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Letters to the Editor

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Response to the Letter from Dr. Vermiglio Regarding Iliadou and Eleftheriadis (2017): CAPD is Classified in ICD-10 as H93.25

We thank Dr. Vermiglio for commenting on our published article "Auditory Processing Disorder (APD) as the Sole Manifestation of a Cerebellopontine and Internal Auditory Canal Lesion." Following his acknowledgment of the merits of behavioral/psychoacoustic tests beyond the standard audiometric test battery, he states that our case report does not "provide clarity for the highly controversial construct of APD." His main objection seems to be our conclusion that "This clinical case stresses the importance of testing for APD with a psychoacoustical test battery despite current debate of lack of a gold standard diagnostic approach to APD." It is not clear why he thinks that this statement is not true, as the specific central auditory processing testing battery used (based on AAA [2010] and BSA [2011] guidelines) was found to be efficient in revealing a specific pathology in the case presented (Iliadou and Eleftheriadis, 2017). There was no attempt to generalize but an effort to show that this battery of tests worked in this specific case.

According to medical dictionaries (Farlex Partner Medical Dictionary, 2012), "gold standard" is the term used to describe a method or procedure that is widely recognized as the best available. This is the same way the term "gold standard" is used in audiology and in the field of central auditory processing disorder (CAPD) (Weihing et al, 2014). Even though in medical terms the gold standard approach describes the best available diagnostic test for a given disorder, current clinical practice guidelines (Kasper et al, 2015) depend on a battery of tests due to the inherent complexity of any given disorder. This permits better diagnostic methods to emerge while still using the best available. We argue that the best available to date are those described in the AAA (2010) and BSA (2011) guidelines. In this sense, it is not clear what Table 1 in Vermiglio's response adds to this discussion. What is questionable is the inclusion of amblyaudia and speech recognition in noise disorder as recognized clinical entities, while proposing as a gold standard method the patient's "self-report." These "clinical entities" are not included in any classification systems available worldwide.

On the contrary, APD or CAPD is a clinical entity recognized by audiological societies throughout the world (ASHA, 2005; AAA, 2010; BSA, 2011; Canadian Interorganization Steering Group for Speech-Language Pathology and Audiology, 2012; Sapere Research Group, 2014; NAL, 2015) and is included in the *International Classification Diseases, 10th edition* (ICD-10) under the code H93.25. ICD-10 defines it as "a disorder characterized by impairment of the auditory processing, resulting in deficiencies in the recognition and interpretation of sounds by the brain. Causes include brain maturation delays and brain traumas or tumors." CAPD is a disorder of the central auditory nervous system with auditory perceptual deficits in the underlying neurobiological activity giving rise to the electrophysiological auditory potentials (Chermak et al, 2017). Heterogeneity is inherent to disorders and if one was to define a clinical entity based on representation of a homogeneous patient group then we should not accept diagnoses such as dyslexia, autism spectrum disorder, or even auditory neuropathy/auditory dyssynchrony disorder. The limitation to the patient is evident in our case as a progressive deterioration of speech perception and impacts her communication abilities. Facilitation of diagnosis and intervention is clearly shown in this APD case. We are sure that arguments surrounding APD are ultimately made to improve diagnosis and intervention facilitating clients' inclusion in the community while improving communicational, social, emotional, and academic-work aspects of life. Putting everything in perspective is important in this sense.

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