INTRODUCTION
Speech and language delay in children is a common presentation to primary care either directly to the GP or through the health visitor, affecting approximately 6% of pre-school children.1 Young children, particularly those with speech delay, can be difficult to examine. Differentiation between an isolated pathology and those with concurrent global developmental delay is crucial. This article presents an example of a common case, considers the learning points, and highlights management principles.

CASE HISTORY
A 2-year-old boy presented to primary care with fewer words than his peers, and with difficulty in non-family members understanding him. On closer questioning he had <10 words of speech. He was born at 39 weeks by normal delivery, not requiring special care baby unit, and passed his newborn hearing screening. Review of his Personal Child Health Record (red book) showed consistent growth along centile lines, and other developmental milestones attained. In the consultation room he played appropriately, made good eye contact, and followed instructions: identifying his nose and ears when asked. On examination, he had normal facies, and otoscopy revealed bilateral dull tympanic membranes. Referral to audiology was made and age-appropriate free-field hearing testing with tympanometry performed. He had hearing thresholds of >40 dB (mild-to-moderate hearing loss) with flat tympanograms indicating a conductive loss in keeping with otitis media with effusion (OME).

For 3 months the child was actively observed and then referred to the ear, nose, and throat consultant. With evidence of persistent conductive hearing loss, he was offered hearing aids or grommets, in keeping with National Institute for Health and Care Excellence guidelines.2 His parents elected for grommet insertion. On follow-up at 2 years, 6 months, his vocabulary had expanded to >100 words, and audiogram showed thresholds <20 dB in the normal range.

ASSESSMENT AND DIFFERENTIAL DIAGNOSIS
Speech and language delay must be separated from variation in speech development, and is defined by children falling behind recognised milestones. Regression or loss of speech and language are particularly concerning.

Initially, a history with a focus on identifying a cause for the speech delay should be taken, including pregnancy and birth history, developmental milestones, and family history. Aspects of the antenatal history that may impact on newborn hearing must be explored. These include TORCH interuterine infections (toxoplasmosis, rubella, cytomegalovirus, and herpes simplex) and maternal drug exposure. Important aspects of the perinatal history include prematurity, hypoxia, birth trauma, and neonatal jaundice. Newborn hearing screening does not occur worldwide and should not be assumed in births outwith the UK. General maternal health is useful, particularly for the exclusion of conditions such as hypothyroidism.

The child’s medical history should be covered, including conditions such as meningitis, head trauma, and seizures, and exposure to ototoxic drugs. Developmental milestones should be noted, including social interactions with peers and family. This is not only to explore the possibility of a global developmental delay/disorder and the possibility of an underlying psychological diagnosis, but may also highlight deprivation and neglect.

It is important to enquire about any family history of hearing loss and speech delay including the possibility of consanguinity, which may point to metabolic or recessive conditions.
In multilingual children total words across all languages should be counted, and will often compensate for the perceived delay. In those with craniofacial abnormalities, especially those with Down’s syndrome, the child may suffer from both conductive deafness and development delay, which will be confounded if not treated.

The case described the child was suffering from speech delay secondary to OME. This is the commonest cause of hearing impairment in the developed world, and is reversible. OME has two peaks of incidence at 2 and 5 years. The current treatment strategy for OME is grommet insertion after a recommended 3-month period of watchful waiting to allow for spontaneous effusion resolution. Hearing aids are a non-surgical alternative but are generally seen as socially unacceptable. Twenty-five per cent of children will require further grommet insertion within 2 years of the first, with a mean number of grommet insertions per child of 2.1. This emphasises the recurrent nature of OME and the importance of close follow-up for these children.

Speech and language delay may be an early presenting feature in children with global developmental delay, and provides a crucial early opportunity to intervene and provide multidisciplinary support. Prompt audiological assessment is essential in all children with speech and language delay to exclude reversible causes.

References