ReSound

For people with Cochlear Implants

Autumn 2019 Issue 64

Autumn / Christmas edition

Manchester CICADA — a charity supporting implant patients

This newsletter has been produced on behalf of the Manchester CICADA Charity

contents

Editorial

Welcome to the Autumn edition of Resound.

As we finish the season for the year we have included a review of all the events we have run this year. The collection shows that we plan to run events all over our region from Southport, to Liverpool, Manchester and into Cheshire. We hope this gives members a chance of attending an event near them at some point of the year and as you can see from the photographs there are lots of different faces (as well as a few regulars)!
If anyone wants copies of photographs that we feature please let me know and I will send them via email.

We have a variety of articles for you as usual, ranging from developments in hearing technology to news from providers and reports from around the world.

On our Facebook group we also have lots of reports and photographs from activities we have been taking part in since the AGM so do have a look, and leave a comment when you can.

Our next meet up will be the AGM next year on Saturday 21st March and will be at the MRI in Manchester. More details will be sent out nearer the time.

Our apps, the Rehabilitation app and the Finger Spelling app, which are both available for Android and Apple phones have now hit three figures for downloads which is encourging, so a big thank you to everyone who has helped with feedback on them. New updates will be released shortly.

On behalf of myself and the EC of CICADA we wish you all a merry Christmas and a happy and fruitful New Year.

We hope you enjoy this issue and if you have any comments, or stories to send along then please let me know.

Kevin Williams - Editor

End of year roundup 2019

As we run up to the Christmas period we thought it would be good to look back over some of the things that we have been involved in over the year which show the variety of activities we are involved with as well as some of the more exotic places we have been to!

March

We opened up the year with our AGM and tour of Gaskell house.

For those of you with longer memories you will recall we had a day out here a while ago but this was the first time we have used the location for our AGM. Gaskell house is normally closed to the public on a Saturday so we had the place to ourselves.

Once the essential AGM business was out of the way and we had had lunch, we had a chance for a personal tour of the house.

The guide was very knowledgable and it was fascinating to see close up such things as correspondence with the important literary notables of the time such as Charles Dickens, Elizabeth Gaskell and the Brontë sisters.

Whilst it might have been an experience to dine in 19th century style unfortunately that wasn't on the itinerary!

April

Following the official event that we have to have, the AGM, we next met up at the newly refurbished Italian Orchard Restaurant.

This is a favourite of ours, especially at the beginning of the year when the weather is somewhat unpredictable. (Ed. things have got worse as I put pen to paper but that was not expected to be sure!)

In common with most modern style refurbishments these days there was a lot of glass and tiling used which didn't help with the accoustics for our party, however, being the resourceful lot we are, we managed to position ourselves in a quieter part of the bar as we waited for the table.

In the restaurant itself we managed to arrange tables at the quieter end of the room which was appreciated and we all enjoyed a delicious meal.

Caroline came all the way from Carlisle so it was great to meet up

Roy and Marion from Blackburn at the Northern end of our area.

May

In May we went for a meal at St. George's Hall in Liverpool, a favourite meeting place for visits to the city, before going on to see the Rennie Mackintosh exhibition at the Walker Art Gallery nearby.

As you can see some of our group were more hardy souls than others when it came to keeeping warm!

The exhibition was very comprehensive, not just pictures but furniture as well although we managed to avoid bringing any 'samples' home with us.

June

In June we carried out a scientific visit to deepest Cheshire. As usual we had lunch first in the rather futuristic restaurant, the black building in the background, before visiting several exhibitions on the huge site.

Fortunately, for a change, the weather was kind and we came away suitably impressed.

Something outside caught our attention!

Just to prove that we actually did get as far as seeing the main attraction!

July

In July we did a return visit to Quarry Bank Mill. We had been there the year before but the Mill had been closed for refurbishment so we had a tour of the apprentice house instead. This year everything was available and we had our own tour guide.

There were plenty of opportunities to see the whole process starting with raw wool right through to spinning demonstrated by the staff.

As you can imagine it was also noisy in some places with the machinery going but we were all equipped with neck loops and our guide had a microphone so we could hear every word, including one or two not meant for the public!

All in all we had a good visit despite the appalling weather outside.

August

August saw us enjoying better weather and we journeyed south to Buxton, the 'Capital of the Peaks'.
There were many highlights of the trip not least the tour in a converted milk float which was just right for our group.
Fully equipped with information, leaflets, a video screen to show pictures of places we were being shown, as they used to be many years ago.

Also included in the tour was the far from home Geordie bus driver, he came to Buxton 20 years ago and didn't make it back! I couldn't help but think of the ancient mariner marooned and going round in circles. However he was totally knowledgeable about everything we were looking at and made the tour really interesting as well as being unusual. I must admit it's been a while since I have seen a real 'unconverted' electric milk float so the engineer in me was suitably impressed.

As well as the fascinating history of the town itself there were some places we went to that even our intrepid members who live in Buxton had not come across before, an example on the right of a local church that had been decorated in the Art Noveau style.

September

In September we thought we would set ourselves the challenge of climbing to the top of the Liver Building, if not for the view then just to say we'd been there.

Some wanted to tie a CICADA flag to the top but that was not encouraged!

As is the usual pattern of events we met for lunch first at a convenient restaurant near by where we could get ready for our trip to the elements.

On arrival though it did look a long way up, however they thoughtfully had provided a lift

to the tenth floor, still several floors and an long climb on a spiral staircase to the first level roof.

The view was excellent and the guide knew his stuff but we were not allowed to go any further and the covert photograph on the left was the nearest we could get to the iconic creatures.

Deaf children with cochlear implant learn words faster than hearing children

For many years scientists tinkered to find a perfect replacement for the damaged or dysplastic inner ear. Cochlear implants receive a sound, convert it into electrical stimuli and send these impulses directly to the auditory nerve, thereby giving hearing impaired children the chance to connect to the world of sounds and noises.

It has so far been assumed that these children reach the language level of children with normal hearing much later. Previous studies showed that from the moment of having the device implanted, children need longer to attain the important steps of learning their mother tongue -- for instance, being able to distinguish the rhythm of their mother tongue from that of another language. This could imply that developmental milestones necessary to start school are also delayed, although they reach all the other developmental stages needed.

A current study at the Max Planck Institute for Human Cognitive and Brain Sciences (MPI CBS) in Leipzig and the University Medical Centre Dresden has now revealed something different: "We observed that when deaf children get their implants, they learn words faster than those with normal hearing. Consequently, they build up certain word pools faster," says Niki Vavatzanidis, first author of the underlying study and scientist at MPI CBS and the University Medical Centre Dresden. Normally, children need fourteen months to reliably recognise that known objects are named incorrectly. Children with an artificial cochlea were already able to do so after twelve months.

The reason for this finding could be that children with cochlear implants are older when they are first exposed to spoken language. Those with normal hearing learn aspects of language, such as the rhythm and melody of their mother tongue, from birth and even in the womb. In deaf children, this only starts at the time of their cochlear replacement, at the age of around one to four years. By this time certain brain structures necessary for language acquisition are already well developed. "It is not just the memory, but also the broader knowledge about their surroundings that is more formed. They already know about objects in their environment and have accumulated non-linguistic semantic categories," states Vavatzanidis. For example, they already know that objects such as cups or meals could be hot and that heat could be something harmful without knowing the word "hot."

The neuroscientists examined these relations with the help of thirty-two children with cochlear implant in both ears. They carried out a test after twelve, eighteen and twenty-four months after implantation that tested their ability to recognise words: The young study participants were shown pictures of objects which were named either correctly or incorrectly. In parallel to this, the scientist analysed the brain activities of the little ones using electroencephalography (EEG). If the researchers detected an effect in the EEG known as N400, they knew that the child registered the incorrect word. This

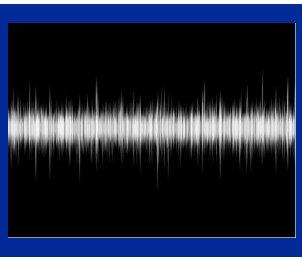
means they had established a stable connection between objects and their names. They had learnt the word.

"Children with cochlear implants could help us understand the general processes of language acquisition and determine which single steps are age-dependent," Angela D. Friederici explains, study leader and head of MPI CBS. "We now know that age does not affect how fast children learn words. On the contrary, they seem to catch up even if they were previously disadvantaged." Upcoming studies should now focus on why some of the affected children, despite these findings, struggle to reach the level of their contemporaries with normal hearing.

Story Source:

Materials provided by Max Planck Institute for Human Cognitive and Brain Sciences. Note: Content may be edited for style and length.

Specially timed signals ease tinnitus symptoms



Millions of Americans hear ringing in their ears -- a condition called tinnitus -- and new research shows an experimental device could help quiet the phantom sounds by targeting unruly nerve activity in the brain.

In a new study in Science Translational Medicine, a team from the University of Michigan reports the results of the first animal tests and clinical trial of the approach, including data from 20 human tinnitus patients.

Based on years of scientific research into the root causes of the condition, the device uses precisely timed sounds and weak electrical pulses that activate touch-sensitive nerves, both aimed at steering damaged nerve cells back to normal activity.

Human participants reported that after four weeks of daily use of the device, the loudness of phantom sounds decreased, and their tinnitus-related quality of life improved. A sham "treatment" using just sounds did not produce such effects.

Results from tests in guinea pigs and a double blind human study funded by the Coulter Foundation validate years of preclinical research funded by the National Institutes of Health, including previous tests in guinea pigs.

The U-M team has new NIH funding for an additional clinical trial to further refine the approach. U-M holds a patent on the concept behind the device and is developing it for potential commercialization.

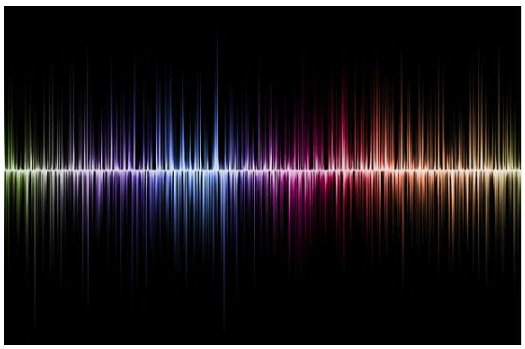
"The brain, and specifically the region of the brainstem called the dorsal cochlear nucleus, is the root of tinnitus," said Susan Shore, the U-M Medical School professor who leads the research team. "When the main neurons in this region, called fusiform cells, become hyperactive and synchronize with one another, the phantom signal is transmitted into other centres where perception occurs.

"If we can stop these signals, we can stop tinnitus. That is what our approach attempts to do, and we're encouraged by these initial parallel results in animals and humans."

A dual-stimulus approach to treating tinnitus

The approach, called targeted bimodal auditory-somatosensory stimulation, involves two senses. The device plays a sound into the ears, alternating it with precisely timed, mild electrical pulses delivered to the cheek or neck.

This sets off a process called stimulus-timing dependent plasticity, or STDP, which was first explored in animals and led to long-term changes in the rate at which the nerves fire. The approach aims to reset the activity of fusiform cells, which normally help our brains receive and process both sounds and sensations such as touch or vibration -- what scientists call somatosensory inputs.



Under normal conditions, fusiform cells help our brains focus on where sounds are coming from, and help us tune out sensations that result from the movement of our own head and neck.

But the U-M team's previous work in animals showed that loud noise can trigger a change in the nerve cells' activity -- altering its timing so that they fire off synchronized signals spontaneously instead of waiting for an actual sound in the environment.

The toll of tinnitus

These events in animals parallel what happens in humans. After exposure to such things as loud noises, head or neck trauma, or other triggering events, some people develop a persistent sensation that they're hearing sounds like ringing or a grinding noise.

Approximately 15 per cent of Americans have some level of tinnitus, but the worst symptoms occur in about 10 per cent of sufferers, according to estimates based on interviews with nationally representative samples of Americans. Many of those with more severe tinnitus also have hearing loss.

Some cases are severe. As many as 2 million people can't work or carry out other daily activities because of the tinnitus itself, or the psychological distress it causes them. Tinnitus is the most common cause of service-connected disability among veterans of the U.S. military.

Current approaches to tinnitus treatment focus include efforts to address the psychological distress it causes, for instance through cognitive behavioural therapy. Other approaches use sound to mask the phantom sounds or attempt to modulate the brain response.

For more severe cases, some patients turn to invasive, and therefore riskier, approaches such as deep brain stimulation and vagal nerve stimulation. The current approach provides a novel and unique, non-invasive strategy that aims to modulate and correct the aberrant neural pathways that cause tinnitus.

Study details

Shore and her colleagues are based in U-M's Kresge Hearing Research Institute, which is part of the Department of Otolaryngology at Michigan Medicine, U-M's academic medical centre. Co-first authors Kendra Marks, David Martel and Calvin Wu are members of the Shore laboratory.

They recruited a particular kind of tinnitus sufferer for their study: those who can temporarily alter their symptoms if they clench their jaws, stick out their tongues, or turn or flex their necks. These manoeuvres, Shore says, appear to be self-discovered ways of changing the activity of fusiform cells -- providing an external somatosensory signal to modulate their

tinnitus.

The U-M device delivers sounds matched to the loudness and pitch of the phantom sounds that each patient hears. It also delivers mild electrical impulses applied to the area of the head involved in the patients' own tinnitus-altering manoeuvres.

The crucial timing of the auditory and electrical stimulation came directly from tests in guinea pigs that had noise-induced tinnitus, reported in the new study. Those tests showed that specific timing between delivery of the two kinds of stimuli was necessary to suppress the hyperactive fusiform cells.

After patients had the device calibrated to their own tinnitus symptoms, they learned to apply its earphones and electrodes for a 30-minute session each day. Half the group received the bimodal sound-and-electricity treatment for the first four weeks, while the other half received just sounds. Then, they all took a four-week break, and started the next four weeks receiving the opposite of what they'd received before. None of them knew which option they got first.

Every week, the patients took a survey about how much their tinnitus was affecting their lives, and a test of how loud their tinnitus sounds were.

Results in human participants

Overall, the loudness of phantom sounds decreased only after the actual, or bimodal, treatment, but not the sham treatment of sound only. For some the decrease was around 12 decibels, about the magnitude of an electric light bulb's hum. Two participants said their tinnitus disappeared completely.

The quality of life survey -- where a low score indicates less impact from tinnitus -- is called TFI, and is measured on a 100-point scale. Statistical modelling of the results revealed that, on average, patients experienced significantly reduced scores for the active treatment, though the size of the effect in individual patients varied. On average, scores also stayed lower for weeks after treatment ended. This effect was not significant for the sham treatment.

No patient experienced a worsening of symptoms or quality of life, or other adverse events. Some said their phantom sounds got less harsh or piercing, or became easier to ignore.

"We're definitely encouraged by these results, but we need to optimize the length of treatments, identify which subgroups of patients may benefit most, and determine if this approach works in patients who have non-somatic forms of the condition that can't be modulated by head and neck manoeuvres," Shore said.

Story Source:

Materials provided by Michigan Medicine - University of Michigan. Note: Content may be edited for style and length.

Local News

from Norah Clewes

Anyone visiting Chester might be interested to know that the regular films shown at The Storyhouse are captioned at 11a.m. and also in the early evening on Mondays.

StoryHouse was converted from the old Odeon Cinema in Northgate Street and now contains a library, theatre, cinema, cafe and bar.
The conversion which won an architectural award was opened by the Queen in 2018.

MED-EL USA announced today that the U.S. Food and Drug Administration (FDA) has approved the company's cochlear implant system for single-sided deafness (SSD) and asymmetric hearing loss (AHL). *This is the first and only time that cochlear implants have been approved for these indications in the United States.*

MED-EL Cochlear Implant (CI) Systems, including SYNCHRONY and the recently FDA-approved SYNCHRONY 2, are now indicated for individuals aged 5 years and older with SSD who have profound sensorineural hearing loss in one ear and normal hearing or mild sensorineural hearing loss in the other ear, or individuals aged 5 years and older with AHL who have profound sensorineural hearing loss in one ear and mild to moderately severe sensorineural hearing loss in the other ear, with a difference of at least 15 dB in pure tone averages between ears. No changes to the approved devices in the MED-EL CI system are required for the new indications.

"People living with single-sided deafness and asymmetric hearing loss have had limited technology options to improve their speech understanding, ability to localize sounds in their environment, and quality of life," said Margaret T. Dillon, AuD, Associate Professor, Director of Cochlear Implant Clinical Research, and lead researcher on the SSD and AHL clinical trial at the University of North Carolina School of Medicine that was instrumental in the FDA approval. "Difficulty in speech understanding in noise and localizing sound are incredibly frustrating aspects of single-sided deafness and asymmetric hearing loss, and it was gratifying to be able to demonstrate the efficacy of MED-EL's cochlear implants to help patients restore a sense of sound that they had been missing."

"Today's historic FDA approval is a significant advance for people who have struggled with single-sided deafness or asymmetric hearing loss for far too long. My father lived with single-sided deafness, which severely affected his ability to communicate and localize sound. His experience was a motivating factor in my choice to become an audiologist, so this has a very personal connection for me," said Raymond Gamble, President & CEO, MED-EL North America. "This milestone demonstrates MED-EL's leadership and commitment to truly living our mission of removing hearing loss as a barrier to communication – including this traditionally underserved population."

Individuals with SSD or AHL must obtain limited benefit from an appropriately fitted unilateral hearing aid in the ear to be

implanted. For adults, limited benefit from unilateral amplification is defined by test scores of 5% correct or less on monosyllabic consonant-nucleus-consonant (CNC) words in quiet when tested in the ear to be implanted alone. For children, insufficient functional access to sound in the ear to be implanted must be determined by aided speech perception test scores of 5% or less on developmentally appropriate monosyllabic word lists when tested in the ear to be implanted alone. Before implantation with a cochlear implant, individuals with SSD or AHL must have at least one month of experience wearing a hearing aid, a CROS hearing aid or other relevant device and not show any subjective benefit.

About Single Sided Deafness (SSD) & Asymmetric Hearing Loss (AHL)

SSD and AHL can be caused by viral infections, Meniere's disease, or trauma to the head or ear. In some cases, the causes of SSD or AHL are unknown. Recent data estimates that 7.2% of Americans report some degree of hearing loss on one side, with 5.7% having mild and 1.5% reporting moderate-or-worse hearing loss on one side, translating to an estimated 4.9 million American Adults facing SSD.1 Until now, treatment options were limited to hearing aids and CROS systems that provide limited or no benefit for people with profound hearing loss in one ear.

People with SSD and AHL experience difficulties hearing in certain listening situations such as noisy environments, and these difficulties have a negative impact on communication and social interaction. SSD can negatively affect speech and language development in children and work performance among adults.

These difficulties can be attributed to the lack of binaural summation, the head shadowing sounds on the opposite side of the hearing ear and the inability to localize sounds. Previously available options in the US such as CROS hearing aids and bone conduction devices do not restore binaural hearing in SSD or AHL patients as they only reroute the signal to the hearing ear. These therapeutic options restore neither sound localization nor spatial hearing, which means patients still face significant difficulties with communication in daily life.

Clinical Trial Data

The approval was based on clinical data from a study at the University of North Carolina at Chapel Hill with 40 participants ages 18 and older to evaluate speech perception in quiet and noise, sound localization and quality of life. Trial participants had single-sided sensorineural profound hearing loss in one ear, or asymmetric hearing loss, for less than 10 years and had used a hearing aid regularly for at least some of that time. All of the people in the study had also tried some type of current hearing device to treat SSD, such as a hearing aid, bone-conduction device, or a CROS hearing aid. Subjects were implanted at the University of North Carolina at Chapel Hill with the MED-EL CONCERT or SYNCHRONY Cochlear Implant System in this prospective, non-randomized, non-blinded, repeated measures clinical study.

Speech Understanding in Quiet:

Both groups of people (SSD and AHL) improved their ability to understand speech in quiet after one year of implant use when tested with the implant alone. For the people with SSD, average scores when repeating single words in quiet increased from 4% before surgery to 55% after 12 months of listening with the implant. For the group of people with AHL, this same test score improved from 6% to

56% in 12 months. In the opposite ear, there was no change in their score over time. When tested with both ears, there was no change compared to the score before surgery.

Speech Understanding in Noise:

When listening to speech in noise, both SSD and AHL groups improved over the first 12 months of listening with the cochlear implant compared to their unaided scores before surgery. The average improvement in the SSD group increased from 38% to 47% in 12 months on the AZ Bio Test, speech and noise from the front. This group also had an average increase from 17% to 53% on the AZ Bio Test when speech came from the front and the noise was on the side of the normal hearing ear. The AHL group saw increases from 23% to 34% when speech and noise came from the front, and 6% to 29% when speech came from the front and noise was on the side of the better hearing ear, also on the AZ Bio Test.

Finding the Direction of a Sound Source:

People in both the SSD and AHL groups significantly improved in finding the direction of a sound after they had listened with the cochlear implant for 12 months. To take this test, listeners sat in a room with 11 speakers arranged in a half-circle in front of them, and they were asked to point to the speaker each sound came from.

Satisfaction Questionnaires:

Listeners were asked to complete two questionnaires about their experiences using the MED-EL cochlear implant. After one year of listening, both groups (SSD and AHL) reported an improvement overall when asked about their impressions of the quality of speech, ability to locate sounds around them, and overall sound quality (SSQ Test) as well as ease of communication, hearing in background noise, and hearing in environments with an echo (APHAB Test).

Contraindications

Contraindications for SSD and AHL are the same as for individuals receiving cochlear implants who have bilateral hearing loss, including:

if the individual is known to be intolerant of the materials used in the implant;

if there is an absence of cochlear development;

if individual has an acoustic neuroma;

if the cause of deafness is non-functionality of the auditory nerve and/or the auditory pathways;

if external or middle ear infections are present or if the tympanic membrane is perforated in the ear to be implanted;

if there are medical contraindications present against surgery of the middle and inner ear and anesthesia as required;

if anatomic abnormalities are present that would prevent appropriate placement of the stimulator housing in the bone of the skull, or prevent placement of the chosen electrode array into the cochlea.

In such cases, using the cochlear implant must be carefully considered prior to surgery;

if the psychological status of the patient is unstable or, if the patient has unrealistic expectations.

In addition, hearing loss of a profound duration for greater than 10 years is a contraindication for the SSD and AHL indication.

Genedrive and Manchester University NHS Foundation trust new test for babies

Molecular diagnostics company Genedrive announced on Monday that its antibiotic-induced hearing loss test, the 'Genedrive MT-RNR1 ID' kit, has obtained CE marking.

The AIM-traded firm said the kit would be used in critical care settings, to screen babies for a genetic mutation, which if present could cause lifelong deafness when they are given certain antibiotics.

It said the RNR1 test was believed to be the first example of a commercial genetic screening test designed for use in an infant emergency care environment.

Genedrive explained that some infants are born with a mutation in their MT-RNR1 gene, making them susceptible to lifelong, profound hearing loss if given the frontline antibiotic 'gentamicin'.

Infants with suspected infection need to be treated with antibiotics within one hour of arriving in a neonatal intensive care unit under national guidelines, but the current genetic tests that check the risk of hearing loss associated with gentamicin treatment are done from a hospital's centralised genetics department, and typically take between three and five days to return results.

The Genedrive test would allow patients to be screened for the mutation upon admission in less than 30 minutes, and those that are found to have the gene mutation could be prescribed an alternative, safer treatment.

"We are very pleased to have achieved this important milestone, pioneering the availability of the first genetic acute care test for infants," said chief executive officer David Budd.

"CE marking of our RNR1 test allows for the next phase, with implementation evaluation by our NHS partners in Manchester and Liverpool.

"At the same time, we will look to the opportunities outside of the UK where CE marking gives us market entry."

Professor William Newman, clinical head of division in genomic medicine at Manchester University NHS Foundation Trust, added that the trust had been "very pleased" to partner with Genedrive in the development and availability of the antibiotic induced hearing loss test.

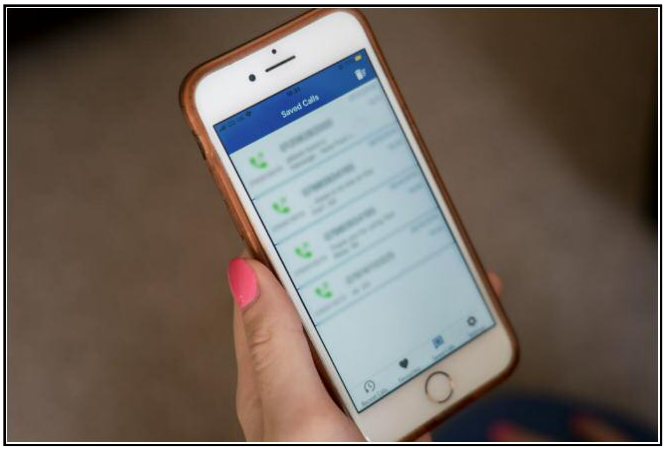
"We are planning to deploy the use of the test across Manchester and Liverpool for the next six to eight months, to show how it can be successfully implemented in an NHS environment.

"There is a huge level of enthusiasm on the sites amongst our neonatal consultants, nursing staff, and patient groups as we launch a truly novel genetic test that offers the possibility of improving the lives of thousands of babies and their families."

BT's new app designed to help deaf community access vital services

BT has updated its text relay service to better support the deaf community in completing tasks over the phone and accessing vital services, such as health and social care.

The Next Generation Service, which translates text into speech and vice versa, has been rebranded as Relay UK to mark the launch of a new app that gives users more ways to make a call without having to use a textphone.



The technology allows people to make calls via a computer or on the move, using a PC, laptop and various tablets and mobile devices.

It also enables users to make a call based on their own accessibility needs by selecting one of three options: Type & Read, Speak & Read, or Type & Hear.

The news comes as new research reveals that 70% of the deaf community – 8.4 million people – need to ask friends or family members for help with making basic calls.

The poll, commissioned by BT in partnership with the UK Council on Deafness, shows that despite the rise in digital technologies, such as web chat and social media, phone calls remain an essential form of communication for 80% of the deaf community, with 46% calling businesses at least once a week.

However, for many, the calling experience for everyday tasks such as booking appointments (90%), paying bills (53%) or purchasing products and services (53%), is poor, with certain services, such as health and social care, inaccessible for a quarter of the deaf community.

The research shows that the biggest barrier (78%) to a successful call is frontline staff who are not trained or are inexperienced at taking calls from deaf customers, while the use of automated transfer services that are inaudible (67%) and a lack of technology available to help handle calls are also highlighted.

BT Ventures managing director Katherine Ainley said: "How we use technology to connect with each other has changed rapidly in recent decades, and this simple service transforms the calling experience for the estimated 12 million deaf people in the UK."

"We know from conversations with the community that bad telephone experiences are putting people off from using the phone to contact businesses, which can make certain services inaccessible. We're urging businesses to alert frontline staff to the service and download our helpful Relay UK Business Toolkit, which includes educational content about the service – and what to expect when taking a call from one of our Relay Assistants."

The Phonak Roger Pen - a quick overview

Some of you who have had a recent updgrade or new processor may have been given the option to have a 'Roger Pen' device so we thought we would include a quick overview of the product for those thinking of asking for one.

What is a Phonak Roger Pen?

Phonak Roger Pen is a wireless microphone that is used in combination with your hearing aids. A Roger Pen effectively turbo charges your hearing aids! It helps you to hear and understand more speech in noise and over distance.

It also helps in reverberent acoustic environments where there are lots of hard surfaces or echo in the room. Phonak Roger Pen is useful to help you hear audio devices such as TV, radio, computers and phones. It's the ideal solution for an all-inclusive listening experience.

How does a Roger Pen work?

It transmits the signal to your hearing aids through a Roger receiver into your hearing aids. You can use it with other Roger transmitters too, like say a Phonak Roger Select or Phonak Roger Table Mic II. They can work in a network of Roger transmitters.

There are different types of Roger receivers. The most popular ones attach directly to your hearing aid, BAHA or cochlear implant speech processor. For almost every hearing instrument and processor there is a compatible Roger receiver.

Roger Pen Technology

Phonak Roger Pen has some very clever technology built into it. It has some sophisticated directional microphone technology that helps it to focus intuitively on the speech you want to hear at the expense of the noise around you. Even in heavy background noise. You control how directional it is by how you hold in naturally in your hand. It just works!

Phonak Roger pen and Roger Clip-on Mic

The Roger Pen has active noise suppression built in so it is always beavering away doing its thing in the background.

Phonak Roger Pen picks up sound remotely (somewhere over there) and inputs the audio DIRECTLY into your ears. It is very effective at overcoming the problems of hearing at distance. As a hearing aid wearer you are naturally at more of a disadvantage hearing speech at distance than someone with good natural hearing. Even with the best quality of hearing aids set up optimally. This remote wireless direct audio streaming device also helps to overcome the reverberation, or echo, in more challenging listening environments.

You remotely and wirelessly stream audio directly into your ears via Phonak Roger Pen. This makes for a very efficient way to hear audio on your favourite devices. Listening to a YouTube clip on your PC is a breeze. Phone calls are so much more clear.

Which environments can a Roger Pen be used in?

The Roger Pen is an all-inclusive wireless accessory that can be used in all environments. Whether at work, at home or in a public place a Roger Pen helps you stay connected and hear conversations whatever the background noise may be.

What are the benefits of a Roger Pen?

Using it alongside your hearing aids or cochlear implants enables you fully understand and engage in one-one or

group conversations in busy day to day situations.
With a Roger Pen you can enjoy calls again by connecting the Pen to your smartphone via Bluetooth, or to ensure you never miss a wrong turn again, you can also connect the Pen to your car's GPS system to hear the directions directly in your hearing aids. Small, lightweight and stylish, it's no word of a lie that the Roger Pen has been carefully designed with discretion in mind. Simply place the Phonak Roger Pen in the situation where maximised hearing is needed and let it do the rest of the work!

End of Season meal in Southport

A group of us recently met up in Southport at what used to be called the Ramada Hotel on the waterfront. We have been there in the past for meals but usually we have eaten in the main dining area which although very pleasant has caused some difficulty with background noise.
This year we had our own private room which was carpeted and curtained and proved to be an excellent choice.
The food was excellent and enjoyed by everyone and there was plenty of time to meet old friends and catch up on news from around the region.

Notes for the diary

Upcoming events:

CICADA 2020 AGM 21st March 2020

Early in the new year we will be getting together our outline of events for 2020. If you have any suggestions of places or types of event you would like to see please let us know via email or post to any of the addresses below.
In the meantime keep up to date by checking the website, www.manchestercicada.org.uk, or our Manchester Cicada facebook page.

Chairman	**Honorary Treasurer**	**Hon Secretary**
John Newton	Alan Corcoran	Kevin Williams
32 Queens road	45 Polefield Road	107 Manchester Road
Buxton	Prestwich	Hyde
Derbyshire	Manchester	Cheshire
SK17 7EX	M25 2GN	SK14 2BX
chairman@manchestercicada.org.uk	treasurer@manchestercicada.org.uk	secretary@manchestercicada.org.uk