Myths vs. Clinical Facts of Newborn Hearing Screening and Early Diagnosis

MYTH: Hearing loss does not occur very often.

FACT: Hearing loss affects about 1-3 per 1000 births, and is considered to be one of the most common congenital findings.

MYTH: There is no rush to identify hearing loss.

FACT: Infants identified with hearing loss before 3 months of age can begin early intervention and avoid speech and language delays; those with late diagnosis and intervention may never catch up.

MYTH: It is OK to combine results from different screening tests to equal a passing result.

FACT: Combining results from different test sessions is NOT recommended and may miss identifying hearing loss.

MYTH: Parents can test a child's hearing by making loud noises near the child.

FACT: Some babies with hearing loss can still startle to loud noises or respond to some softer sounds, but may not be able to hear all the sounds important for speech. Thorough hearing testing is needed to find all types/levels of hearing loss that can affect speech/language development.

MYTH: There are too many referrals from hospitals.

FACT: The REFER rate at hospital discharge in Minnesota is ~4%. After the first outpatient rescreen, only about 1% of all newborns require diagnostic ABR. This meets recommended benchmarks for an effective process.

MYTH: Abnormal otoacoustic emissions (OAEs) along with a flat tympanogram (normal volume) confirms a conductive hearing loss.

FACT: Diagnostic ABR including bone conduction testing is needed in combination with OAEs and tympanograms for a complete diagnosis of type and degree of hearing loss in each ear, and to rule out underlying sensorineural hearing loss.

MYTH: Infants who need diagnostic testing with an audiologist must be sedated.

FACT: Younger infants (ideally between four to eight weeks of age) can typically be tested without need for sedation.

MYTH: Repeated outpatient rescreening is more cost-effective than referring for diagnostic ABR.

FACT: Repeated rescreens often cause infants to become lost to follow-up. Those who continue with multiple screens often still require diagnostic ABR—which then requires sedation—at a significant cost increase.

MYTH: It is not as important to complete diagnostic testing by 3 months of age for infants with a REFER result in just one ear.

FACT: Prompt diagnosis of unilateral permanent hearing loss is best practice, and can lead to more proactive management of middle ear issues that may impact hearing in the better ear.

DEPARTMENT OF HEALTH

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