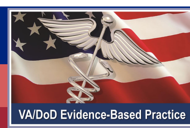
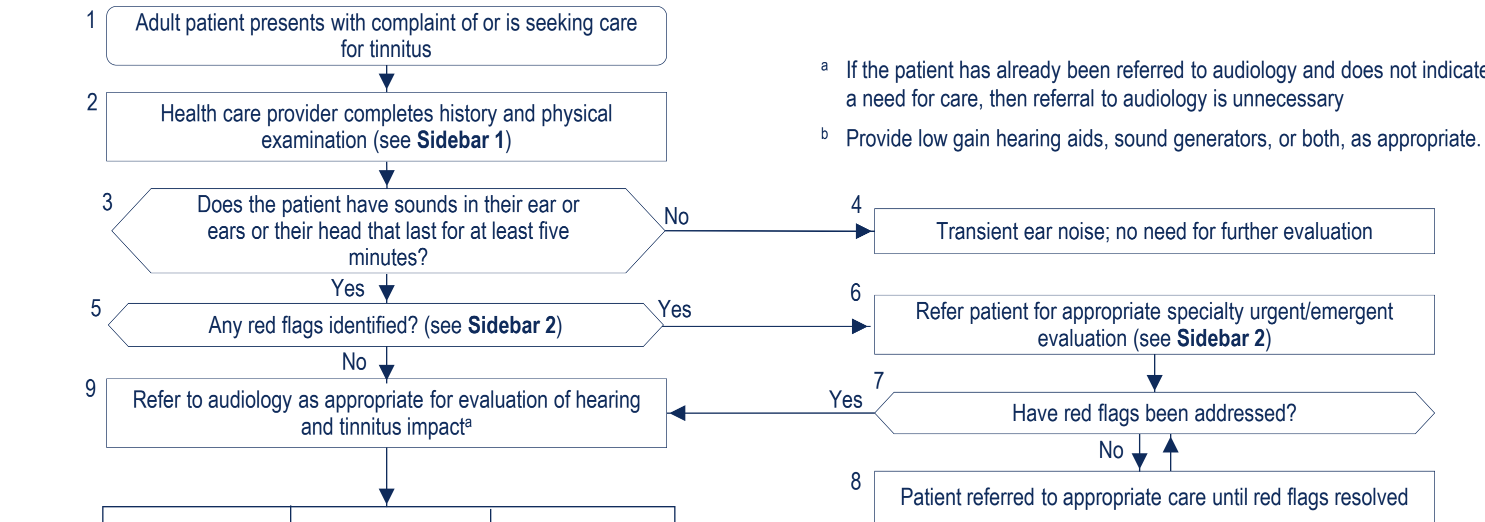


Tinnitus

Module A: Initial Evaluation of Tinnitus



[a] If the patient has already been referred to audiology and does not indicate a need for care, then referral to audiology is unnecessary

[b] Provide low gain hearing aids, sound generators, or both, as appropriate.

Sidebar 1. Relevant History and Symptoms

Provider should first rule out transient ear noise, defined as the perception of sound, usually occurring in one ear at a time and described as high-pitched ringing or tone, lasting fewer than five minutes, and sometimes accompanied by a sense of hearing loss and aural fullness. Transient ear noise is common and does not generally require clinical management. If transient ear noise is ruled out, the following pertinent information should be obtained (not in any particular order).

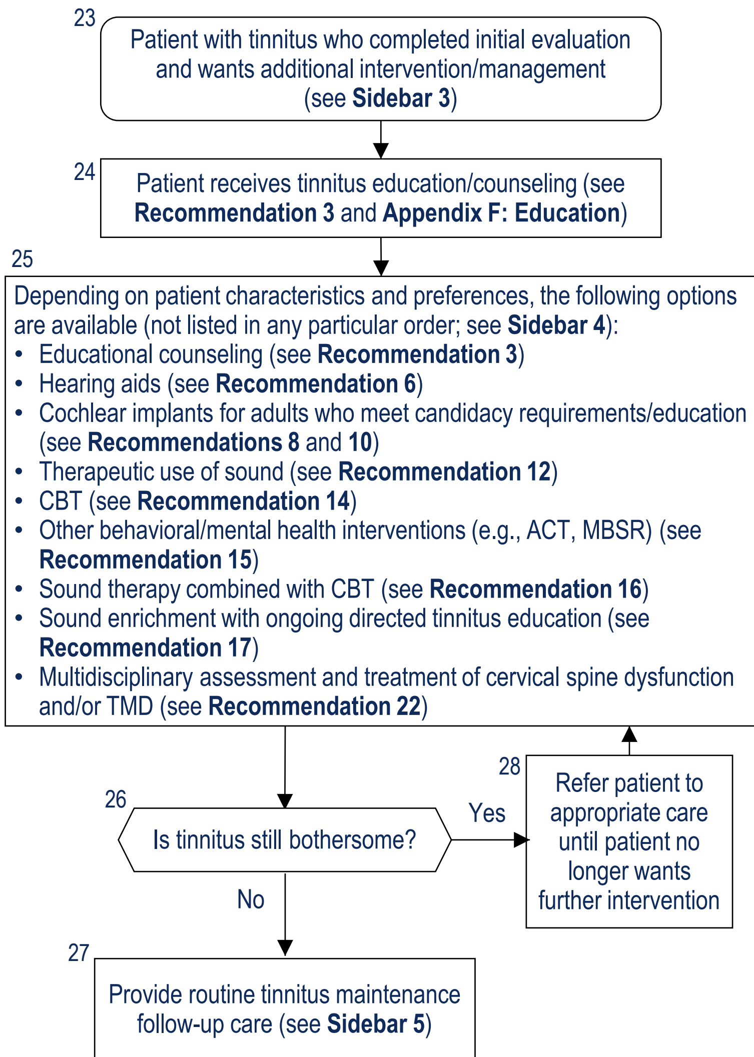
- Frequency, laterality, quality (e.g., pulsatile, non-pulsatile), and intensity of tinnitus
- Circumstance and date of onset of tinnitus
- Impact of tinnitus on sleep, daily activities, or quality of life (screen the patient with a validated instrument, when indicated)
- Hearing loss (e.g., asymmetric, bilateral, unilateral, sudden, recent)
- Ear pressure or fullness with normal ear exam
- Presence of co-occurring conditions, such as anxiety, stress, depression, insomnia, dental issues (e.g., temporomandibular disorder [TMD]), cervical issues
- History of head or neck injury; blast exposure, noise exposure; hearing difficulties; sound tolerance issues; ear pain, drainage, or both; dizziness or vertigo; or possible ototoxic medication (see **Appendix C** in the full CPG)

Sidebar 2. Suggested Referrals[c]

Type	If the patient	Refer to	Status/ Considerations
Urgent (Red Flag) Referrals	Has neurological deficits such as cranial nerve weakness/paralysis, severe vertigo, or stroke symptoms	Emergency department or otolaryngology	Emergency
	Expresses suicidal ideation	Behavioral/mental health or emergency department or 988 Suicide & Crisis Line	Assess for urgent conditions; report suicide ideation and provide escort, if necessary
	Has sudden or unexplained hearing loss or both and/or reports recent head, neck, or acoustic trauma or any combination of the aforementioned trauma	Audiology and otolaryngology	Emergency; must see audiologist before otolaryngologist as soon as possible, ideally on the same day or within 24 hours
	Has otalgia, otorrhea, vestibular symptoms, and/or sudden onset of pulsatile tinnitus.	Otolaryngology and audiology	Urgent; schedule otolaryngology exam as soon as possible
Non-urgent Referrals	Has depression, anxiety, or insomnia	Behavioral/mental health	Assess for urgent conditions; schedule behavioral/mental health assessment as appropriate
	Has hearing difficulties, sound tolerance issues	Audiology (and otolaryngology pro re nata [PRN])	Non-urgent; schedule audiology exam before patient sees otolaryngologist
	Has orofacial issues such as temporomandibular disorder (TMD)	Dental (and orofacial massage provider PRN)	Non-urgent; schedule dental exam before patient sees orofacial massage provider
	Has neck dysfunction or neck injury	Refer to physiotherapist or physical therapist	Non-urgent

[c] Adapted from Henry et al. (2010). A triage guide for tinnitus. Journal of Family Practice. 2010;59(7):389. PubMed PMID: 20625568

Module B: Managing and Improving Quality of Life



Abbreviations: ACT: Acceptance and Commitment Therapy; CBT: cognitive behavioral therapy; MBSR: mindfulness-based stress reduction; TMD: temporomandibular disorder

Sidebar 3. Additional Support to Consider

Basic audiological services will adequately address tinnitus-related problems for many patients. For patients requiring further intervention, consider the following to improve quality of life.

- Address the hearing problem regardless of the label the patient applies to it. Many people say they want help with tinnitus, but they really are seeking help with hearing difficulties.
- Address sound tolerance problems.
- Address behavioral/mental health comorbidities (e.g., mood disorders, insomnia).
- Address specific problems associated with bothersome tinnitus (e.g., relationships with family members and others).
- Address general health and wellness and engage with primary care.
- Inform the patient of indications and timeframes when referrals for additional support are needed.
- Describe stepped care approach or other patient-centered approaches based on services offered at local facility.
- Monitor outcomes.

Sidebar 4. Evidence-Based Practices to Improve Quality of Life with Tinnitus

Intervention	Provided by
Educational counseling (see **Recommendation 3**)	Audiologist; otolaryngology; behavioral/mental health
Hearing aids (activation of sound generator pro re nata [PRN]) (see **Recommendations 6** and **7**)	Audiologist
Cochlear implant considerations when candidacy criteria are met (see **Recommendations 8** and **10**)	Audiologist; otolaryngology
Sound enrichment with ongoing directed tinnitus education by an audiologist (see **Recommendation 17**)	Audiologist
CBT (see **Recommendation 14**)	Behavioral/mental health
Sound therapy combined with CBT (see **Recommendation 16**)	Audiologist; behavioral/mental health
Other behavioral/mental health interventions (e.g., ACT, cognitive therapy, MBSR, relaxation) (see **Recommendation 15**)	Behavioral/mental health
Multidisciplinary approach for assessment and treatment of patients with bothersome tinnitus and TMD, cervical spine dysfunction, or both (see **Recommendation 22**)	Audiologist; dental provider; physical therapist; physiotherapist; orofacial massage provider; otolaryngology

Sidebar 5. Maintenance and Support

When individuals with bothersome tinnitus learn to cope better with the tinnitus functional impact, opportunities exist to plan for maintenance for the additional supports that might be needed to maintain or enhance quality of life with tinnitus. The collaborative planning process should incorporate the following.

- Education about tinnitus, including information about hearing conservation, personalized effectiveness of sound therapy and other strategies for clinical management, and opportunities for general wellness
- Shared decision making with the patient, patient care partners (where appropriate), and the multidisciplinary team
- Issues to think about
  - ♦ Defining the relationship with the provider, management team, or both; scheduling appointments, other contacts, and procedures for addressing urgent needs and referrals to other providers for management of co-occurring conditions
  - ♦ Planning monitoring of symptoms and adherence to an action plan
  - ♦ Discussing methods and availability of tools to support day-to-day self-monitoring
- Engaging caregivers, family members, and significant others in monitoring the need for additional support; when appropriate, identifying early warning signs of hearing loss or increased tinnitus with dangerously loud sounds and reporting sudden changes in hearing or tinnitus to the individual's provider

PATIENT EDUCATION in a NUTSHELL

What to say:

- Tinnitus generally does not get worse unless there are exacerbating factors (e.g., exposure to loud noise, ototoxic drugs, ototoxic chemicals).
- There is no drug treatment for tinnitus, and no vitamin or herb has been found to be more effective than placebo.
- Sound enrichment helps many patients with bothersome tinnitus by reducing the perceptual contrast between tinnitus and the sound environment.
- Learning coping skills can improve quality of life with tinnitus – Cognitive Behavioral Therapy and Progressive Tinnitus Management are examples of tinnitus care that teach coping skills.

AVOID saying:

X There is nothing you can do.
X You will have to learn to live with it.
X I have tinnitus and I am fine.

Access to the full guideline and additional resources is available at: https://www.healthquality.va.gov/.