Learner Objectives

- To recognize appropriate medical referrals based on case history information
- To perform otoscopy using proper bracing techniques
- To perform complete audiometric test battery utilizing best practices
Before completing any audiometric testing, it is important to carefully complete a case history.

We need to know the medications the member is currently on, current health conditions, chronic health conditions, surgeries, and allergies.
- We always check behind the pinnae to look for signs of ear surgery in case the member has forgotten or is not aware that they have had ear surgery.

We also want to know about family history of hearing loss, exposure to loud noise, and current hearing difficulties.
It is important to find out if the member has experienced any of the following symptoms:

- Tinnitus
- Vertigo and Dizziness
- Otalgia (ear pain)
- Aural Fullness
- Hyperacusis
- Sudden Hearing Loss (in one or both ears in the last 90 days)
- Drainage in ear canal (in one or both ears in the last 90 days)
- Foreign body or cerumen
Some drugs and agents are considered to be ototoxic or poisonous to the ears.

A sensorineural hearing loss can result and usually is permanent.

Typically the high frequencies are first affected, and the hearing loss is usually downward sloping.

If you suspect ototoxicity make an immediate medical referral.
Common Ototoxic Drugs/Agents

- Aminoglycoside Antibiotics
  - Streptomycin; Gentamycin; Kanamycin; Vancomycin
- Cancer Chemotherapeutics
  - Cisplatin; Carboplatin
- Loop Diuretics (Furosemide)
  - Lasix; Bumax
- Salicylates
  - Aspirin
- Quinine (used to treat malaria and leg cramps)
This is the perceived sensation of ear noise, often described as a ringing or buzzing in the ear.

It is not a disorder, just the sensation to hear sounds generated by the auditory system.

It is often associated with hearing loss and hearing disorders.

It can be an occasional occurrence, or it can be constant.
Vertigo and Dizziness

- True vertigo is a severe spinning sensation usually of short duration.
- It can be spontaneous, or associated with head movement.
- A person should be evaluated by their medical doctor if they have vertigo or dizziness.
- Complete the audiogram and a medical referral form for them to take to their physician.
Otalgia

- Ear pain or earache
- It is not always associated with hearing disorders, as it can be caused by conditions such as impacted teeth, sinus disease, and inflamed tonsils.
- If directly related to the ear, it may be due to a middle or outer ear pathology.
- Refer to their medical physician for further evaluation.
Aural Fullness

- The perceived sensation of a plugged ear
- This often accompanies vertigo and sudden hearing loss (medical referral)
- It can also be a symptom of a problem involving the middle ear, often related to poor eustachian tube function.
Hyperacousis

- An abnormal sensitivity to sound with normal hearing thresholds.
- Is an internal over-amplification of environmental sounds by the auditory system.
- Environmental sounds of ordinary intensity that do not bother most people, really bother those suffering from hyperacousis (e.g., a sound of 65 dB SPL might be perceived like a 100 dB SPL input).
- This is different from people who simply are “bothered” by loud noise.
- Refer if you find these results.
Sudden Hearing Loss

- A rapid decrease in hearing sensitivity in one or both ears.
- Complete hearing test and make medical referral to their physician immediately!
- This is sometimes a result of a virus attacking the inner ear and if treated quickly can often be reversed.
Drainage from ear(s)

- If the member currently has drainage in their ear canals, DO NOT TEST, make medical referral to their physician for evaluation.
Case History

- Find out why the member is here today? What brought them in for a test?
  - Are they frustrated with their hearing?
  - Is a spouse/family member frustrated?
- What difficulties are they noticing with their hearing?
- Have they tried hearing aids before?
  - If so, what did they like about them? What did they dislike about them?
Let’s first briefly review the parts of the ear and how we hear. The job of the ear is to take sound pressure and translate it into electrochemical energy, because electricity is the language of the brain, and you actually hear with your brain, not with your ear.

The ear is divided into the categories: outer, middle, and inner. The outer ear takes in sound pressure that the pinna helps funnel into the ear canal.

<table>
<thead>
<tr>
<th>Gross division</th>
<th>Mode of operation</th>
<th>Function</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anatomy</td>
<td>• air vibration</td>
<td>• protection</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• amplification</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• localization</td>
</tr>
</tbody>
</table>
The middle ear takes that sound pressure and changes it into mechanical energy.
Next, the inner ear changes the mechanical energy into electrochemical energy.
Finally, the central auditory nervous system is where sound is processed once it gets to the brain. A member’s hearing can be affected at any of these four parts and that is why we must carefully evaluate each part with our audiometric evaluation to determine their type of hearing loss and make appropriate recommendations.
Otoscropy

● Otoscropy is the process of visually observing the ear canal and tympanic membrane with the otoscope.

● We rely on otoscopy to ensure that the ear canal is not obstructed prior to completing the hearing test.

● **Before looking in the ear canal, it is important to carefully look at the outer ear (pinna) and the mastoid process behind the ear.**

● Signs of malformations and previous ear surgery should be noted.
Before placing the speculum into the ear canal, you must inform the member of what you are going to do.

“I am going to use this light to look into your ear. It might feel a little uncomfortable, but it shouldn’t hurt. Please hold real still while I take a peek. I just need to see what the inside of your ear canal and eardrum look like.”
Procedure for performing otoscopy

1. Clean hands with sanitizer.
2. Put on clean pair of gloves.
3. Attach speculum to otoscope.
4. Turn it on and set it to maximum brightness.
5. Use one hand to gently pull the pinna posteriorly (back) in order to straighten the ear canal.
6. While you are pulling back on the pinna with one hand, place the tip of the otoscope into the open ear canal. Make sure that the hand makes contact with the member’s face or head so that you are bracing!
7. Look into the ear canal.
What’s wrong with this picture?

YOU MUST BRACE AT ALL TIMES!!!
Proper Bracing

- This illustration shows that it is acceptable to brace in the three quadrants above or in front of the ear, but never in the quadrant below and behind.
- This rule is applicable to bracing for any purpose – inspection, block placement or impressioning.
- Also, note that it is not acceptable to hold the pinna between the fingers without simultaneously using bracing in the approved quadrants.

North Carolina State Hearing Aid Dealers and Fitters Board

BRACING OF THE MODEL’S HEAD
DURING THE PRACTICUM PORTION OF THE LICENSING EXAMINATION

At its February 8, 2000 Meeting, the Board voted that the phrase “continuously support the model’s head” regarding grading of the Board’s practicum portion of the Licensing Examination shall mean that the head is braced in the anterior and/or superior region surrounding the pinna. Thus, holding the helix region of the pinna between one’s fingers or bracing the head in the posterior-inferior quadrant surrounding the pinna is an unacceptable technique.
Examples of Proper Bracing
Procedure for performing otoscopy

8. Note the condition of the external ear canal.

- Are there excessive amounts of cerumen?
- The normal canal should be smooth and pinkish in appearance.
- Scratches, blood, redness, and excessive wetness are all signs of an abnormality.
Procedure for performing otoscopy

9. As you continue looking into the ear canal (which might require turning the speculum at a slightly different angle), at the end of the canal you will see the tympanic membrane.
   - It should appear a light gray color and very shiny.
   - The cone of light should be clearly visible on the bottom half
   - Note the other landmarks such as the malleus and annular ligament.
   - Note the condition of the tympanic membrane (TM) on your case history form.
Normal Tympanic Membrane

Is clear, and has that healthy, pearly gray appearance

Impacted Cerumen

A canal that is nearly filled with wax. When referring a member for cerumen removal, tell the physician that their ear canals need to be “free of all wax.” We could not take an ear impression unless we can clearly see all four quadrants of the TM.
10. Remove the speculum and place a new speculum on the otoscope before looking in the other ear canal.

- Follow the same otoscopy procedures for looking in the other ear canal.
Foreign body or Cerumen

- When performing otoscopy if you discover a foreign body (anything that doesn’t belong in the ear canal) or cannot visualize the entire tympanic membrane make a medical referral to their physician for evaluation and/or cleaning.
- Do not test or put anything into their ear canal!!!!
Hands-On Practice

- Obtain a case history and perform otoscopy on your mentor.
- Prepare your otoscope and demonstrate proper bracing techniques.
- Describe what you see.
Beginning the audiometric test

- After you have obtained the case history and performed otoscopy let the member know what will be happening next.
- Make sure to give them clear and concise instructions before each test component and check to see if they have any questions.
- Begin with air-conduction testing in their better hearing ear.
“After I place these insert phones in your ears, I want you to listen for the soft beeping sounds and press the button each time you think you hear the tones. Listen carefully for the quiet sounds way off in the distance. It’s okay to press the button even if you are not sure. I will begin with your right (or left) ear. Do you have any questions?”
Standard Threshold Procedure

1. The member should be seated so they are not looking directly at you or the computer screen. Make sure to close the blind on the window so they do not see a reflection from the computer screen on the glass.

2. Place the insert phones so that the red is on the right ear and the blue is on the left ear.
3. Begin the test in the right ear (or the left ear if it is the better hearing ear) at 1000 Hz and 40 dB unless there is a reason to start at a louder level. You want the tone to be at a comfortable level so they know what they are listening for.

4. Present the first series of beeping tones. Use the pulsed tone on the audiometer and present 3-4 beeps.
5. If there is no response at the starting level of 40 dB raise the intensity 20 dB until the member responds to the presentation of the tone.

- It is extremely important to use different time intervals between each series of presentations to prevent a presentation pattern that might cue the member to respond even if they didn’t really hear a tone.
6. As soon as a response is elicited, either at 40 dB or at the raised level, the intensity of the tone is decreased (made softer) in 10 dB steps, until no response is given.

- At this point, it is assumed that the level of the tone is below the patient’s threshold, and threshold determination begins.
Standard Threshold Procedure

7. The intensity of the tone is raised (made louder) in 5 dB steps, until a response is again obtained.

8. As soon as the response is obtained, the intensity is lowered (made softer) by 10 dB.

9. If a response is not obtained, the intensity is increased in 5 dB steps until a response is obtained.
10. Continue the ascending/descending techniques until the member responses to 2 out of 4 opportunities to respond at the same lowest presentation intensity on the ascending runs. This is the threshold.

11. The threshold is recorded on the audiogram with an “O” for the right ear and an “X” for the left ear.
### Audiogram Symbols

<table>
<thead>
<tr>
<th></th>
<th>AIR</th>
<th>BONE</th>
</tr>
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<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>L</strong></td>
<td><img src="image1" alt="Air Symbol L" /></td>
<td><img src="image2" alt="Bone Symbol L" /></td>
</tr>
<tr>
<td><strong>R</strong></td>
<td><img src="image3" alt="Air Symbol R" /></td>
<td><img src="image4" alt="Bone Symbol R" /></td>
</tr>
<tr>
<td><strong>Unmasked</strong></td>
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<td><img src="image6" alt="Unmasked Symbol" /></td>
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<tr>
<td><strong>No Response</strong></td>
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<tr>
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<td><img src="image11" alt="No Response Symbol" /></td>
<td><img src="image12" alt="No Response Symbol" /></td>
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</tbody>
</table>
Standard Threshold Procedure

12. After obtaining the 1K Hz threshold, stay in the same ear and test in ascending order 1500Hz, 2000Hz, 3000Hz, 4000Hz, 6000 Hz, and 8000 Hz.

- Costco protocol is to test all the inter-octaves except 750 Hz (unless there is a 20 dB difference between 500 and 1K Hz)

- Traditional rule states that inter-octave testing is required only when thresholds at adjacent octaves differ by 20 dB or more
13. After testing 8K Hz, go back and recheck the threshold at 1K Hz. It should be +/- 5 dB of the original threshold.

- If it is not, the reliability of the test is in question and the member must be re-instructed.
- All previously measured thresholds must be re-measured.
14. After rechecking 1K Hz, 500 Hz is tested, followed by 250 Hz.

15. Remember to check and see if there is a 20 dB or more difference between 500 and 1K Hz. If there is test 750 Hz.

16. The other ear is now tested using the identical procedure.
Hands-On Practice

- Practice finding air-conduction thresholds using the standard threshold procedure we have just discussed.
- Record the obtained thresholds on a paper audiogram.
  - State exams require you to write out your audiogram so practice this any chance you get!
Masking for Air Conduction

- Masking is required when there is a 70 dB difference between the measured AC thresholds of the test ear (TE) and the measured BC threshold of the NTE when using insert earphones. Apply this rule to every frequency tested.
Masking for Air Conduction

- Masking is required when there is a **40 dB difference** between the measured AC thresholds of the test ear (TE) and the measured BC threshold of the NTE when using **supra-aural or circumaural earphones**. Apply this rule to every frequency tested.
  - Most states will require the use of headphones during their practical exam and will present them with an audiogram that will require masking. It is much easier if our apprentices get “40 dB” in their mind early and get used knowing when they need to mask and how to properly mask. It is recommended that apprentices use the “headphone masking rule” even with the use of insert earphone when testing in the booth.
Masking for Air Conduction

- To mask for air conduction present narrowband noise at the non-test ear AC threshold plus 10 dB.
- Present the tone to the TE at the previously established threshold level.
  - If there is a response, decrease the intensity of the tone by 10 dB and re-establish threshold using the ascending/descending method.
  - If there is no response, increase the intensity of the tone in 20 dB steps until the tone is heard. Re-establish threshold using the ascending/descending method.
Masking for Air Conduction

- Increase masking noise by 5 dB in the NTE and re-establish threshold in the TE.
- Repeat this process until masking has been increased 3 times and the threshold in the TE has not changed. The true masked AC threshold in the TE has been established at that frequency.
- Record the masked AC threshold on the audiogram using the appropriate symbol and document the final masking level used.
- Repeat this procedure to measure the AC threshold for each ear at every frequency where masking is required.
Hands-On Practice

● Using the provided thresholds determine how much masking you would initially need to apply.

● Your mentor will let you know if a response was “heard”.

● Record your final masking level after you have used the plateau method.
## Masking Practice

<table>
<thead>
<tr>
<th></th>
<th>250</th>
<th>500</th>
<th>1K</th>
<th>1.5K</th>
<th>2K</th>
<th>3K</th>
<th>4K</th>
<th>6K</th>
<th>8K</th>
</tr>
</thead>
<tbody>
<tr>
<td>Right</td>
<td>10</td>
<td>15</td>
<td>20</td>
<td>25</td>
<td>30</td>
<td>30</td>
<td>40</td>
<td>45</td>
<td>50</td>
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<tr>
<td>Left</td>
<td>50</td>
<td>50</td>
<td>60</td>
<td>70</td>
<td>75</td>
<td>75</td>
<td>85</td>
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<tr>
<td>Initial Level</td>
<td>20</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Final Masking Level</td>
<td>≥35</td>
<td></td>
<td></td>
<td></td>
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</tbody>
</table>

An example is provided for 250 Hz. With your mentor complete the rest of the audiogram.
UCLs for pure tones should be obtained at 500, 1K, 2K, 3K, and 4K Hz for both the right and left ears.
Instructions for pure tone UCLs

- The member should be instructed as to what they will be hearing and the type of response they are to give.
- “You are now going to hear some loud beeping sounds. When the beeps are more than just loud and are starting to get uncomfortably loud. I want you to push the button (or say stop) so that the sound will stop.”
Loudness Categories

7. Uncomfortably Loud
6. Loud, but o.k.
5. Comfortable, but slightly loud
4. Comfortable
3. Comfortable, but slightly soft
2. Soft
1. Very Soft
0. No Sound
Method for Pure Tone UCLs

- Starting with the better ear or the right ear is hearing levels are symmetrical, present at pulsed tone at 1000 Hz at 70 dB HL.
- Increase the stimulus in 5 dB steps until the member signals you to stop.
  - Make sure to watch the member and stop when you notice a physical sign of discomfort (facial tension, eye twitch, etc) if they have not yet pressed the button.
Method for Pure Tone UCLs

- Repeat the step above.
  - If the indicated levels are less than 10 dB apart, average them and record this value on the audiogram.
  - If the indicated levels are more than 10 dB apart, make another measurement and average all three. Record the UCL value on the audiogram.
- Repeat this procedure for 2000, 3000, 4000 and 500 Hz.
- Repeat the procedure for the other ear.
California Method for Pure Tone UCLs

(provided in candidate bulletin)

- Start the threshold of discomfort (TD) test at the highest frequency to be tested.
  - 4K Hz then per Costco protocol
- Start the presentation of the tone at 70 dB. Present tones in pairs of short bursts. The pause between pairs of presented tones should be no shorter than one second.
  - Beep beep (pause ≥1 sec; increase 5 dB) Beep beep
- Between each pair of presented tones, increase level no more than 5 dB and continue increasing intensity until the instructed level or the limit of the audiometer has been reached.
California Method for Pure Tone UCLs (provided in candidate bulletin)

- Record the values in the same manner you recorded conventional values and mark the point with the initials “TD” at the appropriate spot on the audiogram.

- If there is no subject response when you have reached the maximum output of your audiometer, record that information as an arrow pointing down at the 110 dB line on the audiogram (or whatever dB level is the limit on your audiometer at the frequency being evaluated) and mark that point with TD.
Suggested instructions to the subject:

“You will hear pairs of beeped tones. Each pair of tones will be louder than the last pair. Listen to them as they get louder, even when they become very loud. When the sounds get loud enough to be annoying, raise your finger. I will continue to make them louder. When the tones become so loud you don’t want to listen anymore due to the discomfort, raise your hand.”
California Method for Pure Tone UCLs (provided in candidate bulletin)

- You are advised to observe the subject closely for reflex actions such as eye blinks, change of expression or head jerk can precede the instructed response. These actions of a subject can be an important indication that you have reached the tolerance level of the subject. Note them carefully.
Hands-On Practice

- Obtain tone UCLs on your mentor.
- Record their UCLs below.

<table>
<thead>
<tr>
<th>UCL</th>
<th>500</th>
<th>1K</th>
<th>2K</th>
<th>3K</th>
<th>4K</th>
</tr>
</thead>
<tbody>
<tr>
<td>Right</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Left</td>
<td></td>
<td></td>
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</tbody>
</table>
Advantage to Obtaining Pure Tone UCLs before B/C

- By obtaining pure tone UCLs before doing bone conduction testing you now know what levels of masking are going to be uncomfortably loud for the member.
- Because they have already heard loud sounds they are much more accepting of masking, and don’t perceive the levels to be as loud as they might have, had you not already done UCL testing.
- If more masking is required but not tolerated, make a note on the audiogram and in your outcome note to indicate this.
Bone Conduction Considerations

- Vibrator placement is crucial
- NO interaural attenuation
  - The better cochlea ALWAYS responds no matter where the bone oscillator is placed!
Bone Oscillator/Vibrator Placement

- Place the bone oscillator behind the ear on the mastoid bone.
- Make sure to have the member push back their hair as push as possible if it is in the way.
Bone Conduction Testing

- Is required at 500, 1K, 2K, 4K Hz per company protocol.
- Thresholds need to first be obtained with only the bone oscillator on the mastoid.
- B/C scores may be obtained for the better ear only, if the bone conduction threshold at a specific frequency is within 10 dB of both the right and left air conduction thresholds at that frequency.
Check Your Understanding: #1

- The right A/C threshold is 20 dB and the left A/C threshold is 25 dB. The bone conduction threshold with the bone oscillator on the right mastoid is 15 dB.
  - Do you need to obtain a response from the left mastoid at this frequency? Yes  No

For this example you do not need to obtain a response for this frequency by placing the bone oscillator on the left mastoid. Why? We know that the best cochlea responds and it has responded at 15 dB. This response at 5 dB is within 10 dB of both my right A/C threshold (20 dB) and the left A/C threshold (25 dB). There is no air-bone gap. No further evaluation of this frequency is needed.
Check Your Understanding: #2

- The left A/C threshold is 50 dB and the right A/C threshold is 40 dB. The bone conduction threshold with the bone oscillator on the left mastoid is 40 dB.
- Do you need to obtain a response from the right mastoid at this frequency?
  - Yes  
  - No

Once again both of the A/C thresholds are within 10 dB of the “best cochlea response”. There is no air-bone gap. No further evaluation of this frequency is needed.
Check Your Understanding: #3

- The right A/C threshold is 35 dB and the left A/C threshold is 50 dB. The bone conduction threshold with the bone oscillator on the right mastoid is 30 dB.

- Do you need to obtain a response from the left mastoid at this frequency?
  - Yes    No

In this case we have more than a 10 dB difference between our best cochlea response (30 dB) and the left A/C threshold. We would need to put the bone oscillator on the left mastoid and find the bone conduction threshold for this frequency. Because there is more than a 10 dB difference from the best cochlea response and the A/C threshold on the left we will also need to apply masking.
When to Mask for Bone Conduction

- Mask the non-test ear routinely except when no air-bone gap exists.
- An air-bone gap is a B/C threshold being more than 10 dB (15 dB or more) better than the air conduction threshold.
Masking for Bone Conduction

- If there are any differences more than 10 dB (15 dB or more) then the insert-phone or headphone needs to be placed in the opposite ear.
- Verify the threshold with the ear occluded and then apply masking.
Headphone Placement for Masking B/C

- Make sure that the earphone does not touch any part of the pinna. It should be on the cheek or the temple of the head.
Masking for Bone Conduction

NTE AC threshold
+ 10 dB audibility
+ occlusion effect value

Initial amount of masking in non-test ear

- When we mask for bone conduction we want to make sure that we are effectively masking, or keeping busy, the better hearing cochlea.
- To do this we need to present noise at the non-test ear’s air conduction threshold for that frequency, plus add another 10 dB of noise for audibility.
  - Remember threshold is the level they hear 50% of the time so we want them to know the noise is present.
- Plus we need to add the amount to overcome the occlusion effect at the frequency we are testing.
The occlusion effect (OE) is the enhancement in loudness of bone-conducted sound when the ear canal is plugged or occluded. During B/C testing we have to occlude the ear when we need to mask and this can create an enhancement of B/C hearing in the non-test ear for the lower frequencies. Therefore we must compensate for this by adding more noise. Above are the amounts of additional masking needed to overcome the occlusion effect when masking for bone conduction. These values are in addition to the 10 dB that you add for audibility.

<table>
<thead>
<tr>
<th>Hz</th>
<th>250</th>
<th>500</th>
<th>1K</th>
<th>2K</th>
<th>4K</th>
</tr>
</thead>
<tbody>
<tr>
<td>Add (dB)</td>
<td>15</td>
<td>15</td>
<td>10</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>
Masking for Bone Conduction

- Deliver the initial masking level to the NTE.
- Present the BC tone to the TE at the previously established threshold level.
  - If there is a response, decrease the intensity of the tone by 10 dB and re-establish threshold using the ascending/descending method.
  - If there is no response, increase the intensity of the tone in 20 dB steps until the tone is heard. Re-establish threshold using the ascending/descending method.
Masking for Bone Conduction

- Increase the masking noise by 5 dB in the NTE and re-establish threshold in the TE.
- Repeat this process until the masking has been increased 3 times and the threshold in the TE has not changed. The BC threshold in the TE has been established.
- Record the masked BC threshold on the audiogram using the appropriate symbol and document the final masking level used.
- Repeat this procedure to measure the masked BC threshold for each ear at every frequency where masking is needed.
No. Because there is no interaural attenuation for bone conduction it would be impossible for the “left” bone conduction to respond at levels close to the air-conduction. Even with the bone oscillator placed on the left mastoid the right ear would be able to hear the responses usually at the already established unmasked right A/C threshold or within probably 5 dB of it.
Is this audiogram valid? Why or why not?

No. Because there is no interaural attenuation for bone conduction we do not know if the “left” bone conduction threshold are true thresholds from the left ear or if it is the right ear responding. Masking must be used to determine the true left bone conduction thresholds.
Bone Conduction Masking Practice

- Using the previous audiogram determine the initial amount of masking that you would present to the non-test ear.
- Have your mentor respond if the tone was “heard”.
- Indicate your final masking level after using the plateau method.
- Don’t forget to change your symbol to masked!