treadmill. It's like we are walking on a treadmill but not really getting anywhere because we are adapting to things. They studied lottery winners and found that one year later, life satisfaction was not significantly greater for the winners. This process of adaptation explains why we are not significantly happier despite significant increases in the standard of living over the last 50 years.

The slow movement

The book 'In Praise of Slowness: Challenging the Cult of Speed' by Carl Honore, is something of a handbook for an emerging 'slow movement'.

The 'slow movement' is a backlash against the idea that faster is always better. The idea is that by slowing down we can enjoy richer, fuller lives. It's not about rejecting modern life, but rather striking a balance between fast and slow. That might mean making time for a hobby that slows you down or leaving some gaps in your day rather than striving to fill every moment with activity. Setting aside time where you turn off all technology or seeking out flexible working arrangements may also help you find balance. Some people make even more significant changes such as changing careers or locations. A 2003 Australian study by Hamilton and Mail found that over 90% of people who have made those significant changes are happy with their decision to downsize their lives.

In Western countries, as GDP (Gross Domestic Product) has gone up, happiness levels have either stayed the same or have decreased. Are we ready for a new approach? A BBC poll has asked "should the government's primary objective be the greatest happiness or the greatest wealth?" The greatest happiness was chosen by 81% respondents.

In the Himalayan kingdom of Bhutan they have been measuring happiness levels in the population since 1972. They use their Gross National Happiness (GNH) level as a basis for making policy decisions. For example, they restrict tourism in order to preserve their culture and they banned smoking in 2004 in order to promote national wellbeing. Countries with high levels of income equality, like Scandinavian countries, have higher levels of wellbeing than countries with an unequal distribution of wealth, such as the United States.

Can we change our level of happiness?

David Lykken's twin studies found that about 60% of our life satisfaction relates to either our genetic predisposition or our life circumstances. Beyond that, he feels it is clear that we can change our happiness levels widely – up or down.

Psychologist Martin Seligman became president of the American Psychological Association in 1998. During his term, he drew together the existing knowledge about the positive side of life and ignited the profession's interest in finding out more. In his 2002 book, **Authentic Happiness: Using the New Positive Psychology to Realize Your Potential for Lasting Fulfilment**, Seligman draws on the research and outlines three ways to increase happiness; get more pleasure out of life, become more engaged in what you do and find ways of making your life feel more meaningful.

See the Black Dog Institute fact sheet on Positive Psychology for practical strategies on how to increase happiness.

Where to get more information

The University of Pennsylvania, Positive Psychology Centre: www.ppc.sas.upenn.edu

Authentic Happiness: Using the New Positive Psychology to Realize Your Potential for Lasting Happiness: an online resource for Martin Seligman's book. The website includes questionnaires to help you identify your personal strengths and measure your level of happiness. www.authentichappiness.sas.upenn.edu

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Talk to us on **0401 517 952** to discuss the options.

Wise Words

It does seem such a long time since I studied, but I recall vividly the anxiousness of practicing a newly learned skill for the first time or sitting an examination.

One thing I realised earlier on was that I was responsible for my own learning. Although I had the books, the teachers, all the resources, I needed to ensure I utilised these fully. It was my responsibility to know what needed learning; my responsibility to keep up to date; my responsibility to point out any anomalies; my responsibility to seek advice or clarification when needed.

I try to instil in my own children that the prior knowledge you are weak in one area is no excuse after the fact. That you have that insight should drive you to seek extra assistance.

We are, however, human after all and by highlighting our weaknesses we expose ourselves to vulnerabilities. On the other hand, we might also expose ourselves to the answers we not only seek, but need, to be competent in what we do.

So next time you have a “stupid question”, or are about to ask the same thing you asked last week, brush aside false pride and speak up. Remember; “pride before a fall”.

Jo O’Dwyer

Christmas Find the Word

D V C X Q U I S U S P E W R G
C N A E Z Y R E I N D E E R H
H A R H S W M Y T B Y U T V A
R C O A R Q S A N T A P P U M
I T L A F S H O R T B R E A D
S U S F T H A P P I N E S S C
T D E C O R A T I O N S T X J
M J P R E S E N T S S V R J O
A J F F S P F G T U R K E Y Y
S B U C R I C K E T R H E R U
O G S U N B U R N E D C E I W
A S Y I K Q L R S U R F I N G
U D E C E M B E R J I N G L E
L C F F V P P U D D I N G C L
D S E P B A C H E R R I E S F

CAROLS
CHERRIES
CHRISTMAS
CRICKET
DECEMBER
DECORATIONS
ELF
HAM
HAPPINESS
JINGLE
JOY
PRESENTS
PUDDING
REINDEER
SANTA
SHORTBREAD
SUNBURN
SURFING
TREE
TURKEY

Happy Holidays and
Merry Christmas
from the Directors of HAASA

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