Role of the Pediatrician/Primary Care Provider

The pediatrician or other primary care provider is responsible for monitoring the general health, development, and well-being of the infant. The PCP plays an important role in monitoring birth hearing screening outcomes and ensuring follow-up with rescreening and audiologic diagnostic evaluation when indicated. The PCP is part of the team that ensures that the audiologic and medical assessment is conducted in a timely fashion for infants who do not pass screening. Rescreening guidelines are available on the American Academy of Pediatrics EHDI website in addition to other resources (AAP, 2010; AAP, 2014a, 2014b; AAP Committee, 2017). For all infants suspected or confirmed to be deaf or hard of hearing, the PCP must partner with other specialists, particularly the otolaryngologist, audiologist, geneticist/ genetics counselor, and early intervention specialist to facilitate coordinated and comprehensive care for the infant and family. In 2010, AAP developed the medical-home algorithm (guidelines) for management of infants suspected or confirmed as deaf or hard of hearing (see https://tinyurl.com/y5zzowco).

Middle-ear status should be monitored by the PCP, because the presence of middle-ear effusion has the potential to delay diagnosis of hearing and can further compromise hearing. Surveillance of both middle ear status and developmental milestones is recommended, regardless of the infant's birth hearing screening results or hearing threshold levels (Rosenfeld et al., 2013). Prompt specialty referrals should follow when new or delayed-onset conditions are suspected (Gracey, 2003). Because approximately forty percent of children confirmed as deaf or hard of hearing will demonstrate additional conditions or delays such as autism, blindness, learning differences, genetic syndromes, et cetera, health care providers have an important role in confirming that these children are receiving comprehensive services (Roizen et al., 2014). Regardless of the newborn hearing screening results, the pediatrician or PCP should review every infant's medical and family history for the presence of known risk indicators that require monitoring for delayed- onset or progressive hearing loss (see Table 1). The PCP should also ensure that an audiologic evaluation is completed for these children as recommended (Coenraad, Goedegebure, van Goudoever, & Hoeve, 2010; Fligor, Neault, Mullen, Feldman, & Jones, 2005; Fowler, 2013; Nance, Lim, & Dodson, 2006). In addition, the PCP is responsible for ongoing surveillance of family concerns about speech, language, hearing, auditory skills, and developmental milestones of all infants and children regardless of risk status, as outlined in the pediatric periodicity schedule published by the American Academy of Pediatrics (AAP Committee, 2017).

A growing body of research indicates that children who receive cochlear implants (CI) are at increased risk for developing bacterial meningitis over the general population (Biernath et al., 2006; Gluth, Singh, & Atlas, 2011; Melton & Backous, 2011; Parner et al., 2007). Historically, cochlear implant devices that specifically involved a separate electrode positioner appeared to confer a much higher risk of meningitis over other devices, but have since been eliminated from the market. Starting in 2002, the CDC established guidelines for additional immunization against bacterial meningitis in children with cochlear implants, to be implemented in addition to already-established routine prophylactic vaccinations recommended for all children. The current recommendations of the CDC and FDA vaccine programs are available on the CDC website (CDC, 2016b).