Risk Factors for Early Childhood Hearing Loss

Guidelines for Infants who Pass Newborn Hearing Screening

Minnesota Newborn Screening program

Joint Committee on Infant Hearing (JCIH) Year 2019 Position Statement: Principles and Guidelines for Early Hearing Detection and Intervention—Table 1

	Risk Factor Classification	Recommended Diagnostic Follow-up	Monitoring Frequency
	PERINATAL		
1	Family history* of early, progressive, or delayed onset permanent childhood hearing loss	by 9 months	Based on etiology of family hearing loss and caregiver concern
2	Neonatal intensive care of more than 5 days	by 9 months	As per concerns of on-going surveillance of hearing skills and speech milestones
3	Hyperbilirubinemia with exchange transfusion regardless of length of stay	by 9 months	
4	Aminoglycoside administration for more than 5 days**	by 9 months	
5	Asphyxia or Hypoxic Ischemic Encephalopathy	by 9 months	
6	Extracorporeal membrane oxygenation (ECMO)*	No later than 3 months after occurrence	Every 12 months to school age or at shorter intervals based on concerns of parent or provider
7	In utero infections, such as herpes, rubella, syphilis, and toxoplasmosis	by 9 months	As per concerns of on-going surveillance
	In utero infection with cytomegalovirus*	No later than 3 months after occurrence	Every 12 months to age 3 or at shorter intervals based on parent/ provider concerns
	Mother + Zika and infant with no laboratory evidence and no clinical findings	Standard surveillance	As per AAP (2017) Periodicity schedule
	Mother + Zika and infant with laboratory evidence of Zika +clinical findings	AABR by 1 month	ABR by 4-6 months or VRA (Visual Reinforcement Audiometry) by 9 months
	Mother + Zika and infant with laboratory evidence of Zika -clinical findings	AABR by 1 month	ABR by 4-6 months Monitor as per AAP (2017) Periodicity schedule (Adebanjo et al., 2017)

Additional details about each risk factor is included on pages 29-31 of the JCIH 2019 Position Statement
Note: AAP = American Academy of Pediatrics; ABR = auditory brainstem response; AABR = automated auditory brainstem response
**Infants at increased risk of delayed onset or progressive hearing loss*
**Infants with toxic levels or with a known genetic susceptibility remain at risk
***Syndromes (Van Camp & Smith, 2016)
****Parental/caregiver concern should always prompt further evaluation

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	Risk Factor Classification	Recommended Diagnostic Follow-up	Monitoring Frequency
	PERINATAL		
8	Certain birth conditions or findings: • Craniofacial malformations including: microtia/atresia, ear dysplasia, oral facial clefting, white forelock, and microphthalmia • Congenital microcephaly, congenital or acquired hydrocephalus • Temporal bone abnormalities	by 9 months	As per concerns of on-going surveillance of hearing skills and speech milestones
9	Over 400 syndromes have been identified with atypical hearing thresholds***. For more information, visit the Hereditary Hearing Loss website (Van Camp & Smith, 2016)	by 9 months	According to natural history of syndrome or concerns
	PERINATAL OR POSTNATAL		
10	Culture-positive infections associated with sensorineural hearing loss,*** including confirmed bacterial and viral (especially herpes viruses and varicella) meningitis or encephalitis	No later than 3 months after occurrence	Every 12 months to school age or at shorter intervals based on concerns of parent or provider
11	Events associated with hearing loss: • Significant head trauma especially basal skull/temporal bone fractures • Chemotherapy	No later than 3 months after occurrence	According to findings and or continued concern
12	Caregiver concern**** regarding hearing, speech, language, developmental delay and/or developmental regression	Immediate referral	According to findings and or continued concern

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