The THRESHOLD ©

A T K GROUP PUBLICATION DEVOTED TO OCCUPATIONAL HEARING LOSS PREVENTION AND PROGRAM MANAGEMENT

On The Inside

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ATTENTION MYTK Group Users!

Users of MYTK Group receive automated email notifications when audiometric data is uploaded to the web-based portal. If you are responsible for your Hearing Loss Prevention Program and tasked with administering necessary *time-sensitive* follow-up actions, T K Group reminds you to check the system as soon as you can when email notifications are received.

MYTK Group has numerous reporting options, however to know all you need to know, click on Reports for individuals, plants, and corporations on the Home page. From here, scroll down and select Program Listing. Enter the appropriate date ranges and run the report.

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ATTENTION MYTK Group Users!

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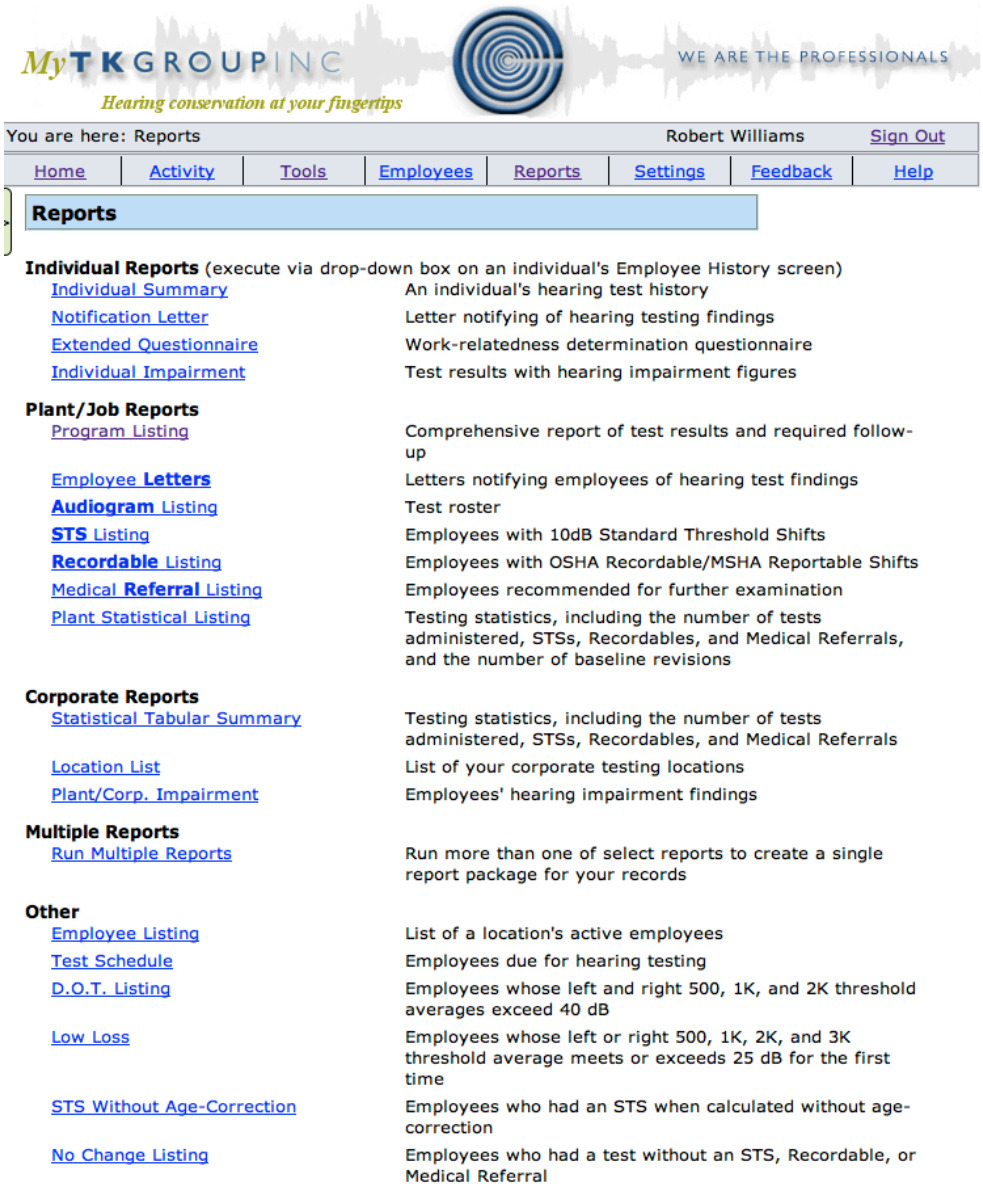

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ATTENTION MYTK Group Users!

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Time Sensitive Follow-up Actions

The need to logon and retrieve reports immediately when your email notification is received is most important so that you can initiate necessary follow-up actions for 10 dB and/or potentially Recordable shift events and Medical Referral recommendations. Please be reminded that 10 dB Standard Threshold Shifts should be retested within 30 days of the initial shift date. For Recordable events, logging to the OSHA 300 Log is not required if a 30 day retest is anticipated. If a Recordable shift is confirmed by retest, that event must be logged within seven (7) days of the confirmation. You may then request a Work Relatedness Determination. If a non-occupationally related determination is returned, you are permitted to "line out" that entry.

If you are new to T K Group, or if you are simply interested in receiving email notification of new newsletter postings, please email robertwilliams@tkontheweb.com and type "Add to Newsletter" in the subject line.

The Threshold is written by Robert Williams, A.uD.

A Review of Tinnitus

Tinnitus, commonly referred to as "ringing in the ears", is prevalent in 20% of any given population; 3 to 7% of those with tinnitus seek clinical intervention due to its debilitating effect on their lifestyle.

Tinnitus may also be accompanied by two additional conditions: Hyperacusis and Misophonia. Hyperacusis is a condition characterized by unusually strong behavioral responses to sound while Misophonia is an extreme dislike of sound. Collectively, Hyperacusis and Misophonia make for a condition called Decreased Sound Tolerance.

Tinnitus may point to any number of potential underlying pathological conditions that must always be investigated. Tinnitus can be generated by certain anatomical structures in and/or adjacent to the ear emitting biological noise called somatosounds; vascular blood flow patterns, tumors, or benign conditions such as patent (open) eustachian tubes may generate somatosounds. However, in a great majority of cases, no identifiable pathology can be determined. This class of tinnitus is often called a "phantom auditory perception"; phantom tinnitus refers to an event that cannot be attributed to the presence of any physical acoustic stimulus. While the cochlea plays a role in phantom auditory perception, a prominent theory called the Neurophysiological Model for Tinnitus suggests that clinically significant tinnitus primarily involves ascending (higher level) auditory and central nervous system centers and that the inner ear is involved only secondarily.

Generally, the model suggests that persons significantly affected by tinnitus at some point in time develop severe negative emotions associated with the tinnitus signal; in turn, a physiological-not psychological chain of events involving the brain's limbic and autonomic nervous systems is activated as a defense mechanism to the signal.

Tinnitus Retraining Therapy has seen success in minimizing, if not completely eradicating, debilitating tinnitus cases. Extensive therapy protocols serve to retrain the brain's physiological response to the troublesome tinnitus signals. This is possible due to the brain's plasticity; humans are able to alter neuronal relays within the brain and reverse negative physiological reactions to the eliciting stimulus.

There remain many fallacies associated with tinnitus and its treatment. No single drug has been proven to systematically induce tinnitus in double-blind studies; however, a certain class of drug (benzodiazepines, i.e. Xanax, Valium, Lorazepam, etc.) may induce transient tinnitus and hyperacusis upon cessation. Caffeine can exacerbate existing tinnitus, but there is no scientific basis to eliminate "normal" caffeine intake. Aspirin does not induce or exacerbate tinnitus in small doses; one to five aspirins a day has no clinically significant influence on tinnitus.

The Neurophysiological Model for Tinnitus truly suggests that tinnitus noise is in one's brain, not one's mind!