The hearing function is known to deteriorate with age, and age-related hearing loss (presbycusis) is common among those over 60. (Am J Epidemiol 1998;148[9]:879.) An audiologist during a typical hearing evaluation considers whether test results conform to expectations for a presbycusis hearing loss, which is a gradually sloping hearing loss in the high frequencies.

What we may fail to consider, however, are the effects of aging on central processing. The American Academy of Audiology Task Force on Central Presbycusis recently published a review of the literature for central presbycusis, concluding that evidence supports the existence of a central presbycusis that arises from a combination of factors involving age- and disease-related issues, including changes in cognitive function. (J Am Acad Audiol 2012;[8]:635.)

The task force focused primarily on perceptual studies in their review. Electrophysiological methods provided an objective approach to assessing central auditory biological function in older adults. Age-related timing deficits have been found in cortical speech-evoked responses, mirroring perceptual deficits in the ability to distinguish voice-onset-time differences. (Clin Neurophysiol 2003;114[7]:1332.) Pervasive neural slowing with increased age may account for these deficits. We investigated evidence for neural slowing in the auditory brainstem to better understand hearing in noise deficits in older adults.

We compared brainstem responses with a speech syllable [da] in younger and older adults who were matched for sex, IQ, and hearing, and found that response amplitudes were smaller and peak latencies were delayed in the older adults’ responses. (J Neurosci 2012;32[41]:14156.) The older adults’ responses also had reduced phase locking, decreased response consistency, and greater levels of neural noise. These age-related effects likely arise from factors affecting neural synchrony and the precision of neural speech encoding, including decreased levels of inhibitory neurotransmitters and temporal jitter. (J Exp Biol 2008;211[Pt 11]:1781; Hear Res 2007; 223[1-2]:114.) These responses may also be affected by decreased cognitive function through top-down modulation of brainstem function.

What is the relevance of these findings for the audiological practice? Older people whose hearing loss symptoms are not reflected in pure-tone or speech audiometry results may be experiencing increased difficulties stemming from central presbycusis. Counseling and management should take into account treatment options beyond providing audibility. A recent study, for example, comparing cochlear implant outcomes in different age groups found that older adults had similar learning curves to young adults when listening to speech in quiet but their learning curves did not maintain the younger adults’ rate of improvement when listening to speech in noise, presumably because of central presbycusis or changes in cognitive function. (Laryngoscope 2012;122[6]:1361.) These results would indicate that older adults may require more auditory training and the use of assistive listening devices to achieve adequate auditory function in difficult listening environments.

The findings of neural slowing in older adults may also be applicable to hearing aid fittings. It has been suggested that slow-acting compression algorithms are more appropriate for those with cognitive declines and also maybe for those who show evidence of central presbycusis, either through a perceptual test of temporal resolution, such as gap detection, or through delayed or degraded brainstem responses to speech stimuli. (J Am Acad Audiol 2007;18[7]:604.) We need to remember, when assessing and counseling older adults who report hearing difficulties, that we hear with our brains, not just our ears, and to consider the ramifications of central presbycusis on auditory function in real-world environments.