Tinnitus: assessment and management

Consultation on draft guideline - Stakeholder comments table
20/09/2019 to 01/11/2019

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Stakeholder	Document	Page No	Line No	Comments Please insert each new comment in a new row	Developer's response Please respond to each comment
Action on Hearing Loss	Guideline	003	004	**We welcome the recommendation that tinnitus support should be given at <u>all stages of care</u>.** Tinnitus can be distressing and it is vital that the right support is available at every stage of the pathway. This is especially important for primary care settings where most people receive tinnitus support and management. The primary outcome is habituation to the tinnitus sound; some people will successfully habituate after the first appointment with their GP after educational support and reassurance.[56] Many people will need onward referral and again, it is vital that the correct educational support is given at each stage of care. Furthermore it is regarded as good, patient-centred practice to engage and inform someone at all stages of their care as stated in NICE's Your Care.[1] We would encourage the committee to consider making recommendations for some services to be available for those who cannot access health care, such as those in care homes. We would also encourage the committee to consider making a research recommendation for parts of tinnitus education and support to be delivered outside of a traditional health care setting. <u>Question 1</u>: GPs are usually first point of contact therefore resources for re-education on tinnitus pathology and management would be appropriate and welcome. Furthermore additional education on the tinnitus pathway both nationally and locally is essential to understand what is available to patients whose tinnitus needs further support. <u>Question 2</u>: There may be some cost implications for training and education of all clinicians. However those who successfully habituate	Thank you for your comment. Recommendations are applicable to all settings where NHS healthcare is provided, and this would include care homes, therefore separate recommendations are not required. Question 1 and 2: Thank you for your response. The committee appreciate the importance of tinnitus support and believe the emphasis the guideline is placing on a two-way process of information-giving and discussion between the clinician and a person with tinnitus is implementable without specific training courses for staff. Question 3: Thank you for your response. We will pass this information to our resource endorsement team. The guideline development team checked the references provided within your comment. The references are not suitable for inclusion within in the relevant evidence review due to incorrect study design/article type (guidance, guideline,

[1] NICE. Your Care. Available at: https://www.nice.org.uk/about/nice-communities/nice-and-the-public/public-involvement/making-decisions-about-your-care/your-care [Accessed 21/10/2019]

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20/09/2019 to 01/11/2019

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				after educational tinnitus support in primary care incur the smallest costs.[2] So emphasizing training could be cost effective in the long term. Question 3: Resources that would be helpful to GPs would be: the Tinnitus Guidance for GPs developed by the BTA[3] and the BSA practice guidance for tinnitus (currently under consultation).[4] A further useful resource would be the multidisciplinary European Guideline for tinnitus.[5]	
Action on Hearing Loss	Guideline	003	015	**We welcome recommendation 1.1.2 that people with tinnitus should be reassured at first point of contact with a healthcare professional.** The onset of tinnitus can be distressing and worrying.[6] Many people seek help from their general practitioner when they first notice tinnitus, and for almost half this is within the first 3 months of symptom onset.[7] An unhelpful or dismissive response at this first point of contact has been shown to negatively affect treatment outcomes.[3] There is evidence to suggest that some healthcare professionals are unhelpful when someone seeks support for tinnitus.[2][8] This is	Thank you for your comment. The committee agree it is important that healthcare professionals provide support and information to patients and appropriate onward referrals are made when needed. The papers referenced were checked by the guideline development team, all studies were not includable due to inappropriate study design/article type (narrative review or patient survey).

[2] Stockdale D, McFerran D, Brazier P, Pritchard C, Kay T, Dowrick C, & Hoare DJ (2017). An economic evaluation of the healthcare cost of tinnitus management in the UK. BMC health services research, 17(1), 577.
[3] British Tinnitus Association 2017 Tinnitus Guidance for GPs. Available at: https://www.tinnitus.org.uk/Handlers/Download.ashx?IDMF=b1389d8f-78eb-4794-b58f-c24fb21a489c [Accessed 21/10/2019].
[4] British Society of Audiology (2018) Draft Practice Guidance: Tinnitus in adults. Available at: http://www.thebsa.org.uk/wp-content/uploads/2019/09/Practice-Guidance_Tinnitus-in-Adults_for-member-consultation_30AUG2019.pdf [Accessed 21/10/2019]
[5] Cima, R.F.F., Mazurek, B., Haider, H. et al. HNO (2019) 67(Suppl 1): 10.
[6] Baguley D, McFerran D & Hall D, 2013. Tinnitus. The Lancet, Volume 382, Issue 9904, 1600 – 1607.
[7] McFerran D, Hoare DJ, Carr S, Ray J & Stockdale D, 2018. Tinnitus Services in the United Kingdom: a survey of patient experiences. BMC Health Services Research, 18, 110.
[8] Wray N, Broomhead E & Stockdale D, 2017. General Practitioner support for tinnitus - a survey of patient experience. Journal of Hearing Science . 7(2): 167-167; RNID, 2010. What's that noise? A profile of personal and professional experience of tinnitus in NI. Available at: https://www.actiononhearingloss.org.uk/about-us/our-research-and-evidence/research-reports/what-s-that-noise-report/. [Accessed 21/10/2019].

Tinnitus: assessment and management

Consultation on draft guideline - Stakeholder comments table
20/09/2019 to 01/11/2019

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Stakeholder	Document	Page No	Line No	Comments Please insert each new comment in a new row	Developer's response Please respond to each comment
				particularly prevalent among GPs, as they are often the first point of contact in the tinnitus pathway.[2] People have been told that they should "learn to live with it" and that there is "no cure".[9] This is possibly due to general lack of awareness and knowledge around the condition, and that there is no clinically proven drug treatment.[10] Furthermore, we have received reports that there is a lack of support in secondary care audiology and/or ENT, often resulting in discharge from the service when all options have been exhausted. There is also evidence that when discharged from secondary care, patients often return to their GP and re-enter the pathway within a short timeframe, resulting in unsatisfactory "revolving door" healthcare.[2] If there is a lack of awareness among GPs this can lead to barriers to referral for the tinnitus pathway. Research has shown that just over half of people are referred to secondary care after their first GP appointment. This figure improves to just over three quarters of people referred after 2 GP appointments. However around a fifth see their GP 3 times before being referred to secondary care.[7]	
Action on Hearing Loss	Guideline	003	017 - 020	**We would encourage the committee to include further positive statements within the recommendations for reassurance.** We agree that talking about tinnitus in a positive way is necessary however we feel the recommendation needs examples of specific positive statements beyond the word "reassurance". Giving positive reassurance should also be dependent on the person's experience of tinnitus. While many people will be experiencing mild tinnitus, those experiencing distressing tinnitus could see reassurance as patronising	Thank you for your comment. This recommendation has been amended to be more positive and reassuring for people with tinnitus. However, the committee agreed that specific statements within the recommendations are not necessary. The guideline development team checked the reference provided within your comment. The study was not suitable for inclusion within this evidence review due to inappropriate study design/article type (guidance)

[9] Newman CW, Sandridge SA, Bea SM, Cherian K, Cherian N, Kahn KM & Kaltenbach J. 2011. Tinnitus: Patients do not have to 'just live with it'. Cleveland Clinic Journal of Medicine. 78(5).
[10] McFerran DJ, Stockdale D, Holme R, Large CH & Baguley DM, 2019. Why Is There No Cure for Tinnitus? Front. Neurosci. 13:802.

Tinnitus: assessment and management

Consultation on draft guideline - Stakeholder comments table
20/09/2019 to 01/11/2019

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Stakeholder	Document	Page No	Line No	Comments Please insert each new comment in a new row	Developer's response Please respond to each comment
				and unhelpful. Furthermore, the statements in the recommendation could be in a positive or negative manner, depending on how the clinician says them. In some ways, the recommendation on line 19 could be delivered in a similar manner to the statement that "you will have to learn to live with it". We would ask the committee to consider including specific positive statements in the recommendation such as "Most tinnitus naturally lessens or disappears with time" as recommended by the BTA.[11]	
Action on Hearing Loss	Guideline	004	001	**We welcome recommendation 1.1.3 that <u>information</u> about tinnitus should be given at all stages of care.** Appropriate and timely information about tinnitus is vital in understanding the condition. Many people find information about it reassuring and this is what they seek when they first make contact with a healthcare professional. Providing timely accurate and tailored information is therefore critical to the outcomes of an individual. There is considerable heterogeneity between peoples' experience of tinnitus but also its pathology, and this should be taken into consideration when giving information. For example someone with tinnitus that is associated with age-related hearing loss may have very different needs to someone who has tinnitus as a result of ototoxic chemotherapy.	Thank you for your comment.
Action on	Guideline	004	001	**We would urge the committee to include clear recommendations**	Thank you for your comment. We haven't reviewed evidence for

[11] British Tinnitus Association 2017 Tinnitus Guidance for GPs. Available at: https://www.tinnitus.org.uk/Handlers/Download.ashx?IDMF=b1389d8f-78eb-4794-b58f-c24fb21a489c [Accessed 21/10/2019].

Tinnitus: assessment and management

Consultation on draft guideline - Stakeholder comments table
20/09/2019 to 01/11/2019

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Hearing Loss				**on information about medication for tinnitus, including other strategies someone might try without medical advice where there is little evidence or the potential to cause harm.** There is no clinically proven drug treatment for tinnitus[12] however many people are prescribed medication to help alleviate the symptoms, this is most commonly in primary care.[13] Anecdotally, some people even try supplements, vitamins or dietary changes to alleviate symptoms without seeking prior medical advice. We would urge the committee to make recommendations for clear information about strategies where there is little evidence for effectiveness such as drug treatment for tinnitus, including information about risks of over the counter medication and/or complementary and alternative therapies.[14]	alternative drug treatments, as they are not included in scope. Betahistine was reviewed in the guideline. The committee acknowledges that there is no clinical benefit associated with the use of betahistine and there is some indication of harm with side effects. The committee recommend that it should not be offered to people with tinnitus: this recommendation has been amended to add clarity. The committee have highlighted in the rationale and impact section associated with the betahistine recommendation that there are currently no drug treatments licensed for tinnitus alone.
Action on Hearing Loss	Guideline	004	005	**We would encourage the committee to include specific recommendations for information about preventative measures people can take to stop their tinnitus and getting worse.** We agree that this is important for people to be informed of what can happen in the future regarding their tinnitus. However there needs to be more clarity when the guideline refers to "exposure to loud noise". The committee should consider including a separate point that encourages safe listening habits to prevent further exacerbation or worsening of tinnitus as well as the risk of noise-induced hearing loss.	Thank you for your comment. The committee agree with your comment, this recommendation has been amended and "safe listening practices" is now listed as an information point for people with tinnitus.

[12] McFerran DJ, Stockdale D, Holme R, Large CH & Baguley DM, 2019. Why Is There No Cure for Tinnitus? Front. Neurosci. 13:802.
[13] McFerran D, Hoare DJ, Carr S, Ray J & Stockdale D, 2018. Tinnitus Services in the United Kingdom: a survey of patient experiences. BMC Health Services Research, 18, 110.
[14] Enrico P, Sirca D & Mereu M (2007) Antioxidants, minerals, vitamins, and herbal remedies in tinnitus therapy. Prog Brain Res, 166:323-30.; Vendra V, Vaisbuch Y, Mudry AC & Jackler RK (2019) Over-the-Counter Tinnitus "Cures": Marketers' Promises Do Not Ring True. Laryngoscope, 129(8): 1898-1906.

Tinnitus: assessment and management

Consultation on draft guideline - Stakeholder comments table
20/09/2019 to 01/11/2019

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Stakeholder	Document	Page No	Line No	Comments Please insert each new comment in a new row	Developer's response Please respond to each comment
				Exposure to loud sounds can be safe depending on the sound pressure level and length of exposure time but some people find their tinnitus can be temporarily increased as a result. This can be distressing but usually subsides and does not cause permanent hearing damage. Prolonged exposure to excessively loud sound can cause damage to the auditory system.[15] This results in noise induced hearing loss which is associated with tinnitus. We therefore urge the committee to include recommendations for information about prevention measures encouraging "safe listening practice".	
Action on Hearing Loss	Guideline	004	016	**We would encourage the committee to include deafness in the list of accessibility requirements.** People with profound deafness and hearing loss can experience tinnitus.[16] d/Deaf people will have very different accessibility requirements to those with hearing loss. If their first language is BSL they will need to have information that can be accessed in this way, for example via an interpreter or video in line with the Accessible Information Standard.[17]	Thank you for your comment. People with profound deafness and hearing loss have been added to the equality impact assessment. Three research recommendations have also been added for this population, proposing the evaluation of tinnitus questionnaires, psychological therapies and amplification devices. The NICE patient experience guideline (CG138), is cross-referred to in this guideline. CG138 covers the use of sign language for those who are d/Deaf.
Action on Hearing Loss	Guideline	004	020	**We would urge the committee to include a recommendation for physical examination and clinical history taking.** We feel that the committee should include explicit recommendations for history taking and physical examination including otoscopy, as	Thank you for your comment. The committee agree that physical examination and clinical history taking is important. However, how physical examinations and clinical history-taking should be conducted is not in the scope of this guideline, and recommendations cannot be made.

[15] WHO, 2015. Make Listening Safe. Available at: https://www.who.int/pbd/deafness/activities/MLS_Brochure_English_lowres_for_web.pdf [Accessed 21/10/2019].
[16] Ng ZY, Archbold S, Harrigan S & Mulla I, 2015. Conspiring together: tinnitus and hearing loss. Available at: https://www.tinnitus.org.uk/Handlers/Download.ashx?IDMF=0ee4755c-c670-4ede-85f5-d7a9391628e3 [Accessed 21/10/2019].
[17] NHS England, 2016. Accessible Information Standard. Available at: https://www.england.nhs.uk/ourwork/accessibleinfo/. [Accessed 21/10/2019]

Tinnitus: assessment and management

Consultation on draft guideline - Stakeholder comments table
20/09/2019 to 01/11/2019

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				temporary occlusion of the ear canal or middle ear pathology have been shown to be associated with tinnitus.[18] Furthermore, assessment and management of wax and outer ear infection can be carried out exclusively in primary care and a recommendation will therefore reduce unnecessary referrals to secondary care for management.	
Action on Hearing Loss	Guideline	004	022	**We welcome the recommendations to refer certain signs and symptoms more urgently to encourage timely referrals, however we believe there have been some omissions from recommendation 1.2.1** We recommend the committee includes the following criteria for onward referral in recommendation 1.2.1: • Sudden onset pulsatile tinnitus and severe vertigo should be included under "sudden onset of significant neurological symptoms or signs alongside facial weakness" (line 26). The sudden onset of the symptoms is critical and could be indicative of cerebrovascular disease or neoplasm.[19] • As vertigo and pulsatile tinnitus are listed in recommendations 1.2.2 and 1.2.3 respectively, we believe it is important to make the distinction with sudden onset and urgency of referral, to avoid an emergency referral mistakenly graded as routine. Tinnitus associated with head trauma should be referred urgently.[20]	Thank you for your comment. For sudden onset of significant neurological symptoms or signs (for example, facial weakness or vertigo), the suspected neurological conditions guideline has been cross-referenced for further guidance, as have acute uncontrolled vestibular conditions such as vertigo, and is now within the refer immediately category. . The committee agreed that significant symptoms associated with head trauma would be neurological and covered within this recommendation. Where there is overlap with the hearing loss guideline the recommendations have been revised to ensure there is consistency between the two guidelines.
Action on Hearing Loss	Guideline	004	025	**We welcome the recommendation to urgently refer those with tinnitus associated with high risk of suicide**	Thank you for your comment and response to the query.

[18] Baracca G, Del Bo L & Ambrosetti U, 2011. Tinnitus and Hearing Loss. In: Møller AR, Langguth B, De Ridder D & Kleinjung T. (eds) Textbook of Tinnitus. Springer, New York, NY
[19] NICE Clinical Knowledge Summaries, 2017. Tinnitus: management. Available at: https://cks.nice.org.uk/tinnitus#!scenario [Accessed 21/10/2019].
[20] British Society of Audiology (2018) Draft Practice Guidance: Tinnitus in adults. Available at: http://www.thebsa.org.uk/wp-content/uploads/2019/09/Practice-Guidance_Tinnitus-in-Adults_for-member-consultation_30AUG2019.pdf [Accessed 21/10/2019]

Tinnitus: assessment and management

Consultation on draft guideline - Stakeholder comments table
20/09/2019 to 01/11/2019

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				Tinnitus can be associated with mental ill-health which, when severe, can be linked to suicidal ideation. A recent literature review concluded that suicidal ideation is complex and it is not feasible to link solely to tinnitus.[21] However case reports and anecdotal evidence do demonstrate that suicidal ideation can occur within any stage of the tinnitus pathway, therefore clinicians need to be vigilant to the signs of it. The guideline will help provide more clarity for those concerned about onward referral of someone with tinnitus at high risk of suicide. Question 1: Additional training will be required for all clinicians in contact with tinnitus patients to recognise the signs of suicidal ideation and be aware of the referral pathways in place. There will need to be particular emphasis for audiologists who are likely to spend the most time with these patients but do not have extensive training in recognising signs of mental ill-health including suicidal ideation.	
Action on Hearing Loss	Guideline	004	028	**We welcome the recommendation to urgently refer those with tinnitus associated with sudden onset hearing loss (in line with the NICE guideline for hearing loss)** Anecdotally, we have received some reports from individuals of delayed treatment for sudden onset hearing loss because it was believed that the underlying cause was a common cold or flu causing congestion. Subsequently, the issue was not treated urgently and the individual was later diagnosed with sensorineural hearing loss. We hope that this recommendation will raise awareness among referring clinicians of the urgency to refer those with sudden onset hearing loss which could be associated with sudden onset tinnitus.	Thank you for your comment.

[21] Szibor A, Mäkitie A, & Aarnisalo AA (2019). Tinnitus and suicide: An unresolved relation. *Audiology research*, 9(1), 222.

Tinnitus: assessment and management

Consultation on draft guideline - Stakeholder comments table
20/09/2019 to 01/11/2019

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Stakeholder	Document	Page No	Line No	Comments Please insert each new comment in a new row	Developer's response Please respond to each comment
Action on Hearing Loss	Guideline	005	001	**We welcome the recommendations to refer certain signs and symptoms more urgently to encourage timely referrals, however we believe there have been some omissions from recommendation 1.2.2** <u>Recommendation 1.2.2</u> • distress affecting mental well-being (including distress that limits their daily activities) despite receiving tinnitus support at first point of contact with primary or community care services Within this recommendation we request that sleep is included as a specific "daily activity". We welcome recommendation 1.2.12 however this refers to assessment of sleep in secondary care. Patients with inadequate sleep identified in secondary care assessment will usually be referred back to their GP for management, therefore sleep should be discussed in primary care to encourage timely referrals to appropriate sleep services.	Thank you for your comment. The committee have now highlighted that sleep is a daily activity that is relevant for this recommendation within the rationale and impact section of the recommendation. The heading for recommendation has been edited, so that general practice is not excluded from doing sleep assessments in people with tinnitus.
Action on Hearing Loss	Guideline	005	005	**We would encourage the committee to remove the phrase "despite receiving tinnitus support at first point of contact" in recommendation 1.2.2** There is a possibility that "at first point of contact" could be misinterpreted by some clinicians, to the extent that people who need urgent onward referral for tinnitus distress are given tinnitus support in primary care and then advised watchful waiting. We feel that this is too lenient, if someone is experiencing distress that is limiting their daily activities, this should warrant urgent referral to secondary care whether they have received tinnitus support at first point of contact or not. Many people will need to be referred onwards at the first appointment but leaving this open to interpretation could mean that some clinicians	Thank you for your comment. For many people presenting with tinnitus, information on tinnitus, advice about managing their tinnitus is frequently sufficient. The committee notes that if people with tinnitus are given appropriate information at the first point of contact (usually the GP) and received appropriate reassurance and management, this can address many of the individual's concerns and the tinnitus may not escalate. Any person with tinnitus who is distressed after this input should be referred on.

Tinnitus: assessment and management

Consultation on draft guideline - Stakeholder comments table
20/09/2019 to 01/11/2019

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				will think they only have to refer in extreme circumstances, such as tinnitus associated with high risk of suicide. This could effectively create a barrier to accessing tinnitus services. A study by McFerran *et al.* (2018) showed that only 55.4% of people were referred to secondary care after their first GP appointment.[22] Therefore we are concerned that misinterpretation of these recommendations could cause increased barriers to referral and therefore delayed management. For many people tinnitus support is appropriate and adequate when delivered positively and sensitively but there are exceptions where tinnitus support in primary care is not sufficient and timely onward referral is essential.	
Action on Hearing Loss	Guideline	005	011	**We urge the committee to include clarity on referral timeframe for recommendation 1.2.3.** Recommendations 1.2.1 and 1.2.2 both state a referral timeframe. There should also be a referral timeframe for recommendation 1.2.3. Furthermore, the first points of recommendations 1.2.2 and 1.2.3, referring to tinnitus distress and annoyance, could depend on the clinician's interpretation of them. Therefore it is important that there is a recommended timeframe to avoid people who need an urgent referral being inappropriately referred as a routine case and waiting for an unspecified length of time.	Thank you for your comment. The committee noted that the recommendation is related to routine referrals and therefore specific timeframes cannot be provided Routine referrals are dependent on local services and recommendations should be followed in line with local pathways. The committee also noted that the NHS Constitution sets out that patients should wait no longer than 18 weeks from GP referral to treatment. The committee recognised the risk of inappropriate routine referrals for people who are distressed by their tinnitus, but agreed that it should be noted that distress is based on the patient perspective rather than clinician interpretation. The committee agreed that referral within 2 weeks for tinnitus related distress should occur following the provision of tinnitus support and the recognition that tinnitus is affecting mental well-being (e.g. distress that limits their daily activities). The committee appreciates that distress can have subjective interpretations but agreed that adding the caveat of "distress affecting mental well-being, despite receiving

[22] McFerran D, Hoare DJ, Carr S, Ray J & Stockdale D, 2018. Tinnitus Services in the United Kingdom: a survey of patient experiences. BMC Health Services Research, 18, 110.

Tinnitus: assessment and management

Consultation on draft guideline - Stakeholder comments table
20/09/2019 to 01/11/2019

Comments forms with attachments such as research articles, letters or leaflets cannot be accepted.

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					tinnitus support" provides a clear distinction between the populations who may be bothered by tinnitus.
Action on Hearing Loss	Guideline	005	011	**We welcome the recommendations to refer certain signs and symptoms more urgently to encourage timely referrals, however we believe there should be an additional criterion in recommendation 1.2.3** We recommend the committee includes the following criterion for onward referral in recommendation 1.2.3: • Tinnitus that has significantly changed in nature in line with the NICE Guideline for Hearing Loss[23] and the BAA Direct Referral criteria.[24]	Thank you for your comment. Tinnitus can change in frequency and duration. The committee considers that tinnitus that has significantly changed is covered by the bullet point 'tinnitus that still bothers the person despite tinnitus support' in recommendation 1.2.6 so the committee does not think it is necessary to include your suggestion.
Action on Hearing Loss	Guideline	006	005	**We welcome that the guideline encourages clinicians to be alert at all stages of care for symptoms of anxiety and depression however we would ask the committee to consider re-wording the recommendation to discuss tinnitus and mental health more broadly.** Tinnitus is often associated with depression, anxiety and mental ill-health; if this is not managed there is potential for harmful outcomes.[25] Therefore clinicians who come into contact with these patients have a duty of care to ensure red flag symptoms associated with mental ill-health are identified and receive prompt and appropriate care.	Thank you for your comment. This recommendation has been updated: the committee have recommended that healthcare professionals are alert at all stages to an individual's mental health and well-being. Healthcare professionals with the relevant qualifications, skills and competencies should deliver care, and training requirements should be met at a local level by the service provider. Your response regarding training will be considered by NICE where relevant support activity is being planned.

[23] NICE 2018 Hearing Loss: Assessment and management. Available at: https://www.nice.org.uk/guidance/ng98 [Accessed 21/10/2019]
[24] British Academy of Audiology, 2016. Guidance for Audiologists: Onward Referral of Adults with Hearing Difficulty Directly Referred to Audiology Services. Available at: https://www.baaudiology.org/files/4614/7828/2156/BAA_Guidance_for_Onward_Referral_of_Adults_with_Hearing_Difficulty_Directly_Referred_to_Audiology_2016.pdf. [Accessed 21/10/2019].
[25] Bhatt JM, Bhattacharyya N & Lin HW, 2016. Relationships between tinnitus and the prevalence of anxiety and depression. Laryngoscope. 127:466–469, 2017

Tinnitus: assessment and management

Consultation on draft guideline - Stakeholder comments table
20/09/2019 to 01/11/2019

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Stakeholder	Document	Page No	Line No	Comments Please insert each new comment in a new row	Developer's response Please respond to each comment
				Question 1: Audiologists are likely to have greater interaction with these patients as tinnitus is often associated with hearing loss, however most audiology training does not emphasise recognition and assessment of these symptoms. Therefore some additional training will be required not only to identify and assess these symptoms but to also make audiologists aware of local pathways and have the confidence to ask the necessary questions if they are concerned about their patient's wellbeing.	
Action on Hearing Loss	Guideline	007	001	**We welcome the assessment of sleep in recommendation 1.2.12 However we urge the committee to provide more clarity as to how this informs a management plan, as in most cases a referral back to the GP would be required.** Currently sleep hygiene is not mentioned in the draft. We feel this should be included as sleep difficulties are among the most frequent complaints associated with tinnitus, which leads to more distress.[26] This reduces quality of life for many individuals and can also cause other health conditions as a result.[27]	Thank you for your comment. Identifying sleep difficulties due to tinnitus is included in the guideline recommendations. Basic advice on sleep management should be provided as part of the information and support offered to people with tinnitus. Specific details on this is outside of the scope of this guideline.
Action on Hearing Loss	Guideline	007	009	**We welcome recommendation 1.2.13 that the effect of tinnitus on quality of life should be discussed** The literature shows that for some people tinnitus can have a significant effect on their quality of life.[28] However there is no standardised questionnaire for measuring the effects of tinnitus on quality of life. Despite this it is encouraging to see the committee recommending a	Thank you for your comment.

[26] Hebert S, Carrier J. Sleep complaints in elderly tinnitus patients: a controlled study. Ear Hear 2007;28:649-55 [PubMed]
[27] Crönlein T., Langguth B., Pregler M., Kreuzer P. M., Wetter T. C., Schecklmann M. (2016). Insomnia in patients with chronic tinnitus: cognitive and emotional distress as moderator variables.
[28] Hall DA, Fackrell K, Li AB, Thavayogan R, Smith S, Kennedy V & Lourenço VM, (2018) A narrative synthesis of research evidence for tinnitus-related complaints as reported by patients and their significant others. Health and Quality of Life Outcomes 16(1): 61; Watts EJ, Fackrell K, Smith S, Sheldrake J, Haider H, & Hoare DJ (2018). Why Is Tinnitus a Problem? A Qualitative Analysis of Problems Reported by Tinnitus Patients. *Trends in hearing*, *22*, 2331216518812250.

Tinnitus: assessment and management

Consultation on draft guideline - Stakeholder comments table
20/09/2019 to 01/11/2019

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Stakeholder	Document	Page No	Line No	Comments Please insert each new comment in a new row	Developer's response Please respond to each comment
				discussion about quality of life as this will allow more personalised care and management for someone with tinnitus.	
Action on Hearing Loss	Guideline	007	016	**We welcome the recommendation to offer audiometry to people with tinnitus but encourage the committee to clarify the term "audiometry" to promote standardisation of assessment**. Tinnitus is commonly associated with hearing loss (see evidence cited in comment 2.), it is therefore possible someone may have tinnitus with an underlying mild hearing loss without realising, perhaps thinking the tinnitus is preventing them from hearing clearly. Fortunately evidence shows that the majority of people (98%) do undergo pure-tone audiometry as part of tinnitus assessment, albeit via different pathways.[29] We welcome the recommendation as this will help promote consistency for those undergoing tinnitus investigation and management. We would also encourage the committee to consider clarifying what they mean by "audiometry" as this could refer to a number of different hearing assessments. Pure-tone audiometry (PTA) is the gold-standard hearing test most routinely used in audiology services to determine hearing threshold level and we would assume the committee is referring to this test in the recommendation. However there are other types of audiometry such as speech, sound-field and extended high frequency audiometry that are not used as routinely as pure-tone.	Thank you for your comment, 'audiometry' is now referred to as 'hearing assessment'. The committee agreed hearing assessments would be performed as standard test and as audiological/ENT centres already have audiometers to provide hearing assessments as part of routine current practice it is not necessary to detail this within the recommendations. A description of what the assessments/tests may include is in evidence review H.
Action on Hearing Loss	Guideline	007	017	**We welcome the recommendation to include tympanometry (when indicated) as part of a full test battery.** People with tinnitus often complain of a blocked sensation which can be related to middle ear pathology such as Eustachian tube dysfunction. It	Thank you for your comment.

[29] McFerran D, Hoare DJ, Carr S, Ray J & Stockdale D, 2018. Tinnitus Services in the United Kingdom: a survey of patient experiences. BMC Health Services Research, 18, 110.

Tinnitus: assessment and management

Consultation on draft guideline - Stakeholder comments table
20/09/2019 to 01/11/2019

Comments forms with attachments such as research articles, letters or leaflets cannot be accepted.

Stakeholder	Document	Page No	Line No	Comments Please insert each new comment in a new row	Developer's response Please respond to each comment
				is important that middle ear pathology is identified or ruled out to help inform management strategy.	
Action on Hearing Loss	Guideline	007	019	**We find the recommendation to not carry out ULLs somewhat restrictive but agree that they can cause distress to some patients with tinnitus.** ULLs have been the subject of debate and scrutiny within the audiological community, so the committees' rationale can be understood. They are a notoriously subjective measure: the available literature does question their test-retest reliability[30] and in some cases they can exacerbate tinnitus and cause discomfort.[31] However, anecdotally uncomfortable loudness levels can be useful for someone with tinnitus when carried out by an experienced clinician. They are occasionally used in practise as a counselling tool and to help set the Maximum Power Output (MPO) of a hearing aid. This avoids over amplifying sound to an uncomfortable level although the evidence does highlight limitations in using ULL results in this way.[32] Not recommending this procedure at all could be disadvantageous to a patient's management plan. We ask the committee to consider advising an audiologist to exercise caution, using their clinical judgement and experience when considering this test, also providing clear explanation the patient. NICE also promote people having the right to make informed decisions regarding their care.[1] This would be approached as a joint decision by an experienced clinician and informed patient.	Thank you for your comment. The committee does not recommend ULL tests as an assessment for tinnitus. They are uncomfortable, causes distress and do not change the management of people with tinnitus. All management options should be made as a part of an informed discussion between the health professional and the person with tinnitus. The use of ULLs in the fitting of hearing aids is outside of the scope of this guideline. The guideline development team checked the references included in your comment. They were not appropriate for inclusion in evidence reviews due to inappropriate study type (guidance and literature review) and incorrect population (hyperacusis).

[30] Baguley DM, Andersson G (2007) Hyperacusis: mechanisms, diagnosis, and therapies. San Diego: Plural Publishing.
[31] British Society of Audiology (2018) Draft Practice Guidance: Tinnitus in adults. Available at: http://www.thebsa.org.uk/wp-content/uploads/2019/09/Practice-Guidance_Tinnitus-in-Adults_for-member-consultation_30AUG2019.pdf [Accessed 21/10/2019]
[32] Mueller HG, Bentler RA (2005) Fitting hearing aids using clinical measures of loudness discomfort levels: an evidence based review of effectiveness. J Am Acad Audiol 16: 461- 472.

Tinnitus: assessment and management

Consultation on draft guideline - Stakeholder comments table
20/09/2019 to 01/11/2019

Comments forms with attachments such as research articles, letters or leaflets cannot be accepted.

Stakeholder	Document	Page No	Line No	Comments Please insert each new comment in a new row	Developer's response Please respond to each comment
				General consensus among the audiology profession is to perform this test in exceptional circumstances and not routinely.[31] The rationale (page 21 line 1-2) states that the results of ULL testing does not affect the management plan, as the main focus is to lessen the distress of tinnitus. However fitting hearing aids for sound enrichment with an appropriate Maximum Power Output level is surely part of lessening distress, or at least reduces the risk of further distress.	
Action on Hearing Loss	Guideline	007	019	**We find the recommendation to not carry out Acoustic Reflex Thresholds somewhat restrictive but agree that this could be distressing to a patient with tinnitus.** Acoustic Reflex Thresholds can be a useful measure to determine problems within the auditory pathway. Traditionally they were used in diagnostic audiology, particularly for detecting retrocochlear pathology. In current practice assessment and detection of retrocochlear lesions has largely been replaced by MRI and other imaging.[33] However ARTs can be carried out during initial assessment in an audiology clinic and may provide useful measures in some cases, for example when someone cannot have an MRI. However, like ULLs we believe that these tests should be administered by an experienced clinician exercising caution and only be used in exceptional circumstances, not as part of a standard test battery. The literature does question their safety in some circumstances.[34] Furthermore automated screening ART tests available through most tympanometers would not be appropriate as the stimulus level and	Thank you for your comment. The committee feels that acoustic reflex testing is uncomfortable, causes distress and does not change the management of people with tinnitus. All management options should be made as a part of an informed discussion between the health professional and the person with tinnitus. The guideline development team checked the references included in your comment. They were not appropriate for inclusion in evidence reviews due to study type (guidance/review of protocols, case study of safety).

[33] Waterval, J., Kania, R., & Somers, T. (2018). EAONO Position Statement on Vestibular Schwannoma: Imaging Assessment. What are the Indications for Performing a Screening MRI Scan for a Potential Vestibular Schwannoma?. The journal of international advanced otology, 14(1), 95–99.
[34] Hunter, L. L., Ries, D. T., Schlauch, R. S., Levine, S. C., & Ward, W. D. (1999). Safety and clinical performance of acoustic reflex tests. Ear & Hearing, 20, 506-514.

Tinnitus: assessment and management

Consultation on draft guideline - Stakeholder comments table
20/09/2019 to 01/11/2019

Comments forms with attachments such as research articles, letters or leaflets cannot be accepted.

Stakeholder	Document	Page No	Line No	Comments Please insert each new comment in a new row	Developer's response Please respond to each comment
				duration cannot be controlled. We would advise against the use of automated screening ARTs for those with tinnitus and instead advise clinicians to perform ARTs manually if they were to carry them out in someone with tinnitus.	
Action on Hearing Loss	Guideline	007	026	**We find the recommendation to not carry out psychoacoustic measures somewhat restrictive but agree these could be distressing for someone with tinnitus.** Psychoacoustic tests such as tinnitus pitch and loudness matching have been used in clinical practice by audiologists for some time, primarily as a counselling tool. However their value as a clinical test has been the subject of debate within the audiological community.[35] The committee's rationale against recommending psychoacoustic measures is largely sensible, the test can be fatiguing and possibly distressing with little measurable value in terms of influencing the management plan. However the rationale also states that the test is used in research settings; there is surely a similar risk to harm in research setting as there would be in clinical practice and therefore not recommending it seems contradictory. As with comments 23 & 24 we feel this test should be considered in circumstances where the patient is fully informed, understands the implications of the test and the clinician performing it has sufficient experience.	Thank you for your comment. The committee does not recommend psychoacoustic testing as a routine clinical assessment for tinnitus. They are time-consuming, often unreliable and do not reflect the level of distress due to or impact of tinnitus on an individual, neither does it change the management. The committee recognises that psychoacoustic testing is performed in research settings but have not recommended its use in a research context. The committee is also aware that psychoacoustic testing is used as part of specific treatment, but the use of psychoacoustic testing to accompany treatment options is outside of the scope of this guideline.
Action on Hearing Loss	Guideline	009	General	**We are concerned by the lack of recommendations for people who are d/Deaf or have profound hearing loss for whom amplification is not appropriate.**	Thank you for your comments. We did not find any evidence for people who are d/Deaf and therefore the committee were unable to make recommendations specifically for this group. However the committee recognised the lack of management options and

[35] Hoare DJ, Edmondson-Jones M, Gander PE, Hall DA (2014) Agreement and Reliability of Tinnitus Loudness Matching and Pitch Likeness Rating. PLoS ONE 9(12): e114553.

Tinnitus: assessment and management

Consultation on draft guideline - Stakeholder comments table
20/09/2019 to 01/11/2019

Comments forms with attachments such as research articles, letters or leaflets cannot be accepted.

Stakeholder	Document	Page No	Line No	Comments Please insert each new comment in a new row	Developer's response Please respond to each comment
				The recommendations for sound therapy (enrichment) and amplification devices are management strategies that cannot be accessed by people who are d/Deaf or have profound hearing loss. There are no recommendations for people in this group for whom hearing aids or sound therapy are inappropriate. We would urge the committee to include specific recommendations for management that can be accessed by those who are deaf or have profound hearing loss. Cochlear implants have been shown to improve tinnitus suppression when this has been measured.[36] We would therefore encourage the committee to refer to this evidence or the recent NICE Technology Appraisal for Cochlear Implants within the Tinnitus guideline.	have introduced additional research recommendations for the management of tinnitus using psychological therapies and amplification devices in people who are d/Deaf or who have a severe to profound hearing loss. Full details can be seen in Evidence Review L and Evidence Review M. The NICE technology appraisal on cochlear implants is for people with severe to profound deafness, the tinnitus population is not covered and it cannot be referred to within this guideline. The study referenced in your comment, was previously assessed but was not includable due to incorrect study design (non-randomised study of retrospective design) and population (not all of the study population had tinnitus).
Action on Hearing Loss	Guideline	009	004	**We consider the language of the title: <u>Sound therapy</u> and amplification devices misleading and would encourage the committee to consider rewording the recommendation to avoid ambiguity.** Recommendations 1.4.1, 1.4.2 and 1.4.3 refer to amplification only. Devices which amplify sound to improve communication and reduce hearing difficulties such as hearing aids and combination devices do provide a level of sound enrichment but this is different to traditional sound therapy. The recommendations appear to only be for amplification and not sound therapy. Sound therapy (or sound enrichment) is the use of a constant sound to help distract someone from their tinnitus, or reduce their awareness of it, with the ultimate goal being habituation. Devices specifically designed for this purpose such as ear-level tinnitus maskers, table-top	Thank you for your comment. The title has been amended with the removal of sound therapy. A research recommendation was made for sound therapies in combination with tinnitus support (see Evidence Review P for further details).

[36] Kim D, et al (2013) Tinnitus in patients with profound hearing loss and the effect of cochlear implantation. 270(6):1803-1808.

Tinnitus: assessment and management

Consultation on draft guideline - Stakeholder comments table
20/09/2019 to 01/11/2019

Comments forms with attachments such as research articles, letters or leaflets cannot be accepted.

Stakeholder	Document	Page No	Line No	Comments Please insert each new comment in a new row	Developer's response Please respond to each comment
				sound generators or pillow speakers are often suggested by audiologists as part of a management plan.[37] The advent of relaxation and mindfulness smartphone apps has allowed more people access to sound therapy. Sound enrichment can also be achieved through the use of hearing aids or combination devices, as the amplified sounds from these devices help to distract from tinnitus. However these devices are not solely used for sound therapy, their primary purpose is improving auditory input and communication, with the potential to facilitate habituation to tinnitus as a secondary benefit. Furthermore, many hearing aids are now being manufactured which can play tinnitus support sounds controlled by a smart phone app – this is available privately and on the NHS. Bluetooth streaming to hearing aids has also been available for some time, allowing people to stream environmental sounds such as wave noise directly into their hearing aids. Therefore sound therapy is available through many different devices and in many different forms. Sound therapy is widely available and currently the preferred method of audiological tinnitus management in the UK.[38] However the evidence for sound therapy is of low quality so we can understand the committee's rationale for not recommending it. It should be noted that absence of results demonstrating effectiveness should not be interpreted as ineffectiveness, especially when the recommendation could indicate significant changes to current practice.	

[37] McFerran D, Hoare DJ, Carr S, Ray J & Stockdale D, 2018. Tinnitus Services in the United Kingdom: a survey of patient experiences. BMC Health Services Research, 18, 110.; Hall DA, Lainez MJ, Newman CW, Sanchez TG, Egler M, Tennigkeit F, et al. Treatment options for subjective tinnitus:self reports from a sample of general practitioners and ENT physicians within Europe and the USA. BMC Health Services Research 2011;11:302.
[38] Hobson J, Chisholm E & El Refaie A (2012) Sound therapy (masking) in the management of tinnitus in adults. Cochrane Database of Systematic Reviews, Issue 11.

Tinnitus: assessment and management

Consultation on draft guideline - Stakeholder comments table
20/09/2019 to 01/11/2019

Comments forms with attachments such as research articles, letters or leaflets cannot be accepted.

Stakeholder	Document	Page No	Line No	Comments Please insert each new comment in a new row	Developer's response Please respond to each comment
				As there is no evidence for effectiveness of sound therapy, we would encourage the committee to make a specific recommendation for information provision so patients can try this themselves should they choose to. Smart phone apps and table-top sound generators are readily available and may provide some relief from the acute symptoms of tinnitus.	
Action on Hearing Loss	Guideline	009	005	**We welcome recommendation 1.4.1 to Offer amplification devices to people with tinnitus who have a hearing loss that affects their ability to communicate.** Hearing aids are a clinically and cost-effective management option for people with hearing loss[39]. Enhancing auditory input through hearing aids not only has the beneficial effect of improving speech intelligibility but also can help distract from tinnitus. There are also additional benefits to hearing aids such as improved communication, reduced social isolation and withdrawal, and improved wellbeing.[39] The NICE guideline for hearing loss states that hearing aids should be offered to people with hearing loss based on need.[40] There is also evidence they provide help for people with tinnitus by increasing auditory input and distracting from tinnitus sound.[41] As well as tinnitus, untreated hearing loss is associated with depression	Thank you for your comment.

[39] Ferguson MA, Kitterick PT, Chong L, Edmondson-Jones M, Barker F & Hoare DJ. (2017) Hearing aids for mild to moderate hearing loss in adults. Cochrane Database of Systematic Reviews, Issue 9. Art. No.: CD012023

[40] NICE 2018 Hearing Loss: Assessment and management. Available at: https://www.nice.org.uk/guidance/ng98 [Accessed 21/10/2019]

[41] Hoare DJ, Edmondson-Jones M, Sereda M, Akeroyd MA, Hall D. (2014) Amplification with hearing aids for patients with tinnitus and co-existing hearing loss. Cochrane Database of Systematic Reviews, Issue 1. Art. No.: CD010151.

Tinnitus: assessment and management

Consultation on draft guideline - Stakeholder comments table
20/09/2019 to 01/11/2019

Comments forms with attachments such as research articles, letters or leaflets cannot be accepted.

Stakeholder	Document	Page No	Line No	Comments Please insert each new comment in a new row	Developer's response Please respond to each comment
				and social isolation. There is also growing evidence that it is associated with dementia.[42] Therefore it is paramount that those with hearing loss and tinnitus are offered bilateral hearing aids should they need them. However, in some areas of the country, hearing aid provision is restricted. In 2015 NHS North Staffordshire CCG implemented a policy that restricted the provision of hearing aids so that people with an average hearing threshold level of less than 41dB HL were not eligible for them. The policy is still in place despite the release of the NICE Guidelines for Hearing loss, which state that hearing aids should be offered based on someone's ability to communicate and hear and not hearing threshold level alone. Furthermore this policy does not make exceptions for people who have tinnitus as well as hearing loss.[43] So if someone has bothersome tinnitus associated with an average hearing threshold level below 41dB HL they would not be eligible for hearing aids which could help provide sound enrichment and alleviate tinnitus symptoms. We therefore welcome the recommendation as this will raise awareness of the effectiveness of hearing aids and encourage their use for those with tinnitus associated with hearing loss. We also hope that the recommendation will influence commissioners to ensure hearing aids are available for all those who need them.	
Action on Hearing Loss	Guideline	009	008	**We welcome recommendation 1.4.1 to consider amplification devices for people with tinnitus who have a hearing loss but do not have difficulties communicating.**	Thank you for your comment..

[42] Livingston G, Sommerlad A, Orgeta V, et al (2017) Dementia prevention, intervention, and care. The Lancet.16;390(10113):2673-2734.
[43] North Staffordshire CCG (2016) Hearing Aids for people with mild to moderate Adult-Onset Hearing Loss. Available at: https://www.northstaffsccg.nhs.uk/governance/policies/commissioning-policies/424-commissioning-policy-hearing-aids-for-mild-to-moderate-adult-onset-hea/file [Accessed 21/10/2019]

Tinnitus: assessment and management

Consultation on draft guideline - Stakeholder comments table
20/09/2019 to 01/11/2019

Comments forms with attachments such as research articles, letters or leaflets cannot be accepted.

Stakeholder	Document	Page No	Line No	Comments Please insert each new comment in a new row	Developer's response Please respond to each comment
				Hearing loss may not be the primary complaint for many people with tinnitus however evidence shows that in most cases that tinnitus is associated with some hearing loss (see evidence cited in comment 2). Evidence also demonstrates that people wait on average 10 years before seeking help for their hearing loss.[44] Therefore increasing auditory input with hearing aids may help with tinnitus percept, but could also provide preventative effects for other comorbidities associated with untreated hearing loss such as depression, social isolation and potentially dementia.[45]	
Action on Hearing Loss	Guideline	009	015	**We welcome the recommendation for psychological therapies in principle however we feel the wording "consider" is not strong enough.** CBT has the strongest evidence base for managing tinnitus.[46] However few people with tinnitus actually receive access CBT with a psychologist in the current tinnitus pathway due to lack of appropriate services.[47] We are concerned that the word "consider" could be interpreted based on services available in the area resulting in a postcode lottery, therefore we encourage the committee to change this to be more directive. We welcome the consideration to improve access to CBT through utilizing digital mediums but are concerned that digital tinnitus-related CBT is not yet publicly available in the UK.[48] However we are aware	Thank you for your comment. Your comments will be considered by NICE where relevant support activity is being planned to assist with the implementation of this recommendation. The "consider" used for the recommendation is standard NICE terminology. Whilst the evidence that evaluated psychological therapies in people with tinnitus-related distress showed a clinical benefit of psychological therapies, the majority of the evidence was graded as low quality taking into account risk of bias, imprecision and inconsistency in the evidence. This limited the level certainty/confidence around the evidence-base, consequently the committee made a weaker recommendation. Economic analyses suggested that it would be more cost effective to use digital CBT and the committee considered that some providers would take the initiative to adapt existing digital

[44] Davis, A., Smith, P., Ferguson, M., Stephens, D., & Gianopoulos, I. (2007). Acceptability, benefit and costs of early screening for hearing disability: a study of potential screening tests and models. *HEALTH TECHNOLOGY ASSESSMENT-SOUTHAMPTON 1*(42).
[45] Ferguson MA, Kitterick PT, Chong L, Edmondson-Jones M, Barker F & Hoare DJ. (2017) Hearing aids for mild to moderate hearing loss in adults. Cochrane Database of Systematic Reviews, Issue 9. Art. No.: CD012023
[46] Cima RFF, et al. (2014) Cognitive-Behavioural Treatments for Tinnitus: A Review of the Literature. Journal of the American Academy of Audiology 25(1): 29-61.
[47] McFerran D, Hoare DJ, Carr S, Ray J & Stockdale D, 2018. Tinnitus Services in the United Kingdom: a survey of patient experiences. BMC Health Services Research, 18, 110.
[48] Weise C, Kleinstäuber M, Andersson G. Internet-delivered cognitive-behavior therapy for tinnitus: a randomized controlled trial. Psychosom Med. 2016;78: 501–10.

Tinnitus: assessment and management

Consultation on draft guideline - Stakeholder comments table
20/09/2019 to 01/11/2019

Comments forms with attachments such as research articles, letters or leaflets cannot be accepted.

Stakeholder	Document	Page No	Line No	Comments Please insert each new comment in a new row	Developer's response Please respond to each comment
				that there is promising data from recent studies suggesting its efficacy.[49] We also agree that high demand for psychological therapies in some locations means that aspects of service delivery will need to be altered to overcome these demands and there may be significant challenges in implementing this. Improvements in technology have allowed more aspects of care to be delivered digitally, for example the advent of video call GP consultations. We would emphasise the need to exercise caution for those referred for digital CBT, ensuring safeguards are in place and that patients have the option to access timely group based or individual psychological therapies if necessary.	CBT tools available for use in other populations, for people with tinnitus. Some of the studies referenced were previously assessed and excluded due to incorrect study design (Cima 2014, Beukes 2015, Beukes 2017). Two studies referenced have now been checked and were not includable due to incorrect study design (McFerran 2018 and Greenwell 2016). Weise 2016 was included in the psychological therapies evidence review (Evidence Review L)
Action on Hearing Loss	Guideline	009	015	**We would encourage the committee to make clear recommendations regarding psychological therapies for those who are deaf or have profound hearing loss.** Despite the evidence cited in comment 29, cochlear implants are not an appropriate option for everyone who is d/Deaf and some people may opt not to have one. However d/Deaf people are twice as likely to experience mental health problems as hearing people. [50] We would therefore encourage the committee to make specific recommendations for psychological therapies for those who are d/Deaf and ensure they have access to these therapies.	Thank you for your comment and for sharing the resource in Question 3 . The committee have discussed this, as no evidence was identified for psychological therapies in those who are deaf or having profound hearing loss, a research recommendation has been made. Full details can be seen in Evidence Review L. The guideline development team checked the references provided. The references refer to reviews of health outcomes in d/Deaf people and not relevant for inclusion in guideline evidence reviews.

[49] Beukes EW, Allen PM, Manchaiah V, Baguley DM, Andersson G. Internet based intervention for tinnitus: outcome of a single-group open trial. J Am Acad Audiol. 2017;28:340–51.; Beukes EW, Manchaiah V, Allen PM, Baguley DM, Andersson G. Internet based cognitive behavioural therapy for adults with tinnitus in the UK: study protocol for a randomised controlled trial. BMJ Open. 2015;5:e008241.; Greenwell K, Sereda M, Coulson N, Hoare DJ. Understanding user reactions and interactions with an internet-based intervention for tinnitus selfmanagement: mixed-methods process evaluation protocol. JMIR Res Protoc. 2016;5:e49.

[50] Fellinger J, Holzinger D & Pollard R (2012) Mental health of deaf people. The Lancet. 279(9820): 1037-1044; Boness C. L. (2016). Treatment of Deaf Clients: Ethical Considerations for Professionals in Psychology. Ethics & behavior, 26(7), 562–585.

Tinnitus: assessment and management

Consultation on draft guideline - Stakeholder comments table
20/09/2019 to 01/11/2019

Comments forms with attachments such as research articles, letters or leaflets cannot be accepted.

Stakeholder	Document	Page No	Line No	Comments Please insert each new comment in a new row	Developer's response Please respond to each comment
				Furthermore, it is vital that someone who uses BSL has access to a BSL therapist and not psychological therapies via an interpreter, this includes digital CBT. Question 3: The Deaf health charity SignHealth has a wealth of online resources that provide information surrounding health of Deaf people in the UK.[51] This includes specific information about mental health and access to mental health services. SignHealth also provide psychological therapies in BSL including face to face and online CBT for deaf people.	
Action on Hearing Loss	Guideline	010	005	**We welcome recommendation 1.4.5. However we urge the committee to provide more clarity around prescribing medication for tinnitus in general.** There is very little low quality evidence to suggest that betahistine is effective when prescribed for tinnitus and therefore we welcome this recommendation but feel it could be clearer.[52] We also feel there is a very apparent lack of information in the draft regarding other medications commonly prescribed for tinnitus. There is no clinically proven drug treatment for tinnitus[53] however many people report they have been prescribed medications specifically for their tinnitus.[54] The study by McFerran *et al*. (2018) found that 20.1% of respondents were prescribed drugs in primary care. Of this group, psychoactive drugs were the most commonly prescribed despite little evidence of their effectiveness for improving tinnitus symptoms.	Thank you for your comment. The committee agrees that there is no clinical benefit associated with the use of betahistine and there is some indication of harm with side effects. The committee recommend that it should not be offered to people with tinnitus: this recommendation has been amended. The fact that there is no clinically proven drug treatment available for tinnitus has been highlighted in the rationale and impact section for the guideline.

[51] SignHealth (2014) The Health of Deaf People in The UK. Available at: http://www.signhealth.org.uk/sick-of-it-report-professionals/ [Accessed 01/11/2019].
[52] Wegner I, Hall DA, Smit AL, McFerran D, Stegeman I. Betahistine for tinnitus. Cochrane Database of Systematic Reviews 2018, Issue 12. Art. No.: CD013093.
[53] McFerran DJ, Stockdale D, Holme R, Large CH & Baguley DM, 2019. Why Is There No Cure for Tinnitus? Front. Neurosci. 13:802.
[54] McFerran D, Hoare DJ, Carr S, Ray J & Stockdale D, 2018. Tinnitus Services in the United Kingdom: a survey of patient experiences. BMC Health Services Research, 18, 110.

Tinnitus: assessment and management

Consultation on draft guideline - Stakeholder comments table
20/09/2019 to 01/11/2019

Comments forms with attachments such as research articles, letters or leaflets cannot be accepted.

Stakeholder	Document	Page No	Line No	Comments Please insert each new comment in a new row	Developer's response Please respond to each comment
				Psychoactive drugs may be prescribed to manage comorbid conditions such as depression and anxiety but there are anecdotal reports that these drugs are prescribed primarily to alleviate tinnitus symptoms. We would encourage the committee to make clear within the guideline that there is no clinically proven drug treatment to avoid inappropriate prescribing for someone with tinnitus. This in turn could help manage expectations if combined with appropriate information around drug treatment for tinnitus, as set out in comment 7.	
Action on Hearing Loss	Guideline	011	018	**We welcome research recommendation 1: Research for CBT for adults with tinnitus delivered by appropriately trained healthcare professionals other than psychologists.** As CBT can be difficult to access in different areas we welcome the research recommendation for other healthcare professionals to be appropriately trained to deliver it for patients with tinnitus. Audiologists would be most appropriate to receive training in CBT for tinnitus as they have most point of contact with tinnitus patients. There are a number of audiologists trained in psychological therapies including CBT[55] but we would welcome research to investigate if this is clinically and cost effective on a larger scale.	Thank you for your comment. The committee agrees that it is important to evaluate the clinical effectiveness and cost-effectiveness of CBT delivered by appropriately trained healthcare professionals such as audiologists. Full details for this research recommendation can be found in Evidence Review L. Details include what the committee would be like research to look like, e.g. outcomes and study design.
Action on Hearing Loss	Guideline	012	001	**We welcome research recommendation 2: Combination management strategy: sound therapy and tinnitus support.**	Thank you for your comment.
Action on Hearing Loss	Guideline	012	006	**We welcome research recommendation 3: Methods for assessing tinnitus in primary care settings**	Thank you for your comment.
Action on Hearing Loss	Guideline	012	011	**We welcome research recommendation 4: Neuromodulation**	Thank you for your comment.

[55] Sweetow RW. Cognitive aspects of tinnitus patient management. Ear Hear. 1986;7:390–6.

Tinnitus: assessment and management

Consultation on draft guideline - Stakeholder comments table
20/09/2019 to 01/11/2019

Comments forms with attachments such as research articles, letters or leaflets cannot be accepted.

Stakeholder	Document	Page No	Line No	Comments Please insert each new comment in a new row	Developer's response Please respond to each comment
Action on Hearing Loss	Guideline	012	016	**We welcome research recommendation 5: Psychological therapies for children and young people**	Thank you for your comment.
Action on Hearing Loss	Guideline	General	General	Action on Hearing Loss welcomes the opportunity to submit comments on the draft NICE guideline: Tinnitus: assessment and management. Action on Hearing Loss is the largest charity in the UK for people with hearing loss, deafness and tinnitus. Our vision is of a world where people are not labelled or limited by their deafness, hearing loss or tinnitus and where people value and look after their hearing. We help people confronting deafness, tinnitus and hearing loss to live the life they choose. We enable them to take control of their lives and remove the barriers in their way. We give people support and care, develop technology and treatments, and campaign for equality. There is no standard treatment pathway for tinnitus in the UK, many services offer a combination of tinnitus support, education, psychological therapies or sound enrichment as well as hearing aids.[56] Therefore the guideline will be vital in ensuring a standardised care pathway is in place for people with tinnitus. Our response will focus on the key issues that relate to people with tinnitus. We are happy for the details of this response to be made public. Please do contact us if you require further information or evidence.	Thank you for your comment.
Action on Hearing Loss	Guideline	General	General	Action on Hearing Loss welcomes that the guidance focuses on varying groups of people affected by tinnitus. More than 11 million people in the UK have hearing loss, about 1 in 6 of	Thank you for your comment.

[56] Stockdale D, McFerran D, Brazier P, Pritchard C, Kay T, Dowrick C, & Hoare DJ (2017). An economic evaluation of the healthcare cost of tinnitus management in the UK. BMC health services research, 17(1), 577.

Tinnitus: assessment and management

Consultation on draft guideline - Stakeholder comments table
20/09/2019 to 01/11/2019

Comments forms with attachments such as research articles, letters or leaflets cannot be accepted.

Stakeholder	Document	Page No	Line No	Comments Please insert each new comment in a new row	Developer's response Please respond to each comment
				the population. The prevalence of hearing loss increases with age. It has been estimated that between 10 and 15% of adults across the UK suffer from tinnitus,[57] with recent data showing that this increases to nearly 17% of 40 to 69-year olds and 25-30% of over 70s.[58] The British Tinnitus Association (BTA) estimate that currently, 1 in 8 people in the UK are living with tinnitus and that this number is expected to increase by 550,000 over the next 10 years. Deafness, tinnitus and hearing loss are serious health conditions that can have a significant impact on health and wellbeing. Tinnitus can have a negative impact on a person's mental health, relationships with family and friends and their ability to sleep, concentrate and work. Throughout this response we use the term "patient" or "person with tinnitus" to describe someone who is accessing the tinnitus pathway.	
Betsi Cadwaladr University Health Board	Guideline	004	004 - 005	1.1.3 We suggest the bullet point ends at 'what tinnitus is'. We are concerned that speculation about possible causes and predictions about the future may not be helpful and are contrary to mindfulness based approaches.	Thank you for your suggestion. Using the clinical history and physical examination of the person, tailored individual information can be given on what may have caused the tinnitus and suggestions on prevention techniques and prognosis and therefore the committee does not think the recommendation needs amending.
Betsi Cadwaladr University Health Board	Guideline	004	028 - 029	We believe clarity could be improved by adding 'which is not explained by external or middle ear causes' to this bullet point. We understand the recommendation states in line with NICE guidance on HL, but think additional info here would help interpretation	Thank you for your comment. The committee recommends that the NG98 recommendation is followed for the assessment of hearing loss. The committee discussed the proposed wording and decided that the wording should not change.

[57] Davis AC, 1989. The prevalence of hearing impairment and reported hearing disability among adults in Great Britain. International Journal of Epidemiology, 18, 911–17.
[58] Dawes P, Fortnum H, Moore DR, Emsley R, Norman P, Cruickshanks K, Davis A, Edmondson-Jones M, McCormack A, Lutman M & Munro K, 2014. Hearing in middle age: A population snapshot of 40-69 year olds in the UK. Ear and Hearing, 35, e44–e51.

Tinnitus: assessment and management

Consultation on draft guideline - Stakeholder comments table
20/09/2019 to 01/11/2019

Comments forms with attachments such as research articles, letters or leaflets cannot be accepted.

Stakeholder	Document	Page No	Line No	Comments Please insert each new comment in a new row	Developer's response Please respond to each comment
Betsi Cadwaladr University Health Board	Guideline	007	001 - 004	We acknowledge the inclusion of a recommendation to explore people's difficulties sleeping and to include this within their management plan. However there is no guidance/recommendation here, or within 1.4 Managing Tinnitus section, as to possible management of those with significant difficulties with their sleep due to tinnitus or the exacerbation of tinnitus through poor sleep hygiene..	Thank you for your comment. Sleep management is outside of the scope of this guideline.
Betsi Cadwaladr University Health Board	Guideline	008	005 - 007	1.3.5 We are concerned that this will significantly and unnecessarily increase the number of referrals for MRI. As it currently reads all people with uni or bil non-pulsatile tinnitus with any degree of hearing loss (an associated Audiological symptom) should be offered MRI. Currently people with bilateral non-pulsatile tinnitus and symmetrical HL would not usually be referred for MRI We suggest changing 'Audiological' to asymmetric Audiological'	Thank you for your comment. The recommendation has been amended, the reference to audiological has been removed.
Betsi Cadwaladr University Health Board	Guideline	009	004	1.4.1 is titled 'Sound therapy and amplification devices' but the three following recommendations only refer to amplification and no reference to sound therapy. Sound therapy devices are used widely within NHS services yet there are no recommendations about their use.	Thank you for your comment. The title has been amended with the removal of sound therapy. The committee agreed that there was limited evidence available to make a recommendation for the use of sound therapies. A research recommendation was made for sound therapies in combination with tinnitus support (see Evidence Review P for further details)
Betsi Cadwaladr University Health Board	Guideline	009	010	1.4.3 we acknowledge that amplification should not be offered to those with tinnitus and normal hearing, however we are concerned that there is a lack guidance as to the use of sound therapy for this patient group.	Thank you for your comment. There was insufficient evidence to recommend sound therapy for people with tinnitus. However, the committee acknowledges that sound therapy is a key intervention for the management of tinnitus and a recommendation for further research has been made (see Evidence Review M).
Betsi Cadwaladr University Health Board	Guideline	010	005 - 008	1.4.5 We are concerned that this recommendation implies that all patients should be informed that Betahistine is not effective and may be harmful to them but also to consider prescribing it. If the evidence shows no benefit and some harm then why mention it to	Thank you for your comment. The committee agrees that there is no clinical benefit associated with the use of betahistine and there is some indication of harm with side effects. The committee recommend that it should not be offered to people with tinnitus:

Tinnitus: assessment and management

Consultation on draft guideline - Stakeholder comments table
20/09/2019 to 01/11/2019

Comments forms with attachments such as research articles, letters or leaflets cannot be accepted.

Stakeholder	Document	Page No	Line No	Comments Please insert each new comment in a new row	Developer's response Please respond to each comment
				patients as a management option or consider prescribing? The recommendation could apply for those already receiving Betahistine as a treatment as part of discussions about future treatment but it doesn't seem appropriate to discuss an ineffective and potentially harmful treatment with new patients.	this recommendation has been amended.
Betsi Cadwaladr University Health Board	Guideline	022	018	Rationale for 1.3.5 refers to accompanying Audiological symptoms. We are concerned that any degree of symmetrical hearing loss could be interpreted as an accompanying Audiological symptom and would result in a significant increase in the number of referrals for MRI	Thank you for your comment. Audiological symptoms has been removed.
British Academy of Audiology	Evidence Review C - D	General	General	This guidance appears to over-state the significance of tinnitus. In my opinion, it is enough for NG98 to state that vertigo etc should be investigated. It would be better to cross reference that document than write a new set of onward referral criteria for patients with tinnitus.	Thank you for your comment. The committee acknowledges that there is some overlap between the tinnitus guideline and the hearing loss guideline, as hearing loss is common in the tinnitus population. However, not every individual with tinnitus has a hearing loss. It is important that there are clear recommendations for appropriate referrals for people with tinnitus presenting with various signs and symptoms. For adults with tinnitus and hearing loss, this guideline should be read in conjunction with the hearing loss in adults guideline (NG98). This has been made clearer in the introduction to the recommendations within the guideline.
British Academy of Audiology	Evidence Review H	005	General	It would be helpful to state here that many people present with tinnitus without realising that they have a hearing loss.	Thank you for your comment. The committee recognises this and recommends that all people referred with tinnitus have an audiological assessment. The fact that many people present with tinnitus without realising that they have hearing loss is now in the introduction for this evidence review and highlighted in the rationale and impact associated with this recommendation.
British Academy of Audiology	Evidence Review J	005	030	Tinnitus is a subjective experience. How can it be 'suspected or confirmed'?	Thank you for your comment. This has been removed from guideline documents.

Tinnitus: assessment and management

Consultation on draft guideline - Stakeholder comments table
20/09/2019 to 01/11/2019

Comments forms with attachments such as research articles, letters or leaflets cannot be accepted.

Stakeholder	Document	Page No	Line No	Comments Please insert each new comment in a new row	Developer's response Please respond to each comment
British Academy of Audiology	Evidence review J	008	003 - 014	This section over-states how common it is to be highly distressed by tinnitus. Replace 'common complaints for those with tinnitus' with 'common factors among adults who seek help for their tinnitus'.	Thank you for your comment. The committee agrees that not everyone presenting with tinnitus is highly distressed by their tinnitus. The wording has been amended, using "factors" instead of complaints.
British Academy of Audiology	Evidence Review J	009	031	I feel this recommendation is less clear here than it is in NG98	Thank you for your comment. The recommendation has been edited to provide clarity. For adults with tinnitus and hearing loss, this guideline should be read in conjunction with the hearing loss in adults guideline (NG98). This has been made clearer within the introduction to the recommendations.
British Academy of Audiology	General	General	General	In a number of places documents refer to 'adults with tinnitus' where I feel they should refer to 'adults seeking help for their tinnitus'. Tinnitus is a very common complaint and the majority of our patients who experience tinnitus are not bothered by it, and only mention it when asked.	Thank you for your comment. The committee felt that it is not necessary to specify that the individual with tinnitus is seeking help. This guideline is applicable for people presenting to healthcare professionals (e.g. general practitioner) who have tinnitus, even if they are not initially presenting with tinnitus and not hugely bothered by it.
British Academy of Audiology	General	General	General	Throughout the document a Local tinnitus Service is referred to although we realise there is variation in these across the country we do feel that a clearer definition of what professionals should be in a local service would have been helpful. The issue is a lot of recommendations on referral routes would be appropriate only to an ENT or Vestibular Physician led service when many local tinnitus services are audiology led. Most of the people referred to secondary services can be managed effectively and usually faster in audiology led tinnitus services without the need for ENT input.	Thank you for your comment. The composition/structure of services and pathways is outside of the scope of this guideline. However, in acknowledgement of the variation in services, the committee has decided to remove reference to "local tinnitus services" to prevent confusion. Your comments will be considered by NICE where relevant support activity is being planned.
British	Guideline	003	017 - 018	"it is common and is rarely associated with an underlying physical or	Thank you for your comment. This recommendation has been

Tinnitus: assessment and management

Consultation on draft guideline - Stakeholder comments table
20/09/2019 to 01/11/2019

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Stakeholder	Document	Page No	Line No	Comments Please insert each new comment in a new row	Developer's response Please respond to each comment
Academy of Audiology				mental health problem" I disagree, in my experience it is often associated with mental health problems such as clinical anxiety.	amended, stating that tinnitus is commonly associated with hearing loss but it is not commonly associated with another underlying physical health problem. Recommendations have been made to be alert to the impact of tinnitus on mental health and well being.
British Academy of Audiology	Guideline	004	020	Tinnitus can manifest itself for many different reasons; in some cases it can be Medical illness (Anaemia, infection, high blood pressure etc.) which is the aggravating factor. Simple Medical tests can be of some use, but this document makes no recommendations.	Thank you for your comment. The scope of this guideline did not include the different causes of tinnitus (except in the context of investigations using imaging) and specific examination methods. The committee have noted the necessity of physical examinations in the committee discussion in Evidence Review C.
British Academy of Audiology	Guideline	004	022	Although we accept referral routes are locally defined, we feel this section requires more clarity on who the right services to refer to are. This does not state who the referral should go to. This needs to state that they should be referred to for example an ear, nose and throat service or an emergency department for sudden onset as in Hearing loss in adults: assessment and management NICE guideline [NG98]	Thank you for your comment. Whilst the NG98 guideline recommends specific referral locations within its recommendations, the committee discussed this and decided that it is not possible to be specific for tinnitus as there is variation in local pathways and care models.
British Academy of Audiology	Guideline	004	025	High risk of suicide also needs defined advice on who a person should be referred to – people presenting as high risk for suicide are not appropriate for referral to audiology/ENT as they need psychological/psychiatric services. It might be better in the list of referral reasons to split those that need urgent ENT from those that need neurology, psychology, psychiatry and audiology to avoid inappropriate referral.	Thank you for your comment. The committee have amended the recommendations for immediate referral. People with tinnitus who are high risk of suicide should be referred immediately to mental health services. For the other sudden onset symptoms and signs requiring referral links to the suspected neurological conditions guideline, stroke guideline, and hearing loss guideline have been provided to access the full recommendations for onward referral.
British Academy of Audiology	Guideline	005	001 - 010	For most of the conditions which require onward referral, it seems that tinnitus may be an incidental symptom. I wonder if it is confusing to suggest that medical professionals need to be alert to such symptoms	Thank you for your comment. This guideline highlights referrals which are prompted by the presentation of tinnitus.

Tinnitus: assessment and management

Consultation on draft guideline - Stakeholder comments table
20/09/2019 to 01/11/2019

Comments forms with attachments such as research articles, letters or leaflets cannot be accepted.

Stakeholder	Document	Page No	Line No	Comments Please insert each new comment in a new row	Developer's response Please respond to each comment
				in patients with tinnitus, rather than being generally alert to them.	
British Academy of Audiology	Guideline	005	004	As above who should this referral be made to? What type of service as a minimum	Thank you for your comment. Referral would be made according to local pathways. The committee discussed if the type of service should be specified and decided it was not helpful to specify the service individuals should referred to because of differences in local service provision across the country.
British Academy of Audiology	Guideline	005	007	Refer to ENT should be stated	Thank you for your comments, the committee agreed that it is not possible to be specific for tinnitus as there is variation in local pathways and care models.
British Academy of Audiology	Guideline	005	008	Refer to ENT should be stated	Thank you for your comment, the committee agreed that it is not possible to be specific for tinnitus as there is variation in local pathways and care models.
British Academy of Audiology	Guideline	005	011	Concerned with the wording of this section "refer people to the local tinnitus service", should this read refer to ENT if they have any of the following…..?	Thank you for your comment. The term "tinnitus service" was not intended to mean a specialist service as the committee acknowledges that access to such services is very limited. In using the term "tinnitus service" the committee meant a service that would see people with tinnitus, e.g. audiology or ear, nose and throat. However, the committee has decided to removal any reference to "tinnitus services" to prevent confusion.
British Academy of Audiology	Guideline	005	011 - 020	All of these are red flags for referral to ENT from an audiology assessment which is the usual point of entry to a local tinnitus service these should all be an ENT referral not a local tinnitus service	Thank you for your comment. The committee have not specified the location for referral. The term "tinnitus service" was not intended to mean a specialist service as the committee acknowledges that access to such services is very limited. In using the term "tinnitus service" the committee meant a service that would see people with tinnitus, e.g. audiology or ear, nose and throat. However, the committee has decided to removal any reference to "tinnitus services" to prevent confusion.

Tinnitus: assessment and management

Consultation on draft guideline - Stakeholder comments table
20/09/2019 to 01/11/2019

Comments forms with attachments such as research articles, letters or leaflets cannot be accepted.

Stakeholder	Document	Page No	Line No	Comments Please insert each new comment in a new row	Developer's response Please respond to each comment
British Academy of Audiology	Guideline	005	023	We are concerned that this recommendation does not encourage a referral for Audiometry in the first instance. The document favours Psychological assessment and only suggests Audiological assessment as a further investigation. However in the rational (17) there is in fact a strong recommendation for audiological testing. Should there be more emphasis within the guideline itself?	Thank you for your comment. The committee agrees that all people referred with tinnitus should have an audiological assessment. The wording in the heading has been changed, with the removal of 'further'.
British Academy of Audiology	Guideline	005	023	This recommendation will be a challenging in practice because without first and foremost addressing hearing loss, there would be an unnecessary demand on Psychological services.	Thank you for your comment. The committee recommends that problems due to tinnitus are reviewed at every point of contact, the committee agrees that addressing a co-existing hearing loss is important. This should be done in parallel to providing tinnitus information and support. Where the latter is done at an early stage of problematic tinnitus, the person with tinnitus may be better able to manage their tinnitus and less likely to develop associated psychological issues requiring psychological services.
British Academy of Audiology	Guideline	007 008	015 011	This rationale states that during audiological assessment, audiometry and tympanometry should be offered. It discourages acoustic reflex testing, uncomfortable loudness / discomfort levels and otoacoustic emissions (OAE's). My difficulty lies with the rational discouraging otoacoustic emissions, it is suggested that this test is unlikely to affect the management plan. The wording within the guideline suggests that this would be contraindicated, this is not the case. Would it be best to omit OAE's from this section as there are many circumstances when this test is appropriate?	Thank you for your comment. The committee discussed this recommendation further and agreed that otoacoustic emissions tests (OAEs) should not be recommended as a routine clinical assessment tool unless tinnitus is accompanied by other symptoms and signs. Whilst OEAs are not unpleasant or harmful, the results are unlikely to affect a person's management plan and should only be offered if tinnitus is accompanied by other symptoms and signs (e.g. mild hearing loss or hearing being monitored for patient on ototoxic medication).
British Academy of	Guideline	008	005 - 007	This guideline is rather vague. What kind of things constitute neurological/audiological symptoms?	Thank you for your comment. Examples have been included in the rationale and impact section associated with this

Tinnitus: assessment and management

Consultation on draft guideline - Stakeholder comments table
20/09/2019 to 01/11/2019

Comments forms with attachments such as research articles, letters or leaflets cannot be accepted.

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Audiology					recommendation.
British Academy of Audiology	Guideline	008	008	Audiological is a vague statement. Could this not use the same definition as NG 98 in section 1.3 Investigation using MRI 1.3.1Offer MRI of the internal auditory meati to adults with hearing loss and localising symptoms or signs (such as facial nerve weakness) that might indicate a vestibular schwannoma or CPA (cerebellopontine angle) lesion, irrespective of pure tone thresholds. 1.3.2Consider MRI of the internal auditory meati for adults with sensorineural hearing loss and no localising signs if there is an asymmetry on pure tone audiometry of 15 dB or more at any 2 adjacent test frequencies, using test frequencies of 0.5, 1, 2, 4 and 8 kHz.	Thank you for your comment. The committee have removed 'audiological' from the recommendation and replaced this with 'otological' to provide greater clarity. For adults with tinnitus and hearing loss, this guideline should be read in conjunction with the hearing loss in adults guideline (NG98). This has been made clearer within the introduction to the recommendations.
British Academy of Audiology	Guideline	009	015 - 028	It would be useful to have a committee consensus/view on tinnitus support delivered by Audiology professionals with counselling qualifications	Thank you for your comment. The committee agreed that tinnitus support should be provided at all stages of care, irrespective of job role or qualifications. The committee were unable to provide recommendations or information about the relevance of specific qualifications.
British Academy of Audiology	Guideline	011	008	'Tinnitus support' works well as a general term in this guidance. It would be useful to have a committee consensus on whether relaxation techniques should continue to be offered, pending the results of further research.	Thank you for your comment. There was limited evidence available in order for the committee to make a consensus recommendation about relaxation strategies. There are different techniques used in clinical practice and thus it would be difficult to recommend one over another without having appropriate evidence available. The committee hopes that further research will be conducted so that when this guideline is updated recommendations can be made.
British Academy of Audiology	Guideline	018	010	There is an implication here for training and resources. Audiologists and Hearing Therapists should be offered training in the use and interpretation of TQ, mini-TQ, CORE – OM and ISI.	Training requirements for health professionals to implement the recommendations would need to be determined locally. Your comments will be considered by NICE where relevant support

Tinnitus: assessment and management

Consultation on draft guideline - Stakeholder comments table
20/09/2019 to 01/11/2019

Comments forms with attachments such as research articles, letters or leaflets cannot be accepted.

Stakeholder	Document	Page No	Line No	Comments Please insert each new comment in a new row	Developer's response Please respond to each comment
					activity is being planned.
British Academy of Audiology	Guideline	General	General	This document presents itself as vague. Who is the target audience? Is it necessary to have a management plan for ALL presenting with tinnitus? A vast majority of individuals will have tinnitus associated with Presbycusis which doesn't cause them any concern, but this document implies that we should make it concerning.	Thank you for your comment. Any person with tinnitus that is bothersome or causing concern should have a management plan and be involved in the development of that management plan. The recommendation has been amended to clarify it is people with ongoing needs identified who should have a management plan.
British Academy of Audiology	Guideline	General	General	It seems that throughout this document there is an overwhelming emphasis on Psychological measures which are only accessible to Registered Psychologists.	Thank you for your comment. The committee have recommended the use of questionnaires to assess psychological impact when more information is required about psychological well-being. Assessment of psychological well-being can be initiated by conversations with the individuals with tinnitus and is not just applicable to registered psychologists.
British Academy of Audiology	Guideline	General	General	It would be useful to have guidance on checking general health (e.g. anaemia), polypharmacy and/or medication side effects as underlying causes of tinnitus. Patients would like to be offered every opportunity to alleviate their tinnitus, even if only a small minority manage to find a solution in this way.	Thank you for your comment. The scope of this guideline did not include the different causes of tinnitus (except in the context of investigations using imaging). The committee have noted the importance of physical examinations and medication review in the committee discussion in Evidence Review C.
British Academy of Audiology	Guideline	General	General	Over-stretched psychological services will not be able to cope with an influx of patients with tinnitus. This guidance creates a risk of over-burdening psychology departments with patients who would normally be considered within the remit of audiology to treat - and therefore increasing waiting times for patients with other mental health conditions.	Thank you for your comment. The committee have recommended that psychological therapies be considered and could be delivered using a digital format. Your comments will be considered by NICE where relevant support activity is being planned.
British Association of Audiovestibular Physicians	General	General	General	We are concerned about the recommendation not to perform otoacoustic emissions as part of the audiological assessment in tinnitus. Otoacoustic emissions are valuable in the assessment of adults and children with tinnitus. There is enough evidence that noise exposure and ototoxicity can affect otoacoustic emissions despite normal hearing and they can contribute to tinnitus. There is a role in optoacoustic	Thank you for your comment. The committee discussed this recommendation further and agreed that otoacoustic emissions tests (OAEs) should not be recommended unless tinnitus is accompanied by other symptoms and signs. Whilst OEAs are not unpleasant or harmful, the results are unlikely to affect a person's management plan and should only be offered if tinnitus

Tinnitus: assessment and management

Consultation on draft guideline - Stakeholder comments table
20/09/2019 to 01/11/2019

Comments forms with attachments such as research articles, letters or leaflets cannot be accepted.

Stakeholder	Document	Page No	Line No	Comments Please insert each new comment in a new row	Developer's response Please respond to each comment
				emissions in objective tinnitus. (page 7) Although there is lack of published clinical trials there is published evidence (e.g review Sheppard et al, 2019, Int Journal audiology) about the benefits of low level noise and sound therapy in tinnitus management (page 9) Prevention of tinnitus has not been discussed at all in the document The consultation lacks of recommendations in tinnitus management in children and young people, in particular support in school, role of teacher of the Deaf.	is accompanied by other symptoms and signs (e.g. mild hearing loss or hearing being monitored for patient on ototoxic medication). The prevention of tinnitus was not identified as a review topic during the scoping stage of the guideline. The committee have, however, made recommendations about information that should be provided to people with tinnitus, including: what can cause tinnitus, what can make it worse and safe listening practices. The committee acknowledges that there are few recommendations for tinnitus management in children and young people. This is due to the absence of evidence. However, research recommendations were made, including assessing tinnitus in children and young people (see Evidence Review E) and psychological therapies (Evidence Review L). The committee agree that support should be provided in education. The committee have now recommended that management plans developed between healthcare professionals and people with tinnitus (including children and young people) should be shared with relevant health, education and social care professionals. The guideline development team checked the reference cited in your comment. The reference was not suitable for inclusion as it was a literature review for the population of tinnitus and/or hyperacusis.
British Association of Audiovestibular	Guideline	005	007	Tinnitus associated with sudden onset vestibular symptoms (controlled or uncontrolled) should be referred at an early stage since patients may not volunteer or notice hearing impairment.	Thank you for your comment. The recommendation has been amended. Tinnitus with acute uncontrolled vestibular symptoms is covered in the recommendation 1.2.2 Controlled vestibular symptoms would be included in the routine referral for tinnitus assessment and management (1.2.6) under

Tinnitus: assessment and management

Consultation on draft guideline - Stakeholder comments table
20/09/2019 to 01/11/2019

Comments forms with attachments such as research articles, letters or leaflets cannot be accepted.

Stakeholder	Document	Page No	Line No	Comments Please insert each new comment in a new row	Developer's response Please respond to each comment
Physicians					the first bullet point tinnitus that bothers them despite tinnitus support.
British Association of Audiovestibular Physicians	Guideline	007	016 - 017	Tympanometry should be routine practice in addition to audiometry since patients may not be able to provide accurate history and clinical otoscopy diagnostic skills can be variable.	Thank you for your comment. Tympanometry is a helpful supporting test in the assessment of hearing loss to help identify the nature of that hearing loss. The committee is aware that tympanometry is used routinely for people presenting with audiological complaints and recommendations are consistent with those in the hearing loss guideline (see NG98 for further details).
British Association of Audiovestibular Physicians	Guideline	022	021 - 023	Wording implies that Vascular AV malformations can be ruled out with routine MRI although in our experience, this would require formal MRA or CTA to be reliable. Hence this statement may provide false reassurance. Wording would benefit from clarification.	Thank you for your comment. The wording in the rationale and impact section associated with the recommendations for non-pulsatile tinnitus has been amended to provide further clarification.
British Association of Audiovestibular Physicians	Guideline	037	016	Pathological causes of Pulsatile tinnitus in the majority of instances can be diagnosed with MRA &/or CTA. However, the radiologist would require to be appropriately guided as to the areas which require imaging. Hence it should be specified that imaging is MRA or CTA of Head, IAM and Neck. Expert consensus at some our centres agree that imaging of neck is crucial for investigation. Although obvious, in guidelines which reach a wide range of clinicians, it would be worth clarifying details.	Thank you for your comment. This recommendations have been amended, the areas which should be scanned are now included in these recommendations.
British Association of Audiovestibular Physicians	Guideline	General	General	The document does not touch upon the cornerstone of diagnostic practice which is the recommended clinical neuro-otological assessment of the patient presenting with tinnitus prior to referral. Is this an area that is within the scope of NICE guideline? Since other peripheral causes such as wax present with tinnitus.	Thank you for your comment. The scope of this guideline did not include the different causes of tinnitus (except in the context of investigations using imaging) and specific examination methods. The committee have noted the necessity of physical examinations in the committee discussion in Evidence Review C.

Tinnitus: assessment and management

Consultation on draft guideline - Stakeholder comments table
20/09/2019 to 01/11/2019

Comments forms with attachments such as research articles, letters or leaflets cannot be accepted.

Stakeholder	Document	Page No	Line No	Comments Please insert each new comment in a new row	Developer's response Please respond to each comment
British Association of Audiovestibular Physicians	Standard Question 1	N/A	N/A	**Q. Which areas will have the biggest impact on practice and be challenging to implement? Please say for whom and why.** A. CBT by non-psychologists. Psychological management in tinnitus in children.	Thank you for your response.
British Association of Audiovestibular Physicians	Standard Question 2	N/A	N/A	**Q. Would implementation of any of the draft recommendations have significant cost implications?** A. No	Thank you for your response.
British Association of Audiovestibular Physicians	Standard Question 3	N/A	N/A	**Q. What would help users overcome any challenges? (For example, existing practical resources or national initiatives, or examples of good practice.)** A. All the above	Thank you for your response.
British Society of Hearing Aid Audiologists	Algorithms	General	General	Please see our comments relating to biases/assumptions that have in our view distorted this draft guideline. Although it is not clear what the algorithm will be used for, or whether it will be used at all, it needs to either be completely re-written or decommissioned – e.g. in a real-world context it conflicts with NG98 as most adults with tinnitus will have a hearing loss and will not appear as presented in a "tinnitus" service etc.	Thank you for your comments. The committee have amended the algorithm, following the amendment of recommendations. The purpose of the algorithm is to provide an overview of the recommendations in the guideline and it refers to other relevant NICE guidelines. It is not a clinical pathway and does not cover every aspect of care for people with tinnitus. The committee notes that whilst there is some overlap between this guideline and NG98, NG98 does not provide guidance for the management of tinnitus. For adults with tinnitus and hearing loss, this guideline should be read in conjunction with the hearing loss in adults guideline (NG98). This has been made clearer within the introduction to the recommendations.

Tinnitus: assessment and management

Consultation on draft guideline - Stakeholder comments table
20/09/2019 to 01/11/2019

Comments forms with attachments such as research articles, letters or leaflets cannot be accepted.

Stakeholder	Document	Page No	Line No	Comments Please insert each new comment in a new row	Developer's response Please respond to each comment
British Society of Hearing Aid Audiologists	Evidence Review C - D	005	009 - 010	"The majority presenting with tinnitus have benign symptoms and do not need an onward referral as they can be supported in primary care. Tinnitus may present as the main complaint or with additional symptoms and or signs" This misses a key point, that most people with tinnitus have a hearing loss (see comments 2 and 3). Therefore, they will not (in the context of how the Committee views primary care – GPs) be "supported in primary care", instead of many will, in fact, be supported by audiology under NG98 (the NICE guideline on adult hearing loss, which includes adults with tinnitus). This must be addressed in the final guideline.	Thank you for your comment. The committee acknowledges that there is some overlap between the tinnitus guideline and the hearing loss guideline, as hearing loss is common in the tinnitus population. The text referred to in the introduction of Evidence Review C-D has been amended to state the people with tinnitus can be managed within general practice and audiology services. For adults with tinnitus and hearing loss, this guideline should be read in conjunction with the hearing loss in adults guideline (NG98). This has been made clearer in the introduction to the recommendations within the guideline.
British Society of Hearing Aid Audiologists	Evidence Review C - D	008	028 - 030	"The committee discussed that hearing loss is a clinical manifestation commonly associated with tinnitus. The committee wished to cross-refer readers to NG98 (recommendations 1.1.2-1.1.4)." As per our comments and other feedback we agree. This important fact, however, is largely lost in the actual guideline. That is why we have called for greater clarity in the final guideline on which populations fall under this guideline and which population will in the main be managed under NG98.	Thank you for your comments. The committee acknowledges that, as many people with tinnitus can also have a hearing loss, this guideline should be read in conjunction with the hearing loss in adults guideline (NG98). A statement to this effect has been added to the introduction of the recommendations . NG98 only covers management for hearing loss, and if a person has both tinnitus and hearing loss, both conditions need to be managed.
British Society of Hearing Aid Audiologists	Evidence Review C - D	009	032 - 037	"This will enable management of potential underlying pathology and signpost accurately to **alternative voluntary or secondary care providers** for further assessment and management. The overarching aim is to ensure a person suffering from tinnitus experiences a high standard of care tailored to the individual's needs. Prognosis of their tinnitus or their underlying general medical problems can be greatly affected if a delay occurs" (our emphasis) NICE should ensure its guidelines are non-biased and neutral on provider type and setting unless there is evidence to support a specific	Thank you for your comment. The intention of this wording was to emphasise the importance of correct referral for appropriate tinnitus assessment and management. The wording has been amended.

Tinnitus: assessment and management

Consultation on draft guideline - Stakeholder comments table
20/09/2019 to 01/11/2019

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Stakeholder	Document	Page No	Line No	Comments Please insert each new comment in a new row	Developer's response Please respond to each comment
				provider/setting type. When NICE fails to ensure this happens it risks undermining confidence in NICE and its guidelines.	
British Society of Hearing Aid Audiologists	Evidence Review E	008	045 - 048	"The committee has specified that the TFI be used in secondary care only. The rationale for this is that the committee was conscious of the potential resource impact of completing and discussing these questionnaires in primary care where general practitioners are limited on time". As we have set out in our other comments, we are very concerned by the lack of evidence and poor logic used to support this very firm statement. It is simply inappropriate and incorrect – e.g. the 'rationale' that follows (e.g. lines 45-48 page 8 and lines 1-4 page 9) is not at all credible. On reading Evidence E it is clear that what the guideline actually means is that GPs do not have time to do this and they are worried about burdening GP colleagues. This is understandable and something the BSHAA supports. The guideline, however, then makes several leaps to conclude this equates to "primary care settings" and thus "TFI be used in secondary care only". This is wrong. Audiologists and ENT can work in primary, community and secondary care settings – and also offer telehealth. The idea that because a GP does not do something a patient must travel to secondary care to complete a questionnaire as stated is bizarre, expensive, and promotes health inequalities. It is also well known that audiologists increasingly work in primary and community-based settings where they provide NHS funded care, so the TFI can take place in these clinics. This section, therefore, needs to be reviewed, as does the entire guideline so that if the guideline means GPs it states that and otherwise stays neutral/objective on location where professionals work unless it	Thank you for your comments. The committee have discussed the terminology used in the guideline and agree that the wording for "primary care" and "secondary care" should be changed. The intention of the wording was to make it clear that healthcare professionals working in general practice are not expected to use questionnaires such as the TFI. The committee appreciates that speciality services such as audiology can in fact be delivered in general practice, community settings and within hospitals. The wording and the recommendation has been changed to reflect this.

Tinnitus: assessment and management

Consultation on draft guideline - Stakeholder comments table
20/09/2019 to 01/11/2019

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Stakeholder	Document	Page No	Line No	Comments Please insert each new comment in a new row	Developer's response Please respond to each comment
				has evidence to support its assertations. The recommendation linked to this (line 23 page 5 in the guideline) will also have to be changed as a result.	
British Society of Hearing Aid Audiologists	Evidence Review M	006	003 - 009	"Hearing loss is a common factor underlying tinnitus, although some people with normal hearing also experience tinnitus. Loss of hearing is often an unnoticeable and gradual process and many people are surprised when they are told that they have a hearing loss. It is quite common for people to assume, incorrectly, that it is their tinnitus rather than their hearing loss that is causing hearing difficulties. Management of hearing loss in adults is covered by NICE guideline NG98. In this review we focus on only those people who have tinnitus" **We strongly agree with this. We also agree that the original scope of this guideline, including evidence searches and analysis, did not duplicate what was done in NG98.** **This has however all been lost in the actual guideline. Unfortunately, we find that the guideline frequently contradicts the above itself at several places, as stated in various comments here.** This is why, as we have set out in our other comments (e.g. see comments 2 and 3), NICE needs to rewrite recommendations so it is clear when readers should use NG98 as the primary resource and what it is they are relying on this tinnitus guideline for.	Thank you for your comments. The committee acknowledges that there is some overlap between the tinnitus guideline and the hearing loss guideline, as hearing loss is common in the tinnitus population. For adults with tinnitus and hearing loss, this guideline should be read in conjunction with the hearing loss in adults guideline (NG98). This has been made clearer in the introduction to the recommendations within the guideline.
British Society of Hearing Aid Audiologists	Evidence Review M	019	005 - 021	As per our comments, this is also completely lost in the actual guideline and needs to be addressed for the same reasons we set out other in comments.	Thank you for your comment. A link to the hearing loss in adults guideline (NG98) is in the amplification devices section, and has been added in the introduction to the recommendations.
British	General	General	General	BSHAA is a professional body for audiologists in the UK and our	Thank you for your comment.

Tinnitus: assessment and management

Consultation on draft guideline - Stakeholder comments table
20/09/2019 to 01/11/2019

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Stakeholder	Document	Page No	Line No	Comments Please insert each new comment in a new row	Developer's response Please respond to each comment
Society of Hearing Aid Audiologists				members are highly trained hearing care professionals who work in a variety of settings including the NHS and independent sector.	
British Society of Hearing Aid Audiologists	General	General	General	BSHAA's response to this consultation aims to help NICE ensure its final guideline is fit for purpose. Our response focuses on helping NICE achieve this goal. More supporting detail is provided below, but **BSHAA is extremely concerned that this overarching point must not be buried by detail**. **The risk of substantial degradation of services for hearing loss is unacceptable**, given that it is the most prevalent source of disability in the UK, and is ranked as one of the highest burdens of disability, (as recognised by WHO). We have one substantial concern that in its current form, the guidance is highly likely to lead to a significant deterioration in access to care for hearing loss amongst the high percentage who have tinnitus as a co-morbidity whilst at the same time increasing the cost of providing hearing care to each individual. As per NG98, the vast majority of hearing care should be provided within routine audiology services, with only a minority requiring referral into specialist audiology. This guidance overturns that recommendation and risks unnecessary referral for the majority of routine cases into more complex care. Diverting routine hearing loss cases into specialist services will lead to service users having much longer waiting times to clinics which are geographically less convenient and accessible. NG98 recommends that the majority of provision of hearing care is community based, which is rarely the case for the specialist treatment that this guideline incorrectly directs patients towards. **It is essential that guidelines for access to and treatment of tinnitus are consistent with and complementary to those for**	Thank you for your comments. The committee acknowledges that there is some overlap between the tinnitus guideline and the hearing loss guideline, as hearing loss is common in the tinnitus population. For adults with tinnitus and hearing loss, this guideline should be read in conjunction with the hearing loss in adults guideline (NG98). This has been made clearer in the introduction to the recommendations within the guideline. The term "tinnitus service" was not intended to mean a specialist service as the committee acknowledges that access to such services is very limited. In using the term "tinnitus service" the committee meant a service that would see people with tinnitus, e.g. audiology or ear, nose and throat. However, the committee has decided to removal any reference to "tinnitus services" to prevent confusion. The committee appreciates that speciality services such as audiology can in fact be delivered in general practice, community settings and within hospitals, and that the majority of people will require routine audiology care. The wording has been changed to reflect this.

Tinnitus: assessment and management

Consultation on draft guideline - Stakeholder comments table
20/09/2019 to 01/11/2019

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Stakeholder	Document	Page No	Line No	Comments Please insert each new comment in a new row	Developer's response Please respond to each comment
				routine hearing loss, and that access to hearing loss treatment is not further undermined in the way this guidance proposes.	
British Society of Hearing Aid Audiologists	General	General	General	1. it is currently set out in a way that will make it difficult to disseminate and use alongside the NICE guideline for adult hearing loss: assessment and management (which included adults with tinnitus and hearing loss) (NG98). This could increase the risk of misreading and misapplication of NICE guidelines and increase the risk of a fitness to practice hearing or even clinical negligence due to poor drafting and lack of attention to detail by NICE when setting out referral guidelines for different population groups etc. NICE must, therefore, do more to ensure: • the guideline does not conflict with NG98 • that referral recommendations are consistent with NG98 (e.g. use "refer" and "consider referring" based on the level of supporting evidence in the same way NG98 does, specify who to refer to (e.g. ENT, A&E etc) as NG98 does etc. • that the issues that arise by trying to merge and extrapolate recommendations in NG98 (which only included adults with tinnitus) with this wider population (all children with tinnitus and adults with 'normal hearing' and tinnitus) are addressed in full; and • the guideline is laid out/presented in a more logical manner for clinicians working on the frontline to make accurate and safe clinical decisions.	Thank you for your comments. The committee acknowledges as many people with tinnitus can also have a hearing loss, this guideline should be read in conjunction with the hearing loss in adults guideline (NG98) for people with tinnitus and hearing loss. A statement to this effect has been added to the introduction of the recommendations . NG98 does not provide guidance for the management of tinnitus. It only covers management for hearing loss, and if a person has both tinnitus and hearing loss, both conditions need to be managed. Whilst NG98 applies only to adults, the committee considered it appropriate for the tinnitus referral recommendations to also apply to children as you would refer in the same way. All recommendations apply to adults, children and young people unless otherwise stated and this has been highlighted in the guideline. The committee reviewed the referral recommendations and have signposted to the relevant related guideline to ensure they are aligned and consistent. Elsewhere the committee decided not to recommend specific locations to refer to due to the variation in service configuration and tinnitus pathways in the UK. In the absence of evidence when considering referral for further investigation and treatment the committee did take into account recommendations made for the same symptoms and signs within other guidelines such as NG98 and NG127, however this was not the approach for the other areas of the guideline. Where the committee agreed the recommendation should be refer rather than consider this was because the population is

Tinnitus: assessment and management

Consultation on draft guideline - Stakeholder comments table
20/09/2019 to 01/11/2019

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Stakeholder	Document	Page No	Line No	Comments Please insert each new comment in a new row	Developer's response Please respond to each comment
				2. NICE is not a lobbying organisation, but an evidence-led/based organisation. It is, therefore, NOT NICE's role to promote, conflate and confuse population-needs when it comes to tinnitus. It is for NICE to help the NHS meet needs in a sustainable and evidence-based way. In our view, NICE has failed to do this with this draft guideline. In this draft tinnitus guideline, NICE has missed a key and central point about population-needs – that an estimated 70 and 90 percent of adults with tinnitus have a hearing loss (as cited in NHS England et al. 2019[i] and the BSA 2019[ii]). **Therefore, in a real-world setting, most adults with tinnitus will present and be managed using NG98 and not this tinnitus guideline.** In fact as the Committee calls for people who report tinnitus to have audiometry (lines 21-22, page 20 of the guideline), there is a strong argument to ensure NG98 is promoted as the principal guidance for the adult population and this NICE guideline focusses on supplementing NG98 with advice on how to manage adults who have 'normal' hearing and tinnitus (i.e. the cohort not covered by NG98) and how to manage those adults with hearing loss and tinnitus who need additional support for their tinnitus distress. Separately, clarity is needed on how to manage the population aged under 18 for both hearing loss and tinnitus and tinnitus without hearing loss, as cross-referencing to NG98 for this population is potentially misleading as NG98 categorically excluded children in literature and evidence-based research. If this guideline wants to extrapolate NG98 recommendations for a different population this should be made clearer in the tinnitus guideline.	different to that of the hearing loss guideline and a person with tinnitus would usually be referred. Where there is overlap with the hearing loss guideline the recommendations have been revised to ensure there is consistency between the two. The committee have discussed the terminology used in the guideline and agree that the wording for "primary care" and "secondary care" should be changed. The intention of the wording was to make it clear that healthcare professionals working in general practice are not expected to use questionnaires such as the TFI. The committee appreciates that speciality services such as audiology can in fact be delivered in general practice, community settings and within hospitals. The wording has been changed to reflect this. The term "tinnitus service" was not intended to mean a specialist service as the committee acknowledges that access to such services is very limited. In using the term "tinnitus service" the committee meant a service that would see people with tinnitus, e.g. audiology or ear, nose and throat. However, the committee has decided to removal any reference to "tinnitus services" to prevent confusion The order and layout of the guideline has been considered by the committee and headings for primary and secondary care removed to aid the reader. Members of this guideline committee have declared their contribution to the BSA guidelines on tinnitus in accordance with the NICE Policy on Declaring and Managing Interests and this has been made available in the Interests register.

Tinnitus: assessment and management

Consultation on draft guideline - Stakeholder comments table
20/09/2019 to 01/11/2019

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Stakeholder	Document	Page No	Line No	Comments Please insert each new comment in a new row	Developer's response Please respond to each comment
				[Note: although we note it is touched on (in the evidence documents), there does not appear to have been any rigorous assessment of NG98 and risks/limitations in generalising recommendations, as evidenced by conflicts/confusion not being addressed etc.] Put simply, many of the problems with the draft guideline appear to stem from extrapolating NG98 – which was based entirely on an adult population and those with hearing loss and tinnitus – to a tinnitus population including children with and without a hearing loss, and adults with tinnitus but without a hearing loss. This mix and match approach as a workaround to a lack of evidence has not worked. It has created a rather confusing guideline. This feedback will clarify how it is confusing for both the professionals as well as members of the public. To address this, in our view, this tinnitus guideline should be consistent with NG98 and supplement it for the adult population not, as it currently does, mix and match and merge various advice incorrectly. 3. Although we appreciate the evidence (as set out in evidence documents A to P) to support recommendations is very limited to non-existent, and that NICE has had to rely on Committee consensus to derive recommendations, it does appear that NICE risks falling into the trap of publishing a confused and somewhat biased guideline. For example, the guideline has confused clinical settings (e.g. primary care and secondary care) with professional groups (GPs and audiologists respectively), and then based on this flawed assumption throughout the consultation documents, NICE has wrongly concluded that patients need to go to secondary care when they do not have to. It then presents this explicitly (e.g. line 23 page 5 of guideline and line 45 in Evidence document E). It is	

Tinnitus: assessment and management

Consultation on draft guideline - Stakeholder comments table
20/09/2019 to 01/11/2019

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Stakeholder	Document	Page No	Line No	Comments Please insert each new comment in a new row	Developer's response Please respond to each comment
				most odd for example for the guideline to be unchallenged on the claim that "The committee has specified that the TFI be used in secondary **care only**" (our emphasis) (line 45 page 8, Evidence document E)".It is not appropriate advice given the lack of clinical evidence to support it and the significantly flawed reasoning given to support the recommendation. It also **risks worsening health inequalities** (a section of members of public (particularly in small towns, village, and remote areas where a 'Tinnitus Service' is not available locally), waiting for longer to access hearing **care service** because the underlying biased and incorrect assumptions. This is particularly significant for people with bilateral symmetrical age-related sensorineural hearing loss who also present with tinnitus. This population makes the bulk of the total population who complains of tinnitus. There is enough evidence to support that hearing aid management of patients with hearing loss, results in significant reduction in tinnitus distress in majority. Why would NICE authorise a guidance that makes these members of public suffer for longer with their distress as well as hearing, when it can be dealt locally and more cost-effectively? It is very important that NICE acknowledges that many NHS funded audiology services are now provided outside secondary care, in primary and community care settings. It is, therefore, not acceptable to claim, especially on the logic set out in the evidence documentation, that a patient should go to secondary care to complete a Tinnitus Functional Index (TFI) questionnaire in a waiting room because GPs do not have time to do it. This confuses and conflates reality because audiology and even ENT clinics can and are run in primary and community care settings and it is more than possible to complete the TFI there. The draft text will therefore just unnecessarily increase capacity pressures and costs in hospital service and inconvenience patients.	

Tinnitus: assessment and management

Consultation on draft guideline - Stakeholder comments table
20/09/2019 to 01/11/2019

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Stakeholder	Document	Page No	Line No	Comments Please insert each new comment in a new row	Developer's response Please respond to each comment
				As a minimum, NICE must show impartiality on the location where care is provided unless evidence indicates otherwise. If NICE wishes to delve into health policy, then it should ensure its recommendations are consistent with and do not contradict the NHS Long Term Plan as the current draft guideline does. The British Society of Audiology (BSA) has recently consulted on its tinnitus guidance for adults. Some NICE Committee members were also noted as authors of the draft BSA guidance. Given both the NICE guideline on tinnitus and the BSA guidance on tinnitus in adults are based largely on Committee consensus it is slightly puzzling that the two projects have taken place at the same time. For example, we are aware that BSA held-off the consultation for its guidance on Aural Care while the NICE's NG98 was pending publication. Notwithstanding that, Given that NICE is aware that its Committee members have special interests in tinnitus and are working on other guidance, as a matter of principle and good governance, it is important that NICE takes a leadership role in the final phase of guideline development in order to ensure the final guideline is objective/non-biased,focusses on population needs, evidence and benefits for patients and the NHS, risk free, does not contradicts NICE's own published guidelines, promotes health equalities and is beyond challenge.	
British Society of Hearing Aid Audiologists	Guideline	003	002	There is significant overlap between NICE's adult hearing loss guideline (NG98) and this guideline with respect to the population covered. The guideline should open with a clear statement that, for people aged 18 and older, this guideline supplements rather than replaces referral and management advice in NG98 which already covers adults who have a hearing loss and tinnitus (which represents the majority when viewing population needs, see NHS England, Public Health England guidance.	Thank you for your comments. The committee acknowledges that there is some overlap between the tinnitus guideline and the hearing loss guideline, as hearing loss is common in the tinnitus population. This guideline should be read in conjunction with the hearing loss in adults guideline (NG98) for people with both tinnitus and hearing loss. The recommendations of both guidelines may need to be followed in parallel This has been made clearer within the introduction to the recommendations.
British	Guideline	004 - 005	020 - 021	There is significant overlap between NICE's adult hearing loss guideline	Thank you for your comments. The committee acknowledges

Tinnitus: assessment and management

Consultation on draft guideline - Stakeholder comments table
20/09/2019 to 01/11/2019

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Stakeholder	Document	Page No	Line No	Comments Please insert each new comment in a new row	Developer's response Please respond to each comment
Society of Hearing Aid Audiologists				(NG98). On this basis Section 1.2, "Assessing Tinnitus" needs to be deconstructed and rewritten in our view. Our advice is to: 1. Separate out people o aged under 18 and o 18 and older 2. Aged 18 and older: Make it clear that NG98 applies to all adults with hearing loss, or suspected of hearing loss, including those with tinnitus and this NICE guidance should be read as a supplement to NG98. Then only include what is additional to NG98 – e.g. how to manage adults with tinnitus who present without hearing loss or have tinnitus that is referable independent of hearing loss, e.g. so that when people read both guidelines together adults with hearing loss, adults with hearing loss and tinnitus, adults-only with tinnitus end up being referred and managed consistently because both guidelines work well together – this is not currently the case (see comment two) 3. Aged under 18: Make it clearer that there is no NICE guideline for children's hearing loss in the main guideline (not only in the evidence documents which few people read). That the Committee recommends that clinicians refer to NG98 on how to manage hearing loss and tinnitus in children (note we expect the Committee or NICE will see at this stage how this is not the correct use of NG98 and might even pose risks, but at least it will make the decision explicit and make it clear to readers who might otherwise understandably, albeit wrongly assume, NICE's advice for children is evidence-based and/or based on a robust process). Make clear how tinnitus in children (aged under 18) should be managed.	that there is some overlap between the tinnitus guideline and the hearing loss guideline, as hearing loss is common in the tinnitus population. For adults with tinnitus and hearing loss, this guideline should be read in conjunction with the hearing loss in adults guideline (NG98) and the recommendations of both guidelines may need to be followed in parallel . This has been made clearer within the introduction to the recommendations. Whilst NG98 applies to adults, it was considered appropriate for the tinnitus referral recommendations to also apply to children because decision to refer would be the same for both populations. The committee does not consider any risk is posed as long as they are referred to and are seen within a children's service. When considering recommendations the committee discussed whether the same management would apply to children and young people as well as to adults. The committee agreed the same intervention would be used for both populations. Where this is not the case the recommendation specifies which population the recommendation is applicable to. To ensure clarity, a statement outlining this has also been added to the introductory section of the recommendations Whilst the NG98 guideline recommends specific referral locations within its recommendations, the committee discussed this and decided that it is not possible to be specific for tinnitus as there is variation in local pathways and care models. Where this guideline signposts to other NICE guidance the recommendations have been checked to ensure consistency, and, where necessary, recommendations have amended to ensure that conflicting guidance has not been given.

Tinnitus: assessment and management

Consultation on draft guideline - Stakeholder comments table
20/09/2019 to 01/11/2019

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Stakeholder	Document	Page No	Line No	Comments Please insert each new comment in a new row	Developer's response Please respond to each comment
				4. Make sure that if criteria in NG98 are presented in this guideline they are correctly referenced. For example, at present o it incorrectly uses "refer" when it should be "consider referring" for some signs/symptoms o it fails to correctly/fully cite the referral pathway recommended in NG98, where it is much clearer on when to refer to ENT, A&E and a stroke service etc.	
British Society of Hearing Aid Audiologists	Guideline	005	016	See comment 5. If NICE takes that feedback on board, signs/symptoms such as "objective tinnitus" should not be buried in the list in section 1.2.3.	Thank you for your comment.
British Society of Hearing Aid Audiologists	Guideline	005	023 - 025	Line 23 states "Initial assessment in secondary care". This is simply not the case and there is no evidence to support such a recommendation, it is based solely on a gross misunderstanding/labelling of clinical settings and incorrectly mixing/matching this with professional groups, which has then been inappropriately applied to this recommendation. We recommend that it should be changed to, "Initial assessment by audiology or ENT (working in primary, community or secondary care settings)". Alternatively, NICE might wish to allow others to complete this, and it might read Initial assessment by a suitably qualified health care professional (working in primary, community or secondary care settings)" – e.g. a psychologist might use the TFI plus other instruments to assess mental health. Given the reasoning set out in Evidence document E this current strong default to secondary care settings is wholly inappropriate. Please see comments, which explain why we strongly object to the recommendation. Line 23 (and supporting document E) should also be changed so that it	Thank you for your comments. The committee have discussed the terminology used in the guideline and agree that the wording for "primary care" and "secondary care" should be changed. The intention of the wording was to make it clear that healthcare professionals working in general practice are not expected to use questionnaires such as the TFI. The committee appreciates that speciality services such as audiology can in fact be delivered in general practice, community settings and within hospitals. The wording has been changed to reflect this.

Tinnitus: assessment and management

Consultation on draft guideline - Stakeholder comments table
20/09/2019 to 01/11/2019

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Stakeholder	Document	Page No	Line No	Comments Please insert each new comment in a new row	Developer's response Please respond to each comment
				is independent of location where ENT and audiology might work and it should also not use "primary care settings" as a synonym for "GPs", nor incorrectly suggest audiologists/ENT only work in "secondary care". We therefore also ask NICE to change line 23 – and supporting text in evidence document E – to "Initial assessment by audiology or ENT (working in primary, community or secondary care settings)"	
British Society of Hearing Aid Audiologists	Guideline	007	015 - 022	This section risks confusing people. Most adults with tinnitus will have an audiological assessment based on the NICE guideline for adult hearing loss (NG98) because it covers adults with tinnitus and hearing loss. This tinnitus guideline should be framed in a way to complement NG98, especially given NG98 provides much more detail on what a routine adult audiological assessment should include. It, for example, should state for adults with hearing loss, or suspected to have hearing loss, use NG98. In addition, it can include recommendations 1.3.3 and 1.3.4. It can then specify which audiological tests should be performed when an adult has tinnitus but no hearing loss – i.e. when NG98 will not apply. With respect to children and adults who might not be able to perform audiometry, recommendation 1.3.1 warrants further consideration – although for adults that are within scope for NG98 this is not an issue as it is already covered in NG98. There should be explicit reference to the questioning and identification of recruitment and/or hyperacusis within the Tinnitus Assessment, as patients may not link both conditions, and this may cause concerns in treatment programmes if they include amplification	Thank you for your comments. The committee acknowledges that there is some overlap between the tinnitus guideline and the hearing loss guideline, as hearing loss is common in the tinnitus population. This guideline should be read in conjunction with the hearing loss in adults guideline (NG98) for people with tinnitus and hearing loss. This has been made clearer within the introduction to the recommendations. For children and those with cognitive or learning difficulties, the committee recommends that hearing test is done according to their level of ability, this is highlighted in the rationale and impact section associated with this recommendation. Sound sensitivities including hyperacusis is not within the scope of this guideline.

Tinnitus: assessment and management

Consultation on draft guideline - Stakeholder comments table
20/09/2019 to 01/11/2019

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Stakeholder	Document	Page No	Line No	Comments Please insert each new comment in a new row	Developer's response Please respond to each comment
				Please see our comments which set out our concerns about the way this guideline has selectively referred to NG98.	
British Society of Hearing Aid Audiologists	Guideline	008	004 - 014	It is important to note that the NG98 process – https://www.nice.org.uk/guidance/ng98/evidence/full-guideline-pdf-4852693117 – included a more extensive review of the evidence on MRI referral criteria in adults presenting with audiological symptoms (including hearing loss and tinnitus) in terms of the sensitivity and specificity of various referral thresholds. It is important the NICE tinnitus guideline is clearer about whether its recommendations in sections related to imaging apply specifically to: - adults with tinnitus and no hearing loss - children with tinnitus and hearing loss - children with tinnitus and no hearing loss Put simply, in our view NICE needs to more clearly set out when NG98 applies and when this guideline applies in terms of referring for imaging.	Thank you for your comments. The committee acknowledges that there is some overlap between the tinnitus guideline and the hearing loss guideline, as hearing loss is common in the tinnitus population. For adults with tinnitus and hearing loss, this guideline should be read in conjunction with the hearing loss in adults guideline (NG98) for imaging recommendations. This has been made clearer within the introduction to the recommendations. The imaging recommendations for people with pulsatile and non-pulsatile tinnitus within this guideline are for both adults and children. All recommendations apply to both populations unless otherwise stated. The approaches taken to review the evidence around imaging was the same for both the hearing loss guideline and this guideline. Relevant evidence was identified for the hearing loss guideline, consequently it was appropriate to make more specific recommendations.
British Society of Hearing Aid Audiologists	Guideline	009	015 - 028	Behavioural Therapies: Audiologist delivered CBT programmes have been shown to be as effective (see Aazh 2016, and P11-line 18-22 of this document), and would be a relevant delivery mechanism, reducing demand to Psychological therapy services. The guidance should include this pathway where the audiologist is appropriately trained and clinically supported	Thank you for your comment. The committee discussed your proposal and decided that there is not enough evidence to support audiology-led CBT programmes. The committee thought that it is important to evaluate the clinical effectiveness and cost-effectiveness of CBT delivered by appropriately trained healthcare professionals such as audiologists and a research recommendation was made. Full details for this research recommendation can be found in Evidence Review L. Details include what the committee would be like research to look like, e.g. outcomes and study design.
British Society of Hearing Aid	Guideline	009	022 - 023	It is notable that the guideline has stated elsewhere that to reduce pressure on GPs, whilst ignoring audiology and ENT services are also based in non-secondary care settings, patients must travel to the	Thank you for your comments. The committee have discussed the terminology used in the guideline and agree that the wording for "primary care" and "secondary care" should be changed. The

Tinnitus: assessment and management

Consultation on draft guideline - Stakeholder comments table
20/09/2019 to 01/11/2019

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Stakeholder	Document	Page No	Line No	Comments Please insert each new comment in a new row	Developer's response Please respond to each comment
Audiologists				hospital (secondary care) to complete a Tinnitus Functional Index (TFI). BSHAA has made it clear that it strongly disagrees with that biased recommendation. Yet here the guidance has been more objective and taken an NHS perspective and is supporting NHS funded digital-based CBT provided by a psychologist for people with tinnitus-related distress. We do wonder if the economic analysis and guideline recommendation favoured band >7 audiologists in secondary care doing CBT, whether the willingness to support online CBT would still exist – i.e. it is confusing that on one hand the guidance can be so regressive and on the other progressive. As we are agnostic on location unless the evidence supports it, the BSHAA does support providing NHS funded psychologist led CBT online because this will allow more adults with more severe tinnitus to access much-needed support while being managed by audiology (e.g. under NG98) for their hearing loss, for example. Again, we urge NICE to challenge the Committee on the need to perform the TFI in a secondary care setting.	intention of the wording was to make it clear that healthcare professionals working in general practice are not expected to use questionnaires such as the TFI. The committee appreciates that speciality services such as audiology can in fact be delivered in general practice, community settings and within hospitals. The wording has been changed to reflect this. Within the UK there is, as yet, no provision of online CBT specifically for tinnitus. One UK study has been conducted; the service has not been rolled out for provision beyond the research setting. The evidence for CBT in tinnitus management is based on psychologists providing that service and the entry level grade for psychologists within the NHS is band 7. The provision of CBT for tinnitus by audiologists is untested (only 1 study exists). The economic modelling for the possibility of audiology delivered CBT is based on this being done by audiologist with the experience of a band 7. The committee appreciates that audiologists providing psychological interventions such as CBT would increase access for people with tinnitus. However, the committee also explained that audiologists could potentially require greater supervision from psychologists which would make the psychological interventions more expensive than if they are delivered by psychologists only. The committee therefore decided to make a research recommendation to explore the clinical and cost-effectiveness of CBT delivered by appropriately trained non-psychologists which would include audiologists.
British Society of	Guideline	011	008 - 014	We agree with the Committee – page 14 lines 5-14 – that "tinnitus support" is preferable to "tinnitus counselling".	Thank you for your comment. In response to your comment about audiologist pay bands, we believe you were referring to

Tinnitus: assessment and management

Consultation on draft guideline - Stakeholder comments table
20/09/2019 to 01/11/2019

Comments forms with attachments such as research articles, letters or leaflets cannot be accepted.

Stakeholder	Document	Page No	Line No	Comments Please insert each new comment in a new row	Developer's response Please respond to each comment
Hearing Aid Audiologists				We have noticed a trend to refer to "counselling" as one way to create new pay bands in audiology. Pay bands in our view are secondary to the scope of practice and qualifications of a regulated healthcare professional. For example, somebody with many clinical and management duties might be on a higher pay band compared to an audiologist who has opted to do a counselling course and offer a niche hearing therapy service. Therefore, although we did not agree with the use of data that assumes only higher pay banded audiologists can offer more specialist tinnitus support – e.g. in terms of audiology input costs and do see that in part as an example of confusing pay bands and scope of practice and value-added for the NHS – we do support using "tinnitus support" rather than "tinnitus counselling" for the reason the Committee sets out.	Evidence Review L on psychological therapies (pg 79, line 46-49). We have now changed the wording to 'the committee stated that they would most likely be a band 7 member of staff' to make the language less strong.
British Society of Hearing Aid Audiologists	Guideline	012	006 - 010	In our view this again highlights a fundamental error, confusing primary care settings as being synonymous only with GPs, this needs to be addressed.	Thank you for your comment. The committee discussed this and have agreed to change the wording; "primary care" has been changed to "general practice" throughout the guideline documents.
British Society of Hearing Aid Audiologists	Guideline	016	024	"Initial assessment secondary care", change to "Initial assessment by audiology or ENT (working in primary, community or secondary care settings)" Please see comments where we set out why this is problematic and why it should be changed. Again, here for ease of reference, it highlights how the guideline has made a series of assumptions which do not hold – e.g. the idea that GPs are primary care and audiologist/ENT are based in secondary care, which not only is incorrect today but also in conflict with the NHS Long Term Plan objectives.	Thank you for your comments. The committee have discussed the terminology used in the guideline and agree that the wording for "primary care" and "secondary care" should be changed. The intention of the wording was to make it clear that healthcare professionals working in general practice are not expected to use questionnaires such as the TFI. The committee appreciates that speciality services such as audiology can in fact be delivered in general practice, community settings and within hospitals. The wording has been changed to reflect this.

Tinnitus: assessment and management

Consultation on draft guideline - Stakeholder comments table
20/09/2019 to 01/11/2019

Comments forms with attachments such as research articles, letters or leaflets cannot be accepted.

Stakeholder	Document	Page No	Line No	Comments Please insert each new comment in a new row	Developer's response Please respond to each comment
				It is, in our view, both wrong and absurd then that NICE guideline based on no evidence should be able to claim an initial assessment has to take place in a secondary care setting because today GPs do not use the recommended Tinnitus Functional Index (TFI), and patients must, therefore, travel to secondary care in order to complete a questionnaire: - "The guideline noted that questionnaires are not commonly used in primary care and there is also variation in how tinnitus is assessed in primary care. The committee believes that research is conducted to examine the optimal method for assessing tinnitus in primary care settings as primary care is a gatekeeper for the further management of tinnitus" (Guideline, lines 18-22, page 17) - The guideline has specified that the TFI be used in secondary care only. The rationale for this is that the committee were conscious of the potential resource impact of completing and discussing these questionnaires in primary care where general practitioners are limited on time" (Evidence E page 8, lines 45-48) This ignores that audiologists – who can use this questionnaire – also work in primary and community-based settings. It also **risks worsening health inequalities** because the underlying incorrect assumptions about where audiologists work means that people might have to travel further to access care where they will complete a questionnaire they could have completed elsewhere.	
British Society of Hearing Aid Audiologists	Guideline	018	027 - 028	"they can be used within other secondary care services such as audiology". Again in follow-up to other comments this is an inappropriate statement in the context of the guideline scope and population need and informing readers etc. Audiology services – provided in primary, community or	Thank you for your comments. The committee have discussed the terminology used in the guideline and agree that the wording for "primary care" and "secondary care" should be changed. The intention of the wording was to make it clear that healthcare professionals working in general practice are not expected to use questionnaires such as the TFI. The committee appreciates

Tinnitus: assessment and management

Consultation on draft guideline - Stakeholder comments table
20/09/2019 to 01/11/2019

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Stakeholder	Document	Page No	Line No	Comments Please insert each new comment in a new row	Developer's response Please respond to each comment
				secondary care settings – can use the questionnaires in question. The random and repetitive references to secondary care throughout this guideline risk undermining trust in the probity and processes at NICE. For example, in this case audiologists and ENT work in community settings, and audiologists are increasingly working in primary care settings, and furthermore, the NHS Long Term Plan is clear on the need to reduce pressure on secondary care and reduce unnecessary visits to hospital etc.	that speciality services such as audiology can in fact be delivered in general practice, community settings and within hospitals. The wording has been changed to reflect this.
British Society of Hearing Aid Audiologists	Guideline	020	019 - 022	The guideline is right in that many people with tinnitus will not know they have a hearing loss and that this could be contributing to their tinnitus (lines 19-21). It is also correct that effective management of hearing loss can help reduce the audibility and impacts of hearing loss (lines 25-25) and people should, therefore, receive audiometry if they report tinnitus (lines 21-22). However, the vast majority of adults with tinnitus will have a hearing loss and this is missed/overlooked in the guideline itself. People reading this tinnitus guideline, for example, will not know that most adults with tinnitus will and should initially be managed via NG98 (see comments 2 and 3). It is essential that NICE makes it clear that most healthcare professionals should be aware that this tinnitus guideline should be read alongside NG98.	Thank you for your comments. The committee acknowledges that there is some overlap between the tinnitus guideline and the hearing loss guideline, as hearing loss is common in the tinnitus population. For adults with tinnitus and hearing loss, this guideline should be read in conjunction with the hearing loss in adults guideline (NG98). This has been made clearer within the introduction to the recommendations.
British Society of Hearing Aid Audiologists	Guideline	022	024 - 025	Although we acknowledge that NG98 is appropriately referenced here, it is very important to note that the majority of adults with tinnitus will have hearing loss and not warrant referral specifically for their tinnitus and therefore more adults with tinnitus will be managed using NG98 and using only parts of this NICE guideline as required. Patients and clinicians would benefit greatly if NICE could rewrite this guideline in order to facilitate dissemination and limit confusion/risk.	Thank you for your comments. The committee acknowledges that there is some overlap between the tinnitus guideline and the hearing loss guideline, as hearing loss is common in the tinnitus population. For adults with tinnitus and hearing loss, this guideline should be read in conjunction with the hearing loss in adults guideline (NG98). This has been made clearer within the introduction to the recommendations.
British Society of Hearing Aid	Guideline	025	028	The recommendation refers to ACT as a third wave CBT approach and therefore, mindfulness based stress reduction (MBSR) should also be considered separately and in line with the economic modelling	Thank you for your comment. No relevant evidence was identified that evaluated mindfulness based stress reduction (MBSR), it was not considered as a management option by the

Tinnitus: assessment and management

Consultation on draft guideline - Stakeholder comments table
20/09/2019 to 01/11/2019

Comments forms with attachments such as research articles, letters or leaflets cannot be accepted.

Stakeholder	Document	Page No	Line No	Comments Please insert each new comment in a new row	Developer's response Please respond to each comment
Audiologists				suggested.	committee.
British Society of Hearing Aid Audiologists	Guideline	029	018 - 019	"Tinnitus is a common condition. In Commissioning services for people with hearing loss (2016) NHS England estimates between 10% and 15% of adults will have tinnitus, and 3% of adults will go on to require a clinical intervention for their tinnitus." We agree with this. However, it leaves the reader unaware that the majority of adults with tinnitus have a hearing loss (see comments 2 and 3) and should follow NG98. It is essential in our view that this opening statement makes it clear, if using NHS supported guidance (endnote i) that over 70% or 90% (if using endnote ii) of adults with tinnitus are likely to have a hearing loss and most will be managed using NG98 and where applicable this guideline in addition to that. That 20% to 30% of adults with tinnitus might not have a hearing loss but should still be referred for an audiological assessment as per NG98 (for hearing difficulties) and this guideline's recommendation that everybody should have audiometry etc., but are likely to be managed using this tinnitus guideline if they are found not to have a hearing loss.	Thank you for your comments. The committee acknowledges that there is some overlap between the tinnitus guideline and the hearing loss guideline, as hearing loss is common in the tinnitus population. The guideline makes clear within this section that tinnitus is often associated with hearing loss. For adults with tinnitus and hearing loss, this guideline should be read in conjunction with the hearing loss in adults guideline (NG98). This has been made clearer within the introduction to the recommendations.
British Society of Hearing Aid Audiologists	Guideline	9	3-9	"Managing tinnitus for people referred to tinnitus service" and recommendation 1.4.1 and 1.4.2 (lines 5-9) must be reviewed. <u>Adults (aged 18 and older)</u> Most adults in the population with hearing loss, or suspected hearing loss and tinnitus-related symptoms will be referred for a routine audiology appointment based on NG98 (the NICE hearing loss guideline) (see our comment 2, point 2) and will **<u>not</u>** be referred to a "tinnitus service" as suggested here in section 1.4. This must be addressed for the following reasons:	Thank you for your comments. The term "tinnitus service" was not intended to mean a specialist service as the committee acknowledges that access to such services is very limited. In using the term "tinnitus service" the committee meant a service that would see people with tinnitus, e.g. audiology or ear, nose and throat. However, the committee has decided to remove any reference to "tinnitus services" to prevent confusion. The committee decided not to recommend specific locations to refer to due to the variation in service configuration and tinnitus pathways in the UK. The committee acknowledges that there is some overlap

Tinnitus: assessment and management

Consultation on draft guideline - Stakeholder comments table
20/09/2019 to 01/11/2019

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				1.4.1 is clearly something that would be based on the evidence set out in NG98, not any evidence collected during the development of this guideline. This is not something that has to take place in a "tinnitus service". This could also result in up-coding in the NHS and people fitted with hearing aids described as "tinnitus patients" when in fact hearing aids will not be fitted for tinnitus – as recommendation 1.4.3 makes clear – and this is actually by definition (referring to NG98) an adult hearing loss service. 1.4.2 offers advice on when to fit a hearing aid in addition to advice set out in NG98. This could, therefore, be complementary clinical advice for adult hearing clinics where these tinnitus patients are most likely to present. Again, this is not something that has to take place in a "tinnitus service" as suggested and by framing it this way could lead to up-coding and result in the NHS spending more money on pathways for no evidence-based or economic reason. We therefore strongly recommend that this is made clear in this guideline – i.e. these patients can be managed by an audiology service as set out in NG98 and if a patient has a non-symptomatic hearing loss (i.e. audiometry detects a hearing loss but this is not the patients primary complaint) but hearing aids help improve tinnitus symptoms because they address what is fundamentally a hearing loss (i.e. the cause and effect is actually unsupported hearing loss resulting in tinnitus), then hearing aids should be provided if this helps address tinnitus. This is not only important for the concerned providers but also for members of the public. It **risks worsening health inequalities** because of the underlying incorrect assumptions. 'Tinnitus Service' is not available in every audiology department but all adult audiology departments will provide 'Hearing Aid Service'. So, a member of the public in their late 60's, presenting to their GP for their tinnitus, should not wait to have a hearing assessment done and hearing aids fitted locally, just because there is no local 'Tinnitus Service'. If after having	between the tinnitus guideline and the hearing loss guideline, as hearing loss is common in the tinnitus population. For adults with tinnitus and hearing loss, this guideline should be read in conjunction with the hearing loss in adults guideline (NG98). This has been made clearer within the introduction to the recommendations. Whilst NG98 applies only to adults, it was considered appropriate for the tinnitus referral and amplification recommendations to also apply to children and young people because management options would be the similar for this population. Therefore, as recommended for adults, children should not be fitted with hearing aids if they do not have a hearing loss. All recommendations within the guideline apply to both populations unless otherwise stated and this has been clarified within the introductory section of the guideline. The committee consider the guideline is consistent with the NHS England model service specification for children's services. The committee agrees that paediatric services need to adhere to quality standards relating to children. However, this document does not provide sufficient information about assessing and managing children with tinnitus with/without hearing loss. The committee agreed that referring to this document is not necessary.

Tinnitus: assessment and management

Consultation on draft guideline - Stakeholder comments table
20/09/2019 to 01/11/2019

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Stakeholder	Document	Page No	Line No	Comments Please insert each new comment in a new row	Developer's response Please respond to each comment
				the hearing devices and initial conversation with their audiologists, the tinnitus distress is significant, their audiologist is best placed to refer them to the nearest Tinnitus Service. This saves money for the NHS, appointment time for the end-users, and makes the care pathway much more efficient. By law, our members (Health and Care Professions Council registered Hearing Aid Dispensers) are required to make appropriate referrals when needed. So, protection to the public is already safeguarded. Audiologists working in NHS hospitals are usually registered via the Registration Council for Clinical Physiologists (RCCP). Although it is voluntary registration, a fitness-to-practice process is in place with RCCP too. 1.4.3 applies to adults specifically covered by this guideline, not NG98 – i.e. adults with tinnitus but no hearing loss were excluded from the scope in NG98. It is clear therefore by simple logic, a "tinnitus service" does not primarily fit hearing aids. Therefore, this tinnitus guideline should complement NG98 in order to avoid conflation and confusion about population needs and the need to commission separate "tinnitus services" to fit hearing aids as this is not at all necessary. If there are specialist tinnitus services they can work with audiology services working to NG98 and the NICE Quality Standard for hearing loss. These might often be run by the same provider/team, but clarity here will help ensure tinnitus support is actually commissioned and funded correctly at the same time as avoiding the risk of up-coding and duplication of services which cost the NHS and thus other patients in foregone care. <u>Children (people aged under 18)</u> It is not clear at all how NICE has read NG98 across to children. Unless the reader dives into the detail this is likely to be missed. It would be best in our view for NICE to make the basis for its recommendations more transparent.	

Tinnitus: assessment and management

Consultation on draft guideline - Stakeholder comments table
20/09/2019 to 01/11/2019

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Stakeholder	Document	Page No	Line No	Comments Please insert each new comment in a new row	Developer's response Please respond to each comment
				In case it is helpful, in our view, it might be best instead to refer readers to the NHS model service specifications for children ▪ hearing services for children, https://www.england.nhs.uk/wp-content/uploads/2016/07/P37-CYP-Service-Specification-Template.pdf which is part of the NHS commissioning framework[iii] Then advise that children should not be fitted with hearing aids if they do not have a hearing loss.	
British Tinnitus Association	General	General	General	Respondents mentioned being prescribed "*benzodiazepines", "painkillers"* and *"Nortriptyline"*. While we know there is no clinically evidenced pharmaceutical treatment for tinnitus we know that many people report being prescribed drugs in primary care (McFerran et al 2018). **We would like to see these guidelines to offer clearer direction to clinicians about prescribing for tinnitus.** McFerran, D., Hoare, D. J., Carr, S., Ray, J., & Stockdale, D. (2018). Tinnitus services in the United Kingdom: a survey of patient experiences. *BMC health services research*, *18*(1), 110.	Thank you for your comment. Drugs can be prescribed to treat comorbid conditions such as depression but these don't treat tinnitus per se. The guideline focused on betahistine because it is more commonly prescribed as treatment for tinnitus. There are no licensed drugs for treating tinnitus and therefore the committee were unable to provide further guidance.
British Tinnitus Association	General	General	General	These guidelines do not mention musical hallucinations / musical tinnitus, and tinnitus heard outside the head. **We want the committee to consider specific recommendations to aid GPs in identifying atypical or unusual tinnitus.** One respondent highlighted, *"it does depend on the type of tinnitus the patient is suffering from. I have musical hallucinations and have received no support or help with this."*	Thank you for your comment. Identifying atypical or unusual tinnitus was not identified for inclusion in the scope of the guideline.
British Tinnitus	General	General	General	**We want the committee to discuss one omission identified by a professional,** "*There seems to be no mention in the guidelines of*	Thank you for your comment. The scope of this guideline does not cover the different causes of tinnitus and specific

Tinnitus: assessment and management

Consultation on draft guideline - Stakeholder comments table
20/09/2019 to 01/11/2019

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Stakeholder	Document	Page No	Line No	Comments Please insert each new comment in a new row	Developer's response Please respond to each comment
Association				*tinnitus as a feature of intracranial hypertension (particularly idiopathic intracranial hypertension: IIH). This is a common condition, of which tinnitus is a common feature, and can cause permanent blindness if not appropriately treated. I would suggest that examination of optic discs to search for papilloedema (ideally by an Ophthalmologist or Optician, or by another clinician appropriately skilled in fundoscopy) should be mandatory where bilateral tinnitus (especially if pulsatile) is accompanied by new headaches or visual disturbances, especially in young women or in the context of obesity or rapid weight gain. Where there is significant loss of visual function, this should be undertaken as a matter of urgency*." See guidelines PMID 1998880 and PMID 29903905.	examination methods. The committee agree a thorough physical examination is important, but the details of this were not identified as a priority to include within the guideline. Recommendations have been made for referrals for people with tinnitus and neurological symptoms including visual disturbances. Upon assessing tinnitus, healthcare professionals should refer to the relevant specialities so that appropriate care can be received.
British Tinnitus Association	Guideline	003	002	98% of the respondents (n=893) agreed with this recommendation. One professional commented, *"Collaborative care planning is vital, there is good evidence for this not only in tinnitus but across disorders.*"	Thank you for your comment.
British Tinnitus Association	Guideline	003	004	We question whether "All stages of care" should include follow-up reviews for those living with long-term tinnitus. One consultation participant stated, *"I think patients should be systematically reviewed after a set number of months after the treatment has finished, so they know that they are not alone and so that they can be assessed to see if they need further/other treatment/support."* Others said: *"Have a regular review procedure for people with long term chronic tinnitus."* *"Ongoing support needed after initial support you are then expected to just get on with it. Tinnitus can last for a lifetime support needs to be ongoing."*	Thank you for your comment. The committee agrees that tinnitus and its impact can change over time. Where tinnitus is troublesome, it can be helpful to review the factors affecting tinnitus and its impact, as the management plan may need to be revised. This has been added into the rationale and impact section associated with this recommendation.
British Tinnitus Association	Guideline	003	011	We completely agree that a management plan should be developed. **What is missing is that the plan should then be available to all healthcare professionals involved with the patient.** One participant	Thank you for your comment. This recommendation has been amended; your proposed change has been accepted by the committee.

Tinnitus: assessment and management

Consultation on draft guideline - Stakeholder comments table
20/09/2019 to 01/11/2019

Comments forms with attachments such as research articles, letters or leaflets cannot be accepted.

Stakeholder	Document	Page No	Line No	Comments Please insert each new comment in a new row	Developer's response Please respond to each comment
				in our consultation stated, *"I would like to see all healthcare professionals involved in the treatment of a tinnitus patient communicating at every step of treatment. What someone thinks is right for mental health treatment could have disastrous effects on the tinnitus treatment and recovery... The healthcare professionals are only experts in their own fields so should liaise with all treating practitioners. If this had been done with my husband he probably would not have killed himself as his symptoms would not have been exacerbated by inappropriate medication and lack of follow up care."* Another said, *"Gather evidence form multiple experts. Recently [one] hospital did not know what was happening at [the other hospital]" (data anonymised in brackets)."*	
British Tinnitus Association	Guideline	003	015	92% of the respondents (n=777) agreed with this recommendation, but additional comments indicate that more work might be required, "*reassurance is important however there needs to be acknowledgement that there are varying levels of tinnitus, so while tinnitus is common, severe tinnitus is less common and very distressing. At the point where it is distressing, I think it will be beneficial to reassure people that the distress it causes will subside."* *"Reassurance is good but as long as it's not patronising. I was told by several GPs to just try to ignore it that was at my lowest point when I had awful dark thoughts. I felt a burden and a failure because I couldn't ignore it."* Many patients are either blocked or return to a GP after being discharged by secondary care resulting in an unsatisfactory and costly revolving-door of healthcare. (McFerran et al. 2018). **We want to consider rewording this recommendation**. Suggest rephrasing this to 'Clearly advise people about the things they can do to help manage tinnitus.' Rephrasing will help minimise healthcare	Thank you for your comment. The wording has been amended. It is clearer that a variety of management strategies can help many people live well with tinnitus. The study referenced was not included as it does not address the question about what information people with tinnitus would want. The research was a quantitative survey of patient experiences)

Tinnitus: assessment and management

Consultation on draft guideline - Stakeholder comments table
20/09/2019 to 01/11/2019

Comments forms with attachments such as research articles, letters or leaflets cannot be accepted.

Stakeholder	Document	Page No	Line No	Comments Please insert each new comment in a new row	Developer's response Please respond to each comment
				professionals from dismissing their concerns and prevent patients from catastrophizing their experience. McFerran, D., Hoare, D. J., Carr, S., Ray, J., & Stockdale, D. (2018). Tinnitus services in the United Kingdom: a survey of patient experiences. *BMC health services research*, *18*(1), 110.	
British Tinnitus Association	Guideline	003	015	**We would also like to consider adding to this recommendation.** The guidelines do not refer to preventative measures that patients can take to avoid making their tinnitus worse. Include information about the steps to take to prevent exacerbating existing tinnitus: "*A recommendation to issue guidance on preventative measures. People with tinnitus could still develop worse tinnitus if they don't protect their ears."*	Thank you for your comment. This recommendation has been amended to include preventative measures.
British Tinnitus Association	Guideline	003	020	Many patients engage in seeking help from inappropriate places that are actively unhelpful. **We want the committee to include/mention strategies that might not be helpful for people and where no evidence is available**, for example, alternative therapies, diet, and caffeine intake. One respondent commented, *"Not a professional to know what might be missing. From my own experience; I would have welcomed unbiased professional advice on diagnosis on the effectiveness of alternative therapies available on the market to ensure the individual doesn't waste time and money looking for a 'cure' that's not there."*	Thank you for your comment. We have not reviewed the evidence for this as it is outside of the scope of this guideline, so the committee are unable to provide comment on this.
British Tinnitus Association	Guideline	004	001	99% of the respondents (n=777) agreed with this recommendation. However, the implementation of the guideline generated many concerns from patients. **We want these guidelines to identify the importance of training and Continuing Professional Development around tinnitus.** Missing from this guidance is the level of knowledge of the	Thank you for your comments. Identification of training and continuing professional development around tinnitus is outside of the scope of this guideline. The committee agree that health professionals delivering care to people with tinnitus should have the required qualifications, skills and competencies. This would

Tinnitus: assessment and management

Consultation on draft guideline - Stakeholder comments table
20/09/2019 to 01/11/2019

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Stakeholder	Document	Page No	Line No	Comments Please insert each new comment in a new row	Developer's response Please respond to each comment
				assessment and management of tinnitus expected from the Health Care Practitioner. If GPs gave good advice it might prevent the cascade of thoughts and behaviours that lead to persistent distress. Participants stated, "*currently the awareness from health practitioners is very low, and therefore this guidance only is effective if all practitioners are appropriately trained*". Another commented, "*The guidance is great, as long as health professionals approach client*s *in a manner that is supportive and not dismissive. It's a big deal to someone trying to adjust, so bear that in mind*." and "*The training level of health care professionals. In my opinion when a patient attends the Audiology department it should be an Audiologist of senior level with further training, specifically in tinnitus management, that should be attending to these patients."* GPs, in particular, were identified as needing the most support with tinnitus patients "*I feel that Tinnitus should be treated in a way that gives people some hope of relief, instead of being told, nothing can be done about it.", "So important that GP's know that there is help available and not just to say you have got tinnitus and there is no cure. It happened to me*." and "*I went to my Dr for help and she told me there is nothing else they can do for me. Sometimes it's easy to feel lost and alone.", "All I got was "You know there's no cure don't you?" from my GP*" and *"On my first GP visit, 20 years ago, I was told there was nothing that could be done and I would just to have to 'learn to live with it'. A very damaging comment that caused me extreme anxiety and depression. I recently learned from being involved with a local Support Group that GP's are still giving negative advice."*	be determined locally. Your comments will be considered by NICE where relevant support activity is being planned'
British Tinnitus Association	Guideline	004	005	**Suggestion to include more common comorbidities**, and factors such as "*neck problems*", "*head injury*" and hormonal changes ("*menopause*" and "*pregnancy*" were mentioned by respondents).	Thank you for your comment. The committee are unable to include specific details about what may have caused/can affect tinnitus, as they are variable and evidence was not reviewed. Therefore, specific recommendations cannot be made.

Tinnitus: assessment and management

Consultation on draft guideline - Stakeholder comments table
20/09/2019 to 01/11/2019

Comments forms with attachments such as research articles, letters or leaflets cannot be accepted.

Stakeholder	Document	Page No	Line No	Comments Please insert each new comment in a new row	Developer's response Please respond to each comment
British Tinnitus Association	Guideline	004	013	100% of the respondents (n=777) agreed with this recommendation. One added suggestion was, "*For those who need it, BSL interpreter should be available*."	Thank you for your comment. The NICE patient experience guideline (CG138), is cross-referred to in the recommendation. CG138 covers the use of sign language for those who are d/Deaf.
British Tinnitus Association	Guideline	004	021	98% of the respondents (n=707) agreed with this recommendation. One professional commented, "*There seems to be no mention of what assessment should be undertaken in primary care. Clearly a history should be taken, which is implicit. However, it is also important to perform otoscopy, mainly to exclude wax impaction, which can be an easily treatable cause of tinnitus."*	Thank you for your comment
British Tinnitus Association	Guideline	004	025	One professional commented, "*Suicidal ideation with intent should have immediate safety netting and assessment by crisis management team."* **We suggest rewording to ensure clarity of patient care to read, "Suicidal ideation with intent (including risk assessment and appropriate follow up by relevant professional)"**	Thank you for your comment. The wording has not changed but the committee have clarified what high risk of suicide means in the rationale and impact section for the associated recommendation, e.g. suicidal thoughts with an intended plan.
British Tinnitus Association	Guideline	005	001	95% of the respondents (n=706) agreed with this recommendation. Professionals questioned how effective the two-week criteria might be, "*Agree in principle but not practical currently without significant increase in personnel with appropriate skills to support this group of people. Significant cost implication to achieve this and significant period of time to achieve this situation*." However patients felt two weeks was not fast enough, *"Referral 'within two weeks' seems leisurely IF the patient is experiencing the symptoms described in this recommendation; if the two weeks window is unavoidable there surely should be some form of counselling to allay initial panic."* and *"2 weeks is a very long time when you're in this situation."*	Thank you for your response. Your comments will be considered by NICE where relevant support activity is being planned. The committee have now described the referral criterion as 'distress affecting mental wellbeing (for example distress that prevents carrying out usual daily activities)' like not being able to leave the house or not being able to go to work. This will be a small proportion of people. In response to the comment that "if the 2 weeks window is unavoidable there should be some form of counselling" the committee agreed with this comment and therefore providing tinnitus support at all stages of care has been emphasised in the guideline.
British	Guideline	005	011	98% of the respondents (n=708) agreed with this recommendation.	Thank you for your comment. The committee noted that the

Tinnitus: assessment and management

Consultation on draft guideline - Stakeholder comments table
20/09/2019 to 01/11/2019

Comments forms with attachments such as research articles, letters or leaflets cannot be accepted.

Stakeholder	Document	Page No	Line No	Comments Please insert each new comment in a new row	Developer's response Please respond to each comment
Tinnitus Association				**Suggestion to include specific, measurable timescales in line with 1.2.1 and 1.2.2**. as the committee has agreed that the impact of tinnitus on a person's wellbeing and mental health is a critical component and a measurable timescale should be included to help patients understand how long they have to wait. *"Patients need to be seen sooner than the current wait time."* *"The timescale between appointments has had a massive effect on my suffering. I was diagnosed 3 months ago I've only just seen an ENT and now have to wait for a tinnitus clinic referral."*	recommendation is related to routine referrals and therefore specific timeframes cannot be provided. Routine referrals are dependent on local services and recommendation should be followed in line with local pathways. The committee also noted that the NHS Constitution sets out that patients should wait no longer than 18 weeks from GP referral to treatment.
British Tinnitus Association	Guideline	005	016	**We are concerned this recommendation may not be practicable**. One professional commented, "*most cases of objective tinnitus will be difficult to diagnose in primary care, as only a few involve sounds that are loud enough to hear without specialised equipment."*	Thank you for your comment. Diagnosis should be possible within primary care as no specialised equipment is needed. Objective tinnitus can be heard with a stethoscope and may be audible to the examiner without any equipment
British Tinnitus Association	Guideline	005	018	**We would like to check the wording.** One professional commented, "*Given that all patients with tinnitus should get an audiogram, and all of those with asymmetric hearing loss should get referred, is there any need to refer persistent unilateral tinnitus to secondary care if it is otherwise mild or responding to primary care management?"*	Thank you for your comment. For those with asymmetric hearing loss, the committee acknowledges that there is a very low incidence of significant pathology, however this does need to be ruled out. If appropriate information and support has been provided to the person with tinnitus by the general practitioner, the distress aspect of tinnitus will be addressed earlier.
British Tinnitus Association	Guideline	005	024	93% of the respondents (n=664) agreed with this recommendation. One professional commented, "*this measure doesn't offer such a good indicator of change, e.g. when auditing services. However as a screening tool it is useful."*	Thank you for your comment.
British Tinnitus Association	Guideline	005	026	97% of the respondents (n=668) agreed with this recommendation. **Following feedback, we would like to add to this wording to** "*specify VAS [visual analogue scales] that show 1. Tinnitus volume 2. Tinnitus intrusiveness 3. Distress resulting from tinnitus. 4. Fear of tinnitus".*	Thank you for your comment. The committee discussed the proposed wording and decided to not change the wording of this recommendation because volume or fear of tinnitus would not assist with the management of the condition. The committee acknowledge VAS can be used to show if the tinnitus is bothersome or intrusive but the questionnaires recommended

Tinnitus: assessment and management

Consultation on draft guideline - Stakeholder comments table
20/09/2019 to 01/11/2019

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Stakeholder	Document	Page No	Line No	Comments Please insert each new comment in a new row	Developer's response Please respond to each comment
					are designed to assess a range of problems associated with tinnitus.The committee noted that two types of VAS can be useful: how much does your tinnitus bother you and how much does the tinnitus interfere with what you do? These examples have been added to the rationale and impact associated with this recommendation and to the committee discussion.
British Tinnitus Association	Guideline	006	001	98% of the respondents (n=665) agreed with this recommendation. One participant commented, "*Do you need the word 'consider'? Surely they should just do this?"* We would like to challenge the ambiguity in the word 'consider'.	Thank you for your comment. The "consider" is standard NICE terminology to indicate the strength of the recommendation when the evidence of benefit is not certain, This recommendation was based on committee consensus
British Tinnitus Association	Guideline	006	005 - 026	95% of the respondents (n=616) agreed with this recommendation. One participant stated, *"The most important thing needed is mental health support. I was not given any mental support even when suicidal. Specialised mental health support is extremely important at the initial onset of tinnitus."* Due to the psychological impact of tinnitus, Bhatt et al (2017), Ziai (2017) and Pattyn et al (2016) **we request a change in wording to greater reflect the impact of tinnitus on mental health and that state that mental health should be discussed at every contact.** Bhatt, J. M., Bhattacharyya, N., & Lin, H. W. (2017). Relationships between tinnitus and the prevalence of anxiety and depression. *The Laryngoscope*, *127*(2), 466-469. Ziai, K., Moshtaghi, O., Mahboubi, H., & Djalilian, H. R. (2017). Tinnitus patients suffering from anxiety and depression: a review. *The international tinnitus journal*, *21*(1), 68-73. Pattyn, T., Van Den Eede, F., Vanneste, S., Cassiers, L., Veltman, D. J., Van De Heyning, P., & Sabbe, B. C. G. (2016). Tinnitus and anxiety disorders: a review. *Hearing*	Thank you for your comment. The wording of this recommendation has been amended to emphasise the impact of tinnitus on mental health. The guideline development team reviewed the references provided in your comment. The three studies were not includable due to incorrect study design (cross-sectional analysis of a survey and literature review) and the aims of the research were not relevant for the evidence reviews conducted.

Tinnitus: assessment and management

Consultation on draft guideline - Stakeholder comments table
20/09/2019 to 01/11/2019

Comments forms with attachments such as research articles, letters or leaflets cannot be accepted.

Stakeholder	Document	Page No	Line No	Comments Please insert each new comment in a new row	Developer's response Please respond to each comment
				research, *333*, 255-265.	
British Tinnitus Association	Guideline	006	008	95% of the respondents (n=602) agreed with this recommendation. Many people responding to this question had little or no knowledge about the questionnaires and so felt unable to comment, *"I have no idea what these questionnaires are or what they can show apart, presumably how badly the condition affects the individual."* Professionals responding had differing views about which questionnaire to use.	Thank you for your comment. The recommendation states that healthcare professionals should discuss the results of any assessments (including questionnaires) with the person with tinnitus.
British Tinnitus Association	Guideline	006	011	96% of the respondents (n=608) agreed with this recommendation. Some respondents questioned how achievable this would be in practice, "*This will only work if the mental health worker knows what tinnitus is and does not say that's not our field." And "Sounds good but unlikely to happen".*	Thank you for your comment.
British Tinnitus Association	Guideline	006	020	99% of the respondents (n=612) agreed with this recommendation. *"Important to look after the psychological wellbeing of children in the early stages."*	Thank you for your comment.
British Tinnitus Association	Guideline	006	024	92% of the respondents (n=608) agreed with this recommendation. **We want a change in wording to have greater emphasis on the impact of tinnitus on mental health**. One healthcare professional expressed specific concerns that they were trained in supporting adults with tinnitus but provided tinnitus support to children having not been trained. They felt they had insufficient knowledge about implementing guidelines on depression for children. The effect on mental health must be discussed at every contact. Although referral should be made where appropriate, tinnitus should continue to be managed by a relevant Health Care Professional.	Thank you for your comment. The wording of this recommendation has been amended to emphasise the impact of tinnitus on mental health. Healthcare professionals with the relevant qualifications, skills and competencies should deliver care, and training requirements should be met at a local level by the service provider**.** Your comment regarding training will be considered by NICE where relevant support activity is being planned.
British Tinnitus Association	Guideline	007	001	99% of the respondents (n=612) agreed with this recommendation. One professional said, "*This is really important, sleep is often an issue and identifying this, normalising it and offering good advice is useful*	Thank you for your comment. The committee has recommended that management plans developed between healthcare professionals and people with tinnitus (including children and

Tinnitus: assessment and management

Consultation on draft guideline - Stakeholder comments table
20/09/2019 to 01/11/2019

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Stakeholder	Document	Page No	Line No	Comments Please insert each new comment in a new row	Developer's response Please respond to each comment
				early on". We want these guidelines to ensure communication between a secondary provider and GP routinely occurs. One suggestion was *"Encourage that they speak to their GP, and note this in a clinic letter to their GP"*	young people) should be shared with relevant health, education and social care professionals .
British Tinnitus Association	Guideline	007	009	100% of the respondents (n=609) agreed with this recommendation. *"Massive impact on close relationships, working relationships and ability to cope with work-related stress. I was a senior quality professional in [industry]. Lack of understanding or seeing it as a 'real' medical condition made all relationships very difficult.*"	Thank you for your comment.
British Tinnitus Association	Guideline	007	015	The technical nature of the further investigations section made it inaccessible for many people from the tinnitus community to comment effectively. One participant said, *"too specialised for layperson with no experience of the treatments recommended."* Another commented, *"definitions should be included in an appendix as there is a lot of medical jargon in the guidance".* Consequently, our response to these recommendations is not representative of those who took part in our consultation. **We would like it noted that people with tinnitus have had limited prospects of informing the guidelines as fully as they might have done. We suggest a plain English guide be published alongside these guidelines to reflect patient-led care.**	Thank you for your comment. The wording of the recommendations have been reviewed and edited to make clearer where possible. A glossary of terms is available in the methods section of the guideline.
British Tinnitus Association	Guideline	007	016	98% of the respondents (n=589) agreed with this recommendation. **Suggest rewording to avoid ambiguity** to, "perform audiometry." "*I don't know what 'audiometry' is. You need to provide an explanation in this question.* While we agree audiometry is important, we would like much clearer clarification as it could refer to several different tests.	Thank you for your comment, 'audiometry' is now referred to 'hearing assessment. Adescription of what the hearing assessments may include is in evidence review H.
British Tinnitus Association	Guideline	007	017	93% of the respondents (n=571) agreed with this recommendation. "*Again I don't know what this is. Need explanation for non-health respondents*"	Thank you for your comment. A definition is available in the glossary of the methods section of the guideline.

Tinnitus: assessment and management

Consultation on draft guideline - Stakeholder comments table
20/09/2019 to 01/11/2019

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Stakeholder	Document	Page No	Line No	Comments Please insert each new comment in a new row	Developer's response Please respond to each comment
British Tinnitus Association	Guideline	007	019	76% of the respondents (n=556) agreed with this recommendation. **We suggest further work on this wording.** We know people are aware of these tests, and some will need justification about why they are not offered. When agreeing with this, some respondents mentioned that the referenced tests could exacerbate their tinnitus (and/or hyperacusis). The 16% of respondents who disagreed with the recommendation stated it was because they felt that each patient should be fully informed about the tests and then given the choice of whether they undertake the tests *"Strongly agree - loud noise is very distressing; you think it's going to make the tinnitus worse."* *"Definitely do not do that! Especially for those of us with hyperacusis!!"* *"I think this should depend on the individual cases as although it would be uncomfortable, if it helped develop a better management plan or find out more information about my tinnitus I would happily do it. However, I can't say if other individuals would feel the same way."*	Thank you for your comment. The committee feels that acoustic reflex testing is uncomfortable, causes distress and does not change the management of people with tinnitus.
British Tinnitus Association	Guideline	007	026	56% of the respondents (n=538) agreed with this recommendation, although 80% of professionals agreed with it. **We would like to committee to review this recommendation from a patient perspective of shared decision making.** While most were in agreement that they would not want it, others felt it should be discussed, allowing people to be involved in discussions and make informed decisions about their care. One participant said, "*I think in order to 'gauge' the problem, in some cases this could be useful."* and "*Ask the patient*". People with the condition felt that having psychoacoustic tests available would mean that they had a fuller picture of their tinnitus and this would motivate them to share with others and empower them to self-manage tinnitus (Pryce et al., 2018). Pryce, H., Hall, A., Marks, E., Culhane, B. A., Swift, S., Straus,	Thank you for your comment. The committee does not recommend psychoacoustic testing as a routine clinical assessment for tinnitus. The committee acknowledges that from a patient perspective some people may think it helpful for reassurance, but they are time-consuming, often unreliable and do not reflect the level of distress due to, or impact of, tinnitus on an individual, neither does it change the management. Comprehensive history and discussion with the person with tinnitus will provide a full picture of the problems associated with, and the impact of, tinnitus and therefore inform management. The guideline development team reviewed the reference included in your comment. The study was not suitable for inclusion due to incorrect study design and intervention (qualitative study about shared decision making).

Tinnitus: assessment and management

Consultation on draft guideline - Stakeholder comments table
20/09/2019 to 01/11/2019

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				J., & Shaw, R. L. (2018). Shared decision-making in tinnitus care–An exploration of clinical encounters. *British journal of health psychology*, *23*(3), 630-645.	
British Tinnitus Association	Guideline	008	005	95% of the respondents (n=549) agreed with this recommendation. **We suggest further work on this wording to make this recommendation more directive.** 1. Change 'Offer' to 'Refer, with informed consent…' 2. One professional commented, *"I would suggest clarifying that headache meeting the criteria for migraine or tension type headache, without any red flags, does not constitute a neurological symptom in this context, and should not be seen as an indication for head imaging."*	Thank you for your comment. The committee have considered your suggestion but think offer is appropriate. The committee's view is that there may be instances when some headaches would warrant imaging the person. This would be as result of assessment of the individual's signs and symptoms.
British Tinnitus Association	Guideline	008	008	92% of the respondents (n=535) agreed with this recommendation.	Thank you for your comment.
British Tinnitus Association	Guideline	008	012	55% of the respondents agreed (n=514) with this recommendation, but **we would request additional wording as patients need to be provided with a good explanation about why they do not need imaging to be undertaken.** 38% disagreed with many highlighting the reassurance that imaging can provide a patient. Quote in agreement: "*They [patients] should be offered a management plan if no tests as often sent away with no hope."* Quote in disagreement: "*Screening should be offered when tinnitus first presents to rule out other problems and to reassure the person with tinnitus."* We suggest further work on this wording to explain to patients why it is offered/not offered and about the process and implications of having a scan.	Thank you for your comment. The committee can only recommend scanning when there is clinical indication. The decision to scan should be made as part of an informed discussion between the clinician and person with tinnitus.
British Tinnitus	Guideline	008	018	90% of the respondents (n=491) agreed with this recommendation **We suggest further work on this wording**. There was general	Thank you for your comment. The committee can only recommend scanning when there is clinical indication. The

Tinnitus: assessment and management

Consultation on draft guideline - Stakeholder comments table
20/09/2019 to 01/11/2019

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Stakeholder	Document	Page No	Line No	Comments Please insert each new comment in a new row	Developer's response Please respond to each comment
Association				agreement to including these tests in the recommendation. Patients stated they found having the tests reassuring, but many people stated they had not had any tests despite having presented with pulsatile tinnitus to their clinicians, "*I have pulsatile tinnitus & no investigations have ever been done!"* There were comments about the wording of this recommendation to be clearer about the tests for people who experience pulsatile alongside non-pulsatile tinnitus.	decision to scan should be made as part of an informed discussion between the clinician and person with tinnitus.
British Tinnitus Association	Guideline	009	003	The guidance gives no recognition to people for whom sound may not be an option in their management of tinnitus. One participant commented, *"There is no acknowledgement in these guidelines that profoundly deaf patients with severe tinnitus currently have few options for professional help and have to try to cope with their own mental abilities and therapies."* We feel that there is an overall lack of recommendations for people who are profoundly deaf, or for whom amplification devices do not work. **We want the committee to include specific recommendations for tinnitus management in patients with profound deafness.**	Thank you for your comments. We did not find any evidence for people who are d/Deaf and therefore the committee were unable to make recommendations specifically for this group. However the committee recognised the lack of management options and have introduced additional research recommendations for the management of tinnitus using psychological therapies and amplification devices in people who are d/Deaf or who have a severe to profound hearing loss. Full details can be seen in Evidence Review L and Evidence Review M.
British Tinnitus Association	Guideline	009	004	99% of the respondents (n=524) agreed with this recommendation. "*My hearing aid does help with the tinnitus a lot, however I could not wait to get one on the NHS - I was in too much distress. It should be looked at to see if an urgent referral for a hearing aid can be made in cases where there is significant distress and severe tinnitus as the effect on mental well being is significant"* and *"I have an ordinary NHS hearing aid and it has really helped me. Without it, I can not hear anything at all because of my tinnitus."* The recommendation only makes reference to amplification devises in subsequent lines. The words '*Sound therapy*' is currently redundant', presumably due to the lack of evidence about their effectiveness (Sereda 2018). **We suggest the committee reviews this title and either include recommendations on sound therapy, identifies a**	Thank you for your comment. The title has been amended with the removal of sound therapy. The committee agreed that there was limited evidence available to make a recommendation for the use of sound therapies. A research recommendation was made for sound therapies in combination with tinnitus support (see Evidence Review P for further details) The study referenced in your comment, was assessed and included in the sound therapy evidence review.

Tinnitus: assessment and management

Consultation on draft guideline - Stakeholder comments table
20/09/2019 to 01/11/2019

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Stakeholder	Document	Page No	Line No	Comments Please insert each new comment in a new row	Developer's response Please respond to each comment
				need for further research or removes the words from line 4 Sereda, M., Xia, J., El Refaie, A., Hall, D. A., & Hoare, D. J. (2018). Sound therapy (using amplification devices and/or sound generators) for tinnitus. *Cochrane Database of Systematic Reviews*, (12).	
British Tinnitus Association	Guideline	009	008	96% of the respondents (n=519) agreed with this recommendation. *"In my experience, any hearing loss is a barrier to communication. I can only contribute fully to a conversation/discussion when I can hear everything that is being said. There is an emotional aspect to missing those quick quips and humorous asides that usually use a different voice to the speaker's normal one."*	Thank you for your comment.
British Tinnitus Association	Guideline	009	010	58% of the respondents (n=510) agreed not to provide amplification devices via the NHS. A common reason amongst the 40% of respondents who disagreed with the recommendation was that the patient should be given a choice to try amplification devices. Quote in agreement: "*They might not have any benefit."* Quote in disagreement: "*Hearing aid devices can be extremely useful to reduce the impact of tinnitus so should be offered as an option to the tinnitus sufferer."* We are concerned that this recommendation may not be implemented as we know (through anecdote and research) that actual practice is different in some clinics, and clinical practice results suggest some success. **We want the committee to recommend carrying out further research into this area.**	Thank you for your comment. The committee recommended that people with tinnitus and normal hearing should not be offered amplification devices because there is unlikely to be an improvement to the impact of the tinnitus and amplification of sound where it is not required is inappropriate. The committee appreciates that there is limited evidence and felt that a specific research recommendation should be added to the guideline. The research question is: What is the clinical and cost effectiveness fitting hearing aid(s) to people with tinnitus who have hearing loss but no perceived hearing difficulties? Full details can be found in Evidence Review M.
British Tinnitus Association	Guideline	009	015	95% of the respondents (n=513) agreed with this recommendation. We are concerned that this recommendation will be a challenging change in practice because of the lack of appropriate services. **We want to change the wording of this recommendation from**	Thank you for your comment. Your comments will be considered by NICE where relevant support activity is being planned to assist with the implementation of this recommendation. The "consider" used for the recommendation is standard NICE

Tinnitus: assessment and management

Consultation on draft guideline - Stakeholder comments table
20/09/2019 to 01/11/2019

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				'*consider*' to something more directive and in the best interests of the patients. *'Consider'* does not give sufficiently clear guidance and may be interpreted more in terms the services available at a local level rather than what is in the best interests for a patient with tinnitus-related distress. Overall there was an agreement with this recommendation. One respondent commented, "*CBT should be at the forefront of therapies, after 13 years I was then offered CBT which has been the most useful."* although many agreed with this recommendation professionals in particular questioned how realistic this would be. One professional stated, "I *would like to work in an NHS where these options are available but I do not see that is achievable in the near future.*" Another stated, "*there is a lack of psychologists treating tinnitus*". Without investment in CBT (and other therapeutic interventions) delivered by suitably trained audiologists with clinical supervision or further access to online CBT the uptake of this recommendation is likely to be more the result of a postcode lottery than what is best for the patient.	terminology. Whilst the evidence that evaluated psychological therapies in people with tinnitus-related distress showed a clinical benefit of psychological therapies, the majority of the evidence was graded as low quality taking into account risk of bias, imprecision and inconsistency in the evidence. This limited the level certainty/confidence around the evidence-base, consequently the committee made a weaker recommendation. Economic analyses suggested that it would be more cost effective to use digital CBT and the committee considered that some providers would take the initiative to adapt existing digital CBT tools available for use in other populations, for people with tinnitus.
British Tinnitus Association	Guideline	010	004	90% of the respondents (n=483) agreed with this recommendation. However, the responses evidenced some confusion around the ambiguous phrasing within this recommendation. **We suggest further work on the wording of this recommendation to give the recommendation greater clarity.** Quotes in agreement: *"Prescribing this to tinnitus patients who have no other medical symptoms gives false hope and increases the anxiety and desperation felt when it doesn't provide a miracle cure, even if it is fully explained that it probably won't help. I don't think it should be prescribed unless there is conclusive evidence of another medical condition that could be helped with this drug."* *"Agree but ensure that this is kept under review if there are any subsequent trials or tests which proves effectiveness."*	Thank you for your comment. The committee acknowledges that there is no clinical benefit associated with the use of betahistine and there is some indication of harm with side effects. The committee recommend that it should not be offered to people with tinnitus: this recommendation has been amended to add clarity.

Tinnitus: assessment and management

Consultation on draft guideline - Stakeholder comments table
20/09/2019 to 01/11/2019

Comments forms with attachments such as research articles, letters or leaflets cannot be accepted.

Stakeholder	Document	Page No	Line No	Comments Please insert each new comment in a new row	Developer's response Please respond to each comment
				Quote in disagreement: "*Do not consider [prescribing] due to lack of evidence."*	
British Tinnitus Association	Guideline	010	005	We welcome the committee's inclusion of betahistine in these guidelines but request greater recognition of prescribing for tinnitus.	Thank you for your comment. The committee agrees that there is no clinical benefit associated with the use of betahistine and there is some indication of harm with side effects. The committee recommend that it should not be offered to people with tinnitus: this recommendation has been amended. The fact that there is no clinically proven drug treatment available for tinnitus has been highlighted in the rationale and impact section for the guideline.
British Tinnitus Association	Guideline	010	012	85% of the respondents (n=497) agreed with this recommendation. Not all respondents agreed with the need for further research across all combination therapies, here responses were either very general, "*Combining therapies is a good idea"* or very specific, *"There is a lot of research already behind TRT which has shown it to be useful see Jastreboff."*	Thank you for your comment. The committee agreed that more research is needed for combination management strategies with the main component being tinnitus support. The committee acknowledges that there is evidence available for TRT and examined this evidence in the relevant systematic review. They decided to not explicitly recommend TRT because within the evidence-base there is variation in how TRT is delivered, which makes it difficult to determine the most clinically effective form (or modification) of TRT. The quality of the evidence also ranged from very low to low, reducing the committee's confidence in the evidence. In addition, the committee agreed that the original form of TRT does not allow people to be actively engaged in the development of their management plan.
British Tinnitus Association	Guideline	010	014	90% of the respondents (n=483) agreed with this recommendation and 5% disagreed.	Thank you for your comment.
British Tinnitus Association	Guideline	011	018	76% of respondents (n=503) agreed with this area of research.	Thank you for your comment.
British	Guideline	012	001	74% of respondents (n=503) agreed with this area of research.	Thank you for your comment.

Tinnitus: assessment and management

Consultation on draft guideline - Stakeholder comments table
20/09/2019 to 01/11/2019

Comments forms with attachments such as research articles, letters or leaflets cannot be accepted.

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British Tinnitus Association	Guideline	012	006	58% of respondents (n=503) agreed with this area of research.	Thank you for your comment.
British Tinnitus Association	Guideline	012	011	47% of respondents (n=503) agreed with this area of research.	Thank you for your comment.
British Tinnitus Association	Guideline	012	016	46% of respondents (n=503) agreed with this area of research.	Thank you for your comment.
British Tinnitus Association	Guideline	013	002	35% of respondents (n=503) agreed with this area of research.	Thank you for your comment.
British Tinnitus Association	Guideline	013	005	32% of respondents (n=503) agreed with this area of research.	Thank you for your comment.
British Tinnitus Association	Guideline	013	009	64% of respondents (n=503) agreed with this area of research.	Thank you for your comment.
British Tinnitus Association	Guideline	016	015	There was general agreement with all these areas of research from the 503 participants of our consultation.	Thank you for your comment.
British Tinnitus Association	Guideline	021	027	We were confused by the rationale behind psychoacoustic tests. The rationale suggests the test should not be carried out due to risk factors, but then refers to cost savings. If psychoacoustic testing is used in research, we feel it is inconsistent that the committee then suggests it has the potential to cause harm. If there is a justifiable consideration regarding risk then the committee should adopt the same procedures used in research. Cost should not be a factor in the decision.	Thank you for your comment. The committee decided to not offer these tests in practice for people with tinnitus because they may increase distress for some people with tinnitus and encourage people to focus on their tinnitus more. The committee also explained that results from a psychoacoustic test would not change the clinical management of a person with tinnitus. Therefore, the committee agreed that the costs that would be incurred by using psychoacoustic tests in practice would not be a cost-effective use of NHS expenditure. The committee took both

Tinnitus: assessment and management

Consultation on draft guideline - Stakeholder comments table
20/09/2019 to 01/11/2019

Comments forms with attachments such as research articles, letters or leaflets cannot be accepted.

Stakeholder	Document	Page No	Line No	Comments Please insert each new comment in a new row	Developer's response Please respond to each comment
					the potential for harm and the costing implications into account when making recommendations. The committee recognises that psychoacoustic testing is performed in research settings but have not recommended its use in a research context.
British Tinnitus Association	Guideline	General	General	The British Tinnitus Association's vision is a world where no one suffers from tinnitus. We provide information, support and research funds to make this vision a reality. We are the only national charity specialising in tinnitus support. We welcome the opportunity to submit comments on the draft *NICE guideline: Tinnitus: assessment and management.* We believe these guidelines if adopted by healthcare professionals, will contribute to ensuring a more standardised care pathway is in place for people with tinnitus. We asked for comments from over 3000 people and received responses to an online survey from 986 members of the public and tinnitus professionals. Our response focuses on the key issues that relate to people with tinnitus, and we illustrate comments using quotes from people in the tinnitus community. We are happy for all the details of this response to be made public. Please contact us if you require further information.	Thank you for your comment.
Cardiff and Vale University Health Board	Guideline	008	005 - 012	One of the implications of 1.3.5 and 1.3.7 is that someone with bilateral tinnitus and symmetrical hearing loss (as its an audiological sign/symptom) could get imaged as well which is not necessary and there is no real evidence for this. Symmetrical audiological findings with bilateral tinnitus and no other symptom does not need imaging.	Thank you for your comment. The recommendation has been amended, the reference to audiological has been removed.

Tinnitus: assessment and management

Consultation on draft guideline - Stakeholder comments table
20/09/2019 to 01/11/2019

Comments forms with attachments such as research articles, letters or leaflets cannot be accepted.

Stakeholder	Document	Page No	Line No	Comments Please insert each new comment in a new row	Developer's response Please respond to each comment
Cardiff and Vale University Health Board	Guideline	008	008	Asymmetrical non pulsatile tinnitus (whether its volume or type) should be managed as symmetrical tinnitus and does not require imaging unless there are other features like asymmetrical hearing loss. This is not routine practice currently and has major service implications and there is no real evidence that it is beneficial either.	Thank you for your comment. Whilst no evidence was identified for imaging non-pulsatile, based on the committee's clinical experiences. Imaging for asymmetrical non-pulsatile tinnitus is routine practice. The committee feels that this practice should be recommended.
Cardiff and Vale University Health Board	Guideline	009	014 - 028	Most places support tinnitus patients with non-psychology-based therapists and this works well for most patients. In an ideal world all tinnitus patients could be routed to psychologists, but they are not freely available, and most centres do not have access to them. Recommending psychology support is probably a good gold standard but not practical for all patients who require some support.	Thank you for your comment. Psychological therapies should be delivered by health professionals with the necessary qualifications, skills and competencies Your comment will be considered by NICE where relevant support activity is being planned.
Cardiff and Vale University Health Board	Guideline	010	004 - 005	As there is no evidence Betahistine is beneficial why should it even be considered for use in tinnitus management?	Thank you for your comment. The committee agrees that there is no clinical benefit associated with the use of betahistine and there is some indication of harm with side effects. The committee recommend that it should not be offered to people with tinnitus: this recommendation has been amended.
ENT UK	Guideline	General	General	Paragraphs: 1.1.2 telling patients there is rarely physical or mental health problem underlying tinnitus at first meeting may not be helpful . After all sensorineural hearing loss (SNHL) is the commonest cause.	Thank you for your comment, the wording has been amended.
ENT UK	Guideline	General	General	1.2.1 this needs to define where to refer people within 24 hours if they are suicidal with tinnitus. Referral to ENT or Audiology is inappropriate as first line management for a suicidal patient. They ought to be referred urgently to Mental Health services with subsequent support from ENT / Audiology.	Thank you for your comment. This recommendation has been amended following committee discussion. There is now a separate recommendation stating that l patients with a high risk of suicide should be referred for assessment by a mental health crisis team immediately.

Tinnitus: assessment and management

Consultation on draft guideline - Stakeholder comments table
20/09/2019 to 01/11/2019

Comments forms with attachments such as research articles, letters or leaflets cannot be accepted.

Stakeholder	Document	Page No	Line No	Comments Please insert each new comment in a new row	Developer's response Please respond to each comment
ENT UK	Guideline	General	General	1.2.2 We have more concerns with: refer within 2 week people who have distress despite already receiving tinnitus support, or tinnitus with vertigo (eg Menieres) within 2 weeks may not be possible for our services. nor necessary. It is very unlikely that we would be able to meet this guideline and it could be more an aspiration than a guideline.	Thank you for your comment. The committee considered a 2 week referral reasonable for people with these symptoms and signs. The recommendation has been amended to clarify it is those people with distress that is preventing them from carrying out usual daily activities. The committee consider this would apply to a very small group of people. People with acute uncontrolled vestibular symptoms has been moved to an immediate referral in line with other NICE guidance Suspected neurological conditions. Service configuration is not within the remit of the guideline and would need to be determined locally.
ENT UK	Guideline	General	General	1.2.3 This need clarifying. referring objective, pulsatile or unilateral tinnitus to the "local tinnitus service" is too vague. It needs to state to a medically led ENT service.it needs medical assessment not audiology alone.	Thank you for your comment. The committee discussed this and decided that it is not possible to be specific for tinnitus as there is variation in local pathways and care models, examples of service locations are provided in the rationale and impact associated with these recommendations.
ENT UK	Guideline	General	General	1.2.4 We do not think most ENT surgeons would find it useful to use questionnaires for all their tinnitus patients. We accept it says consider. (page 16 seems to contradict this) In this section of initial assessment in secondary care no mention is made of blood tests. Whilst these should be used sparingly they are required for acute tinnitus. I have seen acute haemolytic anaemia and acute thyrotoxicosis present with acute tinnitus and there are other examples.	Thank you for your comment. The scope of this guideline did not include the different causes of tinnitus (except in the context of investigations using imaging) and specific examination methods. The committee have noted the necessity of physical examinations in the committee discussion in Evidence Review C.
ENT UK	Guideline	General	General	1.2.9 if there are concerns about anxiety or depression a healthcare professional competent in mental health assessment should assess. This could be helpful for us in setting up such services but they don't really exist in most centres to my understanding so we are opening ourselves up for criticism here. Greater access to psychology input for tinnitus sufferers would be very useful .	Thank you for your comment. Your comments will be considered by NICE where relevant support activity is being planned. If a service does not have access to a healthcare professional competent in mental health assessment then referral to another appropriate NHS service can be made. This reflects the commissioning arrangements within the NHS.

Tinnitus: assessment and management

Consultation on draft guideline - Stakeholder comments table
20/09/2019 to 01/11/2019

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Stakeholder	Document	Page No	Line No	Comments Please insert each new comment in a new row	Developer's response Please respond to each comment
ENT UK	Guideline	General	General	1.3.5 needs slightly rewording. It implies that tinnitus with hearing loss needs an MRI by stating it is required if tinnitus plus "audiological signs and symptoms" May be "materialising" could be added? In many patients there will be a bilateral fairly symmetrical hearing loss with bilateral tinnitus and in our view that would not be an indication for an MRI scan.	Thank you for your comment. The wording has been amended, 'audiological' has been removed.
ENT UK	Guideline	General	General	1.3.8 this should specify an MRI of what ie head and neck	Thank you for your comment. These recommendations have been amended, the areas which should be scanned are now included in these recommendations.
ENT UK	Guideline	General	General	1.4.4 tinnitus related CBT from a psychologist: we no have no access to this from psychologist. It is delivered by tinnitus therapists as we suspect it is in many centres. Although as stated above better access to a psychologist would be a very welcome development for tinnitus services. Areas for research would include better objective measures of tinnitus as without this it is difficult to assess new treatment modalities.	Thank you for your comment. Your comments will be considered by NICE where relevant support activity is being planned. The committee agrees the assessment of objective measures is a potential area for further research but was not considered a priority area..
Hearing Loss and Deadness Alliance	Guideline	003	017 - 020	**We would encourage the committee to include further positive statements within the recommendations for reassurance.** We agree that talking about tinnitus in a positive way is necessary however we feel the recommendation needs examples of specific positive statements beyond the word "reassurance". Giving positive reassurance should also be dependent on the person's experience of tinnitus. While many people will be experiencing mild tinnitus, those experiencing distressing tinnitus could see reassurance as patronising and unhelpful. Furthermore, the statements in the recommendation could be in a positive or negative manner, depending on how the clinician says them. In some ways, the recommendation on line 19 could be delivered in a similar manner to the statement that "you will have to learn to live with	Thank you for your comment. This recommendation has been amended to be more positive and reassuring for people with tinnitus. However,the committee discussed this and decided that specific statements within the recommendations are not necessary.

Tinnitus: assessment and management

Consultation on draft guideline - Stakeholder comments table
20/09/2019 to 01/11/2019

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Stakeholder	Document	Page No	Line No	Comments Please insert each new comment in a new row	Developer's response Please respond to each comment
				it". We would ask the committee to consider including specific positive statements in the recommendation such as "Most tinnitus naturally lessens or disappears with time" as recommended by the BTA.[59]	
Hearing Loss and Deafness Alliance	Guideline	003	004	**We welcome the recommendation that tinnitus support should be given at <u>all stages of care</u>.** Tinnitus can be distressing and it is vital that the right support is available at every stage of the pathway. This is especially important for primary care settings where most people receive tinnitus support and management. The primary outcome is habituation to the tinnitus sound; some people will successfully habituate after the first appointment with their GP after educational support and reassurance.[56] Many people will need onward referral and again, it is vital that the correct educational support is given at each stage of care. Furthermore it is regarded as good, patient-centred practice to engage and inform someone at all stages of their care as stated in NICE's Your Care.[60] We would encourage the committee to consider making recommendations for some services to be available for those who cannot access health care, such as those in care homes. We would also encourage the committee to consider making a research recommendation for parts of tinnitus education and support to be delivered outside of a traditional health care setting. <u>Question 1</u>: GPs are usually first point of contact therefore resources for re-education on tinnitus pathology and management would be	Thank you for your comment. Recommendations are applicable to all settings where NHS healthcare is provided, and this would include care homes, therefore separate recommendations are not required. Question 1 and 2: Thank you for your response. The committee appreciate the importance of tinnitus support and believe the emphasis the guideline is placing on a two-way process of information-giving and discussion between the clinician and a person with tinnitus is implementable without specific training courses for staff. Question 3: Thank you for your response. We will pass this information to our resource endorsement team. The guideline development team reviewed the references provided in your comment. The references are not suitable for inclusion with the relevant evidence review due to incorrect study design/article type (guidance, non-NICE guideline)

[59] British Tinnitus Association 2017 Tinnitus Guidance for GPs. Available at: https://www.tinnitus.org.uk/Handlers/Download.ashx?IDMF=b1389d8f-78eb-4794-b58f-c24fb21a489c [Accessed 21/10/2019].
[60] NICE. Your Care. Available at: https://www.nice.org.uk/about/nice-communities/nice-and-the-public/public-involvement/making-decisions-about-your-care/your-care [Accessed 21/10/2019]

Tinnitus: assessment and management

Consultation on draft guideline - Stakeholder comments table
20/09/2019 to 01/11/2019

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Stakeholder	Document	Page No	Line No	Comments Please insert each new comment in a new row	Developer's response Please respond to each comment
				appropriate and welcome. Furthermore additional education on the tinnitus pathway both nationally and locally is essential to understand what is available to patients whose tinnitus needs further support. Question 2: There may be some cost implications for training and education of all clinicians. However those who successfully habituate after educational tinnitus support in primary care incur the smallest costs.[61] So emphasizing training could be cost effective in the long term. Question 3: Resources that would be helpful to GPs would be: the Tinnitus Guidance for GPs developed by the BTA[62] and the BSA practice guidance for tinnitus (currently under consultation).[63] A further useful resource would be the multidisciplinary European Guideline for tinnitus.[64]	
Hearing Loss and Deafness Alliance	Guideline	003	015	**We welcome recommendation 1.1.2 that people with tinnitus should be reassured at first point of contact with a healthcare professional.** The onset of tinnitus can be distressing and worrying.[65] Many people seek help from their general practitioner when they first notice tinnitus, and for almost half this is within the first 3 months of symptom onset.[66]	Thank you for your comment. The guideline development team reviewed the referenced provided within your comment. All studies are not suitable for inclusion due to inappropriate study design/article type (narrative review or patient survey)

[61] Stockdale D, McFerran D, Brazier P, Pritchard C, Kay T, Dowrick C, & Hoare DJ (2017). An economic evaluation of the healthcare cost of tinnitus management in the UK. BMC health services research, 17(1), 577.
[62] British Tinnitus Association 2017 Tinnitus Guidance for GPs. Available at: https://www.tinnitus.org.uk/Handlers/Download.ashx?IDMF=b1389d8f-78eb-4794-b58f-c24fb21a489c [Accessed 21/10/2019].
[63] British Society of Audiology (2018) Draft Practice Guidance: Tinnitus in adults. Available at: http://www.thebsa.org.uk/wp-content/uploads/2019/09/Practice-Guidance_Tinnitus-in-Adults_for-member-consultation_30AUG2019.pdf [Accessed 21/10/2019]
[64] Cima, R.F.F., Mazurek, B., Haider, H. et al. HNO (2019) 67(Suppl 1): 10.
[65] Baguley D, McFerran D & Hall D, 2013. Tinnitus. The Lancet, Volume 382, Issue 9904, 1600 – 1607.
[66] McFerran D, Hoare DJ, Carr S, Ray J & Stockdale D, 2018. Tinnitus Services in the United Kingdom: a survey of patient experiences. BMC Health Services Research, 18, 110.

Tinnitus: assessment and management

Consultation on draft guideline - Stakeholder comments table
20/09/2019 to 01/11/2019

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				An unhelpful or dismissive response at this first point of contact has been shown to negatively affect treatment outcomes.[3] There is evidence to suggest that some healthcare professionals are unhelpful when someone seeks support for tinnitus.[2][67] This is particularly prevalent among GPs, as they are often the first point of contact in the tinnitus pathway.[2] People have been told that they should "learn to live with it" and that there is "no cure".[68] This is possibly due to general lack of awareness and knowledge around the condition, and that there is no clinically proven drug treatment.[69] Furthermore, we have received reports that there is a lack of support in secondary care audiology and/or ENT, often resulting in discharge from the service when all options have been exhausted. There is also evidence that when discharged from secondary care, patients often return to their GP and re-enter the pathway within a short timeframe, resulting in unsatisfactory "revolving door" healthcare.[2] If there is a lack of awareness among GPs this can lead to barriers to referral for the tinnitus pathway. Research has shown that just over half of people are referred to secondary care after their first GP appointment. This figure improves to just over three quarters of people referred after 2 GP appointments. However around a fifth see their GP 3 times before being referred to secondary care.[7]	
Hearing Loss	Guideline	004	001	**We welcome recommendation 1.1.3 that information about tinnitus**	Thank you for your comment.

[67] Wray N, Broomhead E & Stockdale D, 2017. General Practitioner support for tinnitus - a survey of patient experience. Journal of Hearing Science . 7(2): 167-167; RNID, 2010. What's that noise? A profile of personal and professional experience of tinnitus in NI. Available at: https://www.actiononhearingloss.org.uk/about-us/our-research-and-evidence/research-reports/what-s-that-noise-report/. [Accessed 21/10/2019].
[68] Newman CW, Sandridge SA, Bea SM, Cherian K, Cherian N, Kahn KM & Kaltenbach J. 2011. Tinnitus: Patients do not have to 'just live with it'. Cleveland Clinic Journal of Medicine. 78(5).
[69] McFerran DJ, Stockdale D, Holme R, Large CH & Baguley DM, 2019. Why Is There No Cure for Tinnitus? Front. Neurosci. 13:802.

Tinnitus: assessment and management

Consultation on draft guideline - Stakeholder comments table
20/09/2019 to 01/11/2019

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Stakeholder	Document	Page No	Line No	Comments Please insert each new comment in a new row	Developer's response Please respond to each comment
and Deafness Alliance				**should be given at all stages of care.** Appropriate and timely information about tinnitus is vital in understanding the condition. Many people find information about it reassuring and this is what they seek when they first make contact with a healthcare professional. Providing timely accurate and tailored information is therefore critical to the outcomes of an individual. There is considerable heterogeneity between peoples' experience of tinnitus but also its pathology, and this should be taken into consideration when giving information. For example someone with tinnitus that is associated with age-related hearing loss may have very different needs to someone who has tinnitus as a result of ototoxic chemotherapy.	
Hearing Loss and Deafness Alliance	Guideline	004	001	**We would urge the committee to include clear recommendations on information about medication for tinnitus, including other strategies someone might try without medical advice where there is little evidence or the potential to cause harm.** There is no clinically proven drug treatment for tinnitus[70] however many people are prescribed medication to help alleviate the symptoms, this is most commonly in primary care.[71] Anecdotally, some people even try supplements, vitamins or dietary changes to alleviate symptoms without seeking prior medical advice. We would urge the committee to make recommendations for clear information about strategies where there is little evidence for	Thank you for your comment. We haven't reviewed evidence for alternative drug treatments, as they are not included in scope. Betahistine was reviewed in the guideline. The committee acknowledges that there is no clinical benefit associated with the use of betahistine and there is some indication of harm with side effects. The committee recommend that it should not be offered to people with tinnitus: this recommendation has been amended to add clarity. The committee have highlighted in the rationale and impact section associated with the betahistine recommendation that there are currently no drug treatments licensed for tinnitus alone.

[70] McFerran DJ, Stockdale D, Holme R, Large CH & Baguley DM, 2019. Why Is There No Cure for Tinnitus? Front. Neurosci. 13:802.
[71] McFerran D, Hoare DJ, Carr S, Ray J & Stockdale D, 2018. Tinnitus Services in the United Kingdom: a survey of patient experiences. BMC Health Services Research, 18, 110.

Tinnitus: assessment and management

Consultation on draft guideline - Stakeholder comments table
20/09/2019 to 01/11/2019

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Stakeholder	Document	Page No	Line No	Comments Please insert each new comment in a new row	Developer's response Please respond to each comment
				effectiveness such as drug treatment for tinnitus, including information about risks of over the counter medication and/or complementary and alternative therapies.[72]	
Hearing Loss and Deafness Alliance	Guideline	004	005	**We would encourage the committee to include specific recommendations for information about preventative measures people can take to stop their tinnitus and getting worse.** We agree that this is important for people to be informed of what can happen in the future regarding their tinnitus. However there needs to be more clarity when the guideline refers to "exposure to loud noise". The committee should consider including a separate point that encourages safe listening habits to prevent further exacerbation or worsening of tinnitus as well as the risk of noise-induced hearing loss. Exposure to loud sounds can be safe depending on the sound pressure level and length of exposure time but some people find their tinnitus can be temporarily increased as a result. This can be distressing but usually subsides and does not cause permanent hearing damage. Prolonged exposure to excessively loud sound can cause damage to the auditory system.[73] This results in noise induced hearing loss which is associated with tinnitus. We therefore urge the committee to include recommendations for information about prevention measures encouraging "safe listening practice".	Thank you for your comment. The committee agree with your comment, this recommendation has been amended and "safe listening practices" is now listed as an information point for people with tinnitus.
Hearing Loss and	Guideline	004	016	**We would encourage the committee to include deafness in the list of accessibility requirements.**	Thank you for your comment. People with profound deafness and hearing loss have been added to the equality impact

[72] Enrico P, Sirca D & Mereu M (2007) Antioxidants, minerals, vitamins, and herbal remedies in tinnitus therapy. Prog Brain Res, 166:323-30.; Vendra V, Vaisbuch Y, Mudry AC & Jackler RK (2019) Over-the-Counter Tinnitus "Cures": Marketers' Promises Do Not Ring True. Laryngoscope, 129(8): 1898-1906.
[73] WHO, 2015. Make Listening Safe. Available at: https://www.who.int/pbd/deafness/activities/MLS_Brochure_English_lowres_for_web.pdf [Accessed 21/10/2019].

Tinnitus: assessment and management

Consultation on draft guideline - Stakeholder comments table
20/09/2019 to 01/11/2019

Comments forms with attachments such as research articles, letters or leaflets cannot be accepted.

Stakeholder	Document	Page No	Line No	Comments Please insert each new comment in a new row	Developer's response Please respond to each comment
Deafness Alliance				People with profound deafness and hearing loss can experience tinnitus.[74] d/Deaf people will have very different accessibility requirements to those with hearing loss. If their first language is BSL they will need to have information that can be accessed in this way, for example via an interpreter or video in line with the Accessible Information Standard.[75]	assessment. Three research recommendations have also been added for this population, proposing the evaluation of tinnitus questionnaires, psychological therapies and amplification devices. The NICE patient experience guideline (CG138), is cross-referred to in this guideline. CG138 covers the use of sign language for those who are d/Deaf.
Hearing Loss and Deafness Alliance	Guideline	004	020	**We would urge the committee to include a recommendation for physical examination and clinical history taking.** We feel that the committee should include explicit recommendations for history taking and physical examination including otoscopy, as temporary occlusion of the ear canal or middle ear pathology have been shown to be associated with tinnitus.[76] Furthermore, assessment and management of wax and outer ear infection can be carried out exclusively in primary care and a recommendation will therefore reduce unnecessary referrals to secondary care for management.	Thank you for your comment. The committee agree that physical examination and clinical history taking is important. However, how physical examinations and clinical history-taking should be conducted is not in the scope of this guideline, and recommendations cannot be made.
Hearing Loss and Deafness Alliance	Guideline	004	022	**We welcome the recommendations to refer certain signs and symptoms more urgently to encourage timely referrals, however we believe there have been some omissions from recommendation 1.2.1**	Thank you for your comment. For sudden onset of significant neurological symptoms or signs (for example, facial weakness or vertigo), the suspected neurological conditions guideline has been cross-referenced for further guidance, as have acute uncontrolled vestibular conditions such as vertigo, and is now

[74] Ng ZY, Archbold S, Harrigan S & Mulla I, 2015. Conspiring together: tinnitus and hearing loss. Available at: https://www.tinnitus.org.uk/Handlers/Download.ashx?IDMF=0ee4755c-c670-4ede-85f5-d7a9391628e3 [Accessed 21/10/2019].
[75] NHS England, 2016. Accessible Information Standard. Available at: https://www.england.nhs.uk/ourwork/accessibleinfo/. [Accessed 21/10/2019]
[76] Baracca G, Del Bo L & Ambrosetti U, 2011. Tinnitus and Hearing Loss. In: Møller AR, Langguth B, De Ridder D & Kleinjung T. (eds) Textbook of Tinnitus. Springer, New York, NY

Tinnitus: assessment and management

Consultation on draft guideline - Stakeholder comments table
20/09/2019 to 01/11/2019

Comments forms with attachments such as research articles, letters or leaflets cannot be accepted.

Stakeholder	Document	Page No	Line No	Comments Please insert each new comment in a new row	Developer's response Please respond to each comment
				We recommend the committee includes the following criteria for onward referral in recommendation 1.2.1: • Sudden onset pulsatile tinnitus and severe vertigo should be included under "sudden onset of significant neurological symptoms or signs alongside facial weakness" (line 26). The sudden onset of the symptoms is critical and could be indicative of cerebrovascular disease or neoplasm.[77] • As vertigo and pulsatile tinnitus are listed in recommendations 1.2.2 and 1.2.3 respectively, we believe it is important to make the distinction with sudden onset and urgency of referral, to avoid an emergency referral mistakenly graded as routine. • Tinnitus associated with head trauma should be referred urgently.[78]	within the refer immediately category. The committee agreed that significant symptoms associated with head trauma would be neurological and this is also covered within this recommendation. Where there is overlap with the hearing loss guideline the recommendations have been revised to ensure there is consistency between the two guidelines..
Hearing Loss and Deafness Alliance	Guideline	004	025	**We welcome the recommendation to urgently refer those with tinnitus associated with high risk of suicide** Tinnitus can be associated with mental ill-health which, when severe, can be linked to suicidal ideation. A recent literature review concluded that suicidal ideation is complex and it is not feasible to link solely to tinnitus.[79] However case reports and anecdotal evidence do demonstrate that suicidal ideation can occur within any stage of the tinnitus pathway, therefore clinicians need to be vigilant to the signs of it. The guideline will help provide more clarity for those concerned about onward referral of someone with tinnitus at high risk of suicide. Question 1: Additional training will be required for all clinicians in	Thank you for your comment and response to the query.

[77] NICE Clinical Knowledge Summaries, 2017. Tinnitus: management. Available at: https://cks.nice.org.uk/tinnitus#!scenario [Accessed 21/10/2019].
[78] British Society of Audiology (2018) Draft Practice Guidance: Tinnitus in adults. Available at: http://www.thebsa.org.uk/wp-content/uploads/2019/09/Practice-Guidance_Tinnitus-in-Adults_for-member-consultation_30AUG2019.pdf [Accessed 21/10/2019]
[79] Szibor A, Mäkitie A, & Aarnisalo AA (2019). Tinnitus and suicide: An unresolved relation. *Audiology research*, 9(1), 222.

Tinnitus: assessment and management

Consultation on draft guideline - Stakeholder comments table
20/09/2019 to 01/11/2019

Comments forms with attachments such as research articles, letters or leaflets cannot be accepted.

Stakeholder	Document	Page No	Line No	Comments Please insert each new comment in a new row	Developer's response Please respond to each comment
				contact with tinnitus patients to recognise the signs of suicidal ideation and be aware of the referral pathways in place. There will need to be particular emphasis for audiologists who are likely to spend the most time with these patients but do not have extensive training in recognising signs of mental ill-health including suicidal ideation.	
Hearing Loss and Deafness Alliance	Guideline	004	028	**We welcome the recommendation to urgently refer those with tinnitus associated with sudden onset hearing loss (in line with the NICE guideline for hearing loss)** Anecdotally, we have received some reports from individuals of delayed treatment for sudden onset hearing loss because it was believed that the underlying cause was a common cold or flu causing congestion. Subsequently, the issue was not treated urgently and the individual was later diagnosed with sensorineural hearing loss. We hope that this recommendation will raise awareness among referring clinicians of the urgency to refer those with sudden onset hearing loss which could be associated with sudden onset tinnitus.	Thank you for your comment.
Hearing Loss and Deafness Alliance	Guideline	005	001	**We welcome the recommendations to refer certain signs and symptoms more urgently to encourage timely referrals, however we believe there have been some omissions from recommendation 1.2.2** <u>Recommendation 1.2.2</u> • distress affecting mental well-being (including distress that limits their daily activities) despite receiving tinnitus support at first point of contact with primary or community care services Within this recommendation we request that sleep is included as a specific "daily activity". We welcome recommendation 1.2.12 however	Thank you for your comment. The committee have now highlighted that sleep is a daily activity that is relevant for this recommendation within the rationale and impact section of the recommendation. The heading for recommendation has been edited, so that general practice is not excluded from doing sleep assessments in people with tinnitus.

Tinnitus: assessment and management

Consultation on draft guideline - Stakeholder comments table
20/09/2019 to 01/11/2019

Comments forms with attachments such as research articles, letters or leaflets cannot be accepted.

Stakeholder	Document	Page No	Line No	Comments Please insert each new comment in a new row	Developer's response Please respond to each comment
				this refers to assessment of sleep in secondary care. Patients with inadequate sleep identified in secondary care assessment will usually be referred back to their GP for management, therefore sleep should be discussed in primary care to encourage timely referrals to appropriate sleep services.	
Hearing Loss and Deafness Alliance	Guideline	005	005	**We would encourage the committee to remove the phrase "despite receiving tinnitus support at first point of contact" in recommendation 1.2.2** There is a possibility that "at first point of contact" could be misinterpreted by some clinicians, to the extent that people who need urgent onward referral for tinnitus distress are given tinnitus support in primary care and then advised watchful waiting. We feel that this is too lenient, if someone is experiencing distress that is limiting their daily activities, this should warrant urgent referral to secondary care whether they have received tinnitus support at first point of contact or not. Many people will need to be referred onwards at the first appointment but leaving this open to interpretation could mean that some clinicians will think they only have to refer in extreme circumstances, such as tinnitus associated with high risk of suicide. This could effectively create a barrier to accessing tinnitus services. A study by McFerran *et al.* (2018) showed that only 55.4% of people were referred to secondary care after their first GP appointment.[80] Therefore we are concerned that misinterpretation of these recommendations could cause increased barriers to referral and therefore delayed management. For many people tinnitus support is appropriate and adequate when delivered positively and sensitively but there are exceptions where	Thank you for your comment. For many people presenting with tinnitus, information on tinnitus, advice about managing their tinnitus is frequently sufficient. The committee notes that if people with tinnitus are given appropriate information at the first point of contact (usually the GP) and received appropriate reassurance and management, this can address many of the individual's concerns and the tinnitus may not escalate. Any person with tinnitus who is distressed after this input should be referred on.

[80] McFerran D, Hoare DJ, Carr S, Ray J & Stockdale D, 2018. Tinnitus Services in the United Kingdom: a survey of patient experiences. BMC Health Services Research, 18, 110.

Tinnitus: assessment and management

Consultation on draft guideline - Stakeholder comments table
20/09/2019 to 01/11/2019

Comments forms with attachments such as research articles, letters or leaflets cannot be accepted.

Stakeholder	Document	Page No	Line No	Comments Please insert each new comment in a new row	Developer's response Please respond to each comment
				tinnitus support in primary care is not sufficient and timely onward referral is essential.	
Hearing Loss and Deafness Alliance	Guideline	005	011	**We urge the committee to include clarity on referral timeframe for recommendation 1.2.3.** Recommendations 1.2.1 and 1.2.2 both state a referral timeframe. There should also be a referral timeframe for recommendation 1.2.3. Furthermore, the first points of recommendations 1.2.2 and 1.2.3, referring to tinnitus distress and annoyance, could depend on the clinician's interpretation of them. Therefore it is important that there is a recommended timeframe to avoid people who need an urgent referral being inappropriately referred as a routine case and waiting for an unspecified length of time.	Thank you for your comment. The committee noted that the recommendation is related to routine referrals and therefore specific timeframes cannot be provided Routine referrals are dependent on local services and recommendations should be followed in line with local pathways. The committee also noted that the NHS Constitution sets out that patients should wait no longer than 18 weeks from GP referral to treatment. The committee recognised the risk of inappropriate routine referrals for people who are distressed by their tinnitus, but agreed that it should be noted that distress is based on the patient perspective rather than clinician interpretation. The committee agreed that referral within 2 weeks for tinnitus related distress should occur following the provision of tinnitus support and the recognition that tinnitus is affecting mental well-being (e.g. distress that limits their daily activities). The committee appreciates that distress can have subjective interpretations but agreed that adding the caveat of "distress affecting mental well-being, despite receiving tinnitus support" provides a clear distinction between the populations who may be bothered by tinnitus.
Hearing Loss and Deafness Alliance	Guideline	005	011	**We welcome the recommendations to refer certain signs and symptoms more urgently to encourage timely referrals, however we believe there should be an additional criterion in recommendation 1.2.3** We recommend the committee includes the following criterion for	Thank you for your comment. Tinnitus can change in frequency and duration. The committee considers that tinnitus that has significantly changed is covered by the bullet point tinnitus that still bothers the person despite tinnitus support in recommendation 1.2.6 so the committee does not think it is necessary to include your suggestion.

Tinnitus: assessment and management

Consultation on draft guideline - Stakeholder comments table
20/09/2019 to 01/11/2019

Comments forms with attachments such as research articles, letters or leaflets cannot be accepted.

Stakeholder	Document	Page No	Line No	Comments Please insert each new comment in a new row	Developer's response Please respond to each comment
				onward referral in recommendation 1.2.3: • Tinnitus that has significantly changed in nature in line with the NICE Guideline for Hearing Loss[81] and the BAA Direct Referral criteria.[82]	
Hearing Loss and Deafness Alliance	Guideline	005	023 - 025	**Line 23 states 'Initial assessment in secondary care'.** Please comment 2 about the use of primary care setting to refer to GPs, and secondary care to refer to ENT/audiology. This should be reviewed and be clearer about whether NICE means 'Initial assessment by audiology and ENT' in any setting.	Thank you for your comments. The committee have discussed the terminology used in the guideline and agree that the wording for "primary care" and "secondary care" should be changed. The intention of the wording was to make it clear that healthcare professionals working in general practice are not expected to use questionnaires such as the TFI. The committee appreciates that speciality services such as audiology can in fact be delivered in general practice, community settings and within hospitals. The wording has been changed to reflect this.
Hearing Loss and Deafness Alliance	Guideline	006	005	**We welcome that the guideline encourages clinicians to be alert at all stages of care for symptoms of anxiety and depression however we would ask the committee to consider re-wording the recommendation to discuss tinnitus and mental health more broadly.** Tinnitus is often associated with depression, anxiety and mental ill-health; if this is not managed there is potential for harmful outcomes.[83] Therefore clinicians who come into contact with these patients have a duty of care to ensure red flag symptoms associated with mental ill-health are identified and receive prompt and appropriate care. Question 1: Audiologists are likely to have greater interaction with these	Thank you for your comment. This recommendation has been updated: the committee have recommended that healthcare professionals are alert at all stages to an individual's mental health and well-being. Health care professionals with the relevant qualifications, skills and competencies should deliver care, and training requirements would be assessed at the service provider. Your response regarding training will be considered by NICE where relevant support activity is being planned.

[81] NICE 2018 Hearing Loss: Assessment and management. Available at: https://www.nice.org.uk/guidance/ng98 [Accessed 21/10/2019]
[82] British Academy of Audiology, 2016. Guidance for Audiologists: Onward Referral of Adults with Hearing Difficulty Directly Referred to Audiology Services. Available at: https://www.baaudiology.org/files/4614/7828/2156/BAA_Guidance_for_Onward_Referral_of_Adults_with_Hearing_Difficulty_Directly_Referred_to_Audiology_2016.pdf. [Accessed 21/10/2019].
[83] Bhatt JM, Bhattacharyya N & Lin HW, 2016. Relationships between tinnitus and the prevalence of anxiety and depression. Laryngoscope. 127:466–469, 2017

Tinnitus: assessment and management

Consultation on draft guideline - Stakeholder comments table
20/09/2019 to 01/11/2019

Comments forms with attachments such as research articles, letters or leaflets cannot be accepted.

Stakeholder	Document	Page No	Line No	Comments Please insert each new comment in a new row	Developer's response Please respond to each comment
				patients as tinnitus is often associated with hearing loss, however most audiology training does not emphasise recognition and assessment of these symptoms. Therefore some additional training will be required not only to identify and assess these symptoms but to also make audiologists aware of local pathways and have the confidence to ask the necessary questions if they are concerned about their patient's wellbeing.	
Hearing Loss and Deafness Alliance	Guideline	007	001	**We welcome the assessment of sleep in recommendation 1.2.12 However we urge the committee to provide more clarity as to how this informs a management plan, as in most cases a referral back to the GP would be required.** Currently sleep hygiene is not mentioned in the draft. We feel this should be included as sleep difficulties are among the most frequent complaints associated with tinnitus, which leads to more distress.[84] This reduces quality of life for many individuals and can also cause other health conditions as a result.[85]	Thank you for your comment. Identifying sleep difficulties due to tinnitus is included in the guideline recommendations Basic advice on sleep management should be provided as part of the information and support offered to people with tinnitus. Specific details on this is outside of the scope of this guideline.
Hearing Loss and Deafness Alliance	Guideline	007	009	**We welcome recommendation 1.2.13 that the effect of tinnitus on quality of life should be discussed** The literature shows that for some people tinnitus can have a significant effect on their quality of life.[86] However there is no standardised questionnaire for measuring the effects of tinnitus on quality of life. Despite this it is encouraging to see the committee recommending a discussion about quality of life as this will allow more personalised care	Thank you for your comment.

[84] Hebert S, Carrier J. Sleep complaints in elderly tinnitus patients: a controlled study. Ear Hear 2007;28:649-55 [PubMed]
[85] Crönlein T., Langguth B., Pregler M., Kreuzer P. M., Wetter T. C., Schecklmann M. (2016). Insomnia in patients with chronic tinnitus: cognitive and emotional distress as moderator variables.
[86] Hall DA, Fackrell K, Li AB, Thavayogan R, Smith S, Kennedy V & Lourenço VM, (2018) A narrative synthesis of research evidence for tinnitus-related complaints as reported by patients and their significant others. Health and Quality of Life Outcomes 16(1): 61; Watts EJ, Fackrell K, Smith S, Sheldrake J, Haider H, & Hoare DJ (2018). Why Is Tinnitus a Problem? A Qualitative Analysis of Problems Reported by Tinnitus Patients. *Trends in hearing*, *22*, 2331216518812250.

Tinnitus: assessment and management

Consultation on draft guideline - Stakeholder comments table
20/09/2019 to 01/11/2019

Comments forms with attachments such as research articles, letters or leaflets cannot be accepted.

Stakeholder	Document	Page No	Line No	Comments Please insert each new comment in a new row	Developer's response Please respond to each comment
				and management for someone with tinnitus.	
Hearing Loss and Deafness Alliance	Guideline	007	015 - 022	**'Audiological assessment'** It is important that this section is clearer on which patients will be within the scope of NICE guideline for adult hearing loss (NG98) and the NICE tinnitus guideline.	Thank you for your comments. The committee acknowledges that there is some overlap between the tinnitus guideline and the hearing loss guideline, as hearing loss is common in the tinnitus population., This guideline should be read in conjunction with the hearing loss in adults guideline (NG98) for people with both tinnitus and hearing loss. This has been made clearer within the introduction to the recommendations.
Hearing Loss and Deafness Alliance	Guideline	007	016	**We welcome the recommendation to offer audiometry to people with tinnitus but encourage the committee to clarify the term "audiometry" to promote standardisation of assessment**. Tinnitus is commonly associated with hearing loss (see evidence cited in comment 2.), it is therefore possible someone may have tinnitus with an underlying mild hearing loss without realising, perhaps thinking the tinnitus is preventing them from hearing clearly. Fortunately evidence shows that the majority of people (98%) do undergo pure-tone audiometry as part of tinnitus assessment, albeit via different pathways.[87] We welcome the recommendation as this will help promote consistency for those undergoing tinnitus investigation and management. We would also encourage the committee to consider clarifying what they mean by "audiometry" as this could refer to a number of different hearing assessments. Pure-tone audiometry (PTA) is the gold-standard hearing test most routinely used in audiology services to determine hearing threshold level and we would assume the committee is referring to this test in the recommendation. However there are other types of audiometry such as speech, sound-field and extended high frequency	Thank you for your comment, 'audiometry' is now referred to as 'hearing assessment'. The committee agreed hearing assessments would be performed as standard test and as audiological/ENT centres already have audiometers to provide hearing assessments as part of routine current practice it is not necessary to detail this within the recommendations. A description of what the assessments/tests may include is in evidence review H.

[87] McFerran D, Hoare DJ, Carr S, Ray J & Stockdale D, 2018. Tinnitus Services in the United Kingdom: a survey of patient experiences. BMC Health Services Research, 18, 110.

Tinnitus: assessment and management

Consultation on draft guideline - Stakeholder comments table
20/09/2019 to 01/11/2019

Comments forms with attachments such as research articles, letters or leaflets cannot be accepted.

Stakeholder	Document	Page No	Line No	Comments Please insert each new comment in a new row	Developer's response Please respond to each comment
				audiometry that are not used as routinely as pure-tone.	
Hearing Loss and Deafness Alliance	Guideline	007	017	**We welcome the recommendation to include tympanometry (when indicated) as part of a full test battery.** People with tinnitus often complain of a blocked sensation which can be related to middle ear pathology such as Eustachian tube dysfunction. It is important that middle ear pathology is identified or ruled out to help inform management strategy.	Thank you for your comment.
Hearing Loss and Deafness Alliance	Guideline	007	019	**We find the recommendation to not carry out ULLs somewhat restrictive but agree that they can cause distress to some patients with tinnitus.** ULLs have been the subject of debate and scrutiny within the audiological community, so the committees' rationale can be understood. They are a notoriously subjective measure: the available literature does question their test-retest reliability[88] and in some cases they can exacerbate tinnitus and cause discomfort.[89] However, anecdotally uncomfortable loudness levels can be useful for someone with tinnitus when carried out by an experienced clinician. They are occasionally used in practise as a counselling tool and to help set the Maximum Power Output (MPO) of a hearing aid. This avoids over amplifying sound to an uncomfortable level although the evidence does highlight limitations in using ULL results in this way.[90] Not recommending this procedure at all could be disadvantageous to a	Thank you for your comment. The committee does not recommend ULL tests as an assessment for tinnitus. They are uncomfortable, causes distress and do not change the management of people with tinnitus. All management options should be made as a part of an informed discussion between the health professional and the person with tinnitus. The use of ULLs in the fitting of hearing aids is outside of the scope of this guideline. The guideline development team have reviewed the references provided in your comment. These papers were not appropriate for inclusion in evidence reviews due to inappropriate study type (guidance, literature review) and incorrect population (hyperacusis).

[88] Baguley DM, Andersson G (2007) Hyperacusis: mechanisms, diagnosis, and therapies. San Diego: Plural Publishing.
[89] British Society of Audiology (2018) Draft Practice Guidance: Tinnitus in adults. Available at: http://www.thebsa.org.uk/wp-content/uploads/2019/09/Practice-Guidance_Tinnitus-in-Adults_for-member-consultation_30AUG2019.pdf [Accessed 21/10/2019]
[90] Mueller HG, Bentler RA (2005) Fitting hearing aids using clinical measures of loudness discomfort levels: an evidence based review of effectiveness. J Am Acad Audiol 16: 461- 472.

Tinnitus: assessment and management

Consultation on draft guideline - Stakeholder comments table
20/09/2019 to 01/11/2019

Comments forms with attachments such as research articles, letters or leaflets cannot be accepted.

Stakeholder	Document	Page No	Line No	Comments Please insert each new comment in a new row	Developer's response Please respond to each comment
				patient's management plan. We ask the committee to consider advising an audiologist to exercise caution, using their clinical judgement and experience when considering this test, also providing clear explanation the patient. NICE also promote people having the right to make informed decisions regarding their care.[1] This would be approached as a joint decision by an experienced clinician and informed patient. General consensus among the audiology profession is to perform this test in exceptional circumstances and not routinely.[31] The rationale (page 21 line 1-2) states that the results of ULL testing does not affect the management plan, as the main focus is to lessen the distress of tinnitus. However fitting hearing aids for sound enrichment with an appropriate Maximum Power Output level is surely part of lessening distress, or at least reduces the risk of further distress.	
Hearing Loss and Deafness Alliance	Guideline	007	019	**We find the recommendation to not carry out Acoustic Reflex Thresholds somewhat restrictive but agree that this could be distressing to a patient with tinnitus.** Acoustic Reflex Thresholds can be a useful measure to determine problems within the auditory pathway. Traditionally they were used in diagnostic audiology, particularly for detecting retrocochlear pathology. In current practice assessment and detection of retrocochlear lesions has largely been replaced by MRI and other imaging.[91] However ARTs can be carried out during initial assessment in an audiology clinic and may provide useful measures in some cases, for example when someone cannot have an MRI. However, like ULLs we believe that these tests should be administered	Thank you for your comment. The committee feels that acoustic reflex testing is uncomfortable, causes distress and does not change the management of people with tinnitus.

[91] Waterval, J., Kania, R., & Somers, T. (2018). EAONO Position Statement on Vestibular Schwannoma: Imaging Assessment. What are the Indications for Performing a Screening MRI Scan for a Potential Vestibular Schwannoma?. The journal of international advanced otology, 14(1), 95–99.

Tinnitus: assessment and management

Consultation on draft guideline - Stakeholder comments table
20/09/2019 to 01/11/2019

Comments forms with attachments such as research articles, letters or leaflets cannot be accepted.

Stakeholder	Document	Page No	Line No	Comments Please insert each new comment in a new row	Developer's response Please respond to each comment
				by an experienced clinician exercising caution and only be used in exceptional circumstances, not as part of a standard test battery. The literature does question their safety in some circumstances.[92] Furthermore automated screening ART tests available through most tympanometers would not be appropriate as the stimulus level and duration cannot be controlled. We would advise against the use of automated screening ARTs for those with tinnitus and instead advise clinicians to perform ARTs manually if they were to carry them out in someone with tinnitus.	
Hearing Loss and Deafness Alliance	Guideline	007	026	**We find the recommendation to not carry out psychoacoustic measures somewhat restrictive but agree these could be distressing for someone with tinnitus.** Psychoacoustic tests such as tinnitus pitch and loudness matching have been used in clinical practice by audiologists for some time, primarily as a counselling tool. However their value as a clinical test has been the subject of debate within the audiological community.[93] The committee's rationale against recommending psychoacoustic measures is largely sensible, the test can be fatiguing and possibly distressing with little measurable value in terms of influencing the management plan. However the rationale also states that the test is used in research settings; there is surely a similar risk to harm in research setting as there would be in clinical practice and therefore not recommending it seems contradictory. As with comments 23 & 24 we feel this test should be considered in circumstances where the patient is fully informed, understands the	Thank you for your comment. The committee does not recommend psychoacoustic testing as a routine clinical assessment for tinnitus. They are time-consuming, often unreliable and do not reflect the level of distress due to or impact of tinnitus on an individual, neither does it change the management. The committee recognises that psychoacoustic testing is performed in research settings but have not recommended its use in a research context.

[92] Hunter, L. L., Ries, D. T., Schlauch, R. S., Levine, S. C., & Ward, W. D. (1999). Safety and clinical performance of acoustic reflex tests. Ear & Hearing, 20, 506-514.
[93] Hoare DJ, Edmondson-Jones M, Gander PE, Hall DA (2014) Agreement and Reliability of Tinnitus Loudness Matching and Pitch Likeness Rating. PLoS ONE 9(12): e114553.

Tinnitus: assessment and management

Consultation on draft guideline - Stakeholder comments table
20/09/2019 to 01/11/2019

Comments forms with attachments such as research articles, letters or leaflets cannot be accepted.

Stakeholder	Document	Page No	Line No	Comments Please insert each new comment in a new row	Developer's response Please respond to each comment
				implications of the test and the clinician performing it has sufficient experience.	
Hearing Loss and Deafness Alliance	Guideline	009	General	**We are concerned by the lack of recommendations for people who are d/Deaf or have profound hearing loss for whom amplification is not appropriate.** The recommendations for sound therapy (enrichment) and amplification devices are management strategies that cannot be accessed by people who are d/Deaf or have profound hearing loss. There are no recommendations for people in this group for whom hearing aids or sound therapy are inappropriate. We would urge the committee to include specific recommendations for management that can be accessed by those who are deaf or have profound hearing loss. Cochlear implants have been shown to improve tinnitus suppression when this has been measured.[94] We would therefore encourage the committee to refer to this evidence or the recent NICE Technology Appraisal for Cochlear Implants within the Tinnitus guideline.	Thank you for your comments. We did not find any evidence for people who are d/Deaf and therefore the committee were unable to make recommendations specifically for this group. However the committee recognised the lack of management options and have introduced additional research recommendations for the management of tinnitus using psychological therapies and amplification devices in people who are d/Deaf or who have a severe to profound hearing loss. Full details can be seen in Evidence Review L and Evidence Review M. The NICE technology appraisal on cochlear implants is for people with severe to profound deafness, the tinnitus population is not covered and it cannot be referred to within this guideline. The study referenced in your comment was previously assessed but was not includable due to incorrect study design (non-randomised study of retrospective design) and population (not all of the study population had tinnitus).
Hearing Loss and Deafness Alliance	Guideline	009	003 - 009	**'Managing tinnitus for people referred to tinnitus service' and recommendation 1.4.1 and 1.4.2 (lines 5-9).** It is important that this section is clearer on which patients will be within the scope of NICE guideline for adult hearing loss (NG98) and the NICE tinnitus guideline. In our view recommendation 1.4.1 and 1.4.2 fall within scope of NG98.	Thank you for your comments. The committee acknowledges that there is some overlap between the tinnitus guideline and the hearing loss guideline, as hearing loss is common in the tinnitus population. For adults with tinnitus and hearing loss, this guideline should be read in conjunction with the hearing loss in adults guideline (NG98). This has been made clearer within the introduction to the recommendations. All recommendations within the guideline apply to both adult, children and young people unless otherwise stated and this has been clarified within the introductory section of the guideline.

[94] Kim D, et al (2013) Tinnitus in patients with profound hearing loss and the effect of cochlear implantation. 270(6):1803-1808.

Tinnitus: assessment and management

Consultation on draft guideline - Stakeholder comments table
20/09/2019 to 01/11/2019

Comments forms with attachments such as research articles, letters or leaflets cannot be accepted.

Stakeholder	Document	Page No	Line No	Comments Please insert each new comment in a new row	Developer's response Please respond to each comment
Hearing Loss and Deafness Alliance	Guideline	009	004	**We consider the language of the title: <u>Sound therapy</u> and amplification devices misleading and would encourage the committee to consider rewording the recommendation to avoid ambiguity.** Recommendations 1.4.1, 1.4.2 and 1.4.3 refer to amplification only. Devices which amplify sound to improve communication and reduce hearing difficulties such as hearing aids and combination devices do provide a level of sound enrichment but this is different to traditional sound therapy. The recommendations appear to only be for amplification and not sound therapy. Sound therapy (or sound enrichment) is the use of a constant sound to help distract someone from their tinnitus, or reduce their awareness of it, with the ultimate goal being habituation. Devices specifically designed for this purpose such as ear-level tinnitus maskers, table-top sound generators or pillow speakers are often suggested by audiologists as part of a management plan.[95] The advent of relaxation and mindfulness smartphone apps has allowed more people access to sound therapy. Sound enrichment can also be achieved through the use of hearing aids or combination devices, as the amplified sounds from these devices help to distract from tinnitus. However these devices are not solely used for sound therapy, their primary purpose is improving auditory input and communication, with the potential to facilitate habituation to tinnitus as a secondary benefit.	Thank you for your comment. The title has been amended with the removal of sound therapy. The committee agreed that there was limited evidence available to make a recommendation for the use of sound therapies. A research recommendation was made for sound therapies in combination with tinnitus support (see Evidence Review P for further details).

[95] McFerran D, Hoare DJ, Carr S, Ray J & Stockdale D, 2018. Tinnitus Services in the United Kingdom: a survey of patient experiences. BMC Health Services Research, 18, 110.; Hall DA, Lainez MJ, Newman CW, Sanchez TG, Egler M, Tennigkeit F, et al. Treatment options for subjective tinnitus:self reports from a sample of general practitioners and ENT physicians within Europe and the USA. BMC Health Services Research 2011;11:302.

Tinnitus: assessment and management

Consultation on draft guideline - Stakeholder comments table
20/09/2019 to 01/11/2019

Comments forms with attachments such as research articles, letters or leaflets cannot be accepted.

Stakeholder	Document	Page No	Line No	Comments Please insert each new comment in a new row	Developer's response Please respond to each comment
				Furthermore, many hearing aids are now being manufactured which can play tinnitus support sounds controlled by a smart phone app – this is available privately and on the NHS. Bluetooth streaming to hearing aids has also been available for some time, allowing people to stream environmental sounds such as wave noise directly into their hearing aids. Therefore sound therapy is available through many different devices and in many different forms. Sound therapy is widely available and currently the preferred method of audiological tinnitus management in the UK.[96] However the evidence for sound therapy is of low quality so we can understand the committee's rationale for not recommending it. It should be noted that absence of results demonstrating effectiveness should not be interpreted as ineffectiveness, especially when the recommendation could indicate significant changes to current practice. As there is no evidence for effectiveness of sound therapy, we would encourage the committee to make a specific recommendation for information provision so patients can try this themselves should they choose to. Smart phone apps and table-top sound generators are readily available and may provide some relief from the acute symptoms of tinnitus.	
Hearing Loss and Deafness	Guideline	009	005	**We welcome recommendation 1.4.1 to Offer amplification devices to people with tinnitus who have a hearing loss that affects their ability to communicate.**	Thank you for your comment.

[96] Hobson J, Chisholm E & El Refaie A (2012) Sound therapy (masking) in the management of tinnitus in adults. Cochrane Database of Systematic Reviews, Issue 11.

Tinnitus: assessment and management

Consultation on draft guideline - Stakeholder comments table
20/09/2019 to 01/11/2019

Comments forms with attachments such as research articles, letters or leaflets cannot be accepted.

Stakeholder	Document	Page No	Line No	Comments Please insert each new comment in a new row	Developer's response Please respond to each comment
Alliance				Hearing aids are a clinically and cost-effective management option for people with hearing loss[97]. Enhancing auditory input through hearing aids not only has the beneficial effect of improving speech intelligibility but also can help distract from tinnitus. There are also additional benefits to hearing aids such as improved communication, reduced social isolation and withdrawal, and improved wellbeing.[39] The NICE guideline for hearing loss states that hearing aids should be offered to people with hearing loss based on need.[98] There is also evidence they provide help for people with tinnitus by increasing auditory input and distracting from tinnitus sound.[99] As well as tinnitus, untreated hearing loss is associated with depression and social isolation. There is also growing evidence that it is associated with dementia.[100] Therefore it is paramount that those with hearing loss and tinnitus are offered bilateral hearing aids should they need them. However, in some areas of the country, hearing aid provision is restricted. In 2015 NHS North Staffordshire CCG implemented a policy that restricted the provision of hearing aids so that people with an average hearing threshold level of less than 41dB HL were not eligible for them. The policy is still in place despite the release of the NICE Guidelines for Hearing loss, which state that hearing aids should be offered based on someone's ability to communicate and hear and not	

[97] Ferguson MA, Kitterick PT, Chong L, Edmondson-Jones M, Barker F & Hoare DJ. (2017) Hearing aids for mild to moderate hearing loss in adults. Cochrane Database of Systematic Reviews, Issue 9. Art. No.: CD012023
[98] NICE 2018 Hearing Loss: Assessment and management. Available at: https://www.nice.org.uk/guidance/ng98 [Accessed 21/10/2019]
[99] Hoare DJ, Edmondson-Jones M, Sereda M, Akeroyd MA, Hall D. (2014) Amplification with hearing aids for patients with tinnitus and co-existing hearing loss. Cochrane Database of Systematic Reviews, Issue 1. Art. No.: CD010151.
[100] Livingston G, Sommerlad A, Orgeta V, et al (2017) Dementia prevention, intervention, and care. The Lancet.16;390(10113):2673-2734.

Tinnitus: assessment and management

Consultation on draft guideline - Stakeholder comments table
20/09/2019 to 01/11/2019

Comments forms with attachments such as research articles, letters or leaflets cannot be accepted.

Stakeholder	Document	Page No	Line No	Comments Please insert each new comment in a new row	Developer's response Please respond to each comment
				hearing threshold level alone. Furthermore this policy does not make exceptions for people who have tinnitus as well as hearing loss.[101] So if someone has bothersome tinnitus associated with an average hearing threshold level below 41dB HL they would not be eligible for hearing aids which could help provide sound enrichment and alleviate tinnitus symptoms. We therefore welcome the recommendation as this will raise awareness of the effectiveness of hearing aids and encourage their use for those with tinnitus associated with hearing loss. We also hope that the recommendation will influence commissioners to ensure hearing aids are available for all those who need them.	
Hearing Loss and Deafness Alliance	Guideline	009	008	**We welcome recommendation 1.4.1 to consider amplification devices for people with tinnitus who have a hearing loss but do not have difficulties communicating.** Hearing loss may not be the primary complaint for many people with tinnitus however evidence shows that in most cases that tinnitus is associated with some hearing loss (see evidence cited in comment 2). Evidence also demonstrates that people wait on average 10 years before seeking help for their hearing loss.[102] Therefore increasing auditory input with hearing aids may help with tinnitus percept, but could also provide preventative effects for other	Thank you for your comment..

[101] North Staffordshire CCG (2016) Hearing Aids for people with mild to moderate Adult-Onset Hearing Loss. Available at: https://www.northstaffsccg.nhs.uk/governance/policies/commissioning-policies/424-commissioning-policy-hearing-aids-for-mild-to-moderate-adult-onset-hea/file [Accessed 21/10/2019]
[102] Davis, A., Smith, P., Ferguson, M., Stephens, D., & Gianopoulos, I. (2007). Acceptability, benefit and costs of early screening for hearing disability: a study of potential screening tests and models. *HEALTH TECHNOLOGY ASSESSMENT-SOUTHAMPTON 1*(42).

Tinnitus: assessment and management

Consultation on draft guideline - Stakeholder comments table
20/09/2019 to 01/11/2019

Comments forms with attachments such as research articles, letters or leaflets cannot be accepted.

Stakeholder	Document	Page No	Line No	Comments Please insert each new comment in a new row	Developer's response Please respond to each comment
				comorbidities associated with untreated hearing loss such as depression, social isolation and potentially dementia.[103]	
Hearing Loss and Deafness Alliance	Guideline	009	015	**We would encourage the committee to make clear recommendations regarding psychological therapies for those who are deaf or have profound hearing loss.** Despite the evidence cited in comment 29, cochlear implants are not an appropriate option for everyone who is d/Deaf and some people may opt not to have one. However d/Deaf people are twice as likely to experience mental health problems as hearing people. [104] We would therefore encourage the committee to make specific recommendations for psychological therapies for those who are d/Deaf and ensure they have access to these therapies. Furthermore, it is vital that someone who uses BSL has access to a BSL therapist and not psychological therapies via an interpreter, this includes digital CBT. Question 3: The Deaf health charity SignHealth has a wealth of online resources that provide information surrounding health of Deaf people in the UK. [105] This includes specific information about mental health and access to mental health services. SignHealth also provide psychological therapies in BSL including face to face and online CBT for deaf people.	Thank you for your comment and for sharing the resource in Question 3. The committee have discussed this, as no evidence was identified for psychological therapies in those who are deaf or having profound hearing loss, a research recommendation has been made. Full details including the role of BSL interpreters, can be seen in Evidence Review L.
Hearing Loss and	Guideline	009	015	**We welcome the recommendation for psychological therapies in principle however we feel the wording "consider" is not strong**	Thank you for your comment. Your comments will be considered by NICE where relevant support activity is being planned to

[103] Ferguson MA, Kitterick PT, Chong L, Edmondson-Jones M, Barker F & Hoare DJ. (2017) Hearing aids for mild to moderate hearing loss in adults. Cochrane Database of Systematic Reviews, Issue 9. Art. No.: CD012023

[104] Fellinger J, Holzinger D & Pollard R (2012) Mental health of deaf people. The Lancet. 279(9820): 1037-1044; Boness C. L. (2016). Treatment of Deaf Clients: Ethical Considerations for Professionals in Psychology. Ethics & behavior, 26(7), 562–585.

[105] SignHealth (2014) The Health of Deaf People in The UK. Available at: http://www.signhealth.org.uk/sick-of-it-report-professionals/ [Accessed 01/11/2019].

Tinnitus: assessment and management

Consultation on draft guideline - Stakeholder comments table
20/09/2019 to 01/11/2019

Comments forms with attachments such as research articles, letters or leaflets cannot be accepted.

Stakeholder	Document	Page No	Line No	Comments Please insert each new comment in a new row	Developer's response Please respond to each comment
Deafness Alliance				**enough.** CBT has the strongest evidence base for managing tinnitus.[106] However few people with tinnitus actually receive access CBT with a psychologist in the current tinnitus pathway due to lack of appropriate services.[107] We are concerned that the word "consider" could be interpreted based on services available in the area resulting in a postcode lottery, therefore we encourage the committee to change this to be more directive. We welcome the consideration to improve access to CBT through utilizing digital mediums but are concerned that digital tinnitus-related CBT is not yet publicly available in the UK.[108] However we are aware that there is promising data from recent studies suggesting its efficacy.[109] We also agree that high demand for psychological therapies in some locations means that aspects of service delivery will need to be altered to overcome these demands and there may be significant challenges in implementing this. Improvements in technology have allowed more aspects of care to be delivered digitally, for example the advent of video call GP consultations. We would emphasise the need to exercise caution for those referred for	assist with the implementation of this recommendation. The "consider" used for the recommendation is standard NICE terminology (terminology described in the NICE methods manual: https://www.nice.org.uk/media/default/about/what-we-do/our-programmes/developing-nice-guidelines-the-manual.pdf). Whilst the evidence that evaluated psychological therapies in people with tinnitus-related distress showed a clinical benefit of psychological therapies, the majority of the evidence was graded as low quality taking into account risk of bias, imprecision and inconsistency in the evidence. This limited the level certainty/confidence around the evidence-base, consequently the committee made a weaker recommendation. Economic analyses suggested that it would be more cost effective to use digital CBT and the committee considered that some providers would take the initiative to adapt existing digital CBT tools, available for use in other populations, for people with tinnitus. The guideline development team have reviewed the references provided in your comment. Some of the studies referenced were previously assessed and excluded due to incorrect study design (Cima 2014, Beukes 2015, Beukes 2017) (see Excluded Studies inEvidence Review L. Two other studies were not suitable for inclusion in this evidence review due to incorrect study design (McFerran 2018 and Greenwell 2016). Weise 2016 was included

[106] Cima RFF, et al. (2014) Cognitive-Behavioural Treatments for Tinnitus: A Review of the Literature. Journal of the American Academy of Audiology 25(1): 29-61.
[107] McFerran D, Hoare DJ, Carr S, Ray J & Stockdale D, 2018. Tinnitus Services in the United Kingdom: a survey of patient experiences. BMC Health Services Research, 18, 110.
[108] Weise C, Kleinstäuber M, Andersson G. Internet-delivered cognitive-behavior therapy for tinnitus: a randomized controlled trial. Psychosom Med. 2016;78: 501–10.
[109] Beukes EW, Allen PM, Manchaiah V, Baguley DM, Andersson G. Internet based intervention for tinnitus: outcome of a single-group open trial. J Am Acad Audiol. 2017;28:340–51.; Beukes EW, Manchaiah V, Allen PM, Baguley DM, Andersson G. Internet based cognitive behavioural therapy for adults with tinnitus in the UK: study protocol for a randomised controlled trial. BMJ Open. 2015;5:e008241.; Greenwell K, Sereda M, Coulson N, Hoare DJ. Understanding user reactions and interactions with an internet-based intervention for tinnitus selfmanagement: mixed-methods process evaluation protocol. JMIR Res Protoc. 2016;5:e49.

Tinnitus: assessment and management

Consultation on draft guideline - Stakeholder comments table
20/09/2019 to 01/11/2019

Comments forms with attachments such as research articles, letters or leaflets cannot be accepted.

Stakeholder	Document	Page No	Line No	Comments Please insert each new comment in a new row	Developer's response Please respond to each comment
				digital CBT, ensuring safeguards are in place and that patients have the option to access timely group based or individual psychological therapies if necessary.	in the psychological therapies evidence review (Evidence Review L).
Hearing Loss and Deafness Alliance	Guideline	010	005	**We welcome recommendation 1.4.5. However we urge the committee to provide more clarity around prescribing medication for tinnitus in general.** There is very little low quality evidence to suggest that betahistine is effective when prescribed for tinnitus and therefore we welcome this recommendation but feel it could be clearer.[110] We also feel there is a very apparent lack of information in the draft regarding other medications commonly prescribed for tinnitus. There is no clinically proven drug treatment for tinnitus[111] however many people report they have been prescribed medications specifically for their tinnitus.[112] The study by McFerran *et al*. (2018) found that 20.1% of respondents were prescribed drugs in primary care. Of this group, psychoactive drugs were the most commonly prescribed despite little evidence of their effectiveness for improving tinnitus symptoms. Psychoactive drugs may be prescribed to manage comorbid conditions such as depression and anxiety but there are anecdotal reports that these drugs are prescribed primarily to alleviate tinnitus symptoms. We would encourage the committee to make clear within the guideline that there is no clinically proven drug treatment to avoid inappropriate prescribing for someone with tinnitus. This in turn could help manage expectations if combined with appropriate information around drug	Thank you for your comment. The committee agrees that there is no clinical benefit associated with the use of betahistine and there is some indication of harm with side effects. The committee recommend that it should not be offered to people with tinnitus: this recommendation has been amended. The fact that there is no clinically proven drug treatment available for tinnitus has been highlighted in the rationale and impact section for the guideline. The Cochrane review referenced in your comments was included within the Betahistine evidence review. The other two references have been assessed but are not suitable for inclusion due to incorrect study design (patient survey and narrative review).

[110] Wegner I, Hall DA, Smit AL, McFerran D, Stegeman I. Betahistine for tinnitus. Cochrane Database of Systematic Reviews 2018, Issue 12. Art. No.: CD013093.
[111] McFerran DJ, Stockdale D, Holme R, Large CH & Baguley DM, 2019. Why Is There No Cure for Tinnitus? Front. Neurosci. 13:802.
[112] McFerran D, Hoare DJ, Carr S, Ray J & Stockdale D, 2018. Tinnitus Services in the United Kingdom: a survey of patient experiences. BMC Health Services Research, 18, 110.

Tinnitus: assessment and management

Consultation on draft guideline - Stakeholder comments table
20/09/2019 to 01/11/2019

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Stakeholder	Document	Page No	Line No	Comments Please insert each new comment in a new row	Developer's response Please respond to each comment
				treatment for tinnitus, as set out in comment 7.	
Hearing Loss and Deafness Alliance	Guideline	011	018	**We welcome research recommendation 1: Research for CBT for adults with tinnitus delivered by appropriately trained healthcare professionals other than psychologists.** As CBT can be difficult to access in different areas we welcome the research recommendation for other healthcare professionals to be appropriately trained to deliver it for patients with tinnitus. Audiologists would be most appropriate to receive training in CBT for tinnitus as they have most point of contact with tinnitus patients. There are a number of audiologists trained in psychological therapies including CBT[113] but we would welcome research to investigate if this is clinically and cost effective on a larger scale.	Thank you for your comment. The committee agrees that it is important to evaluate the clinical effectiveness and cost-effectiveness of CBT delivered by appropriately trained healthcare professionals such as audiologists. Full details for this research recommendation can be found in Evidence Review L. Details include what the committee would be like research to look like, e.g. outcomes and study design.
Hearing Loss and Deafness Alliance	Guideline	012	001	**We welcome research recommendation 2: Combination management strategy: sound therapy and tinnitus support.**	Thank you for your comment.
Hearing Loss and Deafness Alliance	Guideline	012	006	**We welcome research recommendation 3: Methods for assessing tinnitus in primary care settings**	Thank you for your comment.
Hearing Loss and Deafness Alliance	Guideline	012	011	**We welcome research recommendation 4: Neuromodulation**	Thank you for your comment.
Hearing Loss and	Guideline	012	016	**We welcome research recommendation 5: Psychological therapies for children and young people**	Thank you for your comment.

[113] Sweetow RW. Cognitive aspects of tinnitus patient management. Ear Hear. 1986;7:390–6.

Tinnitus: assessment and management

Consultation on draft guideline - Stakeholder comments table
20/09/2019 to 01/11/2019

Comments forms with attachments such as research articles, letters or leaflets cannot be accepted.

Stakeholder	Document	Page No	Line No	Comments Please insert each new comment in a new row	Developer's response Please respond to each comment
Deafness Alliance					
Hearing Loss and Deafness Alliance	Guideline	016	024	**'Initial assessment secondary care'.**	Thank you for your comment.
Hearing Loss and Deafness Alliance	Guideline	020	019 - 020	**We agree with the Committee that;** • many people with tinnitus will not know they have a hearing loss and that this could be contributing to their tinnitus (lines 19-21) • effective management of hearing loss can help reduce the audibility and impacts of hearing loss (lines 25-25) and people should therefore receive audiometry if they report tinnitus (lines 21-22) See comment which sets out that most adults with tinnitus will also have a hearing loss and will in fact fall under the scope of the NICE guideline for adult hearing loss (NG98) and the associated NICE Quality Standard. This should be made clearer in the final tinnitus guideline.	Thank you for your comments. The committee acknowledges that there is some overlap between the tinnitus guideline and the hearing loss guideline, as hearing loss is common in the tinnitus population. For adults with tinnitus and hearing loss, this guideline should be read in conjunction with the hearing loss in adults guideline (NG98). This has been made clearer within the introduction to the recommendations.
Hearing Loss and Deafness Alliance	Guideline	General	General	More than 11 million people in the UK have hearing loss, about 1 in 6 of the population. The prevalence of hearing loss increases with age. It has been estimated that between 10 and 15% of adults across the UK suffer from tinnitus,[114] with recent data showing that this increases to nearly 17% of 40 to 69-year olds and 25-30% of over 70s.[115] The British Tinnitus Association (BTA) estimate that currently, 1 in 8 people in the UK are living with tinnitus and that this number is expected to increase by 550,000 over the next 10 years. Deafness, tinnitus and hearing loss are serious health conditions that	The committee acknowledges that there is some overlap between the tinnitus guideline and the hearing loss guideline, as hearing loss is common in the tinnitus population. For adults with tinnitus and hearing loss, this guideline should be read in conjunction with the hearing loss in adults guideline (NG98). A statement to this effect has been added to the introduction to the recommendations . NG98 only covers management for hearing loss, and if a person has both tinnitus and hearing loss, both conditions need to be managed. Whilst NG98 applies only to adults, the committee considered it

[114] Davis AC, 1989. The prevalence of hearing impairment and reported hearing disability among adults in Great Britain. International Journal of Epidemiology, 18, 911–17.
[115] Dawes P, Fortnum H, Moore DR, Emsley R, Norman P, Cruickshanks K, Davis A, Edmondson-Jones M, McCormack A, Lutman M & Munro K, 2014. Hearing in middle age: A population snapshot of 40-69 year olds in the UK. Ear and Hearing, 35, e44–e51.

Tinnitus: assessment and management

Consultation on draft guideline - Stakeholder comments table
20/09/2019 to 01/11/2019

Comments forms with attachments such as research articles, letters or leaflets cannot be accepted.

Stakeholder	Document	Page No	Line No	Comments Please insert each new comment in a new row	Developer's response Please respond to each comment
				can have a significant impact on health and wellbeing. Tinnitus can have a negative impact on a person's mental health, relationships with family and friends and their ability to sleep, concentrate and work. There is significant overlap between the adult population that will be managed using the NICE adult hearing loss guideline (NG98) and this NICE tinnitus guideline. For example, adults with hearing loss and tinnitus were within scope of NG98 and • "Tinnitus is often associated with hearing loss. For example, 75 percent of people with hearing loss might experience tinnitus, whilst only 20 percent to 30 percent of people who report tinnitus have normal hearing. It is estimated that 3 percent of adults might require a clinical intervention for tinnitus." Source: NHS England, Public Health England et al. 2019 – access here https://www.england.nhs.uk/wp-content/uploads/2017/09/joint-strategic-needs-assessment-guidance-jul19.pdf In a practical sense this means many adults in England with tinnitus will in fact also have, or be suspected of having, hearing loss/difficulties and be referred routinely for an audiology assessment via Direct Access Audiology (learn more here: https://www.england.nhs.uk/statistics/statistical-work-areas/direct-access-audiology/). This means many adults presenting for a hearing test will not need to be referred to a specialist "tinnitus service" as text in the draft guideline suggests. Put simply, many adults with tinnitus will also have a hearing loss fall within scope of NG98 and this is not as clear as it could be in the draft NICE tinnitus guideline. This should be reviewed and addressed.	appropriate for the tinnitus referral recommendations to also apply to children as you would refer in the same way. All recommendations apply to adults, children and young people unless otherwise stated and this has been highlighted in the guideline. The committee also acknowledges that hearing loss is common in people with tinnitus; this has now been highlighted in the recommendation about the information that should be provided to people with tinnitus, and in the context section of the guideline. The term "tinnitus service" was not intended to mean a specialist service as the committee acknowledges that access to such services is very limited. In using the term "tinnitus service" the committee meant a service that would see people with tinnitus, e.g. audiology or ear, nose and throat. However, the committee has decided to removal any reference to "tinnitus services" to prevent confusion.

Tinnitus: assessment and management

Consultation on draft guideline - Stakeholder comments table
20/09/2019 to 01/11/2019

Comments forms with attachments such as research articles, letters or leaflets cannot be accepted.

Stakeholder	Document	Page No	Line No	Comments Please insert each new comment in a new row	Developer's response Please respond to each comment
Hearing Loss and Deafness Alliance	Guideline	General	General	Throughout the guideline and evidence documentation "primary care settings" is used when NICE is in fact specifically referring to General Practice, and "secondary care" is used when NICE is in fact referring to ENT and audiology. We would ask NICE to review this and ensure it is agnostic on location unless there is evidence to support a specific setting. This is particularly important given audiologists now work in a range of settings, including primary, community and secondary care; and ENT also offer community-based services. As importantly, if GPs need to improve the care offered it should be explicitly stated. The quickest way to do this is to replace "primary care setting(s)" with "General Practice" and secondary care with "Audiology or ENT".	Thank you for your comment. The committee have discussed the terminology used in the guideline and agree that the wording for "primary care" and "secondary care" should be changed. The intention of the wording was to make it clear that healthcare professionals working in general practice are not expected to use questionnaires such as the TFI. The committee appreciates that speciality services such as audiology can in fact be delivered in general practice, community settings and within hospitals. The wording has been changed to reflect this.
Hearing Loss and Deafness Alliance	Guideline	General	General	It is not clear that referral recommendations in NICE adult hearing loss guideline (NG98) are correctly crossed referenced in the draft tinnitus guideline. For example; • NG98 is more specific on who and where to refer patients to – e.g. ENT, audiovestibular medicine, A&E, stroke service, audiology etc. Given the NICE tinnitus guideline is relying on NG98 for key referral recommendations consistency is important to ensure patients are refereed in a timely manner and to the correct clinic • NG98 is more specific on when to "refer" and when to "consider referring". If the NICE tinnitus guideline is going to cross reference NG98 for referral criteria – as it currently does – then these nuances should also be reflected in the NICE tinnitus guideline.	Thank you for your comments. The committee acknowledges that there is some overlap between the tinnitus guideline and the hearing loss guideline, as hearing loss is common in the tinnitus population. For adults with tinnitus and hearing loss, this guideline should be read in conjunction with the hearing loss in adults guideline (NG98). This has been made clearer within the introduction to the recommendations. Whilst the NG98 guideline recommends specific referral locations within its recommendations, the committee discussed this and decided that it is not possible to be specific for tinnitus as there is variation in local pathways and care models. Where this guideline signposts to other NICE guidance the recommendations have been checked to ensure consistency and recommendations have been amended to ensure that conflicting guidance has not been given.
Hearing Loss	Guideline	General	General	We appreciate that due to the limited evidence the Committee has had	Thank you for your comment. The committee agreed that it is

Tinnitus: assessment and management

Consultation on draft guideline - Stakeholder comments table
20/09/2019 to 01/11/2019

Comments forms with attachments such as research articles, letters or leaflets cannot be accepted.

Stakeholder	Document	Page No	Line No	Comments Please insert each new comment in a new row	Developer's response Please respond to each comment
and Deafness Alliance				to make some difficult assumptions. We are however concerned about whether referral criteria for adults (originally from the NICE guideline for adult hearing loss (NG98)) can be read across to children. In case it is helpful, we signpost the Committee to: a) page 9 of the 2016 NHS England model service specification for children's hearing services https://www.england.nhs.uk/wp-content/uploads/2016/07/P37-CYP-Service-Specification-Template.pdf) b) pages 6, 11, 13-15 in Tinnitus in Children; Practice Guideline, British Society of Audiology 2015, http://www.thebsa.org.uk/wp-content/uploads/2014/06/Paed-Tin-Guide-Pub-Consul-Compressed.pdf, which includes different red flag criteria and referral routes for children compared to NG98 These suggest that referral criteria, clinicians involved, and assessments might vary when considering children and young people (people aged under 18). We would ask NICE to review the guideline and be clearer on how assessing and managing adults (18 and older) and children might vary.	appropriate to cross-refer to NG98 for children and young people in the absence of evidence because the symptoms and signs would lead to the same referral for both populations . The recommendations within this guideline are applicable to all people (adults and children and young people) with tinnitus unless otherwise stated – this is now made clearer in the introduction for the recommendations. The committee consider the guideline is consistent with the NHS England model service specification for children's services. The referral criteria within the tinnitus guideline focuses on the main symptoms and signs associated with this condition that would warrant onward referral, it is not intended to cover all symptoms and signs which would account for differences with the BSA consensus document.
National Community Hearing Association	Algorithms	General	General	Please general comments (*general comment on evidence bias)* relating to biases/assumptions that have in our view distorted this draft guideline. It is not clear what this algorithm will be used for. We would suggest it is either deleted or reworked because, as it currently stands, it is both inaccurate and misleading. For example: On the page titled Child, young person or adult presents to primary care with tinnitus:	Thank you for your comments. The committee have amended the algorithm, following the amendment of recommendations. Changes include the removal of "presents to primary care with tinnitus", The purpose of the algorithm is to provide an overview of the recommendations in the guideline and it refers to other relevant NICE guidelines. It is not a clinical pathway and does not cover every aspect of care for people with tinnitus. The committee notes that whilst there is some overlap between this guideline and NG98, NG98 does not provide guidance for the management of tinnitus. For adults with tinnitus and hearing loss, this guideline should be read in conjunction with the

Tinnitus: assessment and management

Consultation on draft guideline - Stakeholder comments table
20/09/2019 to 01/11/2019

Comments forms with attachments such as research articles, letters or leaflets cannot be accepted.

Stakeholder	Document	Page No	Line No	Comments Please insert each new comment in a new row	Developer's response Please respond to each comment
				▪ "presents to primary care with tinnitus" implicitly and incorrectly assumes that across England the GP is the first point of contact for NHS hearing care. In fact, commissioners are now commissioning open access audiology services so audiologists are the first point of contact and therefore in these cases NG98 https://www.nice.org.uk/guidance/ng98 will apply and most people with hearing loss and tinnitus will be managed by audiology ▪ NG98 https://www.nice.org.uk/guidance/ng98 will apply where there is tinnitus. This NICE guideline for tinnitus will only come into play when children are involved, adults without hearing loss present with tinnitus, and where tinnitus warrants referral under NG98 etc. This algorithm misses all of this and more ▪ 'Non-urgent referral' in the context of actual population needs and NG98 is erroneous (see out comment three). On the page with three key referral categories at the top: ▪ Based on NG98, the diagram is wrong for most adults with tinnitus and hearing loss – e.g. it is wrong that 'tinnitus and hearing loss' is where it is, ditto amplification devices. This might also explain why section 1.4 (lines 3-11, page 9 of the guideline is also incorrect.	hearing loss in adults guideline (NG98). This has been made clearer within the introduction to the recommendations.
National Community Hearing Association	Equality Impact Assessment	003	3.4	"Do the preliminary recommendations make it more difficult in practice for a specific group to access services compared with other groups? If so, what are the barriers to, or difficulties with, access for the specific group? The draft recommendations are not considered to create difficulties for specific groups to access services." We disagree. Older adults are more likely to have to face increased barriers to accessing care* because of non-evidence-based recommendations in the draft guideline.	Thank you for your comments. The committee have discussed the terminology used in the guideline and agree that the wording for "primary care" and "secondary care" should be changed. The intention of the wording was to make it clear that healthcare professionals working in general practice are not expected to use questionnaires such as the TFI. The committee appreciates that speciality services such as audiology can in fact be delivered in general practice, community settings and within hospitals. The wording has been changed to reflect this. The term "tinnitus service" was not intended to mean a specialist service as the committee acknowledges that access to such

Tinnitus: assessment and management

Consultation on draft guideline - Stakeholder comments table
20/09/2019 to 01/11/2019

Comments forms with attachments such as research articles, letters or leaflets cannot be accepted.

Stakeholder	Document	Page No	Line No	Comments Please insert each new comment in a new row	Developer's response Please respond to each comment
				Specifically a) Recommendation 1.2.4 should not have to take place in secondary care (as per line 23 page 5 of the guideline). People should be able to visit audiology or ENT in a primary, community or secondary care setting when there is a choice to do so and complete a TFI there. We have explained why 1.2.4 is based on a biased assumption and must be addressed in any case. b) The term "tinnitus service" is misused (line 3, page 9 of the guideline). Activities on lines 4-9 page 9 do not have to be provided by a "tinnitus service". These can all be delivered by an adult hearing service that is compliant with the NICE adult hearing loss guideline (NG98). Almost every audiology service in England offers an adult hearing service but not every audiology service offers a specialist "tinnitus service", wrongly suggesting more patients need to access a "tinnitus service" can therefore increase barriers to access and worsen health inequalities all because of the way NICE has drafted its guideline. [*Age-related hearing loss is by far the single biggest cause of hearing loss and given tinnitus strongly associated with hearing loss this population is more likely to also have tinnitus, thus the average age of an NHS hearing aid user is 70 or older. Older people – who are likely to have more than one long term condition – will have to travel further than necessary to perform tests or complete questionnaires].	services is very limited. In using the term "tinnitus service" the committee meant a service that would see people with tinnitus, e.g. audiology or ear, nose and throat. However, the committee has decided to removal any reference to "tinnitus services" to prevent confusion.
National Community Hearing Association	Equality Impact Assessment	004	3.6	"Are there any recommendations or explanations that the Committee could make to remove or alleviate barriers to, or difficulties with, access to services identified in questions 3.1, 3.2 or 3.3, or otherwise fulfil NICE's obligation to advance equality? Yes:	Thank you for your comments. The committee have discussed the terminology used in the guideline and agree that the wording for "primary care" and "secondary care" should be changed. The intention of the wording was to make it clear that healthcare professionals working in general practice are not expected to use questionnaires such as the TFI. The committee appreciates

Tinnitus: assessment and management

Consultation on draft guideline - Stakeholder comments table
20/09/2019 to 01/11/2019

Comments forms with attachments such as research articles, letters or leaflets cannot be accepted.

Stakeholder	Document	Page No	Line No	Comments Please insert each new comment in a new row	Developer's response Please respond to each comment
				a) The Committee should remain agnostic about location for care unless there is evidence to support a specific setting. The Committee's current recommendation only to use TFI in secondary care is based on a biased and flawed assumption – we have provided feedback elsewhere about this. Removing the inappropriate reference to secondary care will help reduce barriers/difficulties to accessing services where a patient can be assessed using the TFI b) The term "tinnitus service" is misused (line 3, page 9 of the guideline). Activities on lines 4-9 page 9 do not have to be provided by a "tinnitus service". These can all be delivered by an adult hearing service that is compliant with the NICE adult hearing loss guideline (NG98). Almost every audiology service in England offers an adult hearing service but not every audiology service offers a specialist "tinnitus service", wrongly suggesting more patients need to access a "tinnitus service" can therefore increase barriers to access and worsen health inequalities all because of the way NICE has drafted its guideline.	that speciality services such as audiology can in fact be delivered in general practice, community settings and within hospitals. The wording has been changed to reflect this. The term "tinnitus service" was not intended to mean a specialist service as the committee acknowledges that access to such services is very limited. In using the term "tinnitus service" the committee meant a service that would see people with tinnitus, e.g. audiology or ear, nose and throat. However, the committee has decided to removal any reference to "tinnitus services" to prevent confusion.
National Community Hearing Association	Evidence Review C - D	005	009 - 010	"The majority presenting with tinnitus have benign symptoms and do not need onward referral as they can be supported in primary care. Tinnitus may present as the main complaint or with additional symptoms and or signs." This misses a key point; that most people with tinnitus have a hearing loss. Therefore, they will not (in the context of how the Committee views primary care – GPs) be "supported in primary care", they will in fact also be supported by audiology under NG98 (the NICE guideline on adult hearing loss, which includes adults with tinnitus). This should be made clear in the final guideline.	Thank you for your comment. The committee acknowledges that there is some overlap between the tinnitus guideline and the hearing loss guideline, as hearing loss is common in the tinnitus population. The text referred to in the introduction of Evidence Review C-D has been amended to state the people with tinnitus can be managed within general practice and audiology services. For adults with tinnitus and hearing loss, this guideline should be read in conjunction with the hearing loss in adults guideline (NG98). This has been made clearer in the introduction to the recommendations within the guideline.

Tinnitus: assessment and management

Consultation on draft guideline - Stakeholder comments table
20/09/2019 to 01/11/2019

Comments forms with attachments such as research articles, letters or leaflets cannot be accepted.

Stakeholder	Document	Page No	Line No	Comments Please insert each new comment in a new row	Developer's response Please respond to each comment
National Community Hearing Association	Evidence Review C - D	008	028 - 030	"The committee discussed that hearing loss is a clinical manifestation commonly associated with tinnitus. The committee wished to cross-refer readers to NG98 (recommendations 1.1.2-1.1.4)." As per comment two and three and other feedback, we agree. This important fact is, however, largely lost in the actual guideline. That is why we have called for greater clarity in the final guideline about which populations fall under this guideline and which populations will in the main be managed under NG98.	Thank you for your comments. The committee acknowledges that, as many people with tinnitus can also have a hearing loss, this guideline should be read in conjunction with the hearing loss in adults guideline (NG98). A statement to this effect has been added to the introduction of the recommendations . NG98 only covers management for hearing loss, and if a person has both tinnitus and hearing loss, both conditions need to be managed.
National Community Hearing Association	Evidence Review C - D	009	032 - 037	"This will enable management of potential underlying pathology and to sign post accurately to **alternative voluntary or secondary care providers** for further assessment and management. The overarching aim is to ensure a person suffering from tinnitus experiences a high standard of care tailored to the individual's needs. Prognosis of their tinnitus or their underlying general medical problems can be greatly affected if delay occurs." (our emphasis) We appreciate that the Committee is made up of individuals who work in the voluntary sector and for secondary care providers, however NICE should ensure its guidelines are non-biased and neutral about provider type and setting unless there is evidence to support a specific provider/setting type.	Thank you for your comment. The intention of this wording was to emphasise the importance of correct referral for appropriate tinnitus assessment and management. The wording has been amended.
National Community Hearing Association	Evidence Review E	008	045 - 048	"The committee have specified that the **TFI be used in secondary care only**. The rationale for this is that the committee were conscious of the potential resource impact of completing and discussing these questionnaires in primary care where general practitioners are limited on time". (our emphasis) As we have set out in our other comments (e.g. comment two point three), we are concerned by the lack of evidence and poor logic used to	Thank you for your comments. The committee have discussed the terminology used in the guideline and agree that the wording for "primary care" and "secondary care" should be changed. The intention of the wording was to make it clear that healthcare professionals working in general practice are not expected to use questionnaires such as the TFI. The committee appreciates that speciality services such as audiology can in fact be delivered in general practice, community settings and within

Tinnitus: assessment and management

Consultation on draft guideline - Stakeholder comments table
20/09/2019 to 01/11/2019

Comments forms with attachments such as research articles, letters or leaflets cannot be accepted.

Stakeholder	Document	Page No	Line No	Comments Please insert each new comment in a new row	Developer's response Please respond to each comment
				support this very firm statement. It is both inappropriate and incorrect – e.g. the 'rationale' that follows (e.g. lines 45-48 page 8 and lines 1-4 page 9) is not credible and certainly should not be used in a NICE guideline. On reading Evidence E, it is clear that the Committee actually means that GPs do not have time to do this and they are worried about burdening GP colleagues. This is understandable and something the NCHA, along with other colleagues, will support – this is also why we support open access audiology as GPs explain they would prefer Audiology to be a primary care service and that they were only consulted for advice if a medical condition was suspected. The Committee, however, then makes several leaps to conclude this equates to 'primary care settings' and so "TFI [should] be used in secondary care only". This is false logic and fallacious reasoning. Audiologists and ENT can work in primary, community and secondary care settings – and have also started to offer remote consultation, telehealth etc So, the fact that a GP does not do something does not mean patients must travel to secondary care to complete a questionnaire. It is also well known that audiologists increasingly work in primary and community-based settings where they provide NHS- funded care, so the TFI can be completed in these clinics. This section therefore needs to be reviewed, as does the entire guideline. So, if the Committee means GPs it states that, and NICE ensures its guideline remains neutral/objective about location where professionals work unless it has evidence to support its assertations. The recommendation linked to this (line 23 page 5 in the guideline) will	hospitals. The wording and the recommendation has been changed to reflect this.

Tinnitus: assessment and management

Consultation on draft guideline - Stakeholder comments table
20/09/2019 to 01/11/2019

Comments forms with attachments such as research articles, letters or leaflets cannot be accepted.

Stakeholder	Document	Page No	Line No	Comments Please insert each new comment in a new row	Developer's response Please respond to each comment
				also need to be changed as a result. We comment on this elsewhere in our response.	
National Community Hearing Association	Evidence Review H	007	030 - 036	The link between hearing loss and tinnitus must be better reflected in the final guideline and evidence.	Thank you for your comments. The committee acknowledges that there is some overlap between the tinnitus guideline and the hearing loss guideline, as hearing loss is common in the tinnitus population. For adults with tinnitus and hearing loss, this guideline should be read in conjunction with the hearing loss in adults guideline (NG98). This has been made clearer within the introduction to the recommendations.
National Community Hearing Association	Evidence Review M	006	003 - 009	"Hearing loss is a common factor underlying tinnitus, although some people with normal hearing also experience tinnitus. Loss of hearing is often an unnoticeable and gradual process and many people are surprised when they are told that they have a hearing loss. It is quite common for people to assume, incorrectly, that it is their tinnitus rather than their hearing loss that is causing hearing difficulties. Management of hearing loss in adults is covered by NICE guideline NG98. In this review we focus on only those people who have tinnitus." We strongly agree with this. We also agree that the original scope of this guideline, including evidence searches and analysis, did not duplicate what was done in NG98. This important principle however has been somewhat lost sight of in the draft guideline, seriously undermining its value for clinicians and the NHS. This is why, as we have set out in our other comments, that NICE should recast these recommendations to make clear when readers should use NG98 as the primary resource and what it is they are relying	Thank you for your comments. The committee acknowledges that there is some overlap between the tinnitus guideline and the hearing loss guideline, as hearing loss is common in the tinnitus population. For adults with tinnitus and hearing loss, this guideline should be read in conjunction with the hearing loss in adults guideline (NG98). This has been made clearer in the introduction to the recommendations within the guideline.

Tinnitus: assessment and management

Consultation on draft guideline - Stakeholder comments table
20/09/2019 to 01/11/2019

Comments forms with attachments such as research articles, letters or leaflets cannot be accepted.

Stakeholder	Document	Page No	Line No	Comments Please insert each new comment in a new row	Developer's response Please respond to each comment
				on this tinnitus guideline for.	
National Community Hearing Association	General	General	General	We welcome the opportunity to provide feedback on this draft guideline as we fully support all NHS patients having access to the tinnitus support that they need. Our response is based on a detailed review of the NICE guideline on tinnitus: assessment and management consultation – including analysing the draft guideline, evidence reviews A to P, algorithms, the Equality Impact Assessment, economic model and Committee member list and declarations. Our response is also based on cross referencing back to the full version of NG98 (NICE guideline on hearing loss in adults) as it covered adults with tinnitus and hearing loss. Based on this we have significant concerns about the draft guideline. These include: NICE failing to make clear how most adults with tinnitus will be seen based on the NICE guideline for adult hearing loss (NG98); inconsistent and sometimes inappropriate use of NG98; going beyond the original tinnitus guideline scope; biases which risk distorting service provision and risk unnecessary NHS expenditure; and imprecise and inconsistent referencing of important referral criteria, which increases risk for patients and clinicians in terms of inappropriate referrals and resource use. In our feedback we therefore aim to help address these issues so that the final tinnitus guideline: • adds to and does not conflict with NG98 and is much clearer about when readers should use NG98 – e.g. to minimise risks of inappropriate referral, to ensure that clinicians do not refer the same patients differently based on which NICE guideline they happen to be following, to reduce the risk of a clinical negligence claim due to poor drafting etc.	Thank you for your comments. NICE's methods and processes have been followed in this guideline. Stakeholder feedback has helped us to clarify the recommendations. The committee acknowledges that there is some overlap between the tinnitus guideline and the hearing loss guideline, as hearing loss is common in the tinnitus population. For adults with tinnitus and hearing loss, this guideline should be read in conjunction with the hearing loss in adults guideline (NG98). This has been made clearer within the introduction to the recommendations. The committee have discussed the terminology used in the guideline for the location of services and have changed the wording for "primary care" and "secondary care". The committee appreciates that speciality services such as audiology can in fact be delivered in general practice, community settings and within hospitals. The wording has been changed to reflect this.

Tinnitus: assessment and management

Consultation on draft guideline - Stakeholder comments table
20/09/2019 to 01/11/2019

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Stakeholder	Document	Page No	Line No	Comments Please insert each new comment in a new row	Developer's response Please respond to each comment
				• is much clearer on population needs – including which population with tinnitus will be managed primarily using NG98 and which population is likely to be managed using this tinnitus guideline in a real-world setting • does not conflate and confuse clinical settings and professional groups – so that the final guideline is impartial on location and more focused on patient needs in line with NHS Right Care principles, e.g. people are not incorrectly advised, based on Committee consensus alone, to send patients to secondary care without due regard to equality in access, current and changing clinical practice, etc. • reflects the diverse range of NHS service models that exist across England today – so that NICE recommendations based on Committee consensus do not lead to a tinnitus guideline that is wrong in terms of how a significant majority of adults with tinnitus will, and arguably should, based on stated Committee objectives, access care and support • is not biased – so that the final guideline does not risk distorting clinical pathways and patient access based on Committee experience, opinion, interests or for any other reason etc. Finally, it is important to note that when NICE announced it would be working on a tinnitus guideline it was clear to stakeholders that have assessed the quality of tinnitus research that there would be a dearth of good quality evidence to support any NICE recommendations. There were similar problems when developing NG98, although key recommendations in that guideline are supported by more robust evidence. We therefore do understand how difficult it is to create	

Tinnitus: assessment and management

Consultation on draft guideline - Stakeholder comments table
20/09/2019 to 01/11/2019

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Stakeholder	Document	Page No	Line No	Comments Please insert each new comment in a new row	Developer's response Please respond to each comment
				complex guidelines based on Committee consensus alone. However, in our view, NICE needs to do more to ensure it understands the epidemiological data and its pre-existing guideline(s) in more detail so that external stakeholders are not burdened with having to work through draft guidelines which should not, in our view, be published in their current form which falls below expected NICE standards.	
National Community Hearing Association	General	General	General	To minimise feedback/repetition, we set out some overarching issues here and will refer to comment two as required. There are three main underlying problems with the draft tinnitus guideline: 1. It takes the NICE guideline for adult hearing loss (NG98) and generalises its recommendations to a different population. NG98, in terms of guideline scope and literate/evidence reviews, only covered adults with hearing loss and tinnitus. It did not cover adults without hearing loss and did not cover children at all. Please see section 3.3.1. 3.3.2 and 4.3.3.1.3 in the full version of NG98 https://www.nice.org.uk/guidance/ng98/evidence/full-guideline-pdf-4852693117 for evidence. Although we appreciate that the Committee believes NG98 can be read across to children and adults without tinnitus, mixing and generalising recommendations between NG98 and this NICE guideline increases risks because referral criteria are not consistently applied etc. Therefore, in our view the current approach is both unscientific and clinically inappropriate. In our view, this NICE tinnitus guideline should make it very clear to the reader that it is intended to address care needs for two distinct groups.	Thank you for your comment. The committee acknowledges that there is some overlap between the tinnitus guideline and the hearing loss guideline, as hearing loss is common in the tinnitus population. For adults with tinnitus and hearing loss, this guideline should be read in conjunction with the hearing loss in adults guideline (NG98), and people with tinnitus and hearing should be managed using both guidelines. This has been made clearer within the introduction to the recommendations. The committee also acknowledges that hearing loss is common in people with tinnitus; this has now been highlighted in the recommendation about the information that should be provided to people with tinnitus, and in the context section of the guideline. In the absence of evidence when considering referral for further investigation and treatment the committee did take into account recommendations made for the same symptoms and signs within other guidelines such as NG98 and NG127, however this was not the approach for the other areas of the guideline. The committee acknowledges that there are few recommendations for tinnitus management in children and young people. This is due to the absence of evidence. However, research recommendations were made, including assessing tinnitus in children and young people (see Evidence Review E)

Tinnitus: assessment and management

Consultation on draft guideline - Stakeholder comments table
20/09/2019 to 01/11/2019

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Stakeholder	Document	Page No	Line No	Comments Please insert each new comment in a new row	Developer's response Please respond to each comment
				a) Adults (18 years of age and over). That most adults that report tinnitus will be managed using NG98 (see point two below). Also, that this tinnitus guideline will provide supplementary advice for adults with a hearing loss who need additional support for, or investigation of, their tinnitus and advice for adults with tinnitus but no hearing loss. b) Children and young people (under 18 years of age). Here the Committee needs to reconsider/review when and how children should be referred for tinnitus (with and without hearing loss). The reader for example should be able to more clearly see and understand what assumptions the Committee has made. It is odd, for example, that when referring to children there is neither mention of paediatricians being involved nor much in the way of evidence or documented Committee discussions on the limitations and scope of NG98 and the Department of Health, Provision of Services for adults with tinnitus guidance when considering under 18s. 2. Although Evidence M (e.g. page 6, lines 3-9, page 19, lines 5-21) and Evidence H (e.g. lines 30-36, page 7) refer to the fact that many adults with tinnitus will have a hearing loss, this is lost in the guideline itself and therefore results in a very unhelpful and confusing cross-referencing to NG98. It is not clear, given the absence of any referenced data sources, whether NICE is aware how significant this omission is. We therefore include extracts from national guidance below:	and psychological therapies (Evidence Review L). When considering recommendations the committee discussed whether the same management would apply to children and young people as well as to adults. In most circumstances the committee agreed the same intervention would be used for both populations. Where this is not the case the recommendation specifies which population the recommendation is applicable to. To ensure clarity, a statement outlining this has also been added to the introductory section of the recommendations. The committee agree that support should be provided in education. The committee have recommended that management plans developed between healthcare professionals and people with tinnitus (including children and young people) should be shared with relevant health, education and social care professionals. The term "tinnitus service" was not intended to mean a specialist service as the committee acknowledges that access to such services is very limited. In using the term "tinnitus service" the committee meant a service that would see people with tinnitus, e.g. audiology or ear, nose and throat. However, the committee has decided to removal any reference to "tinnitus services" to prevent confusion. The committee have discussed the terminology used in the guideline and agree that the wording for "primary care" and "secondary care" should be changed. The intention of the wording was to make it clear that healthcare professionals working in general practice are not expected to use questionnaires such as the TFI. The committee appreciates that speciality services such as audiology can in fact be delivered in general practice, community settings and within hospitals. The wording has been changed to reflect this.

Tinnitus: assessment and management

Consultation on draft guideline - Stakeholder comments table
20/09/2019 to 01/11/2019

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Stakeholder	Document	Page No	Line No	Comments Please insert each new comment in a new row	Developer's response Please respond to each comment
				"Tinnitus is often associated with hearing loss. For example, **75 percent of people with hearing loss might experience tinnitus, whilst only 20 percent to 30 percent of people who report tinnitus have normal hearing**. It is estimated that 3 percent of adults might require a clinical intervention for tinnitus." (our emphasis) Source: NHS England, Public Health England et al. 2019 – access here https://www.england.nhs.uk/wp-content/uploads/2017/09/joint-strategic-needs-assessment-guidance-jul19.pdf Put simply, and in a practical sense, more adults with tinnitus are likely to be seen by audiology as part of referral pathways based on NG98 than they are to be referred to a 'tinnitus support service' based on this NICE guideline. On the same basis it is wrong/misleading to relabel a routine adult hearing pathway provided under NG98 as 'tinnitus services' on lines 3-9, page 9 of the guideline. For example, Evidence M states "Management of hearing loss in adults is covered by NICE guideline NG98. In this review we focus on only those people who have tinnitus" (lines 8-9, page 6), NG98 actually covers hearing loss and tinnitus and this section of the guideline only had to cover tinnitus without hearing loss. As such • the recommendations 1.4.1 and 1.4.2 do not have to be provided by a 'tinnitus service' at all • based on 1.4.3 'tinnitus services' do not need to fit hearing aids at all • hearing aids for adults should be fitted using NG98.	

Tinnitus: assessment and management

Consultation on draft guideline - Stakeholder comments table
20/09/2019 to 01/11/2019

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Stakeholder	Document	Page No	Line No	Comments Please insert each new comment in a new row	Developer's response Please respond to each comment
				3. Throughout the evidence documents and guideline there is a significant bias which has adversely affected Committee recommendations and led to errors in the draft guideline. One such bias is that the Committee has confused primary care and secondary care with GPs and audiologists respectively. This is incorrect. For example, both audiology and ENT services are provided in community settings and increasingly NHS funded audiology is provided in primary care settings. NICE should be agnostic about the location where care is provided in line with NHS Right Care principles unless there is evidence to support otherwise – where Committee members happen to operate and criteria encouraging more patients to visit their services is not evidence-based healthcare. One clear impact of this is that the inappropriate use of 'primary care setting' when the Committee actually means 'GPs' has resulted in the Committee stating that patients have to be referred to secondary care (a hospital) to complete a questionnaire known as the Tinnitus Functional Index (TFI) (line 23 page 5 and line 24 page 16 main guideline, lines 45-49 page 8 and lines 1-7 page 8, Evidence E). Whilst we support the use of TFI, the recommendation ignores the fact that NHS funded audiology services are increasingly offered in primary, community and secondary settings and there is no need to require a patient with tinnitus to attend secondary care just because a GP is too busy to use a TFI. The final NICE guideline must address this and other biases in order to ensure it works in the best interests of patients and the	

Tinnitus: assessment and management

Consultation on draft guideline - Stakeholder comments table
20/09/2019 to 01/11/2019

Comments forms with attachments such as research articles, letters or leaflets cannot be accepted.

Stakeholder	Document	Page No	Line No	Comments Please insert each new comment in a new row	Developer's response Please respond to each comment
				NHS.	
National Community Hearing Association	General	General	General	To minimise feedback/repetition, we set out some overarching issues here and will refer to comment three as required. We believe the that current draft guideline needs serious technical review and reworking because in its current form it is difficult to disseminate and use alongside the NICE guideline for adult hearing loss (NG98) and increases risk rather that helping to mitigate them, and could be disregarded which would be regrettable. For example, the current guideline increases the risk of fitness to practise proceedings or even clinical negligence claims against clinicians owing to poor drafting and lack of attention to detail by NICE when setting out referral guidelines for different population groups. It is therefore important that NICE ensures: • the final tinnitus guideline supplements and does not conflict with NG98 • 'consider' and 'refer' recommendations are consistent with NG98 - e.g. use 'refer' and 'consider referring' based on the level of supporting evidence in the same way NG98 does, the draft tinnitus guideline incorrectly and inappropriately changes the strength of some referral recommendations in NG98 from "consider" to "refer" without any evidence or justification • where and who to refer to is consistent with NG98 – e.g. the draft guideline only partly copies over text from NG98 and fails to therefore correctly specify whether patients should be referred to ENT, AVM, A&E, Stroke service etc. • it addresses all issues that arise by trying to merge and extrapolate recommendations in NG98 (which included adults with hearing loss and tinnitus) with this wider population (all children with tinnitus and adults with 'normal hearing' and	Thank you for your comments. The committee acknowledges that there is some overlap between the tinnitus guideline and the hearing loss guideline, as hearing loss is common in the tinnitus population. For adults with tinnitus and hearing loss, this guideline should be read in conjunction with the hearing loss in adults guideline (NG98). This has been made clearer within the introduction to the recommendations. NG98 only covers management for hearing loss, and if a person has both tinnitus and hearing loss, both conditions need to be managed **.** Where the committee agreed the recommendation should be refer rather than consider this was because the population is different to that of the hearing loss guideline and a person with tinnitus would usually be referred. Where there is overlap with the hearing loss guideline the recommendations have been revised to ensure there is consistency between the two. Whilst the NG98 guideline recommends specific referral locations within its recommendations, the committee discussed this and decided that it is not possible to be specific for tinnitus as there is variation in local pathways and care models. Where this guideline signposts to other NICE guidance the recommendations have been checked to ensure consistency and no conflicting guidance has been given. In the absence of evidence when considering referral for further investigation and treatment the committee did take into account recommendations made for the same symptoms and signs within other guidelines such as NG98 and NG127, however this was not the approach for the other areas of the guideline. . The order and layout of the guideline has been considered by

Tinnitus: assessment and management

Consultation on draft guideline - Stakeholder comments table
20/09/2019 to 01/11/2019

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Stakeholder	Document	Page No	Line No	Comments Please insert each new comment in a new row	Developer's response Please respond to each comment
				tinnitus) • the guideline is laid out/presented in a more logical manner for clinicians working on the frontline to make safe, accurate and cost-effective clinical decisions • that NG98 is the main guideline through which adults with hearing difficulties with or without tinnitus access audiology (see 1.1.1 and 1.1.6 NG98 short form) or through which they are initially referred to ENT/A&E/stroke service or for a MRI (see 1.1.2 to 1.1.10 and 1.3.1-1.3.2, NG98 short form). This tinnitus guideline then can supplement the referral advice in NG98. This is also important because the Committee explicitly recommends that people who report tinnitus should first have audiometry to ensure hearing loss is managed as part of any management (lines 21-22, page 20 of the guideline, hence recommendation 1.3.1, 1.4.1 and 1.4.2 tinnitus draft guideline) and therefore for the adult population the referral route will be via NHS Direct Access Audiology based on NG98 which is widely available Put simply, many of the problems with the draft guideline stem from extrapolating NG98. The mix and match approach as a workaround for a lack of evidence has not worked. It has created a confusing guideline. To address this, we believe this tinnitus guideline should be consistent with NG98 and supplement it for the adult population with tinnitus but without hearing loss and children, and not, as it currently does, mix, match and merge various advice incorrectly.	the committee and headings for primary and secondary care removed to aid the reader
National Community Hearing Association	Guideline	001	006	It should be clear that this guideline covers all ages, if that is the case for the final version. It should also be clearer that this should be read alongside NICE's guideline for adult hearing loss (NG98)	Thank you for your comment. For adults with tinnitus and hearing loss, this guideline should be read in conjunction with the hearing loss in adults guideline (NG98). This and the fact that this guideline covers all ages has been made clearer within the introduction to the recommendations.

Tinnitus: assessment and management

Consultation on draft guideline - Stakeholder comments table
20/09/2019 to 01/11/2019

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Stakeholder	Document	Page No	Line No	Comments Please insert each new comment in a new row	Developer's response Please respond to each comment
National Community Hearing Association	Guideline	002	007	The title of this section might need to be changed based on the final version of the guideline.	Thank you for your comment, has been updated.
National Community Hearing Association	Guideline	003	002	There is significant overlap between NICE's adult hearing loss guideline (NG98) and this guideline with respect to the population covered. The guideline should open with a clear statement that for people aged 18 and older this guideline supplements rather than replaces referral and management advice in NG98 which already covers adults with hearing loss and tinnitus – i.e. the tinnitus guideline will 'kick in' for adults when they fall outside the scope of NG98 because they have referable tinnitus and/or no hearing loss.	Thank you for your comments. The committee acknowledges that there is some overlap between the tinnitus guideline and the hearing loss guideline, as hearing loss is common in the tinnitus population. This guideline should be read in conjunction with the hearing loss in adults guideline (NG98) for people with tinnitus and hearing loss. This has been made clearer within the introduction to the recommendations.
National Community Hearing Association	Guideline	003	017	The Committee should consider inserting advice on hearing loss and tinnitus and the benefits of having a hearing test.	Thank you for your comment. This recommendation has been amended, stating that tinnitus is commonly associated with hearing loss but it is not commonly associated with another underlying physical or mental health problem. The committee have recommended hearing tests/assessments for people with tinnitus (see the section on Audiological Assessments).
National Community Hearing Association	Guideline	004	004	The Committee should consider inserting advice on hearing loss and tinnitus and the benefits of having a hearing test – this is especially important for adults aged 50 and older who might present with hearing difficulties and tinnitus.	Thank you for your comment. The recommendation on reassuring people with tinnitus has been amended, stating that it is commonly associated with hearing loss. The committee have also recommended audiological assessments for people referred with tinnitus.
National Community Hearing Association	Guideline	004	021 - 024	In our view this section must be clear that adults with tinnitus and hearing difficulties or suspected difficulties should be managed based on the NICE guideline for adult hearing loss (NG98) which includes tinnitus. This will reduce false positive referrals and the associated stress and costs for patients and the NHS. This text must also be reviewed so that it is consistent with NG98 – e.g.	Thank you for your comment. The committee acknowledges that there is some overlap between the tinnitus guideline and the hearing loss guideline, as hearing loss is common in the tinnitus population. For adults with tinnitus and hearing loss, this guideline should be read in conjunction with the hearing loss in adults guideline (NG98). This has been made clearer in the introduction to the recommendations.

Tinnitus: assessment and management

Consultation on draft guideline - Stakeholder comments table
20/09/2019 to 01/11/2019

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Stakeholder	Document	Page No	Line No	Comments Please insert each new comment in a new row	Developer's response Please respond to each comment
				where to refer and who to etc.	Whilst the NG98 guideline recommends specific referral locations within its recommendations, the committee discussed this and decided that it is not possible to be specific for tinnitus as there is variation in local pathways and care models.
National Community Hearing Association	Guideline	004	026 - 027	This needs to be reviewed because the paragraph on lines 22-24 means lines 26-27 are not consistent with the referral advice in the NICE guideline for adult hearing loss (NG98).	Thank you for your comment.. The committee have revised the recommendations to provide greater clarity. Sudden onset of significant neurological symptoms or signs (for example facial weakness or vertigo) is now in line with the suspected neurological conditions NG127 immediate referral within a few hours or quicker if necessary. Links to this guidance have been given. Where there is overlap between the recommendations made in the hearing loss guideline and those in the tinnitus guideline these have been revised to ensure there is consistency between the two guidelines.
National Community Hearing Association	Guideline	004	028 - 029	This needs to be reviewed because the paragraph on lines 22-24 means lines 28-29 are not consistent with the referral advice in the NICE guideline for adult hearing loss (NG98).	Thank you for your comment. The recommendation has been amended to provide greater clarity and now states people with sudden hearing loss (over a period of 3 days or less) in the past 30 days should be referred (to be seen within 24 hours). Where there is overlap between the recommendations made in the hearing loss guideline and those in the tinnitus guideline these have been revised to ensure there is consistency between the two guidelines.
National Community Hearing Association	Guideline	004 - 005	020 - 021	There is significant overlap between NICE's adult hearing loss guideline (NG98). Section 1.2, 'Assessing tinnitus' needs to be deconstructed and rewritten. Our advice is to:	Thank you for your comments. The committee acknowledges that there is some overlap between the tinnitus guideline and the hearing loss guideline, as hearing loss is common in the tinnitus population. For adults with tinnitus and hearing loss, this guideline should be read in conjunction with the hearing loss in adults guideline (NG98). This has been made clearer within the introduction to the recommendations. Whilst NG98 applies to

Tinnitus: assessment and management

Consultation on draft guideline - Stakeholder comments table
20/09/2019 to 01/11/2019

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Stakeholder	Document	Page No	Line No	Comments Please insert each new comment in a new row	Developer's response Please respond to each comment
				5. Separate out the two key groups o under 18 years of age o 18 years of age and older 6. Make it clear that NG98 applies to all adults with hearing difficulties/loss, or suspected of hearing difficulties/loss, and tinnitus. That for adults this guideline should be read alongside NG98. Then only include what is additional advice to NG98 – e.g. how to manage adults with tinnitus that present without any hearing loss or have tinnitus that is referable independent of hearing loss etc. 7. Make it clear that there is no NICE guideline for children's hearing loss. That the Committee recommends that clinicians refer to NG98 on how to manage hearing loss and tinnitus in children (see comments where we explain why we have concerns about the Committee adapting the approach it has). Make it clearer how tinnitus in children (aged under 18) should be managed, including the active involvement of paediatricians et al. if necessary. In case it is helpful we signpost the Committee to: a) page 3 "tinnitus" section and section 3.5 page 9 of the 2016 NHS England model service specification for children's hearing services https://www.england.nhs.uk/wp-content/uploads/2016/07/P37-CYP-Service-Specification-Template.pdf) b) pages 6, 11, 13-15 in Tinnitus in Children; Practice Guideline, British Society of Audiology 2015, http://www.thebsa.org.uk/wp-content/uploads/2014/06/Paed-Tin-Guide-Pub-Consul-	adults, it was considered appropriate for the tinnitus referral recommendations to also apply to children because decision to refer would be the same for both populations. The committee does not consider any risk is posed as long as they are referred to, and are seen within, a children's service. The committee consider the guideline is consistent with the NHS England model service specification for children's services. The referral criteria within the tinnitus guideline focuses on the main symptoms and signs associated with this condition that would warrant onward referral, it is not intended to cover all symptoms and signs which would account for differences with the BSA consensus document. When considering recommendations the committee discussed whether the same management would apply to children and young people as well as to adults. The committee agreed the same intervention would be used for both populations. Where this is not the case the recommendation specifies which population the recommendation is applicable to. To ensure clarity, a statement outlining this has also been added to the introductory section of the recommendations. Whilst the NG98 guideline recommends specific referral locations within its recommendations, the committee discussed this and decided that it is not possible to be specific for tinnitus as there is variation in local pathways and care models. Where this guideline signposts to other NICE guidance the recommendations have been checked to ensure consistency and no conflicting guidance has been given.

Tinnitus: assessment and management

Consultation on draft guideline - Stakeholder comments table
20/09/2019 to 01/11/2019

Comments forms with attachments such as research articles, letters or leaflets cannot be accepted.

Stakeholder	Document	Page No	Line No	Comments Please insert each new comment in a new row	Developer's response Please respond to each comment
				Compressed.pdf, which includes different red flag criteria and referral routes for children compared to NG98 8. Make sure that if criteria in NG98 are presented in this guideline they are correctly referenced. For example, at present: o it incorrectly uses 'refer' when it should be 'consider referring' for some signs/symptoms o it fails to correctly/fully cite the referral pathway recommended in NG98, where NICE is much clearer about when to refer to ENT, A&E and a stroke service etc.	
National Community Hearing Association	Guideline	005	001 - 003	This text should be reviewed to make sure it and the text below it is consistent with the NICE guideline for adult hearing loss (NG98).	Thank you for your comment. This has been reviewed and the recommendation has been amended to ensure consistency.
National Community Hearing Association	Guideline	005	001 - 012	This is not correct. This contradicts some advice in the NICE guideline for adult hearing loss (NG98). It needs to be corrected.	Thank you for your comment. This has been reviewed and the recommendation has been amended to ensure consistency.
National Community Hearing Association	Guideline	005	004 – 006	This only refers to section 1.1.1 as the "first point of contact" for tinnitus support. This overlooks the NICE guideline for adult hearing loss (NG98) which will include many adults with tinnitus. Lines 4-6 therefore need to be reviewed.	Thank you for your comments. The committee acknowledges that there is some overlap between the tinnitus guideline and the hearing loss guideline, as hearing loss is common in the tinnitus population. For adults with tinnitus and hearing loss, this guideline should be read in conjunction with the hearing loss in adults guideline (NG98). This has been made clearer within the introduction to the recommendations.
National Community Hearing Association	Guideline	005	006 - 007	NICE guideline for adult hearing loss (NG98) is specific about who people should be referred to – e.g. ENT/AVM/A&E etc. This guideline should also state who these patients should be referred to.	Thank you for your comment. This has been made clearer within the introduction to the recommendations. Whilst the NG98 guideline recommends specific referral locations within its recommendations, the committee discussed this and decided that it is not possible to be specific for tinnitus as there is variation in local pathways and care models.

Tinnitus: assessment and management

Consultation on draft guideline - Stakeholder comments table
20/09/2019 to 01/11/2019

Comments forms with attachments such as research articles, letters or leaflets cannot be accepted.

Stakeholder	Document	Page No	Line No	Comments Please insert each new comment in a new row	Developer's response Please respond to each comment
National Community Hearing Association	Guideline	005	008 - 009	This needs to be reviewed because the paragraph on lines 1-3 means lines 8-9 are not consistent with the referral advice in the NICE guideline for adult hearing loss (NG98).	Thank you for your comment. This recommendation has been amended. Sudden hearing loss (over a period of 3 days or less) in the past 30 days is a referral to be seen within in 24 hours. Sudden hearing loss more than 30 days ago or rapidly progressing hearing loss (over a period of 4 to 90 days) is a referral in which people should be seen within 2 weeks. This is in line with the hearing loss guideline
National Community Hearing Association	Guideline	005	011 - 020	This entire section needs to be reviewed and rewritten. It states a strong 'refer' recommendation on line 11. However, many of the signs/system listed are noted as 'consider referring' in NG98. When NG98 was written, 'consider referring' was inserted where there was a lack of evidence to support a' refer' recommendation and where other history, signs and symptoms might help reduce false positive referrals. This tinnitus guideline has not provided any evidence to support changing the strength of the referral recommendation for 'items' listed on lines: 13-14, 17, 18 and 19-20.	Thank you for your comment. The committee agreed by consensus that people with both tinnitus and the symptoms and signs listed should be investigated as a non-urgent referral. Where the recommendation differs from NG98 it is because the population is different to that of the hearing loss guideline and a person with tinnitus would be referred as standard practice. The recommedations have been reviewed and a consider recommendation made for persistent pulsatile tinnitus and persistent unilateral tinnitus **to** avoid confusion with the Hearing Loss guideline
National Community Hearing Association	Guideline	005	013 - 014	This is not correct. Adults should, in most cases, first have audiometry and any hearing loss managed (e.g. as per 1.3.1 page 7, 1.4.1 and 1.4.2 page 9). The current wording is likely to result in over referral to "tinnitus services". In contrast "Objective tinnitus' on line 16 was not included in NG98 and we understand why this should be referred.	Thank you for your comment. The committee recommends that any patient who has troublesome tinnitus has audiometry. We recognise that some may not be aware that they have a current hearing loss, our expectation is that the services providing the audiometry and, if appropriate, hearing aids, should also be able to provide information and support about tinnitus. Where this is insufficient they should be referred for further management for their tinnitus.
National Community Hearing	Guideline	005	016 - 020	This is incorrect. NG98 actually states "**Consider referring** [….] unilateral or asymmetric hearing loss **as a primary concern**" (our emphasis) (see 1.1.6 page 6, NG98 short form), this is because many	Thank you for your comment. The committee agreed by consensus that people with the symptoms and signs listed should be investigated as a non-urgent referral. Where the

Tinnitus: assessment and management

Consultation on draft guideline - Stakeholder comments table
20/09/2019 to 01/11/2019

Comments forms with attachments such as research articles, letters or leaflets cannot be accepted.

Stakeholder	Document	Page No	Line No	Comments Please insert each new comment in a new row	Developer's response Please respond to each comment
Association				people with age-related hearing loss have an asymmetric hearing loss and might also have tinnitus, it is important to establish whether the asymmetry is clinically significant. GPs cannot do this so have to either decide based on presentation (e.g. is it the "primary concern") or refer to audiology to measure the level of hearing loss and asymmetry. This is all documented in the full NICE guideline and supporting/documented Committee discussions	recommendation differs from NG98 it is because the population is different to that of the hearing loss guideline and a person with tinnitus would be referred as standard practice. Referral lessens distress and potentially reduces the number of ongoing appointments.
National Community Hearing Association	Guideline	005	023 - 025	Line 23 states 'Initial assessment in secondary care'. This needs to be changed as it is based on a biased view. It is also contrary to Right Care principles and stands in contradiction to NHS England-NHS Improvements NHS Long Term Plan. We suggest that it should be amended to 'Initial assessment by audiology or ENT (working in primary, community or secondary care settings)' The reasoning set out in evidence document E does not add up. NICE should be agnostic about location or care setting unless there is evidence to suggest otherwise and should ensure it does not use 'primary care settings' as a synonym for 'GPs', nor incorrectly suggest audiologists/ENT only work in 'secondary care'. We therefore ask NICE to change line 23 – and supporting text in evidence document E – to 'Initial assessment by audiology or ENT (working in primary, community or secondary care settings)'. Line 23 in the guideline (and supporting document E) should also be changed.	Thank you for your comments. The committee have discussed the terminology used in the guideline and agree that the wording for "primary care" and "secondary care" should be changed. The intention of the wording was to make it clear that healthcare professionals working in general practice are not expected to use questionnaires such as the TFI. The committee appreciates that speciality services such as audiology can in fact be delivered in general practice, community settings and within hospitals. The wording has been changed to reflect this.
National Community Hearing Association	Guideline	006	003 - 004	Update box to be agnostic on location given lack of evidence to support this.	Thank you for your comment, this change has been made.

Tinnitus: assessment and management

Consultation on draft guideline - Stakeholder comments table
20/09/2019 to 01/11/2019

Comments forms with attachments such as research articles, letters or leaflets cannot be accepted.

Stakeholder	Document	Page No	Line No	Comments Please insert each new comment in a new row	Developer's response Please respond to each comment
National Community Hearing Association	Guideline	006	004 - 026	We support the section 'Assessing the psychological impact of tinnitus'. Section 1.2.8 (lines 8-10) will make more sense when line 23 on page 5 is corrected.	Thank you for your comment. The heading you are referring to has been amended.
National Community Hearing Association	Guideline	007	015 - 022	'Audiological assessment' Please see comments which explain our concerns about how this draft guideline currently misuses NG98. We explain specific issues with audiological assessment below. This section risks confusing people and increasing risks for patients and clinicians who might be unaware of how this guideline interacts/dovetails/overlaps with the NICE guideline for adult hearing loss (NG98) **and** that audiological assessment of children has not necessarily been given the attention it deserves. Regarding 1.3.1, most adults with tinnitus will have an audiological assessment based on NG98, because that guideline covers adults with tinnitus and hearing loss/difficulties and *suspected* hearing loss/difficulties (see 1.1 in NG98 short form). The tinnitus guideline Committee clearly recommends audiometry to rule out hearing loss (e.g. lines 30-36, page 7 Evidence H). In effect signposting to NG98. This tinnitus guideline should therefore be framed to complement NG98, especially given NG98 provides much more detail on what an adult audiological assessment should include. It would be better to state that for adults with tinnitus and hearing loss/difficulties, or suspected to have hearing loss/difficulties, clinicians should follow NG98. NG98 also addresses what to do if an adult cannot perform audiometry.	Thank you for your comments. The committee acknowledges that there is some overlap between the tinnitus guideline and the hearing loss guideline, as hearing loss is common in the tinnitus population. For adults with tinnitus and hearing loss, this guideline should be read in conjunction with the hearing loss in adults guideline (NG98) and the recommendations of both guidelines may need to be followed in parallel . . This has been made clearer within the introduction to the recommendations. Whilst NG98 applies to adults, it was considered appropriate for the tinnitus audiological assessment recommendations to also apply to children because both populations require the same assessment, but are seen within a children's service. The committee are aware that the recommendations made in the BSA tinnitus in children guideline are based on consensus, and have made their own consensus recommendations in acknowledgment of no evidence being available. For children and those with cognitive or learning difficulties, the committee recommends that hearing test is done according to their level of ability, this is highlighted in the rationale and impact section associated with this recommendation.

Tinnitus: assessment and management

Consultation on draft guideline - Stakeholder comments table
20/09/2019 to 01/11/2019

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Stakeholder	Document	Page No	Line No	Comments Please insert each new comment in a new row	Developer's response Please respond to each comment
				Regarding children who might not be able to perform audiometry, recommendation 1.3.1 warrants further consideration. Please see ▪ lines 44-50 page 15 in Tinnitus in Children; Practice Guideline, British Society of Audiology 2015, http://www.thebsa.org.uk/wp-content/uploads/2014/06/Paed-Tin-Guide-Pub-Consul-Compressed.pdf We agree with 1.3.2 "consider" recommendation for tympanometry for adults. We think that for children 1.3.2 should be "offer", please see ▪ lines 34-43 page 15 in Tinnitus in Children; Practice Guideline, British Society of Audiology 2015, http://www.thebsa.org.uk/wp-content/uploads/2014/06/Paed-Tin-Guide-Pub-Consul-Compressed.pdf We agree the NICE tinnitus guideline should include recommendations 1.3.3 and 1.3.4 as these explain what tests not to do if a patient attends a routine audiology appointment but also has tinnitus, which might otherwise be investigated using these tests. The tinnitus guideline can then specify which audiological tests should be performed when an adult has tinnitus but no hearing loss – i.e. when NG98 will not apply.	
National Community Hearing Association	Guideline	008	004 - 014	NG98 – https://www.nice.org.uk/guidance/ng98/evidence/full-guideline-pdf-4852693117 – included a more extensive review of the evidence on MRI referral criteria in adults presenting with audiological symptoms (including hearing loss and tinnitus) in terms of the sensitivity and specificity of various referral thresholds.	Thank you for your comments. The committee acknowledges that there is some overlap between the tinnitus guideline and the hearing loss guideline, as hearing loss is common in the tinnitus population. For adults with tinnitus and hearing loss, this guideline should be read in conjunction with the hearing loss in adults guideline (NG98) for imaging recommendations. This

Tinnitus: assessment and management

Consultation on draft guideline - Stakeholder comments table
20/09/2019 to 01/11/2019

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Stakeholder	Document	Page No	Line No	Comments Please insert each new comment in a new row	Developer's response Please respond to each comment
				It is important the NICE tinnitus guideline is clearer about whether its recommendations in sections related to imaging apply specifically to: - adults with tinnitus and no hearing loss - children with tinnitus and hearing loss - children with tinnitus and no hearing loss. i.e. it should more clearly sets out when NG98 applies and when this guideline applies. In our view the tinnitus guideline should refer to NG98 in cases where adults have a hearing loss and tinnitus and provide any additional advice where adults have tinnitus but not hearing loss (i.e. for those adults that are not included in NG98)	guideline applies to children, young people and adults, with or without hearing loss. This has been made clearer within the introduction to the recommendations. The imaging recommendations for people with pulsatile and non-pulsatile tinnitus within this guideline are for both adults and children. All recommendations apply to both populations unless otherwise stated.
National Community Hearing Association	Guideline	009	003 - 009	'Managing tinnitus for people referred to tinnitus service' and recommendation 1.4.1 and 1.4.2 (lines 5-9) are **incorrect.** This needs to be reviewed and we explain why below. <u>Adults (18 years of age and older)</u> <u>Recommendation 1.4.1</u> is based solely on the NICE guideline for adult hearing loss which includes tinnitus (NG98). It is misleading to claim therefore that this care is delivered as part of "tinnitus services" (as the title on line 1.4 suggests), because this is not the case. Please also note that this current wording could result in up-coding and people fitted with hearing aids described as 'tinnitus patients' when in fact hearing aids will not be fitted for tinnitus alone – as 1.4.3 makes clear. Put simply, recommendation 1.4.1 is by definition delivered as part of NG98 and should not appear in this guideline as presented. Instead this	Thank you for your comments. The term "tinnitus service" was not intended to mean a specialist service as the committee acknowledges that access to such services is very limited. In using the term "tinnitus service" the committee meant a service that would see people with tinnitus, e.g. audiology or ear, nose and throat. However, the committee has decided to remove any reference to "tinnitus services" to prevent confusion. The committee decided not to recommend specific locations to refer to due to the variation in service configuration and tinnitus pathways in the UK. The committee acknowledges that there is some overlap between the tinnitus guideline and the hearing loss guideline, as hearing loss is common in the tinnitus population. For adults with tinnitus and hearing loss, this guideline should be read in conjunction with the hearing loss in adults guideline (NG98). This has been made clearer within the introduction to the recommendations.

Tinnitus: assessment and management

Consultation on draft guideline - Stakeholder comments table
20/09/2019 to 01/11/2019

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Stakeholder	Document	Page No	Line No	Comments Please insert each new comment in a new row	Developer's response Please respond to each comment
				section should be rewritten to make it very clear that this large group of patients with tinnitus should be managed using NG98. Recommendation 1.4.2 advises clinicians to consider offering amplification in people with a hearing loss but who do not report communication difficulties but do have problems with tinnitus. This provides additional advice to NG98 on when to consider a hearing aid fitting. This however is something that should be delivered as part of NG98 (which includes more detail on the fitting and assessment of hearing aids) and not something that has to be delivered in a "tinnitus service" Recommendation 1.4.3 essentially confirms that if adults are outside the scope of NG98 then they do not need to be fitted with a hearing aid. Put simply, adult hearing aid fittings do not take place under this guideline and adults do not have to be referred to a "tinnitus service" to be fitted with hearing aids, but instead can be managed based on NG98. Section 1.4 should make this clear. Children (people aged under 18) It is not clear how NICE has read NG98 across to children. Unless the reader dives into the detail this is likely to be missed. It would be best for NICE to make the basis for its recommendations more transparent. In case it is helpful we signpost the Committee to: ▪ page 18 in Tinnitus in Children; Practice Guideline, British Society of Audiology 2015, http://www.thebsa.org.uk/wp-content/uploads/2014/06/Paed-Tin-Guide-Pub-Consul-Compressed.pdf Please also see comments which explain our concerns about how this	Whilst NG98 applies only to adults, it was considered appropriate for the tinnitus referral and amplification recommendations to also apply to children and young people because management options would be similar for this population. The committee are aware that the recommendations made in the BSA tinnitus in children guideline are based on consensus, and have made their own consensus recommendations in acknowledgment of no evidence being available. All recommendations within the guideline apply to both populations unless otherwise stated and this has been clarified within the introductory section of the guideline.

Tinnitus: assessment and management

Consultation on draft guideline - Stakeholder comments table
20/09/2019 to 01/11/2019

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Stakeholder	Document	Page No	Line No	Comments Please insert each new comment in a new row	Developer's response Please respond to each comment
				draft guideline currently misuses NG98.	
National Community Hearing Association	Guideline	009	022 - 023	We support offering NHS-funded psychologist led CBT online because this will allow more adults with tinnitus to access much needed support whilst being managed by audiology (e.g. under NG98 for their hearing loss). This should improve equality in access overall.	Thank you for your comment.
National Community Hearing Association	Guideline	011	008 - 014	We agree with the Committee – page 14 lines 5-14 – that 'tinnitus support' is preferable to 'tinnitus counselling'. We also agree with the rationale given in Evidence L.	Thank you for your comment.
National Community Hearing Association	Guideline	011	014	The Committee has explained why it has used the term "tinnitus support" rather than "tinnitus counselling" on page 14 (lines 7-14). We agree with the Committee. It is therefore not clear that it is helpful to state "This is sometimes known as tinnitus counselling" (line 14 page 11), suggest delete ~~"This is sometimes known as tinnitus counselling"~~	Thank you for your comment. The committee decided to add in "sometimes known as tinnitus counselling" as they are aware that "tinnitus counselling" is a term used by some in clinical practice and did not want to dismiss this fact.
National Community Hearing Association	Guideline	012	006 - 010	In our view this highlights a fundamental error, confusing primary care settings as being synonymous only with GPs. This needs to be corrected, for example replacing "primary care settings" with 'General Practice'.	Thank you for your comment. The committee discussed this and have agreed to change the wording; "primary care" has been changed to "general practice" throughout the guideline documents.
National Community Hearing Association	Guideline	012	006 – 010	Replace primary care setting with General Practice.	Thank you for your comment. This change has been made.
National Community Hearing Association	Guideline	016	004 - 007	We do not think this is correct.	Thank you for your comment. The timings in the NG98 guideline have been checked and the timings used in the tinnitus referral recommendations are correct.
National Community Hearing Association	Guideline	016	010	Replace primary care with "all settings – e.g. primary, community and secondary care"	Thank you for your comment. This change has been made.
National Community	Guideline	016	024	'Initial assessment secondary care', change to 'Initial assessment by audiology or ENT (working in primary, community or secondary care	Thank you for your comments. The committee have discussed the terminology used in the guideline and agree that the wording

Tinnitus: assessment and management

Consultation on draft guideline - Stakeholder comments table
20/09/2019 to 01/11/2019

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Stakeholder	Document	Page No	Line No	Comments Please insert each new comment in a new row	Developer's response Please respond to each comment
Hearing Association				settings)'. Please see comments where we set out why this is problematic and why it should be changed. Again, here for ease of reference, this highlights how the Committee has adopted a series of assumptions which do not hold water – i.e. the idea that GPs are "primary care settings" and audiologist/ENT are based solely in secondary care settings. This is incorrect and also leads to a recommendation which is in conflict with NHS Long Term Plan objectives. It makes no sense for NICE, based on no evidence, to recommend that initial assessments have to take place in a secondary care setting because today GPs do not use the recommended Tinnitus Functional Index (TFI) or have staff who are competent to do so, and that patients must therefore travel to secondary care in order to complete a questionnaire etc: - "The committee noted that questionnaires are not commonly used in primary care and there is also variation in how tinnitus is assessed in primary care. They thought it important that research is conducted to examine the optimal method for assessing tinnitus in primary care settings as primary care is a gatekeeper for the further management for tinnitus" (Guideline, lines 18-22, page 17) - "The committee have specified that the TFI be used in secondary care only. The rationale for this is that the committee were conscious of the potential resource impact of completing and discussing these questionnaires in primary care where general practitioners are limited on time" (Evidence E page 8, lines 45-48) This ignores the fact that audiologists – who can use this questionnaire	for "primary care" and "secondary care" should be changed. The intention of the wording was to make it clear that healthcare professionals working in general practice are not expected to use questionnaires such as the TFI or TQ. The committee appreciates that speciality services such as audiology can in fact be delivered in general practice, community settings and within hospitals. The wording has been changed to reflect this.

Tinnitus: assessment and management

Consultation on draft guideline - Stakeholder comments table
20/09/2019 to 01/11/2019

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Stakeholder	Document	Page No	Line No	Comments Please insert each new comment in a new row	Developer's response Please respond to each comment
				– also work in primary and community-based settings, as do some ENT services. The recommendation also risks worsening health inequalities, because the underlying biased and incorrect assumption about where audiologists work means that people might have to travel further to access care where they will complete a questionnaire they could have completed elsewhere, and that some will fall out of the pathway for this reason, further wasting NHS secondary care resources and undermining the public health aspects of the service.	
National Community Hearing Association	Guideline	016 017	024 001	Amend "secondary care" so that guideline impartial on location.	Thank you for your comment. This change has been made throughout guideline documents.
National Community Hearing Association	Guideline	017	018 - 021	Replace primary care with General Practice.	Thank you for your comment. This change has been made throughout guideline documents.
National Community Hearing Association	Guideline	018	027 - 028	… "they can be used within other secondary care services such as audiology". We understand that in this example it is only referring to another type of service in secondary care. However, in follow-up to comment three, point three and fifteen, this overlooks that audiology is not just a secondary care service. So, audiology services – provided in primary, community or secondary care settings – can use the questionnaires in question. The random and repetitive references to secondary care	Thank you for your comment. The committee have discussed the terminology used in the guideline and agree that the wording for "primary care" and "secondary care" should be changed. The intention of the wording was to make it clear that healthcare professionals working in general practice are not expected to use questionnaires such as the TFI. The committee appreciates that speciality services such as audiology can in fact be delivered in general practice, community settings and within hospitals. The wording has been changed to reflect this.

Tinnitus: assessment and management

Consultation on draft guideline - Stakeholder comments table
20/09/2019 to 01/11/2019

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Stakeholder	Document	Page No	Line No	Comments Please insert each new comment in a new row	Developer's response Please respond to each comment
				throughout this guideline risk undermining trust in the NICE guideline process.	
National Community Hearing Association	Guideline	020	017 - 027	Refer all readers to the NICE guideline for adult hearing loss (NG98) which includes adults with hearing difficulties, suspect hearing difficulties and tinnitus. i.e. the Committee here is referring to a population covered by NG98.	Thank you for your comments. The committee acknowledges that there is some overlap between the tinnitus guideline and the hearing loss guideline, as hearing loss is common in the tinnitus population. For adults with tinnitus and hearing loss, this guideline should be read in conjunction with the hearing loss in adults guideline (NG98). This has been made clearer within the introduction to the recommendations.
National Community Hearing Association	Guideline	020	019 - 022	The Committee is right that evidence shows that many people with tinnitus will not know they have a hearing loss and that this could be contributing to their tinnitus (lines 19-21). The Committee is also correct to state that effective management of hearing loss can help reduce the audibility and impacts of hearing loss (lines 25-25) and people should therefore receive audiometry if they report tinnitus (lines 21-22). However, most adults with tinnitus will have a hearing loss and this is missed/overlooked in the guideline itself. People reading this guideline for example will not know that most adults with tinnitus will and should initially be managed via NG98 and will not have to be referred to ENT or audiovestibular medicine services if NG98 is followed. It is essential that NICE makes it clear that most healthcare professionals should be aware that this tinnitus guideline should supplement and be read and followed alongside NG98 in order to avoid unnecessary pressures on secondary care and the NHS in terms of false positive referrals to "tinnitus services/pathways".	Thank you for your comments. The committee acknowledges that there is some overlap between the tinnitus guideline and the hearing loss guideline, as hearing loss is common in the tinnitus population. For adults with tinnitus and hearing loss, this guideline should be read in conjunction with the hearing loss in adults guideline (NG98). This has been made clearer within the introduction to the recommendations.
National Community	Guideline	022	024 - 025	Although we acknowledge that NG98 is appropriately referenced here, it is important to note that most adults with tinnitus will have hearing	Thank you for your comments. The committee acknowledges that there is some overlap between the tinnitus guideline and the

Tinnitus: assessment and management

Consultation on draft guideline - Stakeholder comments table
20/09/2019 to 01/11/2019

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Stakeholder	Document	Page No	Line No	Comments Please insert each new comment in a new row	Developer's response Please respond to each comment
Hearing Association				loss and not warrant referral specifically for their tinnitus and therefore, more adults with tinnitus will be managed using NG98 and using only parts of this NICE guideline as required. Patients and clinicians would benefit greatly if NICE could rewrite this tinnitus guideline to facilitate dissemination and limit confusion/risk (see comment two, three and eleven).	hearing loss guideline, as hearing loss is common in the tinnitus population. For adults with tinnitus and hearing loss, this guideline should be read in conjunction with the hearing loss in adults guideline (NG98). This has been made clearer within the introduction to the recommendations.
National Community Hearing Association	Guideline	029	018 - 019	"Tinnitus is a common condition. In Commissioning services for people with hearing loss (2016) NHS England estimates between 10% and 15% of adults will have tinnitus, and 3% of adults will go on to require a clinical intervention for their tinnitus." We agree with this statement which is based on an NHS review of evidence. However, the statement still leaves the reader unaware that most adults with tinnitus also have a hearing loss. It is essential in our view that this opening statement makes it clear that over 70% of adults with tinnitus are likely to have a hearing loss and most will be managed using NG98 and where applicable this guideline in addition. It is important to be clear that, although 20% to 30% of adults with tinnitus are unlikely to have a hearing loss, they should still be referred for an audiological assessment as per NG98 (for hearing difficulties). Those patients will then be managed using this guideline if they are found not to have a hearing loss.	Thank you for your comments. The committee acknowledges that there is some overlap between the tinnitus guideline and the hearing loss guideline, as hearing loss is common in the tinnitus population. The guideline makes clear within this section that tinnitus is often associated with hearing loss. For adults with tinnitus and hearing loss, this guideline should be read in conjunction with the hearing loss in adults guideline (NG98). This has been made clearer within the introduction to the recommendations.
National Community Hearing Association	Guideline	029	018 - 020	**Proposed new text** ▪ "Tinnitus is a common condition. In Commissioning services for people with hearing loss (2016) NHS England estimates between 10 percent and 15 percent of adults will have tinnitus, and 3 percent of adults will go on to require a clinical intervention for their tinnitus. In the NHS JSNA guide it notes that tinnitus is often	Thank you for your comment. Your proposed new text has been used in the guideline.

Tinnitus: assessment and management

Consultation on draft guideline - Stakeholder comments table
20/09/2019 to 01/11/2019

Comments forms with attachments such as research articles, letters or leaflets cannot be accepted.

Stakeholder	Document	Page No	Line No	Comments Please insert each new comment in a new row	Developer's response Please respond to each comment
				associated with hearing loss. For example, 75 percent of people with hearing loss might experience tinnitus, whilst only 20 percent to 30 percent of people who report tinnitus have normal hearing." Explanation Update data so that it is clear how most adults with tinnitus will access audiology services and initial tinnitus support via the NICE guideline for adult hearing loss (NG98). Use data from national NHS strategic needs guidance for hearing loss: "Tinnitus is often associated with hearing loss. For example, 75 percent of people with hearing loss might experience tinnitus, whilst only 20 percent to 30 percent of people who report tinnitus have normal hearing. It is estimated that 3 percent of adults might require a clinical intervention for tinnitus." Source: NHS England, Public Health England et al. 2019 – access here https://www.england.nhs.uk/wp-content/uploads/2017/09/joint-strategic-needs-assessment-guidance-jul19.pdf	
Poole Hospital NHS Foundation Trust - ENT Department	Guideline	003	016	It could be stated that occasional intermittent short-lived tinnitus, occurring randomly between ears, occurs in most people and can be regarded as normal.	Thank you for your comment. This recommendation has been amended, stating that tinnitus may resolve by itself.
Poole Hospital NHS Foundation Trust - ENT Department	Guideline	004	021	Wax impaction can be a cause of tinnitus. Patients with adequate mental health coping strategies and visible wax impaction at presentation in primary care could initially be managed for wax impaction through locally-agreed pathways.	Thank you for your comment. The scope of this guideline did not include the different causes of tinnitus (except in the context of investigations using imaging) and specific examination methods. The committee have noted the necessity of physical examinations in the committee discussion in Evidence Review C.

Tinnitus: assessment and management

Consultation on draft guideline - Stakeholder comments table
20/09/2019 to 01/11/2019

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Poole Hospital NHS Foundation Trust - ENT Department	Guideline	005	004	The term 'affecting mental well-being' is vague and open to subjective interpretation in General Practice. Most patients with tinnitus, at least initially, find it troubling and so this descriptor may unintentionally result in most tinnitus patients being referred to secondary care as two week waits under the draft guidance as it stands.	Thank you for your comment. Referral is recommended if tinnitus continues to be troublesome and affect mental well-being despite receiving tinnitus support. The GP can assess a person's well-being and whether the tinnitus is causing sufficient mental distress to impact on a person's daily activities.
Poole Hospital NHS Foundation Trust - ENT Department	Guideline	005	007	Patients with vertigo / unsteadiness should be referred on their own basis of urgency, rather than coupling them to tinnitus. Otherwise the association between unsteadiness and tinnitus, proposed to necessitate 2WW referral, provides a blueprint for unsteady patients with tinnitus of any nature or duration to be required to be seen within 2 weeks. This will place significant stress on local systems and will mean that other referrals to the service will be inevitably delayed as a consequence.	Thank you for your comment. This guideline highlights referrals which are prompted by the presentation of tinnitus.
Poole Hospital NHS Foundation Trust - ENT Department	Guideline	General	General	For suicidal (immediate referral) or 'affected' (2WW referral) patients, the intervention that will provide an impact for these patients will be psychological therapies and the choice between the different modalities would, we would suggest, be best made by health care professionals trained in this area. Should these urgent referrals, on the grounds of psychological suffering, therefore be best directed to mental health professionals rather than ENT specialists? Early audiological assessment, which could happen independent of ENT services, could assess whether there was an associated hearing loss for which a hearing aid may ameliorate associated tinnitus. Subsequent ENT review would then have a role in excluding other underlying causes including consideration of imaging.	Thank you for your comment. The committee have not recommended referral by a healthcare professional to ENT services for those with significant psychological suffering (e.g. people with suicidal intent) but to mental health services. People with tinnitus may still need to be seen for the management of their tinnitus, e.g. by ENT, audiovestibular medicine or audiology.
Poole Hospital NHS	Guideline	General	General	As far as we are aware, tinnitus-related CBT delivered by a psychology-trained specialist is not currently available as a service in our region.	Thank you for your comment. Your comment will be considered by NICE where relevant support activity is being planned.

Tinnitus: assessment and management

Consultation on draft guideline - Stakeholder comments table
20/09/2019 to 01/11/2019

Comments forms with attachments such as research articles, letters or leaflets cannot be accepted.

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Foundation Trust - ENT Department					
Royal College of General Practitioners	Guideline	003	017	The committee should consider adding a line relating to potential cure and reassurance at initial presentation for example: Tinnitus can be temporary and may resolve by itself	Thank you for your comment. This recommendation has been amended, stating that tinnitus may resolve by itself.
Royal College of General Practitioners	Guideline	008	005	The committee should consider replacing 'and' with 'who also have' to increase the clarity of the statement as the recommendation could be misinterpreted as 'everyone with tinnitus should have MRI'	Thank you for your comment. This has been edited for clarity.
Royal College of General Practitioners	Guideline	008	005	The committee may want to add further clarification on the specific MRI to be ordered with tinnitus some areas perform MRI head and MRI Internal Auditory Meatus. Should we do both or only MRI of the EAM? Again, for the contrast CT scan, clarity over which area should be covered by the CT would be welcomed.	Thank you for your comment. This recommendations have been amended, the areas which should be scanned are now included in these recommendations.
Royal College of General Practitioners	Guideline	008	005	The committee should reword recommendation 1.3.6 in the same style as 1.3.5 to add clarity. For example: 'Consider MRI for people with unilateral or asymmetrical non-pulsatile tinnitus who have **no** associated neurological, audiological or head and neck signs and symptoms. If they are unable to have MRI, consider contrast-enhanced CT'	Thank you for your comment. The committee have agreed to use the same style to make the recommendations for the different sub-populations clearer.
Royal College of General Practitioners	Guideline	010	004	Can the committee consider adding a statement on review of betahistine if it is prescribed? E.g. If betahistine is prescribed, review its effectiveness after 4 weeks and if there is no improvement stop the medication to reduce the risks of harm? This statement will empower GPs to deprescribe this medication after initiated in secondary care if it has little or no effect.	Thank you for your comment. The committee acknowledges that there is no clinical benefit associated with the use of betahistine and there is some indication of harm with side effects. The committee recommend that it should not be offered to people with tinnitus: this recommendation has been amended to add clarity.
Royal College of	Guideline	016	006	Replace 'these' with 'the tinnitus referral recommendations', 'these' refers to the subject of a sentence, i.e. the guideline on hearing loss.	Thank you for your comment. This change has been made.

Tinnitus: assessment and management

Consultation on draft guideline - Stakeholder comments table
20/09/2019 to 01/11/2019

Comments forms with attachments such as research articles, letters or leaflets cannot be accepted.

Stakeholder	Document	Page No	Line No	Comments Please insert each new comment in a new row	Developer's response Please respond to each comment
General Practitioners					
Royal College of Nursing	General	General	General	Dear Colleague, Thank you for the opportunity to contribute to this guideline. The RCN do not have any comments to add on this occasion.	Thank you for your comment.
Royal College of Paediatrics and Child Health	Guideline	General	General	It is felt that this document is very adult orientated even though there has been reference to children at certain points. It would be useful if there was a separate document for children. It is not easy to tease out the information needed on children. Ref: http://www.thebsa.org.uk/wp-content/uploads/2015/03/2015-Paed-Tin-Guidelines-FINAL.pdf	Thank you for your comment. The committee have highlighted that the recommendations within this guideline are applicable to all people (adults and children and young people) with tinnitus unless otherwise stated – see the introduction for the recommendations.
Royal College of Physicians	General	General	General	The RCP would like to endorse the BAAP response.	Thank you for your comment.
Royal Surrey County Hospital – Audiology Department	Evidence Review A	General	General	Cite relevant NHS studies listed below: -Aazh H, Moore BC, Roberts P. Patient-centered tinnitus management tool: a clinical audit. Am J Audiol. 2009 Jun;18(1):7-13. -Aazh H, Moore BCJ and Roberts P. (2008). Patient-centred tinnitus management tool. British Academy of Audiology Newsletter, 11, 8-9. -Aazh H, Moore BCJ and Roberts P. (2008). Patient-centred tinnitus management tool: the impact on quality of care and waiting time. British Society of Audiology News, 55, 28-29. -Aazh H, Moore BC, Lammaing K, Cropley M. Tinnitus and hyperacusis therapy in a UK National Health Service audiology department: Patients' evaluations of the effectiveness of treatments. Int J Audiol. 2016 Sep;55(9):514-22. -Aazh H, Moore BC, Glasberg BR. Simplified form of tinnitus retraining therapy	Thank you for your comment. The guideline development team have checked the cited references. All of the studies were an inappropriate design for inclusion in our reviews (majority were retrospective cross-sectional survey-based studies or clinical audit); some additionally did not have an appropriate comparator as specified in our protocols.

Tinnitus: assessment and management

Consultation on draft guideline - Stakeholder comments table
20/09/2019 to 01/11/2019

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				in adults: a retrospective study. BMC Ear Nose Throat Disord. 2008 Nov 3;8:7. -Aazh, H. and B.C. Moore, A comparison between tinnitus retraining therapy and a simplified version in treatment of tinnitus in adults. Auditory and Vestibular Research, 2016. 25(1): p. 14-23. Cite the studies of audiologist-delivered CBT which report the feasibility of this approach and its effectiveness from the patients' perspective. 1: Aazh H, Moore BCJ. Effectiveness of Audiologist-Delivered Cognitive Behavioral Therapy for Tinnitus and Hyperacusis Rehabilitation: Outcomes for Patients Treated in Routine Practice. Am J Audiol. 2018 Dec 6;27(4):547-558. 2: Aazh H, Moore BCJ. Proportion and characteristics of patients who were offered, enrolled in and completed audiologist-delivered cognitive behavioural therapy for tinnitus and hyperacusis rehabilitation in a specialist UK clinic. Int J Audiol. 2018 Jun;57(6):415-425.	
Royal Surrey County Hospital – Audiology Department	Evidence Review B	General	General	Cite relevant NHS studies listed below. In all of these studies information to patients in NHS have been assessed. -Aazh H, Moore BC, Roberts P. Patient-centered tinnitus management tool: a clinical audit. Am J Audiol. 2009 Jun;18(1):7-13. -Aazh H, Moore BCJ and Roberts P. (2008). Patient-centred tinnitus management tool. British Academy of Audiology Newsletter, 11, 8-9. -Aazh H, Moore BCJ and Roberts P. (2008). Patient-centred tinnitus management tool: the impact on quality of care and waiting time. British Society of Audiology News, 55, 28-29. -Aazh H, Moore BC, Lammaing K, Cropley M. Tinnitus and hyperacusis	Thank you for your comment. The guideline development team have checked the cited references. All of the studies are an inappropriate design for inclusion in our reviews (majority were retrospective cross-sectional survey-based studies or clinical audit); some additionally did not have an appropriate comparator as specified in our protocols.

Tinnitus: assessment and management

Consultation on draft guideline - Stakeholder comments table
20/09/2019 to 01/11/2019

Comments forms with attachments such as research articles, letters or leaflets cannot be accepted.

Stakeholder	Document	Page No	Line No	Comments Please insert each new comment in a new row	Developer's response Please respond to each comment
				therapy in a UK National Health Service audiology department: Patients' evaluations of the effectiveness of treatments. Int J Audiol. 2016 Sep;55(9):514-22. -Aazh H, Moore BC, Glasberg BR. Simplified form of tinnitus retraining therapy in adults: a retrospective study. BMC Ear Nose Throat Disord. 2008 Nov 3;8:7. -Aazh, H. and B.C. Moore, A comparison between tinnitus retraining therapy and a simplified version in treatment of tinnitus in adults. Auditory and Vestibular Research, 2016. 25(1): p. 14-23.	
Royal Surrey County Hospital – Audiology Department	Evidence Review E	General	General	Mention acceptability and relevance of psychological questionnaires to patients seen in an audiology department. Aazh and Moore (2017) assessed the relevance and applicability of psychological questionnaires to patients seeking help for tinnitus and/or hyperacusis. The following questionnaires were administered: Generalised Anxiety Disorder (GAD-7), Short Health Anxiety Inventory (SHAI), Mini-Social Phobia Inventory (Mini-SPIN), Obsessive Compulsive Inventory-Revised (OCI-R), Panic Disorder Severity Scale-Self Report (PDSS-SR), Patient Health Questionnaire (PHQ-9) and Penn State Worry Questionnaire-Abbreviated version (PSWQ-A). In addition, a patient feedback questionnaire was completed asking about the extent to which each questionnaire was relevant to them and how strongly they would recommend its use in the assessment of patients with tinnitus and hyperacusis. 65% of patients had abnormal scores for one or more of the questionnaires. All questionnaires except the PDSS-SR were rated as relevant and recommended for use. The GAD-7, SHAI, Mini-SPIN, OCI-R, PSWQ-A and PHQ-9 are recommended for evaluation of psychological problems for patients seeking help for tinnitus and/or hyperacusis. Abnormal results on these questionnaires may indicate the need for referral for possible treatment	Thank you for your comment. The committee noted that anxiety and depression are often comorbid with tinnitus. The committee acknowledges that many people with tinnitus will go to audiology first, it is absolutely appropriate and relevant that appropriate mental health questionnaires are completed within this setting. The completion of these questionnaires can assist in referral for further assessment and management in psychology services. The committee did not include some of the questionnaires mentioned in your comment (Short Health Anxiety Inventory (SHAI), Mini-Social Phobia Inventory (Mini-SPIN), Obsessive Compulsive Inventory-Revised (OCI-R), Panic Disorder Severity Scale-Self Report (PDSS-SR) and Penn State Worry Questionnaire-Abbreviated version (PSWQ-A)) in the review protocol when it was developed, as they were deemed not broad enough for overall assessment of psychological impact of tinnitus.

Tinnitus: assessment and management

Consultation on draft guideline - Stakeholder comments table
20/09/2019 to 01/11/2019

Comments forms with attachments such as research articles, letters or leaflets cannot be accepted.

Stakeholder	Document	Page No	Line No	Comments Please insert each new comment in a new row	Developer's response Please respond to each comment
				of psychological problems. Aazh H, Moore BCJ. Usefulness of self-report questionnaires for psychological assessment of patients with tinnitus and hyperacusis and patients' views of the questionnaires. Int J Audiol. 2017 Jul;56(7):489-498.	
Royal Surrey County Hospital – Audiology Department	Evidence Review E	General	General	Aazh and Moore 2018 reported that abnormal scores on the questionnaires (THI, VAS, HADS, ISI, and HQ) do not always mean that the patient is currently experiencing distress related to their tinnitus and/or hyperacusis. In several studies Aazh and Moore (2018-19) proposed that in-depth interviews should be used to explore the impact of tinnitus and/or hyperacusis on the patient's life. Aazh H, Moore BCJ. Proportion and characteristics of patients who were offered, enrolled in and completed audiologist-delivered cognitive behavioural therapy for tinnitus and hyperacusis rehabilitation in a specialist UK clinic. Int J Audiol. 2018 Jun;57(6):415-425. Aazh H, Moore BCJ. Effectiveness of Audiologist-Delivered Cognitive Behavioral Therapy for Tinnitus and Hyperacusis Rehabilitation: Outcomes for Patients Treated in Routine Practice. Am J Audiol. 2018 Dec 6;27(4):547-558.	Thank you for your comment. The committee agree that while the referenced questionnaires/outcome measures can be related to tinnitus, distress or difficulties reflected in the questionnaires can relate to conditions other than tinnitus. Therefore,it is important to undertake an in-depth history to find out the problems related to, and impact of, tinnitus on a person's quality of life. Both studies are an inappropriate design for inclusion (retrospective, cross-sectional) and had an inappropriate population (tinnitus and/or hyperacusis)
Royal Surrey County Hospital – Audiology Department	Evidence Review F	General	General	Cite recent NHS studies assessing the relationship and the mechanism in which tinnitus may lead to depression and insomnia 1: Aazh H, Baguley DM, Moore BCJ. Factors Related to Insomnia in Adult Patients with Tinnitus and/or Hyperacusis: An Exploratory Analysis. J Am Acad Audiol. 2019 Oct;30(9):802-809. doi: 10.3766/jaaa.18020. Epub 2019 Apr 22. PubMed PMID: 31044691. 2: Aazh H, Moore BCJ. Tinnitus loudness and the severity of insomnia: a mediation	Thank you for your comment. The guideline development team have checked the cited references. All studies are an inappropriate design for inclusion (retrospective, cross-sectional) and did not address review questions included in this guideline, and some focusing on the population of tinnitus and/or hyperacusis.

Tinnitus: assessment and management

Consultation on draft guideline - Stakeholder comments table
20/09/2019 to 01/11/2019

Comments forms with attachments such as research articles, letters or leaflets cannot be accepted.

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				analysis. Int J Audiol. 2019 Apr;58(4):208-212. doi: 10.1080/14992027.2018.1537524. Epub 2019 Jan 10. PubMed PMID: 30628492. 3: Aazh H, Salvi R. The Relationship between Severity of Hearing Loss and Subjective Tinnitus Loudness among Patients Seen in a Specialist Tinnitus and Hyperacusis Therapy Clinic in UK. J Am Acad Audiol. 2019 Sep;30(8):712-719. doi: 10.3766/jaaa.17144. Epub 2018 Nov 8. PubMed PMID: 30403955. 4: Aazh H, Moore BCJ. Factors Associated With Depression in Patients With Tinnitus and Hyperacusis. Am J Audiol. 2017 Dec 12;26(4):562-569. doi: 10.1044/2017_AJA-17-0008. PubMed PMID: 29209701. 5: Aazh H, Lammaing K, Moore BCJ. Factors related to tinnitus and hyperacusis handicap in older people. Int J Audiol. 2017 Sep;56(9):677-684. doi: 10.1080/14992027.2017.1335887. Epub 2017 Jun 18. PubMed PMID: 28625091.	
Royal Surrey County Hospital – Audiology Department	Evidence Review F	General	General	Mention that recent studies conducted in an NHS tinnitus clinic reported that up to 15% of patients seeking help for tinnitus have suicidal or self-harm ideations. The risk of suicidal thoughts was significantly increased if the patient also suffered from depressed mood and if they had a family history of mental illness. Clinicians who offer tinnitus and hyperacusis rehabilitation should screen for suicidal and self-harm ideations among patients, especially those with symptoms of depression and a childhood history of parental mental illness. Patients with suicidal and self-harm ideations should be referred to mental health	Thank you for your comment. This recommendation has been amended following committee discussion. There is now a separate recommendation stating that all patients with a high risk of suicide should be referred for assessment by a mental health crisis team immediately. The committee agrees that clinicians should be alert to the impact of tinnitus on mental well-being. The guideline development team have checked the cited references. These papers were not relevant to the review protocol, due to incorrect study design (retrospective non-

Tinnitus: assessment and management

Consultation on draft guideline - Stakeholder comments table
20/09/2019 to 01/11/2019

Comments forms with attachments such as research articles, letters or leaflets cannot be accepted.

Stakeholder	Document	Page No	Line No	Comments Please insert each new comment in a new row	Developer's response Please respond to each comment
				services for further diagnosis and treatment. 1: Aazh H, Landgrebe M, Danesh AA. Parental Mental Illness in Childhood as a Risk Factor for Suicidal and Self-Harm Ideations in Adults Seeking Help for Tinnitus and/or Hyperacusis. Am J Audiol. 2019 Sep 13;28(3):527-533. 2: Aazh H, Moore BCJ. Thoughts about Suicide and Self-Harm in Patients with Tinnitus and Hyperacusis. J Am Acad Audiol. 2018 Mar;29(3):255-261.	randomised study, cross-sectional study and service evaluation survey). .
Royal Surrey County Hospital – Audiology Department	Evidence Review G	General	General	Remove the ULL test from the list of the tests to be avoided. There is no research evidence to back up your suggestion. Tiinitus is often accompanied by hyperacusis and ULLs are relvant for the diagnosis and management of hyperacusis. This document should inform clinicians about matters that need to be discussed with the patient in order for shared decision making to occur. The most important negative factors include: (a) The procedure may be uncomfortable; (b) Tinnitus may be triggered or made worse after the procedure, although these effects are usually short-lasting. The most important potential benefits are: (a) The information may be useful for the fitting of hearing aids; (b) The results provide insights into the nature of any problems with sound intolerance/hyperacusis. There are studies that suggest statistically significant links between reduced ULLs and depression (Assi et al., 20181; Aazh and Moore, 2017a2); (c) The results can be used to monitor changes after treatment, as past research has shown that ULLs are sensitive to change as the results of treatment (Formby et al., 20073; Juris et al., 20144); (d) the results can be used for counselling and the selection of treatment options. For example, in a study on 573 patients, Aazh and Moore (2017b) reported that for patients with a between-ear difference in ULL of 10 dB or more, the mean score on the Hyperacusis Questionnaire (HQ) was 22 (SD=8). This was significantly	Thank you for your comment. The use of ULL in the context of hearing loss is outside of the scope of this guideline, this is addressed in the adults with hearing loss guideline (NG98). The use of ULL in the context of hyperacusis is also outside of the scope of this guideline. In the absence of evidence, the committee discussed this and decided that uncomfortable loudness levels/loudness discomfort levels (ULL/LDL) tests should not be used as part of an investigation of tinnitus. Based on the committee's experiences, it is thought to be unnecessary, unpleasant and potentially harmful. They may exacerbate a person's tinnitus and increase distress. Additionally, the results of these tests would not affect a person's tinnitus management plan as the main focus of this is to lessen the distress associated with tinnitus. The guideline development team have checked the cited references. Studies were not includable based on inappropriate study design (retrospective cross-sectional, narrative review, guidance or other experimental design) or incorrect population (hyperacusis or misophonia

Tinnitus: assessment and management

Consultation on draft guideline - Stakeholder comments table
20/09/2019 to 01/11/2019

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Stakeholder	Document	Page No	Line No	Comments Please insert each new comment in a new row	Developer's response Please respond to each comment
				higher (worse) than the mean HQ score of 17.6 (SD=9.5) for the remainder of the patients (p=0.007). Thus, a large interaural asymmetry in ULLs is associated with a higher hyperacusis handicap. Whether hyperacusis is symmetrical or not would influence the management process. It also has been reported that large across-frequency changes in ULL are associated with poorer HQ scores (Aazh and Moore, 2017b). The strong across-frequency variations in ULLs might be an indication of adverse reactions only to specific sounds, which is consistent with the definitions of annoyance and fear hyperacusis (Tyler et al., 2014)6 and misophonia (Jastreboff and Jastreboff, 2014)7. This will influence management options and onward referrals, as patients with misophonia might benefit from further psychiatric evaluations and treatments (Schroder et al., 20138; Schroder et al., 20199; Schroder et al., 201710). The main point, which is widely accepted and supported by evidence, is that the results can be strongly affected by the exact procedure and instructions. If the procedure and instructions are fixed, then the results are usually reasonably repeatable. It would be appropriate to quantify the repeatability of a given procedure and set of instructions. Here is a summary of estimates of repeatability based on the data of Sherlock and Formby (2005): The mean test-retest difference of ULLs is about 2 dB (SD = 6 dB) at 0.5 and 1 kHz, 4.5 dB (SD = 7 dB) at 2 kHz and 2 dB (SD = 6 dB) at 4 kHz (Sherlock and Formby, 2005)11. This means that for 95% of patients the test-retest difference is less than 14 dB over the range 0.5-4 kHz. This is slightly greater than the test-retest reliability for pure tone audiometry (PTA) which is less than 10 dB for 95% of patients. Based on the data reported by Sherlock and Formby (2005)11, the coefficient of repeatability (SD of the change × 1.96) is 11.8 dB at 0.5 and 1 kHz, 13.7 dB at 2 kHz and 11 dB at 4 kHz. If ULLs are measured for patients suspected of having hyperacusis, the	

Tinnitus: assessment and management

Consultation on draft guideline - Stakeholder comments table
20/09/2019 to 01/11/2019

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Stakeholder	Document	Page No	Line No	Comments Please insert each new comment in a new row	Developer's response Please respond to each comment
				recommended starting level needs to be modified. Aazh and Moore (2017c) measured ULLs using the BSA recommended procedure (British Society of Audiology, 2011). According to this, the audiologist should "Start testing at 60 dB HL or at the subject's hearing threshold level for that ear at that frequency, whichever is highest, unless otherwise indicated (Section 2.2)" (p.7). An experience of discomfort during measurement of ULLs was deemed to be present if the starting level of 60 dB HL exceeded a patient's ULL for at least at one of the measured frequencies. Discomfort would have occurred for 24% of the patients using this criterion. The incidence of discomfort would have been reduced to 3.6% if the starting level had been reduced to 30 dB HL and to 0.5% if the starting level had been reduced to 15 dB HL. To avoid discomfort during measurement of ULLs, Aazh and Moore (2017c) recommended that the starting level for a given test frequency should be equal to the measured audiometric threshold at that test frequency and that levels above 80 dB HL should not be used. If the patient did not press the button at 80 dB HL, the ULL should be recorded as not reached. If ULLs are measured for the purpose of setting the MPO of a hearing aid, then higher starting levels may be appropriate to reduce testing time. 1. Assi, H., Moore, R.D., Ellemberg, D. & Hebert, S. 2018. "Sensitivity to Sounds in Sport-Related Concussed Athletes: A New Clinical Presentation of Hyperacusis." Sci Rep, 8, 9921. 2. Aazh, H. & Moore, B.C.J. 2017a. "Factors Associated with Depression in Patients with Tinnitus and Hyperacusis." Am J Audiol, 26, 562-569. 3. Formby, C., Gold, S.L., Keaser, M.L., Block, K.L. & Hawley, M.L. 2007. "Secondary Benefits from Tinnitus Retraining Therapy: Clinically Significant Increases in Loudness Discomfort Level and Expansion of the Auditory Dynamic Range. ." Semin Hear, 28, 227-260.	

Tinnitus: assessment and management

Consultation on draft guideline - Stakeholder comments table
20/09/2019 to 01/11/2019

Comments forms with attachments such as research articles, letters or leaflets cannot be accepted.

Stakeholder	Document	Page No	Line No	Comments Please insert each new comment in a new row	Developer's response Please respond to each comment
				4. Juris, L., Andersson, G., Larsen, H.C. & Ekselius, L. 2014. "Cognitive Behaviour Therapy for Hyperacusis: A Randomized Controlled Trial." Behav Res Ther, 54c, 30-37. 5. Aazh, H. & Moore, B.C.J. 2017b. "Factors Related to Uncomfortable Loudness Levels for Patients Seen in a Tinnitus and Hyperacusis Clinic." Int J Audiol, 56, 793-800. 6. Tyler, R.S., Pienkowski, M., Rojas Roncancio, E., Jun, H.J., Brozoski, T. et al 2014. "A Review of Hyperacusis and Future Directions: Part I. Definitions and Manifestations." Am J Audiol, 23, 402-419. 7. Jastreboff, P.J. & Jastreboff, M.M. 2014. Treatments for Decreased Sound Tolerance (Hyperacusis and Misophonia). Seminars in Hearing, 35, 105-120, 8. Schroder, A., Vulink, N. & Denys, D. 2013. "Misophonia: Diagnostic Criteria for a New Psychiatric Disorder." PLoS One, 8, e54706. 9. Schroder, A., Wingen, G.V., Eijsker, N., San Giorgi, R., Vulink, N.C. et al 2019. "Misophonia Is Associated with Altered Brain Activity in the Auditory Cortex and Salience Network." Sci Rep, 9, 7542. 10. Schroder, A.E., Vulink, N.C., van Loon, A.J. & Denys, D.A. 2017. "Cognitive Behavioral Therapy Is Effective in Misophonia: An Open Trial." J Affect Disord, 217, 289-294. 11. Sherlock, L.P. & Formby, C. 2005. "Estimates of Loudness, Loudness Discomfort, and the Auditory Dynamic Range: Normative Estimates, Comparison of Procedures, and Test-Retest Reliability." J Am Acad Audiol, 16, 85-100. 12. Aazh, H. & Moore, B.C.J. 2017c. "Incidence of Discomfort During Pure-Tone Audiometry and Measurement of Uncomfortable Loudness Levels among People Seeking Help for Tinnitus and/or Hyperacusis " American Journal of Audiolgy, 26, 226-232. 13. British Society of Audiology 2011. British Society of Audiology Recommended Procedure, Determination of Uncomfortable Loudness Levels. Reading, UK: British Society of Audiology.	
Royal Surrey	Evidence	General	General	Cite this study that shows the relationship between tinnitus loudness	Thank you for your comment. The guideline development team

Tinnitus: assessment and management

Consultation on draft guideline - Stakeholder comments table
20/09/2019 to 01/11/2019

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County Hospital – Audiology Department	Review G			and puretone average (PTA) thresholds are only weakly associated. The researchers looked at a retrospective cross-sectional sample of 445 consecutive patients at the Tinnitus and Hyperacusis Therapy Specialist Clinic in Guildford, UK, who had been surveyed with audiological and self-report questionnaires. When analyzing tinnitus severity and hearing loss via a regression model, a .036 increase in loudness per 1-dB increase in PTA threshold was found at a significant level of confidence. "This relationship is very weak and the linear model explains only 4% of the variance in tinnitus loudness, suggesting that factors other than severity of hearing loss may contribute to self-report tinnitus loudness," write the authors. "Tinnitus patients often ask whether the loudness of their tinnitus will increase if their hearing gets worse. Our results suggest that tinnitus will likely get louder, but not by very much." Aazh H, Salvi R. The relationship between severity of hearing loss and subjective tinnitus loudness among patients seen in a specialist tinnitus and hyperacusis therapy clinic in UK. J Am Acad Audiol. 2019;30(8)[Sept]:712-719.	have checked the cited references. Study referenced is not suitable for inclusion as it is based on inappropriate design (retrospective cross-sectional study of relationship between symptoms**)**
Royal Surrey County Hospital – Audiology Department	Evidence Review G	General	General	Use a modified PTA procedure based on research evidence. Aazh and Moore (2017) studied the proportion of patients seen in a tinnitus and hyperacusis therapy clinic at a National Health Service Audiology outpatient clinic for whom the presentation levels recommended by the BSA for pure-tone audiometry exceeded ULLs, leading to discomfort. For 21% of the patients, presentation levels based on the BSA procedure for pure-tone audiometry exceeded the ULL for at least 1 of the measured frequencies (excluding the first frequency tested, 1 kHz): 0.25, 0.5, 2, 3, 4, 6, and 8 kHz. The BSA recommendation to use a starting level 30 dB above the threshold determined for the previous frequency when measuring the audiogram needs to be modified for this population. To avoid discomfort for patients who have tinnitus and/or	Thank you for your comment. In the absence of evidence, the committee discussed this and decided that uncomfortable loudness levels/loudness discomfort levels (ULL/LDL) tests should not be used as part of an investigation of tinnitus as it is thought to be unnecessary, unpleasant and potentially harmful. They may exacerbate a person's tinnitus and increase distress. Additionally, the results of these tests would not affect a person's tinnitus management plan as the main focus of this is to lessen the distress associated with tinnitus. The recommendations in this guideline do not provide specific details on how interventions should be delivered.

Tinnitus: assessment and management

Consultation on draft guideline - Stakeholder comments table
20/09/2019 to 01/11/2019

Comments forms with attachments such as research articles, letters or leaflets cannot be accepted.

Stakeholder	Document	Page No	Line No	Comments Please insert each new comment in a new row	Developer's response Please respond to each comment
				hyperacusis, it would be prudent to begin with a level of 0 dB HL at the starting frequency of 1 kHz and to set the level for subsequent frequencies to be equal to the level at threshold for the previously tested frequency. This would reduce the incidence of discomfort during pure-tone audiometry to less than 1% of patients. Although this modification of the BSA procedure might increase the test time, because the starting level might be well below the actual threshold, the modification is unlikely to lead to any significant difference in threshold estimates (Tyler & Wood, 1980). Aazh H, Moore BCJ. Incidence of Discomfort During Pure-Tone Audiometry and Measurement of Uncomfortable Loudness Levels Among People Seeking Help for Tinnitus and/or Hyperacusis. Am J Audiol. 2017 Sep 18;26(3):226-232.	The study referenced is not suitable for inclusion as it is based on an inappropriate design (retrospective cross-sectional study).
Royal Surrey County Hospital – Audiology Department	Evidence Review K	General	General	Cite the studies of audiologist-delivered CBT which report the feasibility of this approach and its effectiveness from the patients' perspective. 1: Aazh H, Moore BCJ. Effectiveness of Audiologist-Delivered Cognitive Behavioral Therapy for Tinnitus and Hyperacusis Rehabilitation: Outcomes for Patients Treated in Routine Practice. Am J Audiol. 2018 Dec 6;27(4):547-558. 2: Aazh H, Moore BCJ. Proportion and characteristics of patients who were offered, enrolled in and completed audiologist-delivered cognitive behavioural therapy for tinnitus and hyperacusis rehabilitation in a specialist UK clinic. Int J Audiol. 2018 Jun;57(6):415-425.	Thank you for your comment. The guideline development team have checked the cited references. Studies referenced were not suitable for inclusion due to the inappropriate design (retrospective, cross-sectional), inappropriate comparison (single arm no comparator) or incorrect population (tinnitus and/or hyperacusis)
Royal Surrey County	Evidence review L	General	General	Also mention that variations of TRT has successfully been used in NHS UK. Cite the studies below:	Thank you for your comment. The guideline development team have checked the cited references. Studies were not suitable for

Tinnitus: assessment and management

Consultation on draft guideline - Stakeholder comments table
20/09/2019 to 01/11/2019

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Stakeholder	Document	Page No	Line No	Comments Please insert each new comment in a new row	Developer's response Please respond to each comment
Hospital – Audiology Department				-Aazh H, Moore BC, Lammaing K, Cropley M. Tinnitus and hyperacusis therapy in a UK National Health Service audiology department: Patients' evaluations of the effectiveness of treatments. Int J Audiol. 2016 Sep;55(9):514-22. -Aazh H, Moore BC, Glasberg BR. Simplified form of tinnitus retraining therapy in adults: a retrospective study. BMC Ear Nose Throat Disord. 2008 Nov 3;8:7. -Aazh, H. and B.C. Moore, A comparison between tinnitus retraining therapy and a simplified version in treatment of tinnitus in adults. Auditory and Vestibular Research, 2016. 25(1): p. 14-23.	inclusion due to the inappropriate design (retrospective, cross-sectional), inappropriate comparison (single arm or comparator not in protocol) or incorrect population (tinnitus and/or hyperacusis)
Specsavers – Hearcare Group Limited	Guideline	General	General	Specsavers commends NICE for providing interested parties with the opportunity to comment on their draft guidance for tinnitus assessment and management. Given NICE's reputation as an established and trusted source for clinical evidence-based best practice in health and care excellence, we recognise that once the 'Tinnitus assessment and management' guidance has been published in its final form, it will become the de facto 'go to' resource for CCGs when considering commissioning intentions in this area. As a key provider of community audiology services, Specsavers is eager to ensure the skillset and expertise of our clinicians is fully utilised to ensure that patients with suspected or diagnosed tinnitus who are seen in our stores are treated appropriately or directed to the most appropriate source of care or support. By ensuring the NICE guidance fully reflects the role which non-Acute audiology clinicians can play in this area, this will help CCGs to reflect on commissioning opportunities to maximise the skillset and expertise of all community audiology providers (not just Specsavers). This, in turn, could lead to commissioned services which alleviate pressures on:	Thank you for your comment. The fitting of hearing aids should be offered to people with tinnitus who have a hearing loss that affects their ability to communicate (see recommendation 1.5.1). The fitting of hearing aids should be considered for people with tinnitus who have a hearing loss but do not have difficulties communicating., The committee agree audiology services may be provided in a number of different settings including in the community. The commissioning of services is outside of the scope of this guideline, but the committee hope that commissioners take this guideline into consideration in conjunction with the hearing loss guideline when commissioning services. In regards to the potential for community audiology providers to provide tinnitus assessment and navigation clinics, this guideline does not provide guidance on how services should be delivered but focuses on the care that should be provided.

Tinnitus: assessment and management

Consultation on draft guideline - Stakeholder comments table
20/09/2019 to 01/11/2019

Comments forms with attachments such as research articles, letters or leaflets cannot be accepted.

Stakeholder	Document	Page No	Line No	Comments Please insert each new comment in a new row	Developer's response Please respond to each comment
				• Secondary care (increasing community treatment, enabling hospitals to focus time and resources on complex cases) • GP referrers (freeing up capacity by reducing return visits to GPs and optimising the scope for community treatment without the need for an initial GP referral). Having reviewed the draft guidance, we recommend that NICE reflects on the following points and considers how the guidance could be enhanced to optimise the skillset and expertise of community audiology providers: • In what circumstances fitting of hearing aids may be suitable and beneficial for specific cohorts of patients with suspected or diagnosed tinnitus • How the NHS can save money by directing suitable Tinnitus patients into an Audiology rather than an ENT pathway. • How ENT and Audiology services can be commissioned together to provide an integrated pathway for tinnitus patients whose clinical journey may straddle both areas of specialism. Potential for community audiology providers to provide tinnitus assessment and navigation clinics, including interview and clinical examination, and direct onward referral to support organisations and ENT.	
Tinnitus Hub	General	General	General	Management strategies – We noted that most of the management strategies, including psychological therapies, referred to in the draft guideline fall under the "limited evidence category". It is also our experience that these strategies do not benefit the whole tinnitus population, particularly those with intrusive tinnitus (very loud and or intense for example). It is clear that there is an urgent unmet need for pharmacological or medical interventions for the treatment of tinnitus. Tinnitus research is severely underfunded and effective treatments	Thank you for your comment. The investigation of the causes of tinnitus was not identified as an area of priority during the scoping stage of this guideline. Therefore, research recommendations around this cannot be made. The committee decided to make research recommendations for management strategies as they can help people with tinnitus cope with their tinnitus, irrespective of tinnitus severity. Lay members on the committee also expressed that the research recommendations will be beneficial for people with tinnitus. However, a research

Tinnitus: assessment and management

Consultation on draft guideline - Stakeholder comments table
20/09/2019 to 01/11/2019

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Stakeholder	Document	Page No	Line No	Comments Please insert each new comment in a new row	Developer's response Please respond to each comment
				leading to a cure are needed. More funding for basic, scientific research is needed to understand the mechanisms in the brain that initiate and lead to chronic tinnitus. A recent publication by McFerran DJ, Stockdale D, Holmes, et al. titled "Why Is There No Cure for Tinnitus?" (Front in Neurosci, 6 Aug 2019 . htttps://doi.org/10.3389/fnins.2019.00802) attempts to clarify the current tinnitus research landscape and addresses the obstacles that stand in the way of achieving an effective cure for tinnitus. People with tinnitus would like to see more resources put towards research for a cure, rather than psychological and sound therapies that have little or no effect on the actual tinnitus precept.	recommendation has been made for further research into neuromodulation (a medical intervention) – this is one of the key areas that the committee highlighted that requires further research (full details can be seen in Evidence Review O).
Tinnitus Hub	Guideline	003	020	Information for people with tinnitus section – The bullet points imply that first point of contact is between a healthcare professional and a patient with recent onset of tinnitus. Therefore, we suggest an additional bullet point to address patients with longstanding tinnitus who have not yet sought medical assistance and may have not been able to find strategies to cope (later referred to as having persistent tinnitus). *We noted that this section falls under the recommendation for research topic - Primary Care Assessment.*	Thank you for your comment. A separate recommendation about longstanding tinnitus has been added into the information for people with tinnitus section .
Tinnitus Hub	Guideline	004	004 - 005	Information for people with tinnitus section • Insomnia should be considered for inclusion: It is fairly well-established sleep deprivation has an effect on how one copes with tinnitus, as well as being a co-morbidity. In fact, some even report a worsening of their tinnitus itself when they are struggling with a lack of sleep. (Marks E, McKenna L, Vogt F. Cognitive behavioural therapy for tinnitus-related insomnia: evaluating a new treatment approach. Int J Audiol May; 58(5): 311-	Thank you for your comment. This recommendation has been amended to include the impact of tinnitus on sleep. The study referenced in your comment was assessed whilst the relevant systematic review was conducted and was excluded due to incorrect study design (non-randomised study). This appears in the excluded studies table in Evidence Review L on psychological therapies.

Tinnitus: assessment and management

Consultation on draft guideline - Stakeholder comments table
20/09/2019 to 01/11/2019

Comments forms with attachments such as research articles, letters or leaflets cannot be accepted.

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				316, doi: 10.1080/14992027.1547927) *We noted that this section falls under the recommendation for research topic - Primary Care Assessment.* • Noise has been included, please note: Given the link between noise exposure related hearing loss and tinnitus, and noise exposure with no hearing loss and tinnitus (presumed hidden hearing loss), it is widely recognized that there is a strong correlation between noise exposure and the onset of tinnitus or worsening of tinnitus. Nonetheless, there are many unanswered questions relating to the mechanism of tinnitus, hence it is our understanding that there is no clear consensus as to what is a safe level of noise exposure and for what duration for a person with tinnitus. How would a GP or any healthcare professional be able to offer patients advice on noise safety levels in the absence of specific guidelines for tinnitus patients? The perception amongst many of our members, for example, is that there should be lower noise safety levels recommendations for the tinnitus population and, in the absence of clear guidance on the matter, we find that many of our memberso tend to avoid noisy situations, which can result in the following: o Isolation and withdrawal from social situations, which are perceived to be loud but that would not fall under the category of concerts, nightclubs and bars (such as cinemas, pubs, restaurants, churches playgrounds). o Difficulty in implementing CBT and audiologist counselling	

Tinnitus: assessment and management

Consultation on draft guideline - Stakeholder comments table
20/09/2019 to 01/11/2019

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Stakeholder	Document	Page No	Line No	Comments Please insert each new comment in a new row	Developer's response Please respond to each comment
				techniques aiming to restore normal day to day living and to encourage the patient to fully engage in life. o Possible development of sound intolerance - hyperacusis. Additionally, there is a perception that sudden loud noises, such as sirens or even balloons popping can cause an increase in tinnitus intrusiveness due to acoustic shock, which leads many to wear hearing protection for a lot of the time, against healthcare professionals' advice. We agree that standard guidelines for noise safety levels need to be communicated to patients, as you mention in the guidelines. *We noted that this section falls under the recommendation for research topic - Primary Care Assessment.* • 'What might happen in the future' has been included, please note: Patients seldom receive a prognosis. They are often told that their tinnitus will get better with time. Presumably this is meant to convey that the person with tinnitus learns to cope by tuning out the sound of their noise or by using strategies such as distraction or masking to take their attention away from the noise. There have been no long-term prospective studies that would inform patients, clinicians and other healthcare professionals about the natural progression of the condition. For example, are additional sounds likely to occur, is the volume likely to increase and if presently unilateral will it become bilateral? In our experience, some people's tinnitus does appear to worsen over time. *We noted that this section falls under the recommendation for research topic - Primary Care Assessment.*	

Tinnitus: assessment and management

Consultation on draft guideline - Stakeholder comments table
20/09/2019 to 01/11/2019

Comments forms with attachments such as research articles, letters or leaflets cannot be accepted.

Stakeholder	Document	Page No	Line No	Comments Please insert each new comment in a new row	Developer's response Please respond to each comment
Tinnitus Hub	Guideline	004	004 - 005	Information for people with tinnitus section When informing patients about tinnitus we believe they should be made aware of procedures and tests that could make their tinnitus worse. You have mentioned acoustic reflex tests in the rationale section, p.20 1.3.1-1.3.3. Some people report an exacerbation of their tinnitus after an MRI test. Other procedures such as ear syringing are believed to carry risks too. We believe that the introduction of a consent form for tests and procedures carried out by ENTs, audiologists or imaging departments, which may result in worsening of tinnitus, should be considered. *We noted that this section falls under the recommendation for research topic - Primary Care Assessment.*	Thank you for your comment. The committee agree that MRI is loud and some people may find this noise can affect their tinnitus. Radiology departments do provide earplugs if this is the case. This information has been added into the rationale and impact for the imaging reviews and committee discussions in Evidence Review J and Evidence Review K. Other procedures such as ear syringing are outside of the scope of this guideline.
Tinnitus Hub	Guideline	004	004 - 005	Information for people with tinnitus section – When giving information about the condition, healthcare professionals should provide an explanation to patients about the different types of tinnitus: subjective, objective, pulsatile, somatic, iatrogenic. Our members often have discussions and questions relating to the subtyping of tinnitus, which medical professionals don't always seem to be aware of. The heterogeneity of tinnitus has become a widely discussed topic in recent years (Cederroth CR, Gallus S, Hall DA, et al., Editorial: towards an understanding of tinnitus heterogeniety. Front Aging Neurosci 2019; 11:53), however we note that no reference or attempt to classify tinnitus patients is found in the guideline. Somatic tinnitus, for example, has been the subject of much research lately. (Michiels S, Harrison S, Vesala M, Schlee W, The presence of physical symptoms in patients with tinnitus: international web-based survey. Interact J Med Res 2019 Jul 30; 8(3): e14519dol10.2196/14519 and Micheils S, Ganz Sanchez T, Oron Y, et al. Diagnostic criteria for	Thank you for your comment,. Apart from sub-types that can indicate a structural cause identifiable through imaging (for example pulsatile tinnitus and non-pulsatile tinnitus) sub-types based on perception of tinnitus were not considered a priority area to include in the guideline. All studies referenced were not suitable for inclusion due to inappropriate design/article type (editorial/narrative review, survey of patient symptoms, diagnostic criteria)

Tinnitus: assessment and management

Consultation on draft guideline - Stakeholder comments table
20/09/2019 to 01/11/2019

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Stakeholder	Document	Page No	Line No	Comments Please insert each new comment in a new row	Developer's response Please respond to each comment
				somatosensory tinnitus: a delphi process and face to face meeting to establish consensus. Trends Hear. 2018 Jan-Dec; 22:2331216518796403 and Shore S, Zhou J, Koehler S, Somatic tinnitus- neural mechanisms underlying somatic tinnitus. Prog Brain Res. 2007 166:107-23). *We noted that this section falls under the recommendation for research topic - Primary Care Assessment.*	
Tinnitus Hub	Guideline	004	007 - 008	Support section - Please signpost healthcare professionals, and therefore patients, to up-to-date information. *We noted that this section falls under the recommendation for research topic - Primary Care Assessment.*	Thank you for your comment. The committee agree information given should be up to date and have referred to the patient experience guideline which sets out broad principles in information provision.
Tinnitus Hub	Guideline	004	012	Assessing tinnitus section - Prescription for anxiolytics and antidepressants or sleep medication to address some of the co-morbidities of tinnitus mostly occurs in Primary Care. There are some concerns amongst our members that some of these medications may be ototoxic and or have tinnitus as a side effect. More research is required and guidelines necessary. We noted that no neurologist or psychiatrist were included in the committee, which in our opinion would be advisable. *We noted that this section falls under the recommendation for research topic - Primary Care Assessment.*	Thank you for your comment. The committee agree that prescribing in people with tinnitus is an important issue and further research is needed. However, this is outside of the scope of this guideline.
Tinnitus Hub	Guideline	004 - 005	021 - 029 001 - 010	Initial assessment in secondary care Sudden hearing loss – what is the definition? Could "moderate or minor" sudden hearing loss cause tinnitus? How can we establish the hearing loss has been sudden as opposed to progressive in the absence of recent audiometry tests? We are assuming that any kind of sudden hearing loss can benefit from medical interventions (such as oral steroids or intratympanic steroid injections), thus should these	Thank you for your comment. The onset of hearing loss is determined by the person telling the health professional the time in which it developed. This will enable the health professional assess if it was sudden or progressive. Sudden hearing loss is defined according to the time in which it developed either over 3 days or less within the past 30 days, or over 3 days or less more than 30 days ago. The recommendations apply to any kind of

Tinnitus: assessment and management

Consultation on draft guideline - Stakeholder comments table
20/09/2019 to 01/11/2019

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Stakeholder	Document	Page No	Line No	Comments Please insert each new comment in a new row	Developer's response Please respond to each comment
				interventions be extended to moderate sudden hearing loss as well, particularly in the case of tinnitus patients who may benefit from any gain in hearing thresholds?	sudden hearing loss and the committee agrees that people should be seen for medical intervention as highlighted in recommendations.
Tinnitus Hub	Guideline	005	011 - 020	Assessing tinnitus section - Please include the following: • Detailed medical history and thorough medical examination. Offering blood test to ascertain no anaemia, diabetes or hypertension is present. According to published guidelines (Cima RFF, Mazurek B, Heider H et al., A multidisciplinary European guideline for tinnitus; diagnostics, assessment, and treatment. HNO (2019) 67(Suppl 1):10-42), tinnitus is a symptom associated with multiple medical disorders which should be identified or excluded. • Determining if there are TMD (temporomandibular disorder) symptoms, as only head and neck issues have been included and an association between TMD and tinnitus has been established (Bousem EJ, Koops EA, vanDijk P, Dijkstra PU. Association between subjective tinnitus and cervical spine or temporomandibular disorders: a systematic review. Treands Hear 2018 Jan-Dec; 22: 2332126518800640.doi11771233121651880064O.) • Assessing subtypes of tinnitus - subjective, objective, pulsatile, somatic, iatrogenic. GPs could then include the above information in their referral to secondary care and, in the case of suspected TMD, a recommendation for the jaw area to be imaged as well.	Thank you for your comment. The committee agree that physical examination and clinical history taking is important. However, how physical examinations and clinical history-taking should be conducted is not in the scope of this guideline, and recommendations cannot be made. The committee agree that MRI is loud and some people may find this noise can affect their tinnitus. Radiology departments do provide earplugs if this is the case. This information has been added into the rationale and impact for the imaging reviews and committee discussions in Evidence Review J and Evidence Review K. Temporomandibular disorder (TMD) was not identified as a priority are for inclusion in the scope. Apart from sub-types that can indicate a structural cause identifiable through imaging (for example pulsatile tinnitus and non-pulsatile tinnitus) sub-types based on perception of tinnitus were not considered a priority area to include in the guideline.

Tinnitus: assessment and management

Consultation on draft guideline - Stakeholder comments table
20/09/2019 to 01/11/2019

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				This will represent a saving in cost, avoiding patient referral to imaging by the oral surgery/maxillofacial department further on and be beneficial to patients who are reluctant to undergo repeated MRI scans, due to the high level of noise emitted. As far as MRIs are concerned, the healthcare practitioner referring to MRI should advise patients to wear hearing protection; the imaging team will not necessarily be aware of dangers of noise exposure in tinnitus patients (as we suggested above a consent form could be introduced). One of the frequently asked questions from our members if the headphones alone, offered at MRI scans, are sufficient. *We noted that this section falls under the recommendation for research topic - Primary Care Assessment.*	
Tinnitus Hub	Guideline	005	023	Secondary care assessment section Does not refer to any tests performed nor specify who the secondary care practitioner would be, i.e. ENT, Neurologist, Maxillofacial specialist.	Thank you for your comment. People with tinnitus need to be referred according to their clinical presentation and local pathways. Specific tests beyond those mentioned in this guideline and details about the healthcare professionals' roles are out of the scope of this guideline.
Tinnitus Hub	Guideline	006	019	Assessing the psychological impact of tinnitus section Anxiety and depression resulting from tinnitus would require tinnitus focused psychological interventions, as per your suggestion on p.9, 1.4.4. The guidelines to those psychological interventions should therefore be included rather than signposting to the NICE website on generic guidelines or anxiety and depression. Although it is recommended that patients with tinnitus be asked about insomnia, no recommendations are made for addressing sleep problems. A preliminary investigation by Marks E, McKenna L and Vogt F, titled	Thank you for your comment. Because this section is concerning psychological assessment the committee does not think it appropriate to refer to recommendations on psychological therapies. This guideline recognises the need for and recommends psychological intervention but does not cover the nature of that intervention. Basic advice on sleep management should be provided as part of the information and support offered to people with tinnitus. Specific details on this is outside of the scope of this guideline. The guideline committee reviewed the reference provided in your comment. The study was assessed when the relevant systematic review was conducted and excluded due to incorrect

Tinnitus: assessment and management

Consultation on draft guideline - Stakeholder comments table
20/09/2019 to 01/11/2019

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Stakeholder	Document	Page No	Line No	Comments Please insert each new comment in a new row	Developer's response Please respond to each comment
				Cognitive behavioural therapy for tinnitus-related insomnia: evaluating a new treatment approach (Int J Audiol 2019 May;58(5):311-316) suggests that CBTi may be an effective therapy for insomnia in tinnitus patients. Additionally, as anxiety, depression, insomnia are often co-morbidities the above point is particularly relevant. *We noted that this section falls under the recommendation for research topic - Primary Care Assessment.*	study design (see Excluded Studies in Evidence Review F).
Tinnitus Hub	Guideline	007	009 - 011	Assessing how tinnitus affects quality of life – We would welcome some guidelines for teachers and employers. *We noted that this section falls under the recommendation for research topic - Primary Care Assessment.*	Thank you for your comment. The guideline is intended to cover all settings where NHS-commissioned care is provided.
Tinnitus Hub	Guideline	007	016	Further investigations – Audiological Assessment We believe that people for whom no hearing loss is detected, should be offered an extended high frequency hearing tests to better help determine the cause of their tinnitus such as higher frequency hearing loss for example.	Thank you for your comment. No evidence was identified that evaluated the use of high frequency audiometry. Therefore, this could not be recommended.
Tinnitus Hub	Guideline	008	012 - 014	Further investigation section – At the point of imaging an MRI focusing on the jaw should be given if TMD is suspected.	Thank you for your comment. The committee discussed your suggestion and decided a recommendation for this is not appropriate. A MRI scan will be based on clinical findings, including TMD dysfunction as part of head and neck signs and symptoms. An appropriate clinical examination of this area would be part of the examination process and imaging requested if required.

Tinnitus: assessment and management

Consultation on draft guideline - Stakeholder comments table
20/09/2019 to 01/11/2019

Comments forms with attachments such as research articles, letters or leaflets cannot be accepted.

Stakeholder	Document	Page No	Line No	Comments Please insert each new comment in a new row	Developer's response Please respond to each comment
Tinnitus Hub	Guideline	009	009	Sound therapy and amplification devices – There is some evidence that hearing aids can be helpful for tinnitus patients with very minor hearing loss (Bennett CD, Hearing aid use with minimal high-frequency hearing loss. Otolaryngol Head Neck Surgery 1989 100(2): 154-7), not only those with tinnitus who have a hearing loss that affects their ability to communicate, or those with tinnitus who have a hearing but no difficulty in communicating. In terms of sound therapy could you be more specific? Does this refer to sound enrichment and masking or to a specific therapy?	Thank you for your comment. The committee concluded that there was insufficient evidence to recommend sound therapy. A recommendation for further research evaluating sound therapy (with tinnitus support) was made, the sound therapy component including sound enrichment or masking (see Evidence Review M). The guideline development team have checked the cited reference.. The study referenced was previously assessed and excluded due to incorrect population (hearing loss) and incorrect comparison (single arm, no comparator)
Tinnitus Hub	Guideline	010	024	Assessing the psychological impact of tinnitus section The point directly above also applies to children. *We noted that this section falls under the recommendation for research topic - Primary Care Assessment. It also falls under the recommendation for research topic –* *Psychological therapies for children and young people.*	Thank you for your comment.
Tinnitus Hub	Guideline	011	018 - 025	CBT – We agree that CBT and psychological therapies should be tinnitus focused, as per your suggestion on p.9, 1.4.4. It is our understanding that standard CBT techniques, for example, promote *exposure*, which contradicts longstanding techniques that aim to take away the focus from the tinnitus. We therefore agree with a more tailored approach, which would need to be reflected in specific guidelines, be included in these overarching guidelines. In summary CBT / CBTI or any psychological therapy should be: • Tailored to tinnitus patients • More accessible	Thank you for your comment. The committee noted that CBT should be delivered in a tinnitus context by clinicians who have some understanding of tinnitus and within a service which assesses and manages tinnitus or by a service with a close liaison with such a service. It is likely that tinnitus and any co-existing anxiety and depression will interact. It is therefore appropriate that the therapy addresses these issues as necessary. If tinnitus is the main issue then it will best be addressed by a CBT service that is aligned with the main service. If the main issue affecting the patient is a co-existing anxiety or mood disorder then it will be better if that is addressed

Tinnitus: assessment and management

Consultation on draft guideline - Stakeholder comments table
20/09/2019 to 01/11/2019

Comments forms with attachments such as research articles, letters or leaflets cannot be accepted.

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				• Specified in these guidelines as anxiety, depression and insomnia, which psychological therapies try to address, are co-morbidities.	by an appropriate service.
Tinnitus Hub	Guideline	012	001 - 005	Combination therapies – We note that you suggest more research into combination therapy. Will wearable noise generators be considered as well? They are currently standard practice in the UK and while not helpful to some, they do benefit others.	Thank you for your comment. The proposed research question includes noise generators as part of a combination intervention, full details can be seen in Evidence Review P – Combination management strategies.
Tinnitus Hub	Guideline	General	General	A&E – We would welcome the inclusion of guidelines for A&E departments dealing with tinnitus patients.	Thank you for your comment. The committee recommends tinnitus support at all points of contact and stages of care by all healthcare professionals, including A&E staff. No recommendations specific to A&E staff were identified by the committee.
Tinnitus Hub	Guideline	General	General	Hyperacusis assessment and treatment – Should be considered as part of the guidelines. Hyperacusis often results from tinnitus or is a co-morbidity of tinnitus, and people with tinnitus may be treated for hyperacusis differently compared to those without tinnitus as there may be additional risks (real or perceived) associated with noise exposure for patients with tinnitus.	Thank you for your comment. The committee recognises that hyperacusis is troublesome for many people with tinnitus. However, this guideline focuses on the assessment and management of tinnitus. Managing sound sensitivities such as hyperacusis (without tinnitus) were excluded from the guideline scope. The committee have made a recommendation to make a management plan for those people with identified needs which would take into account other factors such as sound sensitivities.
University Hospitals Coventry and Warwickshire NHS Trust (UHCW)	Guideline	008	017	Guidance on investigation of pulsatile tinnitus references imaging only. In my experience patients are referred for tinnitus support who have pulsatile tinnitus that has not been investigated in relation to underlying causes such as high blood pressure. It would be useful to have a section here giving guidance on underlying pathologies that should be managed prior to referring for tinnitus support at secondary or tertiary level.	Thank you for your comment. The assessment of underlying pathologies or causes of tinnitus (except for investigations using imaging) are outside of the scope for this guideline. We would anticipate that these pathologies are identified as part of a comprehensive history and examination.
University of Nottingham	Guideline	003	017	Whilst the incidence of sinister medical pathology, and of frank psychological problems, in persons with tinnitus is uncommon, it is not rare. Further, in such affected individuals, identification, diagnosis, and	Thank you for your comment. This recommendation has been amended, stating that tinnitus is commonly associated with hearing loss but it is not commonly associated with another

Tinnitus: assessment and management

Consultation on draft guideline - Stakeholder comments table
20/09/2019 to 01/11/2019

Comments forms with attachments such as research articles, letters or leaflets cannot be accepted.

Stakeholder	Document	Page No	Line No	Comments Please insert each new comment in a new row	Developer's response Please respond to each comment
				treatment are urgent. The statement at present assumes that no such pathologies are present, without any evidence. A suggested rewording of this statement to reflect these concerns is: 'it is not commonly associated with an underlying medical or mental health problem, and effort will be expended to identify such situations when they are present	underlying physical or mental health problem.
University of Nottingham	Guideline	003	017	Hearing loss is a 'physical problem', and it is very commonly co-incident with tinnitus	Thank you for your comment. This recommendation has been amended, stating that tinnitus is commonly associated with hearing loss but it is not commonly associated with another underlying physical or mental health problem.
University of Nottingham	Guideline	004	022	Ambiguity whether the referral is within 24hrs, or the consultation. Suggest 'Immediate referral for assessment and management to be seen within 24hrs'	Thank you for your comment. The committee have revised the recommendations to provide clarity and to bring in line with the suspected neurological conditions NG127 immediate referral within a few hours or quicker if necessary, and the hearing loss guideline NG98 refer immediately to be seen within 24 hours..
University of Nottingham	Guideline	004	025	Phrase 'high risk of suicide' is ambiguous and unhelpful. Please specify risk.	Thank you for your comment. The wording has not changed but the committee has clarified what high risk of suicide means in the rationale and impact section for the associated recommendation, e.g. suicidal thoughts with an intended plan.
University of Nottingham	Guideline	005	026	The TFI is essentially a series of Visual Analogue Scales. If a person is unable to complete a TFI, why would they be able to complete a single VAS?	Thank you for your comment. The TFI is not a VAS. There may be scenarios where the TFI is difficult to complete because of literacy levels, use of VAS would help in this case.
University of Nottingham	Guideline	006	008	Recommendation for TQ and mini-TQ for assessing psychological impact of tinnitus, although at present these are commonly used in Germany, less so in the UK.	Thank you for your comment. There is no general consensus about which tinnitus questionnaire should be used in clinical practice to provide an assessment of the general impact of tinnitus and its psychological impact. The committee agreed to recommend TFI (see rationale and impact section for the

Tinnitus: assessment and management

Consultation on draft guideline - Stakeholder comments table
20/09/2019 to 01/11/2019

Comments forms with attachments such as research articles, letters or leaflets cannot be accepted.

Stakeholder	Document	Page No	Line No	Comments Please insert each new comment in a new row	Developer's response Please respond to each comment
					recommendation) in order to reduce variation and standardise care. The committee agreed that TQ or mini-TQ is considered as an adjunct to the TFI, noting that it is in fact used within the UK. The advantage of the TQ is that the normative data are from a UK (rather than a US or Australian) population.
University of Nottingham	Guideline	006	008	On psychometric testing the TQ is no more sensitive to psychological aspects of tinnitus than the TFI	Thank you for your comment. During protocol development for the systematic review looking at questionnaires that assess psychological impact, a review of diagnostic evidence was considered but it was agreed that as there is no gold standard, this reviewing approach was not be suitable. If there was a gold standard questionnaire used in practice, then the committee would have considered the approach of assessing diagnostic evidence in a systematic review. The committee acknowledged and agreed that in light of the scarcity of validated tinnitus questionnaires that assess psychological impact, the TQ and mini TQ are the most appropriate for assessing psychological impact. The committee noted that the TQ and mini-TQ are currently used within current practice and agreed that there should be standardisation in care.
University of Nottingham	Guideline	006	012	Is this **competent** to score a questionnaire, or to assess and refer (eg complete an action plan)?	Thank you for your comment. A healthcare professional who is competent in mental health assessment within local mental health pathway will have the necessary skills and competencies to use the questionnaire specified or Clinical Outcomes in Routine Evaluation – Outcome Measure and agree an action plan.
University of Nottingham	Guideline	006	016	Diagnostic assessment using the Clinical Outcomes in Routine Evaluation - Outcome Measure would be welcomed, but this tool is developed for evaluating the impact of clinical management programme and so should also be recommended to be administered as a post-treatment follow up as well.	Thank you for your comment. The committee discussed the various questionnaires and measures available to assess the impact of tinnitus. A consensus recommendation was made to consider the use of the TFI to assess tinnitus as it provides the broadest assessment of the impact of tinnitus and incorporates a

Tinnitus: assessment and management

Consultation on draft guideline - Stakeholder comments table
20/09/2019 to 01/11/2019

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					variety of components. It was also specifically designed to measure change, i.e. before and after an intervention is delivered. The rationale and impact associated with this recommendation highlights that 'assessment methods' (this could include CORE-OM if the TFI is not suitable due to language issues or cognitive impairment) can be used to assess the impact of tinnitus before and after an intervention to further inform management plans.
University of Nottingham	Guideline	007	022	Clarify if hearing loss is one of the symptoms and signs referred to	Thank you for your comment. This recommendation has been amended, OAEs is recommended if there is tinnitus associated with signs and symptoms, one of these signs is hearing loss.
University of Nottingham	Guideline	007	026	The proscription of psychoacoustic testing is too strong. Patients appreciate such testing, and it is required for pitch-based treatments such as notched noise, and neuromodulation, and the Guideline makes no Recommendation against these	Thank you for your comment. The committee does not recommend psychoacoustic testing as a routine clinical assessment for tinnitus. They are time-consuming, often unreliable and do not reflect the level of distress due to or impact of tinnitus on an individual, neither does it change the management. The committee recognises that psychoacoustic testing is performed in research settings but have not recommended it's use in a research context. The committee is also aware that psychoacoustic testing is used as part of specific treatment, but the use of psychoacoustic testing to accompany treatment options is outside of the scope of this guideline.
University of Nottingham	Guideline	008	006	Prefer otological to audiological	Thank you for your comment. The committee agreed that 'otological' is used instead of 'audiological'.
University of Nottingham	Guideline	008	008	Prefer otological to audiological	Thank you for your comment. The committee decided to add 'otological' into the recommendation.
University of Nottingham	Guideline	008	013	Prefer otological to audiological	Thank you for your comment. This recommendation has been amended, otological has been added.

Tinnitus: assessment and management

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University of Nottingham	Guideline	009	005	This statement lacks meaning and value without a definition of hearing loss. The BSA definition in the PTA Recommended Procedure is advised.	Thank you for your comment. Hearing loss is defined within the hearing loss guideline (NG98), this is cross-referred to within the recommendation.
University of Nottingham	Guideline	009	020	Suggested rewording: 'offer them an intervention from the next step, **when available and acceptable**, in the following order '	Thank you for your comment. The committee does not determine provision of services, and hopes that this recommendation will support the provision of these services by commissioners. Your comment will be considered by NICE where relevant support activity is being planned.
University of Nottingham	Guideline	014	005	Agree that 'tinnitus counselling' should not be used: *counselling* is a protected term	Thank you for your comment.
University of Nottingham	Guideline	016	027	The benefits and harms and also cost effectiveness and resource use of questionnaires to assess tinnitus were discussed by the panel, but the panel did not seem to consider the content validity (do they measure what they say they measure) of the TFI and TQ, nor the feasibility of administration of the TQ. While there may be little evidence on content validity, it is nevertheless one of the most important attributes of a questionnaire in clinical practice (https://www.ncbi.nlm.nih.gov/pubmed/29550964). We note that the TQ comprises 52 questions, which is not feasible to give during a standard clinical appointment.	Thank you for your comment. The committee did in fact discuss the content validity of the TFI and TQ. During protocol development for the associated systematic reviews, a review of diagnostic evidence was considered but it was agreed that as there is no gold standard (all tinnitus questionnaires have limitations) this reviewing approach was not suitable. . If there was a gold standard questionnaire used in practice, then the committee would have considered the approach of assessing diagnostic evidence in a systematic review. The committee acknowledged and agreed that in light of the scarcity of validated tinnitus questionnaires, the TFI and TQ are the most appropriate for assessing the impact of tinnitus. The TFI provides a broad assessment of tinnitus covering numerous domains. The TQ also purports to assess a number of factors in tinnitus complaint; the largest of these is emotional distress. In regards to the feasibility of the TQ, it was noted that the TQ is commonly completed outside of the standard clinical appointment whilst the individual with tinnitus is waiting to be seen. Additionally, TQ is only recommended when additional psychological assessment is required. The mini-TQ which has fewer questions has also been recommended, healthcare professionals may decide to use this

Tinnitus: assessment and management

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					questionnaire if there are concerns about the length of time available for assessment with a questionnaire.
University of Nottingham	Guideline	024	021	We are pleased to see that two recent Cochrane reviews, on sound therapy and betahistine, have been included in their entirety. This underlines the benefit of initial discussion between the NICE team and the Cochrane authors to ensure equivalence in the protocol as much as possible.	Thank you for your comment.

**None of the stakeholders who comments on this clinical guideline have declared any links to the tobacco industry.*

Registered stakeholders

[i] NHS England, the Local Government Association, the Association of Directors of Public Health, Public Health England et al. 2019, Joint Strategic Needs Assessment Guidance https://www.england.nhs.uk/wp-content/uploads/2017/09/joint-strategic-needs-assessment-guidance-jul19.pdf

[ii] BSA, 2019, draft guidance on tinnitus management adults, available from the BSA and/or NICE Committee members on the BSA working group

[iii] NHS England, 2016, Commissioning Services for People with Hearing Loss: A Framework for Clinical Commissioning Groups https://www.england.nhs.uk/wp-content/uploads/2016/07/HLCF.pdf