SUN-test (Speech Understanding in Noise): a method for hearing disability screening

A. Paglialonga, G. Tognola, F. Grandori
CNR - Consiglio Nazionale delle Ricerche, Istituto di Ingegneria Biomedica (IsIB), Milan, Italy

Abstract

The SUN-test (Speech Understanding in Noise) is a speech-in-noise test to screen adults and older adults for hearing disability. The SUN-test consists in a short list of intervocalic consonants (VCV, vowel-consonant-vowel) in noise that are presented in a three-alternatives forced choice (3AFC) paradigm by means of a touch-screen interface. Based on the number of stimuli correctly identified, the tested subject gets one of three possible test outcomes: no listening difficulties, a hearing check would be advisable, or a hearing check is recommended. This paper reviews the main results obtained with the SUN-test in the Italian language in a population of nearly 1,300 adults and older adults with varying degrees of audiometric thresholds and audiometric configurations, tested both in low and in high ambient noise settings. Results obtained in the tested population revealed that the outcomes of the SUN-test were in line with the outcomes of pure-tone testing, and that the test performance was similar both in low and in high ambient noise (up to 65 dB A). Results obtained with the SUN-test were not biased by the age of the subject because the performance of younger and older subjects in the test was similar. The mean duration of the SUN-test was nearly 40 s/ear, and was lower than 1 minute per ear even in subjects older than 80 years so that both ears could be tested, on average, in 2 minutes. The SUN-test was considered easy or slightly difficult by nearly 90% of subjects; test duration was judged short or fair by nearly 95% of subjects, and the overall evaluation of the test was pleasant, or neutral, in more than 90% of subjects. Overall, results of this study indicated that the SUN-test might be feasible for application in adult hearing screening. The test is fast, easy, self-convincing, and reflects differences in hearing sensitivity between the tested subjects. The outcomes of the SUN-test were not influenced by the noise level in the test room (up to 65 dB A) indicating that the test, as such, might be feasible to screen adults and older adults both in clinical and in non clinical settings, such as convenient care clinics, hearing aid providers, or pharmacies, where the ambient noise is, typically, not controlled.

Introduction

Hearing disability is indeed one of the most common chronic health conditions in older adults, and has important implications for the quality of life, in that it may generate burdening effects such as functional decline, depression and social isolation (see, e.g. Arlinger, 2003; Carabellese et al., 1993; Weinstein & Ventry, 1982).

It is estimated that nearly 50 percent of persons over the age of 60 years, and more than 80 percent over 70 years, experience some degree of hearing loss (Cruickshanks et al., 1998; 2010). Yet, hearing impairment in adults is still largely undetected and undertreated, in the lack of accepted guidelines, protocols and legislation (Liu et al., 2011; Yueh et al., 2003; 2010). Remarkably, in most cases hearing loss in adults takes a long time to develop: it is a progressive process, and does produce a slow habituation to the impairment. It is documented that typically most hearing aid users have lived with hearing loss for more than ten years before seeking a hearing aid and that, as a result, their impairments have typically progressed from moderate to severe levels (Davis et al., 2007).

As early as in 1991, Mulrow & Lichtenstein (1991) had argued that the three commonly accepted criteria for a community screening program are, actually, satisfied for adult hearing screening, i.e.: i) the burden of disability is significant enough; ii) effective treatments are available, and iii) accurate, practical, and convenient screening tests exist. Remarkably, the need to establish effective programs of adult hearing screening and early intervention is being increasingly emphasized (Davis et al., 2007; Grandori et al., 2009). Some recent initiatives and projects have promoted awareness and research on adult hearing screening such as, for example, the 2009 NIDCD/NIH Working Group (Donahue et al., 2010), the Project AHEAD III (2008-2011) or Project HearCom (2004-2009). Significantly, medium and large scale pilot pro-
grams of adult hearing screening have been established in Europe in the very last years, e.g., in the United Kingdom, the Netherlands, Italy, and Cyprus (Grandori et al., 2009; see also Pagliaionga et al., 2011 and Thodi et al., 2011).

In line with the World Health Organizations International Classification of Functioning, Disability and Health (World Health Organization, 2001), consensus is emerging that hearing screening in adults should move from the screening of an impairment (which is a loss or abnormality in body structure or physiological function) to a screening of a hearing handicap or hearing disability (Danemark et al., 2010). Some individuals with hearing impairment may not perceive any hearing disability and, vice versa, others with minimal or no hearing impairment may report considerable disability (Schow, 1991). This is particularly true in adults and older adults, because hearing (dis)ability is a combination of peripheral and cognitive processing (Schneider et al., 2010; Pichora-Fuller & Singh, 2006) that requires, concurrently, the ability to hear, to listen, to comprehend, and to communicate (Kiessling et al., 2003), and so the deficits in communication that result from a decrease in hearing sensitivity may be commonly compounded by a decrease in the ability to understand speech in a background of competing noise or speech (Gates et al., 2008).

As a matter of fact, in the seventh to the ninth decades of life the decline in speech understanding is, typically, significantly faster than the decline in peripheral hearing sensitivity, particularly when speech is distorted, reverberated, or presented in noise (Divenyi et al., 2005; Akeroyd, 2008). Measures of hearing impairment are only a partial picture of disability and are not a reliable predictor of the lived experience of hearing handicap and disability. It is no surprise that the most common complaint of adults with self-reported hearing disability is just the difficulty to understand speech in situations with background noise, reverberation, or competing speech (Kramer et al., 1998). Speech-in-noise tests, which are sensitive to declines both in hearing sensitivity and distortion, are widely acknowledged measures of the ability to hear in noise and can target the real experienced listening difficulties in adults more effectively than pure-tone audiometry (Killion & Niquette, 2000).

The SUN-test (Speech Understanding in Noise) is a speech in noise test that was recently developed and optimized to screen adults and older adults for hearing disability (Grandori et al., 2010). The SUN-test is composed of a short list of intervocalic consonants (VCV, vowel-consonant-vowel) in noise that have been normed for intelligibility, and that are presented in a three-alternatives forced-choice (3AFC) paradigm by means of a touch-screen interface: Based on the number of VCV correctly identified, the tested subject gets one of three possible test outcomes: no listening difficulties, a hearing check would be advisable, or a hearing check is recommended. The test was first developed in the Italian language and then adapted also in other languages, such as English, German, French, and Spanish.

Overall, the SUN-test in various languages has been administered to about 2,500 adults in an age range of 13 through 95 years. This paper reviews the main results obtained with the SUN-test in the Italian language in a population of ~1,300 adults and older adults with varying degrees of audiometric thresholds and audiometric configurations, tested both in low and in high ambient noise. The performance and the main features of the SUN-test will be illustrated, and the feasibility of using the SUN-test to screen adults and older adults, either in clinical or in non-clinical settings, will be discussed.

### Methods

In the results discussed here, a population of 1,273 subjects (aged 13-89 years) were tested with the SUN-test in the Italian language. Subjects were all mother-tongue Italian speakers. All subjects also underwent air conduction pure tone audiometry (PTA) at 1, 2, and 4 kHz. To evaluate the feasibility of using the SUN-test as a screening tool also in non-clinical environments such as, for example, convenient care clinics, hearing aid providers, or pharmacies where, typically, the ambient noise is higher than in clinical settings, the same testing procedure was performed in two different settings:

1. **low ambient noise settings** (default settings). Testing was performed in quiet rooms, where the ambient noise was checked to be below the maximum permissible ambient sound pressure levels set by standard ISO 8253-1 (ISO, 1989). A group of 374 subjects (173 males, 201 females; age 14-89 yrs, mean age 63 yrs, s.d. 13 yrs) were tested in low ambient noise settings; of these, 41 subjects had unilateral hearing aids and were tested only in the unaided ear, whereas the remaining 333 subjects were tested in both ears, for a total of 707 ears tested;

2. **high ambient noise settings**. Testing was performed in booths placed close to underground stations, main railway stations and drugstores. The ambient noise was measured every day, in each booth and in each location and was, on average, 65 dB A (s.d. 3 dB). A group of 899 subjects (387 males, 512 females; age 13-87 yrs, mean age 53 yrs, s.d. 16 yrs) were tested in high ambient noise settings; of these, 60 subjects had unilateral hearing aids and were tested only in the unaided ear, whereas the remaining 839 subjects were tested in both ears, for a total of 1,738 ears tested.

At the end of the test session, all subjects were asked to fill in an evaluation questionnaire to give their feedback on the whole test procedure. The questions were: i) How would you grade the task? (easy/neutral/stressful); ii) How would you grade test duration? (short/fair/long); and iii) Overall, how would you grade the test? (pleasant/neutral/stressful).

### Results

Table 1 shows the distribution of the SUN-test outcomes obtained in the 374 subjects (707 ears) tested in low ambient noise and in the 899 subjects (1,738 ears) tested in high ambient noise.

<table>
<thead>
<tr>
<th>Low ambient noise</th>
<th>N. of Ears</th>
<th>N. of Subjects</th>
<th>Tested unilaterally</th>
<th>Tested bilaterally</th>
</tr>
</thead>
<tbody>
<tr>
<td>No listening difficulties</td>
<td>379/707</td>
<td>14/374</td>
<td>122/574</td>
<td></td>
</tr>
<tr>
<td>(53.6%)</td>
<td>(3.7%)</td>
<td>(32.7%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>A hearing check would be advisable</td>
<td>226/707</td>
<td>63/374</td>
<td>143/574</td>
<td></td>
</tr>
<tr>
<td>(32.0%)</td>
<td>(1.6%)</td>
<td>(38.2%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>A hearing check is recommended</td>
<td>102/707</td>
<td>21/374</td>
<td>68/574</td>
<td></td>
</tr>
<tr>
<td>(14.4%)</td>
<td>(5.6%)</td>
<td>(18.2%)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>High ambient noise</th>
<th>N. of Ears</th>
<th>N. of Subjects</th>
<th>Tested unilaterally</th>
<th>Tested bilaterally</th>
</tr>
</thead>
<tbody>
<tr>
<td>No listening difficulties</td>
<td>806/1738</td>
<td>14/899</td>
<td>241/899</td>
<td></td>
</tr>
<tr>
<td>(46.4%)</td>
<td>(1.5%)</td>
<td>(26.6%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>A hearing check would be advisable</td>
<td>601/1738</td>
<td>23/899</td>
<td>350/899</td>
<td></td>
</tr>
<tr>
<td>(34.0%)</td>
<td>(2.6%)</td>
<td>(38.9%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>A hearing check is recommended</td>
<td>331/1738</td>
<td>23/899</td>
<td>248/899</td>
<td></td>
</tr>
<tr>
<td>(19.0%)</td>
<td>(2.6%)</td>
<td>(27.6%)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
In low ambient noise settings, more than half (53.6%) of the ears tested with the SUN were found to have no listening difficulties, about one third (32.0%) were advised to do a hearing check, and nearly 15% were recommended to do a hearing check. Similarly, in high ambient noise slightly less than half of the tested ears (46.4%) were found to have no listening difficulties, about one third (34.6%) had a hearing check would be advisable as test outcome, and nearly 19.0% had a hearing check is recommended as test outcome. In Table 1 the distribution of the SUN-test outcomes is also shown with respect to the number of subjects tested, whereby in subjects tested bilaterally the test outcome was given based on the worse ear. Again, it could be observed that comparable results were obtained in the two different test settings: 30-35% of subjects were classified in the no listening difficulties category, nearly 40% were advised to do a hearing check, and less than 30% were recommended to do a hearing check.

Depending on the PTA thresholds at 1, 2, and 4 kHz, the tested ears were also classified into one out of three PTA classes: Class I included ears with thresholds ≤40 dB HL at 1, 2, and 4 kHz; Class II included ears with thresholds ≤40 dB HL at 1 and 2 kHz and threshold > 40 dB HL at 4 kHz; and Class III included ears with thresholds > 40 dB HL at 2 and 4 kHz.* As a result, of the 707 ears tested in low ambient noise, 468 ears were assigned to Class I, 146 to Class II, and 93 to Class III; of the 1,738 ears tested in high ambient noise, 1,469 ears were assigned to Class I, 199 to Class II, and 70 to Class III.

The distribution of the SUN-test outcomes in ears classified in each of the three PTA classes is shown in Table 2 for both test settings: low ambient noise and high ambient noise.

From Table 2 it could be observed that there was a straightforward correlation between the three PTA classes and the three SUN-test categories: the majority (65%) of ears in PTA Class I (i.e., ears with thresholds ≤40 dB HL up to 4 kHz) tested in low ambient noise had no listening difficulties in the SUN-test, and only a minor percentage (6%) of ears in PTA Class I were recommended to do a hearing check. Vice versa, the majority (~84%) of ears in PTA Class III (i.e., ears with thresholds >40 dB HL at least at 2 and 4 kHz) were either advised (34.4%) or recommended (49.5%) to do a hearing check, and only 16% of them had no listening difficulties in the SUN-test. The straightforward correlation between the three SUN-test categories and the three PTA classes was also observed in high ambient noise settings. Nearly half (50.4%) of ears in PTA Class I had no listening difficulties in the SUN-test, and only a minor percentage (16%) of them were recommended to do a hearing check. Vice versa, the majority (~84%) of ears in PTA Class III were either advised (28.6%) or recommended (55.7%) to do a hearing check, and nearly 16% of them had no listening difficulties in the SUN-test. As to ears in PTA Class II, nearly 41% fell in the a hearing check would be advisable category both in low and in high ambient noise settings, whereas the proportion of ears classified in the no listening difficulties category varied in the range 28-39%, and — dually — the proportion of ears in the a hearing check is recommended category varied in the range 19-31%. Because the PTA Class II includes ears with thresholds higher than 40 dB HL at 4 kHz but not at 2 kHz, it is reasonable to expect a higher variability of speech-in-noise recognition performance, as documented in the literature. As a matter of fact, the pure tone threshold at 4 kHz is not per se an adequate predictor of speech reception threshold, but only if combined with thresholds at lower frequencies, at least at 2 kHz (Smoorenburg, 1992). Accordingly, Ventry & Weinstein (1983) recommended not to rely on a fail at 4 kHz when screening for hearing handicap with pure tone thresholds.

Hearing thresholds at 4 kHz can be thus expected to be poorly correlated with speech in noise performance, whereas the combination of hearing thresholds at 4 and 2 kHz is a better predictor of the ability to hear speech in noise. Results previously observed in ears in PTA Class I and Class III (i.e., ears with thresholds either lower or higher than 40 dB at both 4 and 2 kHz), are in line with these evidences because the agreement between the SUN-test outcomes and PTA was more straightforward.

The outcomes of the SUN-test were also studied as a function of the age of the tested subjects. Figure 1 shows the mean test score (i.e., the number of VCV correctly identified by the tested subjects) as a function of age, in ears classified in each of the three PTA classes. The maximum score that can be obtained with the SUN-test in the Italian language is 12. Data in Figure 1 are from ears tested in low ambient noise settings; results obtained in high ambient noise settings were fully comparable. Statistical analysis (Kruskal Wallis test) revealed that there was no significant effect of age on mean test score in ears belonging to PTA Class I and Class II, neither in low ambient noise settings (Class II: χ²=9.45, df=7, P=0.2217) nor in high ambient noise settings (Class II: χ²=15.31, df=7, P=0.065; Class III: χ²=11.01, df=7, P=0.137). The only significant effect

Table 2. Distribution of the SUN-test outcomes in ears classified in each of the three PTA classes, in low ambient noise (upper table) and in high ambient noise (lower table). Numbers and percentages are reported over the total number of ears classified in each of the three PTA classes.

<table>
<thead>
<tr>
<th>Low ambient noise</th>
<th>PTA Class I</th>
<th>PTA Class II</th>
<th>PTA Class III</th>
</tr>
</thead>
<tbody>
<tr>
<td>No listening difficulties</td>
<td>306/468</td>
<td>57/146</td>
<td>15/93</td>
</tr>
<tr>
<td>A hearing check would be advisable</td>
<td>133/468</td>
<td>61/146</td>
<td>32/93</td>
</tr>
<tr>
<td>A hearing check is recommended</td>
<td>29/468</td>
<td>28/146</td>
<td>46/93</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>High ambient noise</th>
<th>PTA Class I</th>
<th>PTA Class II</th>
<th>PTA Class III</th>
</tr>
</thead>
<tbody>
<tr>
<td>No listening difficulties</td>
<td>740/1469</td>
<td>55/199</td>
<td>11/70</td>
</tr>
<tr>
<td>A hearing check would be advisable</td>
<td>499/1469</td>
<td>82/199</td>
<td>29/70</td>
</tr>
<tr>
<td>A hearing check is recommended</td>
<td>230/1469</td>
<td>62/199</td>
<td>39/70</td>
</tr>
</tbody>
</table>

Figure 1. Mean values (± 1 s.d.) of the SUN-test scores as a function of age in the 787 ears tested in low ambient noise, in each of the three PTA classes.

*The cut-off value of 40 dB HL was set following the suggestions by Ventry & Weinstein (1983) for adult hearing screening, also in line with the definition of disabling hearing impairment given by the World Health Organization (2008) and the threshold used by the Veterans Health Administration to define hearing loss (US Congress, 1987).
of age was found in the youngest age group in PTA Class I both in low 
($F^2=48.13$, $df=7$, $P<0.05$) and in high ambient noise settings 
($F^2=202.58$, $df=7$, $P=0$), because ears in the youngest age group (i.e., 
$\leq 50$ years) had a significantly higher mean score than all the other age 
groups (Mann Whitney post-hoc test; $P<0.05$), whereas no statistically 
significant differences in test scores were observed among all the other age 
groups in ears in PTA Class I. Thus, with the exception of the 
youngest age groups in PTA Class I, the outcomes of the SUN-test in 
each of the three PTA classes did not vary with increasing age. The only 
significant effect was a better test outcome only in the youngest sub-
jects with good hearing thresholds (PTA Class I). Stated differently, the 
performance of younger and older adults in the SUN-test was indeed 
the same, provided that differences in hearing sensitivity were taken 
to account.

The time needed to complete the SUN-test was also measured. 
Overall, the mean test time was 41 s/ear (s.d. 10 s); the lowest test time 
was 26 s/ear (in a very young subject aged 22 years tested in high ambi-
tone). Figure 2 shows the mean test time as a function of age in ears 
tested in low ambient noise settings; results obtained in high ambient noise 
settings were identical. As illustrated in Figure 2, test time increased with increasing 
age, from an average of about 36 s/ear in subjects younger than 50 years to 48 s/ear in the 
older age groups. The observed increase of test time with age was statisti-
cally significant (one-way ANOVA test, $F=9.38$, $df=7$, $P=10^{-11}$), indicating that – as can be expected – older subjects were slightly slow-
er than younger ones in performing the SUN-test. However, the mean 
test time was in any case lower than 1 minute per ear, both in low and 
high ambient noise, even in the older age groups.

Table 3 reports results of the evaluation questionnaire administered 
to the 374 subjects tested in low ambient noise and to the 899 subjects 
tested in high ambient noise. The distributions of the answers given to 
the questionnaire in the two different test settings were almost identi-
cal. Overall, nearly 85% of the subjects reported the test easy (64%) or 
slightly difficult (22%) to be performed, whereas only 14% judged the 
test difficult. The vast majority of subjects (i.e., nearly 95%) rated the 
test duration as short (~70%) or fair (26%), whereas only a minor pro-
portion of subjects (4-5%) considered the test long. As to the overall 
judgment of the SUN-test procedure, more than 55% of the tested sub-
jects judged the test as pleasant, nearly 35% expressed no particular 
concern, and less than 8% rated the test as stressful.

![Figure 2. Mean values (± 1 s.d.) of test time as a function of age in the 707 ears tested in low ambient noise.](image)

Table 3. Distribution of the answers to the evaluation question-
aire administered to the 374 subjects tested in low ambient noise (center column) and to the 899 subjects tested in high ambient noise (right hand column).

<table>
<thead>
<tr>
<th>Low ambient noise</th>
<th>High ambient noise</th>
</tr>
</thead>
<tbody>
<tr>
<td>Easy</td>
<td>64%</td>
</tr>
<tr>
<td>Slightly difficult</td>
<td>22%</td>
</tr>
<tr>
<td>Difficult</td>
<td>14%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>How would you grade test duration?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Short</td>
</tr>
<tr>
<td>Fair</td>
</tr>
<tr>
<td>Long</td>
</tr>
<tr>
<td>Overall, how would you grade the test?</td>
</tr>
<tr>
<td>Pleasant</td>
</tr>
<tr>
<td>Neutral</td>
</tr>
<tr>
<td>Stressful</td>
</tr>
</tbody>
</table>

Discussion

In this paper, the main results obtained using the SUN-test in the 
Italian language in a population of 1,273 adults, tested both in low and 
in high ambient noise settings were reviewed. In view of these results, 
the following main features of the SUN-test can be highlighted:

Fast test procedure

The mean duration of the SUN-test was ~40 s/ear, and ranged from 

- Nearly 35 s/ear for subjects aged ≤50 years to nearly 50 s/ear for subjects aged >80 years. Thus, test time was typically lower than 1 minute per ear and, in any case, lower than 1 ½ minutes per ear, even in the older age groups. The total time needed to test both ears was thus, on average, 2 minutes, and never exceeded 3 minutes even in the older subjects. This is particularly relevant to adult hearing screening, because when the test duration increases, inattentiveness and fatigue are likely to occur and may alter the test outcomes, particularly in older subjects.

Reliability

The outcomes of the SUN-test were in line with the outcomes of pure tone testing in adults tested both in low and in high ambient noise (see Table 2). For example, 65% of ears with good pure tone thresholds (PTA Class I) tested in low ambient noise were classified in the category no listening difficulties by the SUN-test, whereas 70% of ears with poor pure tone thresholds (PTA Class III) were classified in the a hearing check would be advisable or a hearing check is recommended categories. Remarkably, the observed agreement between the SUN-test outcomes and PTA is fully in line with what reported in the literature for existing, and more time-consuming, speech in noise tests, for which the correlation with pure tone thresholds (normally averaged in the range 0.5-4 kHz) is typically lower than 0.7 (Bosman & Smoorenburg, 1995; Wilson et al., 2007).

Low cognitive load

The analysis of test scores and test duration as a function of age 
(Figures 1 and 2) showed that, once ears are classified based on their 
PTA Class, the mean score in the SUN-test did not vary with increasing 
age, neither in low ambient noise nor in high ambient noise; also, test 
time remained lower than 1 minute per ear even in the older subjects. 
Stated differently, the performance of younger and older subjects in the 
SUN-test was strikingly similar, thus indicating that the cognitive load 
associated with the task was limited and did not influence the test out-
comes in the older subjects. A limited cognitive load is particularly re-
relevant to adult screening because it is well known that, especially in
older adults, an increase in the cognitive load associated with a listening task typically can lead to a dramatic decrease in the subject's listening performance.

Acceptability

Results of the evaluation questionnaire in both low and high noise settings showed a favourable feedback from the tested population. The SUN-test was considered easy or slightly difficult by nearly 90% of subjects; test duration was judged short or fair by nearly 95% of subjects, and the overall evaluation of the test was pleasant or neutral in more than 90% of subjects. By the use of simplified interactions and a short test sequence, the perceived complexity of the task was kept to a minimum. Also, the preliminary instructions on how to use the touchscreen and how to perform the test were easy to understand and typically required less than 1 minute, in such a way that the SUN-test can be considered nearly a self-administered test. Acceptability of the test procedure represents a significant added value in hearing screening because it could be helpful to increase the subjects awareness of their decreased hearing ability and, thus, possibly improve their attitude to behaviour change.

Feasibility

Results observed in high ambient noise settings were strikingly similar to results obtained in low ambient noise, indicating that the outcomes of the SUN-test were not influenced by the noise level in the test room (at least up to 65 dB A) and that the test, as such, might be feasible to screen adults both in clinical and in non clinical settings, such as convenient care clinics, hearing aid providers, or pharmacies, where the ambient noise is, typically, not controlled.

Conclusions

Overall, results of this study indicated that the SUN-test might be feasible for application in adult hearing screening. The test is fast, self convincing, acceptable and, also, reflects differences in hearing sensitivity between the tested ears. Results obtained with the SUN-test are not biased by the age of the subject: the performance of younger and older subjects in the test is similar and the test time is low even in the oldest subjects. This is because the cognitive load associated with the SUN-test is low and does not influence the test outcomes, even in the older age groups. The outcomes of the SUN-test are, also, not influenced by the noise level in the test room (up to 65 dB A), indicating that the test, as such, is feasible to screen adults both in clinical and in non clinical settings, such as convenient care clinics, hearing aid providers, or pharmacies.

References


