

Transcription of RCGP Podcast

Deafness and Hearing Loss in Primary Care

Interviews with GP and ENT surgeon

**Featuring Dr Devina Maru, RCGP Clinical Champion for Deafness and Hearing Loss,
Dr Graham Easton, Professor of Communication Skills and Dr Chris Ramdin, ENT surgeon and GP.**

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**Dr Devina Maru**

Hello and welcome to part two of our podcast on the spotlight project Deafness and hearing loss in primary care. I'm Dr Devina Maru, a GP specialty registrar currently based in Greenwich, South East London, and the RCGP National Clinical Champion for the spotlight project on Deafness and hearing loss.

In our first podcast, we spoke to Linda Parton, a patient with hearing loss and an audiologist, Frankie Oliver, who also works for Action on Hearing Loss charity. In this podcast, we have two new guests, Dr Graham Easton, a GP with an interest in ENT and a Professor of communication skills at Barts and the London School of Medicine and Dentistry, where he runs workshops for students on hearing impairment. And Dr Krishan Ramdoo, who is and ENT surgeon and now a GP Speciality Registrar and a clinical entrepreneur for NHS England. Thank you for both for joining us today.

Dr Graham, I've read your fantastic book, The Appointment, and you speak about one of your consultations with the patient having hearing difficulties, from the experience of working as a GP and with your interest in this field of Deafness and hearing loss, what tips would you give your GP colleagues during consultations with patients with hearing loss?

**Dr Graham Easton**

Well, if you consider that the average GP is seeing at least four patients a day with hearing loss, that's sufficient to interfere with our ability to communicate with these. It's something we see commonly and it's important. It’s central to our patient's health and wellbeing just as important losing hearing as it is losing sight or balance or any other sense. And I suppose my main point would be have it high on your agenda. Everything else follows is nothing of rocket science about what I'm going to say about communicating with people with hearing loss. But it's got to be something that's in your mind and also trying to imagine what it must be like for someone with hearing loss to navigate the system, come into a GP surgery. We get our students, first year medical students to wear earplugs and try having a conversation. And it's amazing way to get them to sort of empathise and think about some of the practical issues.

Anyway, the basics, I would say, are gain attention, make sure that someone is aware that you're trying to talk to them. That might mean tapping them gently on the arm if they aren't looking at you, but then face to face communication. A lot of people with hearing loss will want to see your lips. They'll be reading your lips even if they've got a hearing aid. It may not be working to give them perfect hearing. Make sure that the light's okay. You know, sometimes people are in dark rooms. They can't you can't see you properly. Certainly, watch the whole thing of turning to face away and looking at your computer.

But don't cover your mouth. I don't know whether you have done this, I certainly sometimes cover my mouth a bit. And it's, you know, it's easily done. And actually, just to be aware that actually that can be like putting a barrier up. I think the other thing that I've seen, and I've done this myself, doctors have a tendency to shout or to talk more loudly and slowly to people with hearing loss. And actually, if you've got a hearing aid that can distort the sound and might be uncomfortable, but it also looks aggressive potentially, so the advice generally is use your normal speaking voice and volume, just speak clearly. Check that you've been understood. Look for those cues of people with that glazed look perhaps that shows they haven't quite understood or heard what you said or perhaps an inappropriate response to something that you've said. We've got to be on the lookout for people who may not know they've got hearing loss. And don't just keep repeating stuff if someone can't understand just saying it louder and louder.

Try saying it in a different way. Don’t waffle. Get to the point. That helps because it's exhausting listening, trying to listen to someone if you've got hearing loss. And of course, writing things down can be helpful sometimes. But I think bottom line, be patient and think of what it must be like to try and navigate the system.

**Dr Devina Maru**

That's very useful Graham, learning about these top communication tips. And as you said, first-year medical students are starting to learn this now. So, it's not just GP trainees, it's starting earlier in your career. Can't be too early, to be honest. I totally agree.

So, I understand you’re part of the NICE guideline committee for Hearing Loss in Adults: assessment and management. Would you discuss the signs and red flags GPs should be aware of when assessing a patient with hearing loss?

**Dr Graham Easton**

Absolutely, I mean, it was a fascinating learning experience for me to be on that committee, particularly working with people with hearing loss and hearing impairment. I learnt so much even after years of working as a GP. I think the first thing I would say is that of course, as GPs, we're used to sort of checking and excluding the common treatable causes of hearing loss, so, ear wax otitis externa, otitis media, middle ear effusions related to a recent upper respiratory tract infection. And we can deal with that, no problem. The thing is, when there's no obvious cause for the hearing loss, having ruled out those sort of things, there's a very clear recommendation from the committee, which was, don't delay, refer to audiology if you're not sure what the cause is, because there is some evidence that that GP is a sort of delaying until things get worse. So that's the first thing to say.

But yes, there are red flags that we need to be looking out for, for serious or even life-threatening conditions that are potentially treatable. The list is long. You can look them up. We all know where to go to look those up. So I'm not going to pretend to cover all of them at all. But I suppose here are the key ones. And Chris can perhaps talk further about other aspects of this in a minute, but the first thing is sudden onset or rapidly progressive hearing loss is a red flag. So sudden onset is defined as over a period of three days or less and within the last 30 days, so if they come to you within 30 days or one of these periods, that's an acute otological emergency. And they need to be seen immediately at A&E or by the ENT team. And the reason is that there are all sorts of potentially treatable causes. It could be autoimmune disease, it could be chronic infection, it could be a rapidly expanding vestibular schwannoma, it could be a stroke, in which case obviously follow the stroke pathway.

If it's more than 30 days ago so still rapid hearing loss over for over three days, but more than 30 days ago that it happened, they still need to be seen urgently in A&E. That's the advice, within two weeks. And then this idea of rapidly progressing hearing loss. So maybe not sudden over three days or less, but somewhere between four to 90 days of rapidly progressing hearing loss, they still need to be seen urgently. And delaying any of these referrals could lead to increased morbidity. They need to be investigated and treated.

The other key immediate referral that's required is a unilateral hearing loss with additional localising signs or symptoms. So, for example, altered sensation in the face or facial droop. It could be, for example, something like an aggressive cholesteatoma, which is this abnormal build up in the middle ear or the mastoid spaces of epithelial cells and keratinocytes, which can be invasive and horrible or a tumour or even a stroke. So those people need to be seen immediately too.

And then the final sort of immediate referral advice is for otalgia ear pain and otorrhea discharging ear with hearing loss in an immunocompromised patient or someone with diabetes, for example, if they're not responding to treatment over 72 hours. And they need immediate referral because it could be a sign of necrotising otitis externa, which used to be called malignant otitis externa. And that's where otitis externa extends and invades the skull base and cranial nerve cells, so its potentially really unpleasant.

**Dr Devina Maru**

And I would like to just highlight, make sure you refer early! That's the key point in this whole podcast. Thank you, Graham.

So, Krishan, welcome. I know you were an ENT surgeon before. So as an ENT surgeon regularly receiving referrals from GPs, what tips would you recommend for GPs dealing with patients with hearing loss? And in what ways can primary and secondary care work together more efficiently?

**Dr Krishan Ramdoo**

So I think Graham, he did a great job of actually listening out what are the referral criteria. And actually, you know, from sitting on both sides of the fence, having been an ENT registrar at a senior level in London and now switching over to general practice, we're able to deal with those referrals. But I think in the otology clinic, and if we if we take that rather than the whole ENT, the majority of the cases coming through aren't actually life threatening.

So we deal with the red flags. But the thing I would say and you know, when I was receiving referrals is, yes, we would tick off these lists, make sure we've dealt appropriately with the red flags where they've gone for an MRI scan. But what I always used to feel was that we would deal with our red flag and then they would go back to the GP. And now sitting on the other side of the fence, I think is when you get that referral back that saying, OK, all your red flags have been ruled out, that patient actually still has an issue. They presented to you for a problem with hearing or their ear.

And I think the key as sitting in the GP environment is actually well, let's start to think outside the box and say, well, okay, if someone has come in and we’ve ruled out all the red flags. Hearing loss, as we know, can manifest in a number of different ways. It can relate to falls, social isolation, depression and is the biggest modifiable risk factor for dementia.

And I think the key is finding that balance. So where we get secondary primary care working together is, yes, in primary care we need to refer in, but actually in primary care so that we're not just referring every patient who comes in with a hearing loss. Let's think outside. Is there something else that we can do earlier in the pathway or identify early in the pathway? So if someone does presents, say, with feeling a bit lonely, not communicating with you as you would have expected over a period of time, you might think, well, actually, that might be a hearing loss. And what don't we get them straight into audiology rather than wait to two for the red flags to present.

**Dr Devina Maru**

That's a very useful insight, as you have worked both in secondary and in primary care. But a key thing is to look at all the risk factors and think about why they possibly could have hearing loss to get to the cause of it. So, I understand you're also a founder of a healthcare start-up involved in ear care and wax treatments. Please, would you tell us more about the importance of earwax removal?

**Dr Krishan Ramdoo**

Yes, certainly so.

And as I said in my intro, so I'm part of the NHS England clinical entrepreneur program. And with that, I was able to think of a solution which the pathway to access hearing care is actually quite disjointed and difficult for patients. They go from the GP to the audiologist. If the audiologist finds there is wax, they have to go back to the GP. We're no longer offering that service, they then have to go into ENT, they remove it, then back to the GP and then finally onto the audiologist.

So what I wanted to try and do was develop a solution which kind of brings that all together, but in an innovative way using technology and ultimately better for the patient. And it's a solution which we call Tympahealth, but it's born out of the NHS, its an actual formal NHS spin out. But, it clips onto your smartphone, allows you to look in the ear, take a picture in high definition, do wax removal, do a screening hearing tests and create a hearing health record for that patient, so that at any point in that journey, that digital record can be sent either to the ENT specialist all the kit has been designed that it can be used by healthcare assistants or nurses, so the GP can review it and appropriately refer.

And I think the key parts, which I think is that we were looking at the wax pathway and everyone's going into hospital. So that's a relatively safe procedure. The importance of it is wax is normal for every individual. You mentioned as one of the first causes of someone coming in for a hearing loss, but it affects about 30 to 40 percent of people. And I think the importance of it being assessed and removed allows you then to progress management. And I think what I wanted to aim from developing that technology was to make care more accessible to patients and also patients who are in nursing homes, for example.

There was a patient who, this really struck home to me, the impact that this can have, a very simple example. But there was a patient who is an 89-year-old lady who was deaf in one ear and in the other ear she was waiting on the pathway to get ear wax removal done. So we went into the home and it just so happens her daughter was there with her. And we had trained up the HCA and removed the wax. She removed the wax. And the daughter said, well, let me just see if she can hear me better.

And she said, I love you, mum. And her mum replied back, I love you, too. And her daughter just burst out crying. And for me, that made it, just that simple intervention. And if we had had to take that patient who was already on the pathway of waiting to have wax removal done and move her from there to the GP. And on that pathway I described the fact that we were able to deliver in our own environment, an environment that she's used to, made me realise that actually there's a big chance for this to help in those environments as well.

**Dr Graham Easton**

Can I ask a question Krishan, I just want to learn a bit more about the what you put into the ear. So there is a camera on one end of it, and it’s also able to do wax removal?

**Dr Krishan Ramdoo**

The wax removal, the micro suction part is done with a normal suction probe which is done in the hospital. But what you're enabling yourself to do is rather than irrigation, which was traditionally done in GPs, where you're blindly putting water into the ear, it allows you to look on your screen and perform the wax removal as is done in the hospital.

**Dr Devina Maru**

That’s very innovative. And what you've created sounds like it's more accessible than having a micro suction kit in your GP practice, which can be quite expensive.

Thank you for listening. And if you enjoyed this podcast do listen to part one, where we speak to a patient with hearing aids and an audiologist who also works for Action on Hearing Loss charity. Do visit our resources on deafness and hearing loss on <https://www.rcgp.org.uk/hearingloss>.

Thank you both, Krishan and Graham for being here today.