CORRESPONDENCE

Perspectives on the Pathophysiology and Treatment of Sudden Idiopathic Sensorineural Hearing Loss

by Prof. Dr. med. Markus Suckfüll in volume 41/2009

Almost Cynical

The information that sudden idiopathic sensorineural hearing loss does not need to be treated as a medical emergency is very helpful for primary care physicians in private practice, because this renders immediate referral to ear, nose, and throat doctors or immediate inpatient admission unnecessary.

The pathophysiology and therapy of sudden hearing loss are not known, but to conclude on the basis of doctors' ignorance of the subject that treatment should be categorized as an individual health service (paid for by patients themselves) seems almost cynical to me, especially as the author emphasized earlier how negatively unilateral hearing loss affects the lives of those who experience it.

The article was lacking information on the course of the pathology with or without treatment. In order to offer therapeutic options to patients, patients with sudden hearing loss will have to be informed about the course of the disease. How common is spontaneous remission, for example? Maybe the author might provide some relevant information now?

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REFERENCES

1. Suckfüll M: Perspectives on the pathophysiology and treatment of sudden idiopathic sensorineural hearing loss. Dtsch Arztebl Int 2009; 106 (41): 669–76.

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Misplaced Metaphor

The informative and well researched article would have benefited from a psychosomatic perspective. Without such a perspective, sudden idiopathic sensorineural hearing loss assumes a status of "the writing on the wall" for the patient because of the uncertain therapeutic options, the high risk of recurrence, or even the risk of stroke.

If the author hypothesizes that, pathogenetically, ischemic problems may be implicated, then the importance of a patient's work stress and social stress in terms of thrombophilic changes has to be pointed out (1–3)—conditions that are responsive to behavioral preventive measures, in contrast to hereditary components.

Further, addressing sudden idiopathic sensorineural hearing loss as an indicator of vascular risk without considering the biopsychosocial context is not without its problems. As long as we have to assume heterogeneous and unexplained causes, it does not seem appropriate to counsel patients in this direction. The often heard sentence, "You have an infarction in your inner ear," is a misplaced metaphor and usually labels a patient as a victim.

Where no definite, effective, conventional treatment for sudden idiopathic sensorineural hearing loss exists, tertiary prevention should be considered. Where somatic medicine currently meets its limitations, maldevelopments are common in the shape of dysfunctional attention to the (physical) body, expectations of catastrophic events, and/or active "doctor shopping." Patients need good information and a feeling of self efficacy. This is the only way to prevent chronification and decompensation of the symptoms of sudden idiopathic sensorineural hearing loss—such as tinnitus and vertigo—and to avoid social or professional destabilization.

Sudden idiopathic sensorineural hearing loss and its sequelae can therefore become a genuine mission for psychosomatic therapy or rehabilitation.

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REFERENCES

1. Kittel F, Leynen F, Stam M, et al.: Job conditions and fibrinogen in 14226 Belgian workers. The Belstress study. European Heart Journal 2002; 23(23): 1841–8.
2. Ripke A: Experimentelle Studie zur Thrombozytenaktivierung durch psychisch induzierten Stress bei Patienten mit vermehrten Ängsten [Dissertation]. Lübeck: Universität zu Lübeck; 2006.
3. Siegrist J: Adverse health effects of high-effort/low-reward conditions. Journal of Occupational Health Psychology 1996; 1(1): 27–41.
4. Suckfüll M: Perspectives on the pathophysiology and treatment of sudden idiopathic sensorineural hearing loss. Dtsch Arztebl Int 2009; 106 (41): 669–76.

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Patients Are Completely Unaware

How can the treatment with glucocorticoids be regarded as the gold standard if not a single study thus far has shown efficacy for any treatment of sudden idiopathic sensorineural hearing loss on the evidence base of a phase III study?

The term "gold standard" in itself implies a rating as a first class treatment on the basis of good evidence.

On this background, the attempts of the professional association of ear, nose, and throat physicians to transform the treatment of sudden idiopathic sensorineural hearing loss into an individual health service do seem ambiguous. Obviously, a treatment that is the worldwide "gold standard" but is not covered by the health

insurers can easily be sold as an individual health service.

The victims in all this confusion of different opinions and competing interests are the patients, who in their ignorance often make great personal sacrifices in order to afford such individual health services.

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REFERENCES

1. Suckfüll M: Perspectives on the pathophysiology and treatment of sudden idiopathic sensorineural hearing loss. Dtsch Arztebl Int 2009; 106 (41): 669–76.

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Joint Federal Committee

In his article, Professor Suckfüll refers to a publication from the German Association of Otorhinolaryngologists (Deutscher Berufsverband der Hals-Nasen-Ohren-Fachärzte) which purportedly advises to bill for the treatment of hearing loss as an individual health service.

This is correct, but the reasons for this practice are given by a decision of the joint federal committee.

The drug guideline in force on 1 April 2009 defines that medications previously used to treat sudden hearing loss cannot be prescribed as a service covered by the insurers, nor do they meet the cost-benefit criteria.

Professor Suckfüll explains the therapeutic options in great detail. For otorhinolaryngologists in private practice a further prescription of these medications would inevitably have economic consequences.

For this reason the the professional association—supported by the Federal Association of Physicians who treat members of statutory medical insurance schemes—advises billing for such medications as individual services.

This highlights once more the fact that the therapeutic independence of physicians in private practice within the context of the statutory health insurance is limited by legal guidelines and that the scarcity of resources is not openly addressed. Ultimately it is the patient who remains the victim in all of this.

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REFERENCES

1. Suckfüll M: Perspectives on the pathophysiology and treatment of sudden idiopathic sensorineural hearing loss. Dtsch Arztebl Int 2009; 106 (41): 669–76.

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Ineffective Treatments Are Harmful

With regard to the suggested therapeutic measures—primarily infusions of various substances—all existing studies that claim to meet at least minimum standards of methodological quality have had a negative result. In spite of this clear situation, even the relevant specialty groups kept recommending their use. The fact that Professor Suckfüll clearly articulates the lacking evidence base is therefore to be welcomed.

Ineffective treatments are not "neutral"; they are harmful. All listed therapeutic options are associated with risks. Speaking for myself, I acted as an expert in the case of a death due to sepsis caused by an infected catheter that had been used for infusion treatment of sudden hearing loss.

It is therefore with considerable dismay that I noted the sentence: "For this reason, the German Association of Otorhinolaryngologists (Deutscher Berufsverband der Hals-Nasen-Ohren-Fachärzte) ... currently directs that the treatment of sudden, idiopathic sensorineural hearing loss is to be billed as an individual, rather than insurance-covered, service" in the article.

This is akin to openly admitting that treatments that do not meet the criteria of efficacy and harmlessness continue to be proposed or at least offered. This is likely to do lasting damage to the public's trust in doctors. Suckfüll himself asks the question of whether situation will remain unchanged. Regrettably, the trend towards detrimental medicine on the basis of individual health services seems to have made further progress, although this certainly does not focus primarily on patients' wellbeing. Under no circumstances must individual health services be allowed to become a melting pot for treatment methods that cannot be billed to the health insurers because they do not conform with the required quality standards.

Doctors are advised to reflect on the situation self critically and correct this trend, before external regulations are imposed that put a stop to such practices.

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REFERENCES

1. Suckfüll M: Perspectives on the pathophysiology and treatment of sudden idiopathic sensorineural hearing loss. Dtsch Arztebl Int 2009; 106 (41): 669–76.

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Unacceptable Subgroups

In his CME article on the treatment of sudden idiopathic sensorineural hearing loss, Professor Suckfüll postulates several allegedly necessary diagnostic measures ranging from ear microscopy to tympanometry to acoustic evoked response audiometry. However, he does not deliver any proof of the benefits of these recommendations—decided on the basis of a consensus.

He rightly points out that no confirmed proofs exist for the treatment of sudden hearing loss. In this context, the "selective literature search" takes its revenge, so to speak: the studies by Desloovere (1, 2), which—in

addition to the cited one by Klemm et al—disprove the benefits of treatment with plasma expanders, are not mentioned. It is entirely unacceptable to extract subgroups from studies with negative evidence, with the intention of deducing positive recommendations. The recommendation to offer HAES infusions—which are known for their potential to cause renal damage (3) and lifelong persistent pruritus (4, 5)—as individual health services is completely misplaced in a CME article.

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REFERENCES

1. Desloovere C, Lörz M, Klima A: Sudden sensorineural hearing loss—influence of hemodynamical and hemorheological factors on spontaneous recovery and therapy results. Acta Otorhinolaryngol Belg 1989; 43(1): 31–7.
2. Bundesärztekammer – Arzneimittelkommission der deutschen Ärzteschaft: Rückenschmerzen bei Anwendung Hydroxyethylstärke-haltiger Infusionslösungen. Dtsch Arztebl 1995; 92(19): A-1402.
3. Reimann S, et al.: Hydroxyethylstärke-Speicherung in der Haut unter besonderer Berücksichtigung des Hydroxyethylstärke-assoziierten Juckreizes. Dtsch Med Wschr 2000; 125: 280–5.
4. Suckfüll M: Perspectives on the pathophysiology and treatment of sudden idiopathic sensorineural hearing loss. Dtsch Arztebl Int 2009; 106 (41): 669–76.

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Fear and Insecurity

The review by Professor Suckfüll of sudden idiopathic sensorineural hearing loss reminds us that neither etiology, nor risk factors, nor treatment options in this relatively common pathology (160 per 100 000 population) (1) have been scientifically studied, and that the number of cases of spontaneous remission is substantial. Somewhat prominently stated, however, is the idea—pointedly articulated and supported by a CME question—in the literature review that sudden hearing loss may be a warning signal for stroke. In support, Suckfüll cites a publication (2) that compared 1423 patients in whom sudden sensorineural hearing loss had been encrypted with 16 413 appendectomy patients—on the basis of a notification system in Taiwan, retrospectively, and with exact age and sex.

He concludes that the risk of stroke was 1.64 higher than that of the control group. The authors of the original study interpreted this association—still termed speculation—rather more cautiously and point out the limitations of their database, but Suckfüll amplifies the statement and asks for this association in the CME appendix by making an unequivocal statement.

It does make perfect sense to examine hearing loss patients internistically and neurologically, in order to detect existing vascular risk factors early, and treat these if required. This was the most important finding in the original study by Lin et al (2).

We worry that presenting an undifferentiated association between hearing loss and stroke, which is postulated as confirmed, will only serve to undermine the confidence of doctors who are not continually confronted with this pathology and to increase their professional anxieties in their consultation with patients.

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REFERENCES

1. Klemm E, Deutscher A, Mösges R: A present investigation of the epidemiology in idiopathic sudden sensorineural hearing loss. Laryngo-Rhino-Otol 2009; 88: 524–7.
2. Lin HC, Chao PZ, Lee HC: Sudden sensorineural hearing loss increases the risk of stroke: a 5-year follow-up study. Stroke 2008; 39(10): 2744–8.
3. Suckfüll M: Perspectives on the pathophysiology and treatment of sudden idiopathic sensorineural hearing loss. Dtsch Arztebl Int 2009; 106 (41): 669–76.

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