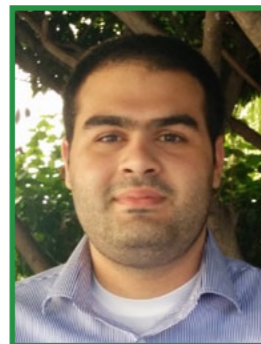


Hearing Aids for Elderly Suffering from Presbycusis



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Introduction

Hearing loss is a worldwide issue affecting the quality of life of the elderly population; the latter constitutes a significant load on government's treasuries due to the fact that they are considered to be an unproductive segment of the community. Despite this fact, governments remain yet aloof from attending to the need for improving the quality of life of elderly which starts by screening, planning, intervention, and treatment. The paper will layout the importance of using hearing aids to ameliorate the quality of life of elderly suffering from presbycusis; subsequently highlighting the need to screen for hearing loss at early stages among the elderly.

Prevalence

Hearing is an imperative aspect of our everyday life. It is the basis of communication and exchange of information (Dalton et al., 2003). It also influences language development and further facilitates the expansion and growth of our knowledge and thoughts (Lotfi et al., 2009). Presbycusis, hearing loss among the elderly, ranks among the older Americans as the third most prevalent chronic

disease (Lotfi et al., 2009).

World Health Organization (WHO) predicts an epidemiological transition resulting in a rise in the number of the older population worldwide. This rise in the older population aged 65 and above has been estimated to be between 18% and 50% from the year 2010 to 2020 (WHO, 2013). Moreover, the WHO (2013), global estimates reported that one third of the elderly population aged 65 and above suffers from hearing loss. Therefore, hearing loss prevalence is estimated to rise while decreasing the quality of life of the older population affected by it. (Dalton et al., 2003).

Consequences

According to the literature, the impact of untreated hearing loss on elderly population's quality of life may be profound (Ciorba et al., 2012; Al-Ruwali&Hagr, 2010; Chia et al., 2007; Pugh, 2004; Dalton et al., 2003; Strawbridge et al., 2000; Keller et al., 1999). It has been noted to reduce social interaction and functional activities (Ciorba et al., 2012). Other studies described presbycusis as a possible reason behind various adverse effects on the elderly psychological, social and physiological well-being (Al-Ruwali&Hagr2010; Chia et al., 2007). In addition, Presbycusis could cause cognitive dysfunctions; such as difficulty in focusing, distracting thoughts, confusion, which tend to decrease self-esteem and cause communication disorders resulting in loneliness (Ciorba et al., 2012). Hearing loss affects the elderly capacity to contribute to social activities as it limits their engagement in communication and day to day activities. This results in a sense of seclusion from family, friends, and their community, emotional distress, embarrassment, frustration, anxiety, isolated depression and a sense of guilty being dependent (Johnson & Danhauer, 2010; Ciorba et al., 2012). Mondelli & Souza (2012), study assessed the quality of life of elderly before and after the use of hearing aid, and revealed that, poor social relations are a health risk factor and has been considered as harmful as smoking, high blood pressure, obesity and lack of physical activities. Moreover,

with time, seniors may develop communication disorders that make it difficult to manage them in elderly houses (Lotfi et al., 2009).

Therapy

Literature highlighted the benefits of using hearing aids among elderly suffering from presbycusis (Ciorba et al., 2012). In a study conducted by Tsakiropoulou et al. (2007), it was recorded that the impact of presbycusis on the quality of life can be reduced by addressing the needs of the elderly population and providing and fitting them with the appropriate hearing aid. Furthermore, the study results showed a positive impact where rapid improvement in hearing ability was noted from all the patients after being fitted with hearing aids (Tsakiropolou et al., 2007). Elderly using hearing aids for the first time also where noted to experience less anxiety and depression following their fitting (Ciorba et al., 2012). In their meta-analysis, Chisolm et al. (2007) reported that hearing aids were effective in reducing the psychological, social, and emotional consequences of presbycusis in elderly. Furthermore, Cox, Alexander, & Gray (2005) explored that programmable hearing aids provide the most efficient effect in bettering the quality of life of elderly suffering from presbycusis thus improving self-confidence, enhancing participation in social activities and having a positive effect on the individual's overall health (Dutt et al., 2002).



An indirect benefit of providing hearing aids to elderly suffering from presbycusis is its cost effectiveness in the long run (McClellan&Rivlin2014); Chao & Chen (2008) reported that the use of hearing aids can be considered a cost-effective strategy for rehabilitation.

Regional Findings

According to the United Nations (UN), two thirds of the older population aged 65 and above, are located in developing countries (United Nations, 2013). In Egypt, almost 50% of the population aged 65 and above suffers from hearing loss, of which only 39% wear hearing aids (Abdel-Hamid, Khatib, Aly et al., 2007). In Saudi Arabia, it was also found that presbycusis prevalence increased with age (Al Ruwali&Hagr, 2010).

Lebanon

In Lebanon, where to our knowledge no relevant studies were found, 11.9% of the population is aged 65 and above (United Nations, 2013). Acknowledging the fact that there is a worldwide increase in the elder population, and a high percentage of elderly in developing countries, enhancing their quality of life in Lebanon and other developing countries in the region should be of great importance. One way to do so is by enhancing the elderly population's hearing capabilities.

Conclusion

The Ministry of Public Health must take lead in promoting and supervising the process of screening for presbycusis. From an ethical perspective it is imperative that governments pioneer in setting periscope strategies in addressing presbycusis in early stages so that the quality of life of the continuously increasing elderly population does not wither only the number of age.

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Infos

Le Sel, Ce Poison... Que Savez-Vous?

Partout dans le monde, nous consommons trop de sel; souvent le double de ce qui est recommandé. Or, ce régime salé a une influence directe sur la pression artérielle et donc sur le risque d'accidents cardiaques et vasculaires. Il est temps de ranger la salière!

Le constat est sans appel: dans les pays développés, nous consommons trop de sel. En fait, l'apport de sel ne devrait pas dépasser 5g/jour (ce qui équivaut à 2g de sodium) selon l'Organisation Mondiale de la Santé (OMS).

Et pourtant! Il est en moyenne, en France, de 8,7 g/j chez les hommes et de 6,7g/j chez les femmes. Plus largement, en Europe, l'apport quotidien de sel oscille entre 8 et 11g et il n'est pas rare qu'il atteigne 20g par jour! Même chez les jeunes, l'excès est de mise: entre 3 et 17 ans, la consommation moyenne de sel est de 5,9g/j chez les garçons et de 5,0g/j chez les filles.

En Amérique du Nord et en Asie, la situation est la même. Les Américains consomment environ deux fois plus de sodium que ce qui est recommandé. Un excès qui a d'importants impacts sur la santé, en particulier sur le plan cardiovasculaire car trop de sel rime avec risque accru d'hypertension artérielle, d'accident vasculaire cérébral, et de maladies rénales, entre autres.

Pour limiter la consommation de sel, qui a augmenté partout dans le monde au cours du dernier siècle (principalement du fait de l'essor des produits agroalimentaires industriels), l'OMS a édicté les recommandations suivantes:

- Chez les adultes, la consommation de sel ne devrait pas excéder 5 g/jour, l'équivalent d'une cuillère à café de sel.
- Pour les bébés de 0 à 9 mois, il ne faut pas ajouter de sel à l'alimentation.
- Entre 18 mois et 3 ans, l'apport en sel doit être inférieur à 2 g.

MERS-CoV

Middle East respiratory syndrome coronavirus

Important information for health care workers

Practise yourself and encourage others to apply standard infection control precautions. This is the only way you can protect yourself and prevent the spread of MERS-CoV infection in health care facilities.

▶ The common symptoms are:

Fever
(38° C and higher)

Cough

Difficulty in breathing

Be acutely aware of these symptoms among patients who have recently returned from countries affected by MERS-CoV or who have had contact with camels

Wash your hands with soap or alcohol antiseptic for at least 40 seconds before and after:

- touching any patient
- before aseptic procedures
- after body fluid exposures
- touching patients' surroundings
- before and after wearing any PPE (personal protective equipment)

Practise yourself and encourage others to observe respiratory hygiene in health care facilities by covering nose and mouth when coughing or sneezing

When you are performing a special procedure, such as intubating, wear:

- long-sleeved gown
- gloves
- eye protection
- particulate respirator, such as N95 mask, to protect yourself

Use a medical mask if you are close to a patient with acute respiratory symptoms

Report your illness immediately to the concerned authority if you start coughing, sneezing or develop fever after you have provided care to a suspected MERS-CoV patient

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World Health Organization

Regional Office for the Eastern Mediterranean