

18 weeks commissioning pathways

Tinnitus

Supplementary information to be read in conjunction with the pathway

Reference	Supplementary Information
Noise/s in ear/s / head	This pathway is for adults and adolescents (who are defined as 16yrs plus for the purpose of this pathway). Tinnitus includes noises in & around the head
1.1 Symptom Description	Tinnitus is the perception of sound in one or both ears, or in the head in the absence of an external noise. Tinnitus may be associated with any of the following symptoms: hearing difficulties, dizziness, imbalance, pressure / blockage in the ear, ear discharge, ear pain, neurological symptoms & hyperacusis (defined as hypersensitivity to sound) Hallucination / voices and or music may need mental health referral +/- referral to general medicine specialist
1.2 Prevalence	National study of hearing in the Tinnitus Handbook (2000) gives tinnitus prevalence at 7.5% in people with little noise exposure and 20.7% in those with high lifetime noise exposure Increase with age 12-38% under 40 yrs, 62% over 40 yrs (Davis 2003). 74% in pts with hearing difficulties (Coles 1990). Sleep disturbances in 5-8%. Severe/ life altering in 1%(McCombe et al, 1999)
1.3 Self Assessment & Self Care	Websites that may be helpful to your tinnitus include *British Tinnitus Association website www.tinnitus.org.uk *RNID website www.rnid.org.uk *Hypersensitivity to sound www.hyperacusis.net Others *www.dontlosethemusic.com *www.tuneouttinnitus.org.uk Medication includes over the counter & prescribed medications, which may result in a side effect of tinnitus It is important that the patient understands that there are many ways to manage the tinnitus, and that in the first instance they should visit their GP (or appropriately trained health professional) so that such causes of tinnitus as an external ear infection could be treated or wax removed
1.4 Primary Prevention	HSE website for noise at work (noise calculator, audio demonstration of hearing loss): www.hse.gov.uk/noise
1.7 Red Flags	EXIT off pathway if patient has *symptoms of dizziness or loss of hearing *associated neurological symptoms
2.0 Primary Assessment	e.g. GP and / or direct access audiology services Removal of wax by a qualified practitioner, with appropriate equipment, under the suitable conditions, using an evidence based technique (otomicroscopy, syringing, or suction clearance) which is appropriate & acceptable to the individual patient www.gpnotebook.co.uk/simplepage.cfm

2.0 Primary Assessment	COMMISSIONING AND CONTRACTING See the Contractual Levers for 18 week Pathways for more detailed directions and guidance that underpin primary care contracting. Before starting commissioning consider existing primary care medical contracts. Are you already paying for this work? Is it more appropriate to commission this stage of the pathway from primary care contractors? Have your Practice Based Commissioning (PBC) groups considered this pathway for any service redesign? Have you considered the contractual options to commission the pathway at primary care level? Is the current primary care contract fully utilised? Is there capacity to commission additional activity under additional or enhanced service arrangements?
2.2 Diagnostics - Primary Care Audiology Service	2.2.1 Only appropriate for non troublesome / brief episodes of tinnitus 2.2.2 Tinnitus pts may find it difficult to perform an audiogram (BSA protocol). BSA recommended procedure guide on pure tone audiometry (BSA March 2004) states that subjects with tinnitus may have problems with detection of tones around tinnitus frequency and extra care should be taken when using high levels masking noises as they can exacerbate tinnitus
2.2 Diagnostics - Primary Care Audiology Service	COMMISSIONING AND CONTRACTING Generic Patient Reported Outcome Measures exist for this pathway (EQ5D). Currently clinical consensus has not been reached for a condition specific measure.
2.4 Treatments (Tx)	2.4.1 Consider BTA, RNID sources of information and referral to an expert patient programme. No negative counselling as Tinnitus Mx requires cognitive and behavioural changes the info provided should be done in such a way as not to cause further problems later in the pathway. Spontaneous resolution occurs in 25% of cases (Smith and Coles 1987, epidemiological studies) 2.4.2 Recommended return in 1-3 months if patients deem necessary. Sooner if pt condition deteriorates CBT & Counselling include relaxation & stress management and sleep tactics. Consider communication packages within the adult hearing loss pathway if appropriate 2.4.4 Medications include Prescribed and OTC (over the counter)
2.4 Treatments (Tx)	SERVICE IMPROVEMENT For good practice pre-operative assessment guidance, use the hyperlink above or see the website.
2.5 Rehabilitation & Review	COMMISSIONING AND CONTRACTING Generic Patient Reported Outcome Measures exist for this pathway (EQ5D). Currently clinical consensus has not been reached for a condition specific measure.
2.6 Escalation thresholds, decision aids, remote advice	HAC Code of Practice clause 5 , TTSA guidelines. These two documents refer to the reasons for specialist referral. Gp notebook cites as the referral criteria from primary care: Unilateral tinnitus, particularly when associated with deafness, pulsatile or persistent tinnitus, the patient insist on seeing specialist, the practitioner feels uncomfortable with managing tinnitus, adequate resources are not available in the practice, tinnitus is severe enough to interfere with daily activities, tinnitus with severe anxiety urgent assess, Objective tinnitus(heard by the examiner)
2.6 Escalation thresholds, decision aids, remote advice	COMMISSIONING AND CONTRACTING Can the quality of primary care be improved to help referrals?
2.6 Escalation thresholds,	TECHNOLOGY

decision aids, remote advice	Oldham Community PAS system for recording 18 week journeys through ICATs or other intermediate services
2.7 Red Flags	Consider psychological referral in severe debilitating distress Unilateral tinnitus may be indicative of a retro-cochlear lesion e.g. acoustic neuroma
3.0 Specialist Assessment	e.g. Consultant lead service, medical, surgical or scientific If pts whose main complaint is tinnitus and additionally suffers with dizziness/ imbalance or/and hearing difficulties then run tinnitus pathway in conjunction with/ parallel to dizziness / hearing loss pathway
3.2 Diagnostics (Dx) Specialist Audiology Services	SERVICE IMPROVEMENT A summary of service improvement knowledge for UK Radiologists is available. See the hyperlink or website for information.
3.2 Diagnostics (Dx) Specialist Audiology Services	3.2.2 VNG/ ENG inc rotation, Caloric, VEMP. LDL's as required. OAE +/- suppression, speech audiometry, brain stem auditory evoked responses 3.2.3 MRI for non pulsatile tinnitus (exclude acoustic neuroma). CT occasionally may be relevant in elderly patients where MRI is contraindicated. MRI / MRA or CT / CTA are most relevant for pulsatile tinnitus. CT for middle ear disease. 3.2.4 Blood tests Haem, biochemistry e.g. susceptibility to aminoglycoside toxicity
3.4 Definitive Treatments (Tx)	3.3 Consider using Tinnitus Handicap Inventory (Newman et al, 1986) 3.4.1 Consider BTA , RNID sources of information and referral to an expert patient programme - details of local courses at www.expertpatients.co.uk/public/ 3.4.2 Patient specific treatment plan and tools with parameters. Recommended return within 1-3 months if pts deem necessary, sooner if condition deteriorates 3.4.3 Counselling & CBT, relaxation & stress management, sleep tactics. Consider communication packages within the adult hearing loss pathway. Patients referred to this level are the ones who a) have a condition that requires further investigation, or b) have not been responsive to the interventions offered at the primary Ax level & have continued to experience distress. At this level the health care practitioners expertise enables him / her to work with a pt to facilitate change in behaviour, thoughts, attitudes, skills etc within a goal orientated framework 3.4.6 e.g. grommet insertion, tympanoplasty, stapedectomy, mastoid surgery but not neuro - otological
3.4 Definitive Treatments (Tx)	SERVICE IMPROVEMENT For good practice pre-operative assessment guidance, use the hyperlink above or see the website.
3.5 Rehabilitation, Review & QOL measurement	COMMISSIONING AND CONTRACTING Generic Patient Reported Outcome Measures exist for this pathway (EQ5D). Currently clinical consensus has not been reached for a condition specific measure.
3.7 Red Flags	Exit - If extreme distress constrains effective tinnitus treatment then exit to mental health service If distress levels allow pt to receive effective tinnitus Tx then dual pathways

	If dizziness consider running dual pathways
4.0 Supra Specialist Assessment	e.g. Multidisciplinary specialist tertiary tinnitus service or neuro-otological service
4.2 Diagnostics (Dx)	4.2.3 & 4.2.4 Do not repeat path / imaging unless clinical indications 4.2.2 In case of associated dysacusis & suspected central auditory processing disorders run parallel Adult hearing pathway (APD section)
4.2 Diagnostics (Dx)	SERVICE IMPROVEMENT A summary of service improvement knowledge for UK Radiologists is available. See the hyperlink or website for information.
4.4 Definitive Treatments (Tx)	4.4.1 British acoustic neuroma pts website www.bana-uk.com/ British Cochlear implant group www.bcig.org.uk/ menieres society www.menieres.org.uk Pt BAHA website www.baha-users-support.com 4.4.2 In specific cases there is need to add a cochlea implant or BAHA Review frequency of scanning on a pt specific basis after 5 yrs of scanning 4.4.3 Mental health expert as as required 4.4.4 Off label prescription e.g. Baclofen, Gabapentine 4.4.6 Complex otological neuro-otological surgery, implantable ear devices inclusive of cochlear implants, BAHA, middle ear implants, transcranial surgery, embolisation
4.4 Definitive Treatments (Tx)	SERVICE IMPROVEMENT For good practice pre-operative assessment guidance, use the hyperlink above or see the website.
4.5 Rehabilitation, Review & QOL measurement	COMMISSIONING AND CONTRACTING Generic Patient Reported Outcome Measures exist for this pathway (EQ5D). Currently clinical consensus has not been reached for a condition specific measure.