

Guidelines for the grading of tinnitus severity: the results of a working group commissioned by the British Association of Otolaryngologists, Head and Neck Surgeons, 1999

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Guidelines for the grading of tinnitus severity

Tinnitus is a common experience with up to one third of the adult population experiencing it at some time in their life. Less than 1% of the adult population have tinnitus of sufficient severity to affect their quality of life seriously (although up to 8% may seek medical advice about it). Much of the severity of tinnitus relates to the individuals' psychological response to the abnormal tinnitus signal. The prevalence of tinnitus increases in association with high frequency hearing loss. There is, unfortunately, no diagnostic test that either confirms the presence of tinnitus or its severity. Currently there is no satisfactory severity grading system. A five-point severity grading scheme is therefore proposed and the entry criteria detailed. The five severity points are: slight, mild, moderate, severe and catastrophic. Categorization as 'severe' or 'catastrophic' should be, by epidemiological definition, very rare. General guidance, theory and evidential support are contained within.

Keywords *tinnitus severity grading*

Currently, there are a variety of scoring and grading systems available for assessing tinnitus severity. Unfortunately, their use is not uniform and in the medico-legal arena the three-point scale of 'mild/moderate/severe' is woefully inadequate. In addition, there is on-going debate about the best treatment/management paradigm for tinnitus and a rising tide of medico-legal claims for tinnitus (with or without hyperacusis and often with little in the way of associated hearing loss).

It was against this background that the remit of this group was set: to try and produce guidelines to allow a more accurate and uniform approach to grading of tinnitus severity.

Definition

There are many definitions of tinnitus but a simple and useful one is as follows: 'Tinnitus is the conscious experience of a

sound that originates in the head or neck, and without voluntary origin obvious to that person'.¹

Aetiology and epidemiology

Tinnitus is a symptom with multiple aetiologies. Perhaps the most comprehensive classification is that provided by Coles² and shown in Fig. 1.

One of the most important works with regard to epidemiology is that of Heller and Bergman³ in which 94% of a group of normal hearing young adults experienced a tinnitus-like perception when placed in a soundproof room. This would imply that the potential to experience some kind of tinnitus is almost universal in very quiet conditions.

The National Study of Hearing (1985) undertaken by the MRC,⁴ and other epidemiological studies^{2,5–10} provide the following information regarding tinnitus in the general population:

1. A third of all adults report having had tinnitus at some time;

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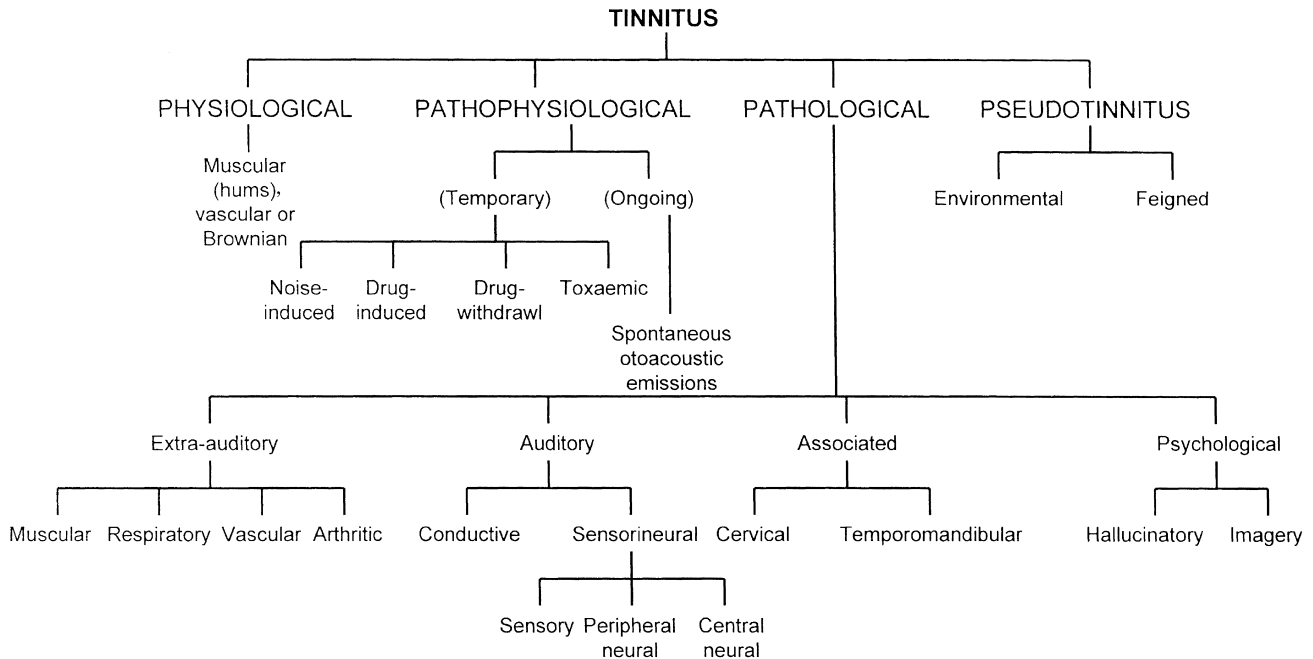


Figure 1. Aetiology of tinnitus.

2. Ten to 15% of adults report prolonged spontaneous tinnitus (lasting longer than 5 min and not immediately following loud noise or oto-toxic drugs);
3. Nearly 5% report troublesome and annoying tinnitus that can affect their ability to get to sleep;
4. 0.5–1% of adults report tinnitus of such severity as to have a significant adverse effect on their quality of life;
5. The prevalence of tinnitus increases in association with a high-frequency hearing loss (although the association between severity of tinnitus and degree of hearing loss is very weak);¹¹
6. Tinnitus annoyance and distress tend to become less with the passage of time;
7. Hyperacusis (as distinct from recruitment) is found as an associated symptom in about 40% of tinnitus sufferers. Hyperacusis can be defined as an undue sensitivity and distress to everyday sounds that would not normally trouble a 'normal-hearing' individual. This symptom too can vary from very mild to severe and is extremely troublesome.

Further useful figures are that approximately 3% of adults will have had a hospital visit for their tinnitus and 8% will have sought medical advice from their GP regarding the condition. It appears less likely that those individuals who have only tinnitus, and no complaint of associated hearing loss, will be referred on to a hospital specialist.² Despite this, it is still probably reasonable to assume that it is the more distressing case that will be referred on for hospital assessment or will seek medical attention in the first place.

In summary, although it would seem that the experience of tinnitus is common, and more so in the presence of a hearing loss, severe tinnitus is fortunately uncommon and, even when troublesome, becomes less so with the passage of time.

Severity grading

OVERVIEW AND PROBLEMS

The first, and probably main problem, with tinnitus is that it is a subjective symptom; there is no objective measure. Attempts have been made previously to match tinnitus in pitch, timbre and intensity, and make the assumption that the characteristics of an external sound can be meaningfully related to those of an internally generated sound. There is a consensus that psychoacoustic tests of this kind give little or no useful information regarding tinnitus severity¹² nor is there any useful relationship between perceived loudness of tinnitus and complaint behaviour.^{13,14}

Even more than the perception, the reaction is subjective. Furthermore, it has become clear in recent years that the 'problem' of tinnitus relates far more to the individual's psychological response to the abnormal tinnitus signal than to the signal itself.

Altered mood state (particularly anxiety and depression) is often associated with tinnitus distress.^{15–17} However, in some cases the altered mood state predates tinnitus onset,¹⁵ making it difficult to know whether tinnitus causes psychological disturbance, or whether psychological disturbance facilitates

the emergence of tinnitus. High levels of anxiety and depression were also found in tinnitus clinic patients using the Crown–Crisp Experiential Index.¹⁴

Hiller and Goebel¹⁶ have concluded that psychiatric disorders are the most severe side-effects resulting from chronic tinnitus. However, the fact that psychiatric disorders do not occur in all individuals with tinnitus suggests that some individuals are more vulnerable than others and that, in these vulnerable patients, the additional stress of tinnitus may result in a psychiatric disorder. These vulnerable individuals may be the ones with pre-existing psychological disturbance.

McKenna¹⁸ reported that 45% of individuals complaining of tinnitus had a psychological disorder (in comparison to 64% of those complaining of vertigo and 27% of those complaining of hearing loss). He also found that tinnitus patients experienced more difficulties in concentration and information processing than hearing loss controls.

Consequently, one might expect an individual's reaction to a potentially challenging stimulus, such as tinnitus, to be influenced by that person's mental robustness and well-being, personality and social stress.¹⁹ This would imply that in assessing tinnitus severity, in fact, one may be grading psychological state as much as tinnitus experience.

Finally, there is the problem of two different requirements for a grading system. On the one hand, a fairly robust, yet simple, scoring system is needed for every day clinical practice and for medico-legal work. On the other hand, a more thorough assessment (perhaps with more increments) is needed for research to assess the results of the various tinnitus treatment strategies. A common system that can address the needs of both would, however, have much to commend it.

SUBJECTIVE MEASURES

Baguley *et al.*²⁰ used a simple system to rate tinnitus in a series of 129 patients pre and post removal of vestibular schwannoma.

- Mild: only perceived when there is no background noise;
- Moderate: perceived over background noise but does not affect sleep;
- Severe: Perceived over background noise, significant effect on sleep with problems getting to sleep or being awakened by tinnitus.

This simple system is derived in part from that of Klockoff and Lindblom:²¹

- Grade I: audible only in silent environments;
- Grade II: audible only in ordinary acoustic environments, but masked by loud environmental sounds; can disturb falling asleep, but not sleep in general;
- Grade III: audible in all acoustic environments, disturbs falling asleep, can disturb sleep in general, and is a dominating problem that affects quality of life.

Glorig (1987, see Shulman)²² proposed a series of questions to quantify the extent to which tinnitus was a problem for the patient. The use of these questions has a fundamental philosophy that 'one must accept the answers of the patient as being truthful and correct in any and all patients claiming compensation or liability' (paraphrased by Shulman). This would be a hard pill to swallow for many familiar with the English legal system.

Thus, one flaw in all the grading systems described above is that they allow the subjective view of a patient, who has catastrophized their tinnitus experience, either due to psychological factors or a desire for compensation, to express that view within the grading system unchecked.

In a summary of 10 tinnitus questionnaires in use since 1983, Sissons²³ reported five main categories of complaint contributing to tinnitus distress. These were:

1. Emotional distress and patient's view of tinnitus;
2. Sleep disturbance;
3. Auditory perceptual difficulties;
4. Interference with work and leisure;
5. Effects on general health.

The most effective way of measuring these variables is to use one of the psychometrically validated questionnaires available. These questionnaires have the advantage over a simple three-point scoring system of being standardized, and having good reliability and validity. These factors should minimize some of the inaccuracy and bias inherent in subjective assessments. Two such questionnaires are the Tinnitus Handicap Inventory (THI)^{24,25} and the Tinnitus Questionnaire (TQ).^{26,27}

The TQ should take 5–15 min to complete. It is suggested that the test be completed with someone present to offer encouragement and simple explanation. Internal consistency is high, as is test–retest variability. Scoring takes 10 min. The test is available, in printed form, from the Psychological Corporation. The questionnaire is copyright and non-photocopiable. As the test was produced in the UK, it is fully anglicized.

The Tinnitus Handicap Inventory (THI) is a 25-item self-report questionnaire that has Functional, Emotional and Catastrophic subscales. It has excellent convergent validity, construct validity and test–retest reliability. The THI takes 10 min to complete and it is suggested that the test be completed with someone present to offer encouragement and simple explanation. Scoring takes 5–10 min with a score of 4 for a 'yes', 2 for 'sometimes' and 0 for 'no'. The test is not copyright and can be reproduced. The test was developed for the USA but does not need modification for the UK.

These two questionnaires aim to measure slightly different aspects of tinnitus experience. Work in progress in Cambridge has utilized both questionnaires in a randomized order of presentation.²⁸ The questionnaires were mailed to the patients before attendance at the Tinnitus Clinic. At the time of

writing, data are available for analysis on 35 patients wherein a correlation between the total TQ and THI scores of 0.641 ($P < 0.0001$) was found. This would seem to indicate, therefore, that there is little to choose between the two questionnaires in terms of results, although there appear to be some slight administrative advantages in using the THI.

OBJECTIVE MEASURES

Unfortunately there are no objective measures of tinnitus severity. However, there may be some more objective surrogate measures of tinnitus severity, for instance GP or hospital attendance. It would certainly be useful to see such confirmatory evidence of a problem.

Of course, an audiogram is not completely objective but does represent a relatively objective measure of hearing status. There might, therefore, be some role for audiometry in the assessment of tinnitus severity, particularly in the light of the increased prevalence of tinnitus in the presence of a high frequency hearing loss.

Suggested grading of tinnitus severity

The use of the Tinnitus Handicap Inventory (THI, see Appendix 1) is recommended for research purposes. It may be useful in a clinical setting but its use is NOT recommended in a medico-legal context for reasons that are detailed in the discussion. The presence or absence of hyperacusis may have relevance to the overall condition of the individual concerned but is irrelevant to the severity of any tinnitus.

- Grade 1 - slight (THI 0–16). Only heard in a quiet environment, very easily masked. No interference with sleep or daily activities.

This grading should cover most people who are experiencing but are not troubled by tinnitus;

- Grade 2 - mild (THI 18–36). Easily masked by environmental sounds and easily forgotten with activities. May occasionally interfere with sleep but not daily activities;
- Grade 3 - moderate (THI 38–56). May be noticed, even in the presence of background or environmental noise, although daily activities may still be performed. Less noticeable when concentrating. Not infrequently interferes with sleep and quiet activities.

The majority of people suffering tinnitus should fall into Grades 2 and 3;

- Grade 4 - severe (THI 58–76). Almost always heard, rarely, if ever, masked. Leads to disturbed sleep pattern and can interfere with ability to carry out normal daily activities. Quiet activities affected adversely. There should be documentary evidence of the complaint having been brought to the general (or some other) medical practitioner (prior to any medico-legal claim). Hearing loss is likely to be present but its presence is not essential. Given the

epidemiological data, grading in this group should be uncommon;

- Grade 5 - catastrophic (THI 78–100). All tinnitus symptoms at level of severe or worse. Should be documented evidence of medical consultation. Hearing loss is likely to be present but its presence is not essential. Associated psychological problems are likely to be found in hospital or general practitioner records. Given the epidemiological data, grading in this group should be extremely rare.

Discussion

As has become clear throughout this document, the biggest problem facing any attempt to grade tinnitus severity is the lack of any objective measure. We have, therefore, tried to take the known epidemiological and clinical data and combine that with our own clinical, medico-legal and research experience to produce a severity scale that we hope will have some practical validity and value. Clearly, the best way to test this grading system is with use and the best endorsement will be its use.

It is, of course, axiomatic of good practice that all questions are asked in an open fashion; more store being placed on volunteered information than that provided by leading questions. Symptoms should appear in an appropriate chronological fashion. It must be emphasized that the whole history must 'hang together', with the tinnitus having a place, both chronologically and in severity, that makes clinical sense. This aspect of the examination is really only gained by experience. A skilled practitioner will just get a 'feel' for the whole picture.

Hyperacusis has been found as an additional symptom in approximately 40% of tinnitus sufferers. It is probable that it shares, as its cause, an undue sensitivity of the auditory pathways. It was not within our remit to grade the severity of hyperacusis and so we have not addressed this issue. Although the presence of this additional symptom may adversely affect the individual's overall condition, it has no impact on the assessment or severity of tinnitus and so should be addressed separately.

It is probable that an additional severity scoring system may be required for hyperacusis but, as it seems a relatively new symptom in clinical consciousness, perhaps the passage of a little more time and consequently more experience of it will prove beneficial.

It is improbable that the use of the THI would present problems in the research arena. However, its use in the medico-legal context is fraught with risk. It risks 'leading' the claimant and there is a widespread feeling that it might encourage exaggeration. Whether it finds regular use in a more general clinical setting would remain to be seen. Certainly, there would be some merit in investigating whether the 'clinical' part of the grading system matches up with the

THI scores; the figures chosen were taken from the analysis by Newman *et al.* of their THI.²⁵ There is, of course, some debate as to whether the UK-based tinnitus questionnaire²⁷ may be a better choice than the US-based THI. Current work on this²⁸ would indicate that there is little to choose between the two tests and there are certainly some administrative advantages in using the THI, in terms of reproduction and copyright, hence our choice.

There is increasing research evidence of a psychological vulnerability towards the development of tinnitus.^{29,30} Evidence of this vulnerability can be found from examination of the subject's medical records and from a variety of psychological profile questionnaires. However, although they may demonstrate a propensity towards development of the condition, they do not predict the experience of severity and so we have chosen not to include them in these guidelines.

With regard to our 'objective' measures, we have really focused on two areas. The first is the value of an associated hearing loss. We are, in no way, suggesting that the presence of a hearing loss be required to allow an individual to be graded as severe. However, there is no escaping the epidemiological data that indicates that the prevalence of tinnitus increases with an increasing high frequency hearing loss. In other words, in the presence of a high frequency hearing loss, a parallel complaint of tinnitus is more probable. There is, in addition, some evidence that in the presence of a significant hearing loss, tinnitus severity tends to be greater.¹¹

Our second thrust has been the presence in the medical notes of a complaint of tinnitus. Again, this is not essential to allow a 'severe' grading; there are, of course, many reasons why an individual should fail to seek medical help for the problem. However, there is evidence to support the fact that most individuals with distressing tinnitus will seek medical help.⁶

Once again, these factors really need to be seen in context of the subject and his complaint; for the examiner, the findings must all hang together to allow a reliable severity grading.

Finally, given the epidemiological data available to us, it can be appreciated that tinnitus is not often a severe problem and for this reason the majority of sufferers should be found in Grades 2 and 3. A grading of 4 should be uncommon and a grading of 5 should be very rare. A Grade 1 score reflects an experience of tinnitus without any distress. The aetiology is irrelevant to the actual severity of the tinnitus. This document refers to adults and not children.

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Appendix 1. Tinnitus handicap inventory

NAME _____
HOSPITAL NO _____

DATE _____

Instructions: The purpose of these questions is to identify problems your tinnitus may be causing you. Please answer 'yes', 'no' or 'sometimes' to each question.

F1) Because of your tinnitus is it difficult for you to concentrate?	YES	NO	SOMETIMES
F2) Does the loudness of your tinnitus make it difficult for you to hear people?	YES	NO	SOMETIMES
E3) Does your tinnitus make you angry?	YES	NO	SOMETIMES
F4) Does your tinnitus make you confused?	YES	NO	SOMETIMES
C5) Because of your tinnitus are you desperate?	YES	NO	SOMETIMES
E6) Do you complain a great deal about your tinnitus?	YES	NO	SOMETIMES
F7) Because of your tinnitus do you have trouble falling to sleep at night?	YES	NO	SOMETIMES
C8) Do you feel as though you cannot escape your tinnitus?	YES	NO	SOMETIMES
F9) Does your tinnitus interfere with your ability to enjoy social activities (such as going out to dinner, to the cinema)?	YES	NO	SOMETIMES
E10) Because of your tinnitus do you feel frustrated?	YES	NO	SOMETIMES
C11) Because of your tinnitus do you feel that you have a terrible disease	YES	NO	SOMETIMES
F12) Does your tinnitus make it difficult to enjoy life?	YES	NO	SOMETIMES
F13) Does your tinnitus interfere with your job or household responsibilities?	YES	NO	SOMETIMES
F14) Because of your tinnitus do you find that you are often irritable?	YES	NO	SOMETIMES
F15) Because of your tinnitus is it difficult for you to read?	YES	NO	SOMETIMES
E16) Does your tinnitus make you upset?	YES	NO	SOMETIMES
E17) Do you feel that your tinnitus has placed stress on your relationships with members of your family and friends	YES	NO	SOMETIMES
F18) Do you find it difficult to focus your attention away from your tinnitus and on to other things?	YES	NO	SOMETIMES
C19) Do you feel that you have no control over your tinnitus?	YES	NO	SOMETIMES
F20) Because of your tinnitus do you often feel tired?	YES	NO	SOMETIMES
E21) Because of your tinnitus do you feel depressed?	YES	NO	SOMETIMES
E22) Does your tinnitus make you feel anxious?	YES	NO	SOMETIMES
C23) Do you feel you can no longer cope with your tinnitus?	YES	NO	SOMETIMES
F24) Does your tinnitus get worse when you are under stress?	YES	NO	SOMETIMES
E25) Does your tinnitus make you feel insecure?	YES	NO	SOMETIMES