Newsletter of The Acoustic and Meningioma Network

AMNET NEWS

AMNET IS AN EASTERN COUNTIES, SELF-HELP GROUP OF FORMER AND NEW ACOUSTIC NEUROMA AND MENINGIOMA PATIENTS AND CARERS, BASED IN ADDENBROOKE'S HOSPITAL, CAMBRIDGE UK

Winter 2001
Issue 20

Treatment for Acoustic Neuroma

A talk by Mr Robert Macfarlane - Consultant Neurosurgeon
Addenbrooke's Hospital, Cambridge

Mr Macfarlane, Consultant Neurosurgeon at Addenbrooke's Hospital, introduced his talk by informing the group that there is now a new ENT consultant on the team working with Mr Moffat called Mr Patrick Axon. His appointment is part of an ongoing plan to preserve the expertise which has built up in this field at Addenbrooke's. He outlined some of the findings of research carried out on operations for acoustic neuroma in Cambridge which started in 1981 and now total over 700. Numbers have risen steadily over the years, although there has been a slight drop in the last two years, due to the increased accessibility of stereotactic surgery in the form of the Gamma Knife. There are now two of these machines in London. He addressed the comparison of microsurgery and Gamma Knife later in his talk.

Surgical treatment of Acoustic neuromas

Charles Balance is credited with removing the first acoustic neuroma in the early 1900s - he is reported to have used his finger to remove the tumour, but the patient did survive for 3 years. Walter Dandy was a pioneer of the excision of acoustic neuromas in the first half of the 20th century and he carried out partial removal of the tumour to reduce pressure on the brain stem because mortality was much less than if an attempt was made to remove the whole tumour. The translabrynthine approach to removal of acoustic neuroma was first developed by William House.

Mr Macfarlane described the two surgical approaches to the removal of acoustic neuromas: the translabrynthine approach involves obtaining access to the tumour through the ear. This results in a total loss of hearing. The retrosigmoid approach which accesses the tumour from behind the ear aims to leave the hearing apparatus of the ear intact. The majority of operations take the translabrynthine approach as this improves the result for the facial nerve and often hearing is so poor in the affected ear that it is not worth saving.

Presenting symptoms

Of the patients seen in Cambridge there are roughly equal numbers of men and women and most fall between the ages of 40 and 70. Patients are referred from the Cambridge area, the East Anglian region and also from much further afield. If they come from outside Cambridge the diagnosis has usually already been made by the referring consultant. The majority of patients present with hearing loss which has been slowly progressive, but is occasionally sudden. Other presenting symptoms include imbalance and tinnitus. The tinnitus may be mild (not heard above ambient noise), moderate (can be heard above ambient noise) or severe (stops people from sleeping or wakes them up from sleep). Tinnitus may be constant, intermittent or pulsatile and is usually high frequency. Very few patients present with severe tinnitus.

Tumour size

The size of tumours is variable and they are graded as small - less than 1.5cm, medium - 1.5 to 2.5cm and large - greater than 2.5cm.

Large tumours may cause an increase of fluid in the brain as the tumour can block the holes which allow circulating fluid to drain. If this occurs a shunt is put in which allows fluid to drain through a tube into the abdomen. The shunt is usually left in place after surgery and only removed or replaced if it is causing problems.

The surgery can take a long time and it is important to have a team of people available to do the operation. Success rates in terms of factors such as facial nerve recovery are related to the size of the tumour and the skill of the surgeon. It is important for surgeons to be well trained in the techniques and now neurosurgeons will specialise in particular areas of the speciality in order to become more experienced and skilled. It is a continuing learning experience.

Facial nerve

During surgery the facial nerve may be traumatised. The facial nerve stimulates the production of tears as well as movement of the face. As the nerve fibres regrow after surgery the nerve stimulating tears may connect with the facial muscles. This will result in production of tears when the facial muscles are moved - this is known as crocodile tears and is a problem for many patients. It is rare for patients to recover from crocodile tears. Metallic taste is also a problem for some patients and is a result of trauma to the nerve of taste on the front part of the tongue. This problem will often recover.

Next meeting

The next meeting will be on **Saturday 8th December 2001 in the David Dunn Suite at Addenbrooke's Hospital** at12 noon.

Balance
Problems with balance may also be present after surgery. If the patient has normal balance, often because the brain has adjusted to the loss already, then it will remain normal but otherwise it may take time to recover balance.

Tinnitus
Tinnitus can develop after surgery in about a quarter of patients but in the majority of cases this will be mild tinnitus.

Hearing loss
Hearing is lost if the translabrynthine approach is taken, but people will often adjust to hearing loss on one side well, as long as the hearing on the other side is normal. This approach does provide a better result for the preservation of the facial nerve with larger tumours. If hearing is saved it should be useful hearing.
In a small number of patients there may be a leak of cerebro -spinal fluid which may recover or may need more surgery.

Stereotactic Surgery
Stereotactic surgery is now more easily available. It may be delivered using a Gamma Knife which is a specialised machine able to deliver a high dose of radiotherapy to a very small area. This means the radiotherapy can be delivered to the tumour while affecting as little as possible of the surrounding tissue. A frame is used to keep the head immobile and a helmet is used to direct multiple doses as a cumulative dose on the tumour. The machine is very expensive and specialised for use on the head area and there are only three in this country.
Most hospitals have a linear accelerator (LINAC) which can be used on many different types of tumour. It produces a single beam rather than multiple beams but moves in a continuous arc so that the overall effect is very similar to the Gamma Knife
The patient will be scanned with a frame attached to the head so the dosage can be worked out very precisely and then the radiation is given. In determining the dose various factors need to be considered including the fact that a bigger tumour will need a larger dose so there is more chance of the surrounding tissues receiving a higher dose. If the periphery of the tumour receives a high dose there is more risk of facial palsy or numbness. On the other hand, with too low a dose it is less likely that the tumour will be controlled and therefore may need surgery later.

Benefits
- Negligible mortality - there are not the risks associated with anaesthetics and open surgery.
- Short hospital stay
- Early return to work
- Early results of hearing preservation - 58% patients have good preservation at 4 years post surgery.
- Low risk of facial palsy (2 - 17%) although there is no difference between gamma knife and 'good surgery'. It also needs to be borne in mind that gamma knife is usually carried out on small tumours so the results should be compared with results from surgery on small tumours only.

Disadvantages
- Unsuitable for larger tumours (over 2.5 - 3 cm)
- Lack of tumour control (75% reduced, 18% unchanged 7% increase)
- Hydrocephalus / delayed cranial nerve palsy may occur.
- Theoretical potential for second tumours 10 - 20 years later
- Subsequent surgery is more difficult possibly involving only sub-total excision and greater risk of cranial nerve palsy.

Patients need to consider reasons and risk carefully and the choice between radiosurgery and microsurgery needs to be considered in relation to:
- Tumour size
- General fitness and age
- Hearing in contra-lateral ear
- Risk - there may be a difference between how doctors and how patients perceive risk particularly in relating short term and long term risk.

Questions
Mr Macfarlane answered a number of questions including queries about watch and wait, shunts and recovery of facial paralysis. In this case he says that electroneuronography tests are carried out after the operation while patients are still in hospital which will show if there is electrical activity in the nerve. This indicates a better chance of improvement in facial function. There should be some recovery by 9 to 12 months. If there is no improvement at this stage patients will be referred for possible further treatment. He also reported that follow-up MRI scans are now being carried out only at two years because they have found no evidence of re-occurrence at 5 years.

He acknowledged that doctors are not always aware of problems patients have when they come to outpatients and acknowledged the support provided by AMNET. He thanked AMNET for their work with this group of patients.

We would like to thank Mr Macfarlane for giving us his time and for a very interesting talk.

Editorial

Dear all

Newsletter time has come around again and this time it is nearly Christmas. So maybe I can be one of the first to wish you a Merry Christmas and all best wishes for the New Year

We have lots of things I hope you will find interesting this time. There is the report on Mr MacFarlane's talk from the last meeting and a feature on headaches. Rachel has contributed again so I hope you will all consider putting pen to paper or fingers to email and send her some thoughts. This could be a really good way of us all supporting each other!

I hope you enjoy the newsletter and would be very pleased to hear from any of you

Best wishes

British Acoustic Neuroma Association
Pre-Treatment Survey July 1999 - October 2000
Published March 2001

Some of you may have participated in this survey organised by BANA so I am reproducing the results from their Summer newsletter.

Purpose

To determine the experience of patients from the time they first recognise symptoms to the time they received treatment, by analysing the number of visits to professionals over time. Accuracy of initial diagnosis was also taken into account, as were prescriptions and treatments.

Method

A ten question survey form was designed and sent out to all BANA members. Data was collected over fifteen months, producing a total of 472 responses. It had been hoped to exceed 500 completed survey forms, but the few remaining forms coming in did not justify a further extension in time. Each survey form was manually reviewed and scored against a set of complicated criteria. There was no way of reading or scoring these forms mechanically, and many respondents provided significant narrative in support of their answers.

Results

The results are presented by question, and are in percentages not absolute patient numbers. Where an answer did not fall into one of the pre-set categories, these were placed collectively under 'Other''.

Conclusions

- By far the majority of patients are repeatedly misdiagnosed at Primary Care level. Over 90%
- By far the majority receive inappropriate treatment at Primary Care level. Over 90%
- The majority of NHS patients wait up to 12 months for an appointment with a consultant. Over 60%. Private patients are generally seen within three weeks of referral.
- By far the majority don't receive an MRI scan for up to two years after their first GP visit. Over 80%
- By far the majority don't have their treatment options adequately explained to them. Over 75%.
- Less than half of NHS patients receive treatment within three months of diagnosis. Only 45%. Private patients are generally treated within 6 weeks.

Addenbrooke's Patient Liaison Service (PALS)

What is PALS?

This new service at Addenbrooke's will provide 'on the spot' help, advice and support for patients, relatives and carers.

They are there to:

Help answer your questions about any aspect of your care while you are in hospital;

Listen to your suggestions if you think there is something we can do to improve our service both for our patients and our visitors;

Support you while you stay at Addenbrooke's - we understand that being in hospital can be an anxious time - not just for you, but for your family and friends.

If there are things that are worrying you, we can also put you in touch with organisations who can provide you with support and advice.

If you live in Norfolk you may be interested in:

WBAS

Welfare Benefits and Advocacy Service

This is an organisation offering a full range of services and information to disabled people and their carers. Our advisors are all trained to give accurate information and advice on all aspects of disability including:

Benefits advice and form filling, the Appeals process, Housing Issues including Council Tax and Housing Benefit, the Motability Scheme and mobility issues and Independent Living.

We have an extensive database of information on many organisations and services related to disability and the issues concerning disabled rights. We are a voluntary organisation and all of our volunteers are either disabled or have an in depth working and personal knowledge of disability.

For further information or an appointment to come and see us please phone 01603 666951 Monday to Thursday between 9.30 am and3.30 pm, Friday between 9.30 and 2.30 pm and Saturday between 10.00 am and 12.00 pm

Affiliated to DIAL UK, RADAR, CPAG & MS Association in conjunction with NORFOLK COUNTY COUNCIL SOCIAL SERVICES

Headache

This article is drawn from an article written by Dr Marc L
for the American Acoustic Neuroma Association Newsletter in M

Dr Mayberg states that headaches after microsurgical treatment of acoustic neuroma are a common, yet under-appreciated complication of the procedure. Headaches are a rare symptom before surgery but surveys, including Ray Maw's survey of our own membership have suggested that between 27 and 50% of patients suffered headaches sometimes persisting for over 3 years.. The typical picture presented is of headache beginning around 2 - 3 weeks after surgery. This is characterised by progressively increasing aching and tenderness localised around the area of the incision and occasionally the pain spreads from this site to the entire head and many patients describe a feeling of pressure encircling the skull. Often the neck muscles are stiff and tender, and head movements or physical activity can initiate severe spasms or shock-like sensations which radiate up into the back of the head or down into the neck and shoulder. A characteristic of these headaches is that they are precipitated by coughing or sneezing which can trigger a headache which lasts for hours or days.

Potential causes

Although the specific cause of these headaches is unknown recent studies have suggested some factors which may contribute to the pain.

Surgical approach

This is a controversial topic. There is little data available on the connection between radiosurgery and headaches although what there is suggests the incidence is low. It has been noted by one group of surgeons that patients with the retrosigmoid approach to acoustic neuroma had substantially higher headache rates than those who had a translabrynthine approach, especially for small tumours. However another group found that although headaches were initially more severe in the retrosigmoid group, by one year there was no difference in headaches compared to patients with translabrynthine surgery. The ANA survey suggested that in cases following all surgical approaches significant headaches were present immediately after surgery and persisted in more than 50% patients for more than 3 years.

Craniectomy vs Craniotomy

Craneictomy means making an opening in the skull without replacing the bone, in a craniotomy the opening is created in such a way that the bone or some other material, such as plastic, is replaced in the bony opening. The dura, or covering of the brain is very sensitive, it has been suggested that headaches occur when cervical (neck) muscles are scarred or adhered to the pain-sensitive dura. Research has shown that a group of patients with cranioplasty, a plastic replacement for bone, had significantly less severe headaches than a group who didn't have cranioplasty.

Aseptic Meningitis

Meningitis is inflammation or irritation of the meninges or covering of the brain. Aseptic meningitis is this inflammation without infection. It is thought that several aspects of the surgery may predispose to this, but the one which is unique to acoustic neuroma surgery is the drilling of the intracranial bone in order to expose the tumour in the internal auditory canal. The resulting bone dust is distributed around the meninges in that area and can be difficult to remove completely. This bone dust can induce aseptic meningitis. Research has supported this theory and measures are taken during surgery to reduce the distribution of bone dust within the spinal fluid which has caused a reduction in post-operative headaches.

Muscle Pain

The neck muscles are extremely sensitive to pain and the pain from the cervical muscles is frequently perceived in the posterior part of the head. Tension headaches are a very common form of headaches which are attributed to stress producing tightness and spasm in the neck muscles which is manifested as headache affecting the back of the head. Many features of post-surgical acoustic neuroma headaches are consistent with this type of head pain, which is localised to the site of surgery, including tenderness and spasm of the muscles and worsening by stress or physical activity. Minimising incisions in the neck muscles can help to reduce incidence of headaches in patients.

Therapy

Cranioplasty

As suggested above this covering of the bony opening in the skull with a plastic graft may reduce headaches, but the evidence is only anecdotal so far and the disadvantage to this therapy is that it would require another operation.

Medication

As inflammation plays a large part in the origin of the pain anti-inflammatory agents are the most common form of treatment. Corticosteroids (eg Prednisolone, Dexamethasone) are very effective anti-inflammatories and

es

Mayberg
May this year.

can bring about rapid improvement. However these drugs have serious long term ill effects so should only be taken under medical supervision for a short period and then gradually reduced. Non-steroidal anti-inflammatory agents are the mainstay of treatment for acoustic neuroma headaches. These drugs such as Ibuprofen and Naprosyn can be brought over the counter but should only be taken after consultation with your doctor as they do have some side effects.

Local therapy to neck muscles

If the headache proves intractable to medical treatment, local therapy applied to the neck muscles may be effective in many cases. This will include various forms of physiotherapy, range of motion exercises, local heat application and massage, and learning muscle relaxation techniques.

In his closing summary Dr Mayberg emphasises that although the specific causes of headache following acoustic neuroma are not fully understood, there has been substantial progress in recent years and surgeons are doing their best to use measures which will prevent their occurrence.

Practical Hints and Tips

Taken from BANA booklet
'Headaches following acoustic Neuroma surgery'

- Simple massage to back of head and lower part of skull
- Be conscious of your posture Try not to hold your head in a rigid position
- Avoid excesses such as alcohol, smoking, coffee and foods which seem to make things worse.
- Learn to relax - there are tapes and classes or even just a good book!
- Check food labels for items you think upset you eg Monosodium Glutamate
- Applying heat or cold to the affected area using a heat pad or ice pack (this could be a pack of frozen peas!).
- Use of complementary therapies such as aromatherapy, reflexology, hypnotherapy, acupuncture.

HEADACHES

by Ray Maw

A paper by R. Jackler in Neurotology "Headaches Following Acoustic Neuroma Surgery" states "Of interest, an inverse relationship between tumor size and incidence of headaches was noted." In simple terms, this means that if you have a small tumour you are more likely to have headaches than if you had a large tumour. This is a rather surprising finding. However, I had a small tumour and, following my operation, had a continuous headache with intermittent excruciating headaches about every other day. So my case supported this finding.

As time went on my headaches were getting worse and beginning to send me into spasm so that all I could do was to lie down and kick until it went off. This often would last up to an hour or so. The only thing that helped was "Imigran", a quite powerful drug which sent me off to sleep. Upon waking, usually about an hour later, I found that my headache had returned back to its normal lower level. After 15 months, in desperation, I took to studying every bit of information I could find on the subject of headaches. This included an American booklet sent to me by Alison. This contained an article by Barbara White that caught my attention. She had exactly the same experiences as myself. However after two years she was prescribed *"a different medication for day and night"* and went on to say ***"A miracle occurred, that's what it seemed like to me. Within three days my headaches disappeared and in the year since I've only had two or three mild ones"***. Sadly, she didn't say what the medication was; nevertheless I was determined to find out. My GP agreed to help by pursuing seven possibilities that I had identified from my studies. The first three were negative; but after referring me to the Pain Clinic at Addenbrooke's to see Dr. Munglani number four turned out to be the ***"miracle"***. For me, **my headaches disappeared in only three hours**. The ***"miracle"*** cure was Diclofenac which is a form of Voltorol, an anti-inflammatory medication used to treat arthritis. By taking it every day my headaches were held at bay completely. To offset the possible side-effects of "tummy troubles" I was advised to take Ranitidine at the same time. After six months I changed to Aceclofenac which is not so powerful but still kept me free of any headaches. After a further six months I was advised to stop taking any more pills except Ibuprofen when I felt a headache coming on. This very rarely happened and even then my headaches were quite mild.

I suggest to anyone suffering similar persistent and severe intermittent headaches that you ask your GP if he would recommend trying this medication. About a third of those who I know have tried it find that it helps to varying degrees. It would be interesting to hear from other members who have had similar experiences with headaches.

Rachel's Corner

DON'T FRIGHTEN THE HORSES

This is a real danger for those with facial palsy. Not only horses, but in my case children too. There are two groups here; those who are especially repelled because they knew you pre-operatively and think you have turned into a monster, and those who have never seen you before and just assume that you are a monster.

Mrs. Wright from Norwich writes:

. . . "I was busy selecting fruit when a small boy standing beside me suddenly shouted "Mum, Mum, look, a pirate". Alas, when I smiled, what must have seemed like a leer or grimace to him caused him to run off screaming".

Mrs. Wright remarks that part of the problem is her black eye patch, and I have found that you can buy pink ones for 40 pence from Boots. They are not very comfortable in my experience, but that might be because writing this column has made me big-headed . . . .

What do readers suggest? To what extent is it worth trying to explain our appearance?

Next newsletter we shall publish suggestions and consider horticultural matters. So far only one member has taken the trouble to write to me.

If this column is going to work I must have contributions. Short ones are most acceptable. So contact me before you forget on the subject of keeping up appearances and/or headache-free weeding.

Mrs Rachel Pearson
4, The Oaks
Horringer
Bury St Edmunds
Suffolk IP29 5SH
e-mail rachel.pearson1@btinternet.com

Snippets

VISLUBE EYE DROPS

Ray has asked me to remind you that he is still supplying Vislube Eye drops. A number of members have found these drops helpful. Vislube is normally used by contact lens wearers and contains no preservatives. It may be difficult to obtain over the counter from pharmacists although it is available from some opticians. Ray can supply these drops at a cost of £4.40 per box of 20 monodose units. If you would like to know more please contact **Ray Maw on 01787 248036**

SPENDING MONEY

As you will have been aware at the AGM we have a fairly healthy bank account at present and the committee is looking at ways of using some of our funds to benefit members. If you have any ideas please write and let me know or contact Alison.

CHANGING FACES

Changing Faces is an organisation which aims to help people cope with facial disfigurement. They have just produced a new booklet called 'Facing Disfigurement with Confidence' which explains the myths and realities about disfigurement, contains real life stories and describes the work of Changing Faces.

You can get a free copy of this booklet by sending a stamped addressed envelope marked 'Confidence' to **Changing Faces, 1-2 Junction Mews, London W2 1PN**

The envelope should be at least A5 size with a stamp for 44p. If you would like multiple copies of the booklet to *distribute* to your colleagues and friends, we would ask that you make a donation of £2 per booklet.

postbag

The first two letters in our postbag acknowledge the receipt of funds. First a very big thank you to Dawn and Peter Holmes who worked hard to raise some funds for us.

Sheerness, Kent

Dear Chris
Please accept this Cheque for £35 as a donation to the AMNET charity funds. My wife Dawn, raised this money at a local charity fair in Sheerness at the Trinity Hall on September 22nd, organised by her cousin Mr Austin Wiseman. My wife has been raising money for various charities for several years now, and decided that this Autumn Fair any money she raised would go to AMNET. Dawn raised money by selling home made cakes and breads.
Preparation for this started back in July and over the next two months gradually filled our freezer with an assortment of cakes and bread.

Yours sincerely
Peter Holmes

The other donation we had was a bit of a surprise and I thought you might like to hear about this organisation.

Share Gift
The Orr Mackintosh Foundation
24 Grovenor Gardens
LONDON SW1W 0DH

Dear Mr Monk
I am delighted to enclose a donation of £100 with best wishes of the trustees of The Orr Mackintosh Foundation. As you have not received a donation from us before, I thought it might be helpful to give you a few details about the Foundation. We accept shares as charitable donations, principally in small 'odd lots' which are useless to their owners because the cost of selling them would be greater than their worth. We aggregate these donated shares and distribute the proceeds to various charities.
The scheme is now in it's fifth year - to date we have given away well over £650,000 and have supported more than 250 charities. We encourage our supporters and share donors to tell us which charities they support and the donation reflects that policy.
Please contact me if you would like any further information about Sharegift.

Yours sincerely
Bridgit Roe Charity Director

The last letter is a follow up to one in our spring edition from Carole Walden who had Gamma Knife treatment at the Cromwell Hospital last December.

Diss, Norfolk

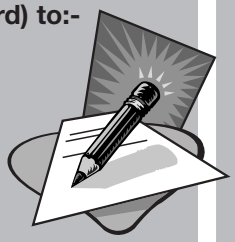
Dear Alison
I think it would be right to update my letter in the newsletter. Since I wrote to you the Cromwell Hospital has negotiated with Health Authorities and can now offer the follow up scan and consultation with Mr Lindquist at NHS cost, so this can now be available following Gamma Knife treatment at Cromwell. I have not yet seen the letter from my Health Authority but I understand that authorisation has to be sought each time. I am thankful to many people, including yourself, for help and information, and also to the Norfolk Health Authority.
An update on my health - I am still working full time, but I have had three weeks off sick, having been plagued since Easter with infections of one sort or another. I finally caved in at the end of July, thoroughly exhausted with everything, the other physical problems on top of the difficulty hearing, tinnitus, off balance, etc was too much. As I am not usually prone to catching everything, I wonder whether my immune system, has not been as good as it was. Anyway, I seem to mostly have recovered now after the rest and apart from feeling very tired sometimes, am coping as before. One positive thing is that the very bad headaches I was suffering before the Gamma Knife Treatment seem to have disappeared. I still get the odd headache, but nothing like they were. I do have a slight occasional twitch above my right eye, not much, but enough to notice. I am not sure what that is yet, or whether it is connected. So far, so good.

Best wishes
Carole Walden

PARK BENCH GOES ON THE INTERNET

Some of you may have heard about the world's first internet bench in Abbey Gardens Bury St Edmunds. The story made the world press. What you may not have realised is that one of our members was an instigator of this innovative development. As you can see in the picture Mayor Councillor Brian Bagnell was the first to use the bench when it was opened. He reports that there have been some subsequent problems with vandalism but the bench is still operating - it may prove a little cold for some in the winter though!

Please think about writing something for your newsletter. It can be anything you feel will be of interest to members.
Anything from a few lines to a couple of pages
It all helps to make the newsletter more interesting.
Contributions on paper and/or disc (Microsoft Word) to:-
Chris Richards
12 Sudeley Grove
Hardwick
CAMBRIDGE
CB3 7XS
by
28th February 2002



AMNET Advisory Panel at Addenbrooke's Hospital

Mr David Baguley MSc MBA
Principal Audiological Scientist

Jean Hatchell
Clinical Nurse Practitioner

Mr Robert Macfarlane MD FRCS
Consultant Neurosugeon

Mr David Moffat BSc MA FRCS
Consultant in Otoneurological and Skull Base Surgery

Mr N J C Sarkies MRCP FRCS FRCOphth Consultant Opthalmic Surgeon

Sue Woodford RN
Staff Nurse Clinic 10

BANA has produced some new booklets which may be of interest:-

A Basic Overview of Diagnosis and Treatment of Acoustic Neuroma

The Facial Nerve and Acoustic Neuroma

Headache after Acoustic Neuroma Surgery

Eye care after Acoustic Neuroma Surgery

Balance

All these booklets are available from Alison or direct from BANA . There is a charge of £2.00 for some of them.

Next time you go surfing don't forget our AMNET web-page on http://ii-group.com/amnet
If you want to suggest any contents please let us know.

Also which-doctor.co.uk

The new web-site search directory to help you find a doctor with a particular skill, service specialist or research interest, anywhere in the UK.
http://www.which-doctor.co.uk
email info@which-doctor.co.uk

Addresses and Web sites

Addenbrooke's new website
www.addenbrooke's.org.uk

Changing Faces
(Registered Charity 1011222)
1-2 Junction Mews, London W2 1PN
Tel 0202 7706 4232
Email: info@faces.demon.co.uk
Website http://www.changing faces.co.uk
Changing Faces acts as a resource for the empowerment of people with facial distinctions. Free information packs and booklets are available.

Surfing the Net?

RNID Tinnitus Helpline
(Registered Charity 207720)
Castle Cavendish Works, Norton Street, Nottingham NG7 5PN
Tel/Textphone 0115 942 1520
For further information:
Email: tinnitushelpline@binternet.com
Website: http://www.rnid.org.uk

The British Tinnitus Association (BTA)
(Registered Charity 1011145)
Web site: http://www.tinnitus.org.uk/
Email:bta@tinnitus.org.uk
The BTA is a charitable organisation which supports a network of self-help groups and contacts. The association provides information and advice to help people to come to terms with tinnitus and supplies helpful retraining audio casette tapes and details of relaxation cassettes. For an annual subscription members receive "Quiet", the association's quarterly journal.
Contact: BTA 4th floor, White Building, Fitzalan Square, Sheffield S1 2AZ

A Necessary Note

AMNET News is very appreciative of the opportunity to publish items relevant to the interests of acoustic neuroma and meningioma patients. This includes instances where members of AMNET have experienced relief, improvement, difficulties or otherwise and write to us of their experiences in order to pass on information for the interest and possible benefit of other members. However, AMNET cannot endorse proprietary products or be held responsible for any errors, omissions or consequences resulting from the contents of this Newsletter.

BANA

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Tel 01623 632143 Fax 01623 635313
Email bana@btclick.com

Library

Book Amnesty Alison is missing a number of books she has sent out over the years. If you have borrowed books from AMNET we would be grateful if you could check your bookshelves and return any books you may find. This can be done anonymously if you wish. We would just like to keep a good supply for new people who request information.

FORTHCOMING MEETINGS

Our next meeting will be on **Saturday 8th December 2001** in the David Dunn Suite at Addenbrooke's Hospital. Doors will open at **12 noon** and we hope everyone will bring a little food to contribute to the refreshments. We will have some visitors from Addenbrooke's to talk to us and hope everyone will have an opportunity to discuss issues of particular interest to them.

The first meeting for 2002 will be on **13th or 20th April** at 13.00 hrs. Speaker to be confirmed.

Facial Stimulators

AMNET has some Facial Trophic Stimulators which are available to members for short term loan. There is a charge of £20 at present which includes maintenance and postage. If you would like to know more please contact:**Margaret Allcock on 01493 700256**

Chairman	Secretary	Treasurer	Newsletter Editor	New Patients Officer	AMNET Librarian
Alison Frank	**Tony Monk**	**Joanne See**	**Christine Richards**	**Neil Bray**	**Ray Maw**
01953 860692	01353 778423	01487 814380	01954 211300	01223 561234	01787 248036