In this age of electrophysiological techniques for identifying hearing loss in children of virtually any age, it is perhaps worthwhile to remind our younger colleagues of the incredible changes wrought by those dedicated professionals who literally fought, over many years, for universal hearing screening of the newborn. Fifty years ago the diagnosis of hearing loss in children was a very different playing field. The most common complaint impelling parents to seek help was “not talking,” that is, failure to develop speech and language at an appropriate age. Many parents waited until the child was three to four years old before deciding that something might be wrong. Valuable years for speech and language acquisition were gone forever. Pediatric audiometry was in its infancy; pure-tone testing of two and three year olds was often an exercise in futility. Over the years many behavioral techniques were suggested but reliably successful testing of children less than two years old has always been elusive.

Yet a small cadre of dedicated audiologists never lost sight of the ultimate goal, identifying hearing loss at the earliest possible age in order to assure the development of adequate speech, language, and cognitive skills. They were unwavering in their determination that every newborn child should be screened for hearing loss. It seemed an impossible dream until the advent of ABR and otoacoustic emissions raised hope that the goal might actually be achieved. Finally, in 1993, the National Institute on Deafness and Communicative Disorders (NIDCD) convened a Consensus Symposium that endorsed universal infant screening for hearing loss and recommended a two-stage screening process in which all newborns are screened by otoacoustic emissions and failures are followed up by ABR. With this impetus, state after state implemented an infant screening program. Today there are mandated screening programs in every state and the District of Columbia.

But one persistent question has remained unanswered. Does universal screening actually reduce the age at which hearing loss is detected and intervention initiated? In this issue of JAAA, authors Yvonne Sininger, Amy Martinez, Laurie Eisenberg, Elizabeth Christensen, Alison Grimes, and Jasmine Hu present results of a survey addressing that very question. By taking advantage of the staggered start-up of screening programs in California between 2002 and 2005, the investigators were able to identify a cohort of 63 infants and toddlers, all of whom had verified hearing loss, but some of whom had been screened and some of whom had not. This permitted them to ask the question “In the children who had been screened, was diagnosis and intervention in fact earlier than in the children who had not been screened?” Results showed that, when compared to children who had not been screened, children who had been screened were diagnosed an average of 24.6 months earlier, fitted with amplification 23.5 months earlier, and enrolled in early intervention programs 20 months earlier.

These results offer an impressive answer to those opponents of infant screening who have insisted, among other objections, that there was no evidence that universal infant screening would, in fact, result in earlier identification and intervention for children with hearing loss. Investigator Sininger and her colleagues are to be congratulated for adding one more important datum to the growing body of support for the concept of universal infant screening for hearing loss.

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