Classification of hearing loss is an essential component of audiological assessment. Classifying hearing loss according to the type, degree and configuration of hearing loss is the primary information required to determine further test procedures and to direct medical and/or audiological interventions.

Hearing Loss – Classification

Hearing status is typically quantified according to the hearing threshold (lowest intensity at which a signal is just audible to a person (measured in decibel or dB) across several frequencies (measured in Hertz or Hz). The gold standard to determine hearing thresholds is pure tone audiometry (PTA) (see Pure Tone Audiometry chapter); it is recorded on a chart called an audiogram (Figure 1).

Using these tests in both ears one can ascertain the type, degree, configuration and symmetry of hearing loss. The combination of bone and air conduction tests allows one to differentiate between pathology located in the external and middle ear as opposed to the cochlea and central auditory pathway.

It is important however to note that these tests must be done as part of an audiological test battery so as to confirm and crosscheck the audiomeric results. Some types of hearing loss also require other tests to determine the exact type of hearing loss. Auditory neuropathy is one such condition and requires advanced tests including auditory brainstem responses (see chapter on auditory brainstem response) and oto-acoustic emissions (see chapter on otoacoustic emissions).

Conductive hearing loss

Conductive hearing loss indicates an obstruction to the flow of sound energy from the atmosphere to the inner ear. Pathology causing conductive hearing loss blocks the natural transduction of energy through the external ear canal and middle ear (Figure 2).
Figure 2: Hearing loss related to the structure of the ear

Flow of sound energy may be blocked in the outer ear canal e.g. by wax impaction; flow may be blocked in the middle ear in the cases of otitis media with effusion or any other condition which changes the sound conduction properties of the middle ear structures (Table 1). Many types of conductive hearing loss are reversible e.g. with removal of wax plugs or drainage of middle ear effusions. Audiograms show normal bone conduction but abnormal air conduction thresholds (Figure 3).

**Conductive hearing loss**
- Wax impaction in ear canal
- Atresia of ear canal
- Perforation of tympanic membrane
- Otosclerosis
- Dislocation of ossicular chain
- Cholesteatoma
- Otitis media with effusion

**Sensorineural hearing loss**
- Genetic hearing loss (syndromic & non-syndromic)
- Congenital infections (e.g. Rubella, CMV)
- Acquired infections (measles, mumps, toxoplasmosis, meningitis, syphilis)
- Otoxicity (aminoglycosides, loop diuretics, cytotoxic drugs, antimalarials)
- Noise induced hearing loss
- Presbyacusis

Table 1: Examples of causes of conductive and sensorineural hearing loss

**Figure 3: Audiogram of a patient with conductive hearing loss**

**Sensorineural hearing loss**

This is a broad term used to describe reduction of auditory threshold sensitivity. The pathology may be located in the **cochlea** and/or in the auditory nerve and central nervous system auditory structures **(retrocochlear)** (Table 1, Figure 2). The causes of sensorineural hearing loss are varied (Table 1).

Historically it was difficult to clearly differentiate between sites-of-lesion in the sensory and neural systems because they are so closely linked. There are also deteriorating effects secondary to the primary lesion e.g. noise induced damage to the cochlea may also cause secondary atrophy of the central auditory pathway. Audiological advances such as otoacoustic emissions (see chapter on otoacoustic emissions) and auditory brainstem evoked responses (see chapter on auditory brainstem response) have however increased our diagnostic specificity of the primary site-of-lesion.

Audiograms of sensorineural hearing loss show hearing loss that equally affects air and bone conduction (Figure 4).
Mixed hearing loss

Mixed hearing loss refers to the combined presence of both conductive and sensorineural hearing loss (Figure 5).

Auditory Neuropathy

Auditory neuropathy is a type of hearing loss which technically can be considered a subgroup of sensorineural hearing loss, but has a very characteristic presentation with a specific subset of symptoms and diagnostic test results. The clinical presentation is varied and consequently has been referred to as auditory neuropathy spectrum disorder (ANSD). These patients have significant sensorineural hearing loss despite evidence of normal outer hair cell function, and the neural response is absent or abnormal as measured by the auditory brainstem response.

They may present with any degree and configuration of hearing thresholds despite absent or very abnormal auditory nerve functioning as measured by the auditory brainstem response. Furthermore, speech perception is disproportionately poor with respect to the hearing loss.

The signature diagnostic finding is the presence of normal or near-normal outer hair cell functioning as measured by the cochlear microphonic response; this can be visualised on the auditory brainstem response. Otoacoustic emissions are also generally present despite significant loss of hearing sensitivity.

Degree and configuration of hearing loss

The degree of hearing loss is quantified for each ear as an indication of severity of hearing loss. The PTA for air conduction thresholds at 500, 1000 and 2000 Hz is traditionally used to classify the degree of hearing loss in each ear. Table 2 illustrates a commonly used classification of the degree of hearing loss based on PTA. Normal adult hearing thresholds are generally considered to be ≤25dB.
Table 2: Degree of hearing loss based on the PTA of 500, 1000 and 2000 Hz air conduction thresholds

<table>
<thead>
<tr>
<th>Pure tone average (dB HL)</th>
<th>Degree of Hearing Loss</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt; 15</td>
<td>Normal</td>
</tr>
<tr>
<td>16 – 25</td>
<td>Slight</td>
</tr>
<tr>
<td>26 – 40</td>
<td>Mild</td>
</tr>
<tr>
<td>41 – 55</td>
<td>Moderate</td>
</tr>
<tr>
<td>56 – 70</td>
<td>Moderately severe</td>
</tr>
<tr>
<td>71 – 90</td>
<td>Severe</td>
</tr>
<tr>
<td>≥ 90</td>
<td>Profound</td>
</tr>
</tbody>
</table>

*Hearing loss configuration* is classified in accordance with the shape of the air conduction audiogram across the frequency spectrum. Different configurations may be associated with certain etiologies of hearing loss. A commonly used classification system is presented in *Table 3*.

<table>
<thead>
<tr>
<th>Term</th>
<th>Descriptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Flat</td>
<td>≤5dB average difference per octave</td>
</tr>
<tr>
<td>Gradually sloping</td>
<td>6-10dB rise or fall per octave</td>
</tr>
<tr>
<td>Sharply sloping</td>
<td>11-15dB rise or fall per octave</td>
</tr>
<tr>
<td>Precipitously sloping</td>
<td>≥16dB rise or fall per octave</td>
</tr>
<tr>
<td>Rising</td>
<td>Better hearing at the higher frequencies</td>
</tr>
<tr>
<td>Trough or saucer</td>
<td>≥20dB more loss at middle frequencies than 250 and 8000Hz</td>
</tr>
<tr>
<td>Notch</td>
<td>Sharply poorer at one frequency, with recovery at adjacent frequencies</td>
</tr>
</tbody>
</table>

*Table 3: Configurations of hearing loss based on air conduction PTA*

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