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

Summer 2002
Issue 22

The History of Anaesthetics –

a talk by Dr Phillip Morris Consultant Anaesthetist at Addenbrooke's Hospital

Reported by Chris Richards

Dr. Morris introduced himself as a consultant anaesthetist working in the Neurosurgery Department, mainly on acoustic neuromas. His talk outlined the history of anaesthetics to the present day

Although it is assumed that the giving of anaesthetics was not undertaken until the nineteenth century, agents which were capable of putting people to sleep had been available from a much earlier time. Diethyl ether, obtained by the distillation of alcohol with sulphuric acid, was first made in about 1540 by Valerius Cordus. A contemporary, Paracelcus, almost certainly used ether anaesthesia on animals; the religious climate of the time made it impossible for this new approach to surgery to be used on people as the experimenters would probably have been burned at the stake as heretics. Other methods used in these times to enable surgery to be carried out included clamps being placed on limbs in order to compress the nerves thus allowing relatively painless amputation. Crushed iced was also used in the eighteenth century to numb limbs prior to amputation on the battlefield.

The eighteenth century saw the beginnings of what has been called pneumatic chemistry, with the discovery of gases such as carbon dioxide, oxygen and nitrous oxide. Beddoes, a Bristol physician, attempted to treat various illnesses with the inhalation of these newly discovered gases. His assistant, Humphrey Davy, (later to become Sir Humphrey Davy of miner's lamp fame), made the gases for Beddoes. In about 1797 Davy noticed that inhalation of nitrous oxide relieved the pain of an attack of gingivitis, inflammation of the gums, and went as far as to propose its use for the relief of pain during surgical operations.

Other important discoveries took place in the late 1700's. The Reverend Stephen Hales made the first direct measurements of arterial blood pressure, (in a mare), and one Charles Kite used an endotracheal tube, a tube that went into the windpipe, to revive a patient who had drowned, but none of these developments were recognised by the establishment of the day.

By the nineteenth century Faraday was said to have described the narcotic effects of ether in 1818, but it was not used in the treatment of surgical patients. In 1824 Henry Hill Hickman described carbon dioxide narcosis in mice, but this did not generate any interest. Von Liebig synthesised chloroform, another potent anaesthetic, in 1831.

Next meeting

Our next meeting will be the AGM which will be held on **Saturday 6th July 2002** in the **Alice Fisher Lecture Theatre at Addenbrooke's Hospital, Cambridge.** Doors will open at 13.00hrs and the meeting will start at 13.30 hrs.

It is Open Day at the hospital that day so parking may be more difficult than usual, but there will plenty to see if you want to come early and look around.

Our speaker, following the AGM will be Ms Johanna Beyts who is a vestibular scientist working at the Royal National Throat, Nose and Ear Hospital in London. The title for her talk will be – 'New methods for rehabilitating patients with a balance problem'

AMNET is a member Organisation of BANA, The British Acoustic Neuroma Association
AMNET is a registered Charity No. 1073908

Ether was first used in surgical operations in the USA from about 1842 onwards. Horace Wells, a New England dentist, after observing a travelling fairground chemist who administered nitrous oxide, laughing gas, as part of his act , noticed that the recipients felt no pain following injuries received during their frolics. Wells learned how to use nitrous oxide and began to use it in the painless extraction of teeth. His first attempted public demonstration in a hospital in Boston, Massachussetts, was disastrous as his patient was a very large man and was not fully anaesthetised. Nitrous oxide was an effective pain reliever, but not a powerful anaesthetic. In 1846 William Morton gave the first demonstration of ether anaesthesia.

Chloroform was first identified as an effective anaesthetic by Simpson and some friends in Edinburgh. They indulged in after dinner experiments inhaling various vapours to see how well they worked. The effectiveness of chloroform as an anaesthetic was immediately obvious. Unfortunately chloroform causes irregular rhythms of the heart in susceptible people and was thus responsible for a number of deaths, the first being a fifteen year old girl called Hannah Greener in 1848. Despite this, the clinical use of anaesthetics was pioneered by John Snow who wrote books on the use of chloroform and ether and was also responsible for administering chloroform to Queen Victoria during the birth of Prince Leopold. A doctor called Clover gave more than 4000 chloroform anaesthetics without a death. The reason for his success was that he monitored his patients carefully by taking their pulse regularly and he used a large bag to mix chloroform with air so that he could give a known concentration of chloroform to each patient thereby reducing the risks of heart problems.

In 1917 a standard anaesthetic machine, the Boyles machine, was developed for delivering anaesthetic gases including cylinders of oxygen and nitrous oxide and a means of giving ether by inhalation. The basic elements of this machine have changed little over the years, although the design is now rather more sophisticated. However, anaesthetics in the early 20th century was still very much the poor relation to surgery, with the anaesthetic usually being given by the lowest member of the team. This began to change with the endowing of the first academic Chair of Anaesthesia in Oxford by Lord Nuffield in 1935.
From the 1920's new drugs began to be developed. Barbiturates, first synthesised in 1854, and which could put people to sleep had been taken orally since the 1880's. By 1934 these were developed in intravenous form, including thiopentone sodium which is still the most commonly used intravenous anaesthetic worldwide. Curare, a muscle relaxant, first brought to Europe from South America in the sixteenth century, was introduced to facilitate relaxation of the abdominal muscles allowing greater surgical access. In 1956 the inhalational anaesthetic halothane was developed by the pharmaceutical industry. This was the first anaesthetic which was designed to have specific properties. It was much easier to use than the earlier ether anaesthetics.

Throughout the second half of the twentieth century intravenous anaesthesia has become a better and more pleasant way of inducing anaesthesia than the inhalational technique. Drugs other than thiopentone have been developed, for example Propofol, which can be given by intravenous infusion and are cleared from the body very quickly. Recovery from anaesthesia with these newer agents is free from some of the side effects of the inhalational agents. These new drugs are particularly good for surgery on the brain as they reduce regional cerebral blood flow by lowering the level of activity in the brain thus improving operating conditions. These drugs can now be delivered by computerised pumps which can be programmed to keep the dose of drug in the blood relatively stable.
Patient monitoring is another crucial part of the anaesthetist's role and over the last twenty years sophisticated machines have been developed which monitor heart rate and
rhythm, blood pressure and oxygen saturation in the blood throughout the operation. This allows preventative action to be taken very quickly if something appears to be going wrong.
One of the problems when waking patients up after prolonged surgery lasting many hours was that of hypothermia; the patients had become cold and they could not be woken up until they had warmed up. Now a machine blows warmed air onto patients during surgery, preventing hypothermia so that they can be woken up immediately after the operation.
Dr. Morris concluded by pointing out that improvements in monitoring and the drugs which keep patients asleep, development of new muscle relaxants and very potent pain relieving drugs acting during the operation, as well as the reduction of side effects following anaesthesia by the drugs having been cleared from the body very quickly, have all contributed to a much safer and more comfortable experience for patients undergoing surgery.

We would like to thank Dr. Morris for giving us his time and entertaining us with a very interesting talk.

2002 BANA AGM

The Board of Trustees hereby giver notice of the Annual General Meeting of the British Acoustic Neuroma Association to be held on Saturday 29th June 2002 at The Boardroom, Queen's Medical Centre, Nottingham. The meeting will start at 11.00 hrs and following official business there will be a presentation by Professor Coakham ' Some aspects of Acoustic Neuroma Surgery' and a presentation by Miss Anderton on 'Eye Care following Acoustic Neuroma Surgery'.
For further details contact Head Office on 01623 623143

Editorial

Hello everyone

The time for the AGM has come round again. As usual the AGM will be held at the beginning of our summer meeting. We would like to welcome you all to attend what will be our sixth AGM. All the Committee members are willing to stand again but we are still looking for new blood. If you think you might like to try the job, possibly just for a year, please contact one of the committee members. The job would not be too onerous – meetings are held four or five times a year at Addenbrooke's and where possible we try to arrange them on the same day as the AMNET meetings. We really would appreciate some fresh faces and new ideas so please think about it!

I thank Alison for her kind comments but would like to say that the newsletter this time could still do with some more contributions from all of you out there. As I keep saying – this is your newsletter so let's hear from you – anything which you think may interest other members – short or long (I do reserve the right to edit!). So come on all you budding journalists or even send me something you have seen in a newspaper, magazine or on the web.

Looking forward to hearing from you

Regards

Annual General Meeting of

AMNET

will be held on

Saturday July 6th at 13.30hrs

In the

Alice Fisher Lecture Theatre
Education Centre
Addenbrooke's Hospital
Cambridge

Agenda

Apologies

Chairman's Report

Treasurer's Report

Election of Officers – Chairman
Secretary
Treasurer

Election of other committee members

Any other business

If you wish to nominate yourself or anyone else for the committee please contact Alison Frank on 01953 860692

The Old Schoolhouse
The Green
Old Buckenhanm
Norfolk NR17 1RR

A note from your Chairman

Alison has asked me to include this message from her.

As we approach our sixth AGM, on behalf of all our members I would like to say thank you for the consistently high standard of the newsletter collated and edited by Chris Richards. At meetings her pen is flying taking concise and accurate notes from the speakers talk and during committee meetings she (gently!) bullies us into providing and searching for copy so we end up with an informative and excellent newsletter. Many thanks Chris, and keep up the good work.
Alison

A NEW SUPPORT GROUP FOR PEOPLE WITH A MENINGIOMA

THE MENINGIOMA ASSOCIATION UK

Everyone of you knows, probably at first hand, what an invaluable source of information and support AMNET provides. The group grew out of the need for help when people are diagnosed with an acoustic neuroma. It is rare, so you are not very likely to have come across anyone else with the same condition, and it can be a lonely and difficult experience to handle on your own. AMNET helps people with an acoustic neuroma and sometimes also people with meningioma.

Meningiomas are actually more common than acoustic neuromas and unlike acoustic neuroma tumours they do not arise only in one brain location. Also the symptoms people will experience vary according to the meningioma's size and position. Here in the UK there is no organisation that addresses the specific needs of people with meningioma. Caroline Batt and Ella Pybus are changing that situation. They believe that meningioma patients also need their own support group - for someone to talk to, for unbiased information on treatment options, and for up-to- date facts about this type of tumour. They describe below what a meningioma is, how doctors diagnose it, and briefly outline present-day treatment options.

What is a meningioma?

A meningioma is a tumour of the meninges, which is the protective lining of the brain and spinal cord. Meningiomas have several features in common with acoustic neuromas. Like acoustic neuromas, they are usually benign (non-cancerous) and slow growing. However, meningiomas are more common, making up nearly 20% of all primary brain tumours. They also have a marked predominance in women. Unlike acoustic neuromas, which are always in the same location, meningiomas may occur in different places in the brain, and occasionally even in the spinal cord.

Signs and diagnosis

Symptoms of a meningioma can vary greatly, depending on where the tumour is growing. Symptoms are caused by brain displacement or compression, not by invasion. However, these tumours can be so slow growing that they may go undetected for years. They can grow in and around cranial nerves that control function so that eyesight, taste, smell, swallowing or other movement may be affected. They may cause fits, or muscle weakness. Occasionally they occur in clusters.

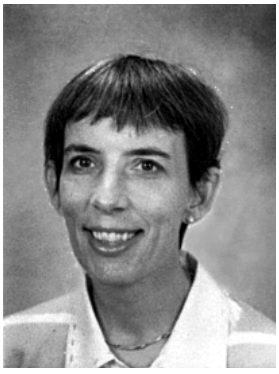
Meningiomas are generally diagnosed with a CT scan or a MRI scan. A contrast-enhanced MRI scan (with an injection of a type of 'dye' to highlight the tumour) is usually done to determine the exact location and size of the tumour. Occasionally, an angiogram will be done, where dye is used to show up the blood vessels in the brain and their relationship to the tumour. To confirm the exact type of tumour, a biopsy or sample of cells may be taken from the tumour during surgery and examined under a microscope. Where a biopsy is considered too risky the diagnosis may be made from radiology and clinical presentation.

Treatment

Patients with meningiomas can often be cured by complete surgical removal of the tumour or tumours. However, many meningiomas, particularly skull-based tumours, cannot be completely removed. In addition, a few meningiomas recur despite apparently complete surgical removal. Radiation therapy may then be used to control their regrowth. Radiosurgery may also be used instead of neurosurgery to control small tumours. Choice of treatment of the meningioma depends upon its location, size and the rate of progression of the symptoms. For meningiomas located near the surface of the brain surgery is often appropriate. Complete surgical removal may not be possible with meningiomas that are skull based. For these meningiomas radiosurgery is often a consideration for treatment, both to kill the meningioma and to spare normal function. Finally, a 'watch-and-wait' attitude can be adopted for some patients, for instance if the patient is elderly, and/or there are few or no symptoms. This will involve regular new scans to detect any tumour progression.

Caroline Batt and Ella Pybus explain why they set up a new support group

'A simple reason, really - because we know the problems that may be associated with meningioma only too well. Both of us have lived with the condition for many years. I (Caroline) was first treated with neurosurgery at The National Hospital in London in 1993. It turned out to be the first of many craniotomies, but that's another story. More recently, in 2000 I had a course (30 sessions) of radiotherapy at The Middlesex Hospital.'



Caroline Batt

Ella Pybus

'After six years of investigations, I (Ella) was finally diagnosed in 1994 with a meningioma that was so deep in the brain that surgery was out of the question, and I was told that no treatment was possible. In December 1999 the situation changed and I had fractionated stereotactic radiotherapy at Addenbrookes. We both know too, the effect a tumour may have on someone's working life since we had to give up our careers prematurely because of sight and other impairments caused by the tumours.'

An on-line affair!

We live in different counties – Hertfordshire and Suffolk – but we met on-line through an American web-based meningioma support group, which we had to do because there was no group specifically for meningioma in this country. Although they do a vital and important job, most British brain tumour support groups or associations are mainly directed at cancer or malignant tumours. Our new group, Meningioma Association UK, aims to offer both support and a forum for sharing information for all those coping with this particular condition. It is open to anyone with an interest in meningioma, either personal or professional. We have benefited from AMNET's experience and continue to be grateful for the encouragement and advice given by Alison Frank and other AMNET members: we want to maintain close links with you all.

Present and Future

What we can do now is provide anyone who contacts us with unbiased information. We are there if someone would like to ask questions about meningioma or simply wants someone to talk to when they need it. So far we have been able to help with the medical jargon that often confuses, to help people arrange a second opinion, or to send them a guide to getting the most out of a hospital consultation. We are currently preparing a fact sheet for AMNET's library of resources and additional material for the AMNET website. Eventually we would like to establish a website of our own, and if anyone can help us with this we'd be thrilled to hear from them. We would be pleased to hear from anyone who wants to help us in *any* way. We need to grow if the group is to be successful!

Getting in touch

If you can help in any way or simply want to know more, our contact details appear below:

Caroline Batt and Ella Pybus
The Meningioma Association UK
53 Pine Grove, Brookmans Park, Herts AL9 7BL
Tel: 01787 374084
e-mail: MeningiomaUK@aol.com

AMNET Library

PROGRESS REPORT: 2001/2002

During the past year the number of information packs available in the library has been increased from five to eleven.

As highlighted by the findings of "Project Focus" carried out in 1999, emphasis has been given to the distribution of relevant information to new members as quickly as possible after their acoustic neuroma operation. A general information pack is sent out to new members immediately after joining AMNET together with a questionnaire. The questionnaire asks if they would like to receive information (almost everyone does) and gives us details of any post-operative they may have and also tells us which of them is the most troublesome. Information packs are sent out one at a time on loan concerning each of the most significant and troublesome problems. Any of the individual documents that members would like to keep are sent to them by return. Assessment sheets enable us to ensure that the information being sent out is the most helpful that we have in the library. Sadly, over the past year the numbers of new members has dropped alarmingly.

Of course we still try to provide information to any of you who have residual post-operative problems. ***Please ring us or drop us a line if you feel we might be able to help or need to talk to someone about your problems.***

Upon request, samples of Vislube continue to be sent out to members suffering from dry eyes. Vislube is an eye drop which does not contain preservatives and does not impair vision. (It is not normally available from a pharmacist or optician). Between a third and a half of those receiving samples find it helps and ask for supplies. Supplies are sent out when required until they are no longer necessary.

We are also continuing with research work particularly related to "*rates of recovery*" from post-operative AN problems. Very little information is available on this important aspect. Our current research is based upon the surveys carried out in August 1998 and August 2000. By carrying out *a follow-up survey* in August 2002, it will enable us to gain much more accurate and valuable information on rates of recovery from specific post-operative problems. **I hope we can once again call upon your wonderful response.**

Ray Maw

Rachel's Corner

As the saying has it, "You're never the same when air gets to your brain". My family and friends always thought me a bit odd anyway, so the change was not so marked, but for others the surgery marks a turning point which can be unexpected and indeed devastating. We all mourn the loss of the person we were, and adjust with varying degrees of difficulty to the new one. One of our members has shown immense courage in coming to terms with having his surgery in a country which is not his native one and where language is often a barrier rather than a bridge to human relations. Giuseppe Vullo has sent us a poem which he wrote as part of his English course. In it he talks about the importance of something as everyday as a television set when your life has become quite restricted.

MY UNPLASTICISED COMPANION

It is nice to come home, retire away from it all.
Inside, the familiar surroundings of sofa, chairs,
Table and . . . . our television
Are here always in faithful wait.

The day has been hard for some, dead and empty
For some others.
With no cares in mind at what is happening in the
World, this is the time to have a few blissful
Hours, before the nightcap.

At the pressing of a button our trusty television . . . . it is on!
Now no-one can say "I am alone".
With the News at six o'clock, the quiz show at
Seven, the soap at seven-thirty . . . .
However the night's star programme is
The Royal Variety Performance, the kind of show
Where stars and starlets display their
Talents and receive the Queen's or Prince Charles's
Shake of hands and applause.

Comedians are doing their best to make us laugh,
The singers are singing our favourite song,
A song of love found, lost and yet found once again . .
Tears following that sweet melody.
They run slowly on to the face, quietly and silently,
Tears, remorseful, regretful tears for days,
Joyful days long gone, for they will never, ever come back.

Now is the magician's turn with some amazing tricks,
The comedian reappears once again, to leave us
With a joke and a laugh.

It was a good family show. But now is time to go
To bed; the next programme (and also the one after)
Is a "Rep", a repeated programme requested "By
Public Demand" and shown once again.

Worse to come is that after eleven o'clock,
Most of the night, it is a "no pleasant view" zone,
A violent film or a stupid, cheap,
Low life programme, usually related to nudity
Or drugs, going on until the morning.

Pain and bitterness, gazing through the
Window, bring back to mind what the
Outside world sometimes, somewhere
Really looks like.

This is the time to switch the television
Off and go to bed, with that hope, that
Tomorrow will be a better day!

Other readers may call to mind little comforts which help them through the day or night. Not many of us can write poems but please send me jottings about what helps *you*. It may just help someone else.

Rachel Pearson
4 The Oaks
Horringer
Bury St. Edmunds
Suffolk IP29 5SH

E-mail: Rachel.Pearson1@btinternet.com

postbag

I have one letter this time from Eileen Johnson who has also been in touch with Ella and Caroline and relates her experiences obtaining treatment for a meningioma

Tetbury, Gloucester

Dear Editor

Having seen an article in a newspaper about stereotactic radiotherapy as successful treatment for brain tumours I saw a consultant who told me I should have the meningioma which had been diagnosed removed by surgery urgently and gave a possible date. Although in a state of shock I did manage to ask him if I could be treated with stereotactic radiotherapy (I said I had read of a child with a brain tumour who had successful treatment).
The consultant replied "Not suitable in your case" and showed me and my husband out of the door.
We were really shocked by his reaction and this set me thinking and I just knew surgery was not for me. This feeling was so compelling, I knew I had to find out much more about my meningioma. The consultant was brief and he didn't expect me to ask any questions. I did manage to ask what the risks were and possible outcome. He quoted a success percentage and mentioned epilepsy which could be controlled.
I then asked my GP for a second opinion. She gave it a lot of thought as to the best person to refer me to. I mentioned the report in the newspaper about stereotactic radiotherapy or similar as opposed to surgery. I was given an appointment with a neurosurgeon in another area and as I only had a very short time before the scheduled operation (which I didn't want) I went privately. Although being a neurosurgeon this consultant knew about the various possible treatments and arranged for me to see Dr Brada at the Royal Marsden Hospital in Fulham. He informed me that there was no urgency to have either an operation or radiotherapy treatment, but that if I developed any obvious symptoms of sight problems indicating the meningioma was growing in size I could undergo radiotherapy at the Royal Marsden. I have an Admission Card should the meningioma increase in size and cause danger to the optic nerve. I have MRI scans once each year and have appointments at six monthly intervals to check my eyes and periphery fields. I could not wish for better care.
Sincerely

Eileen Johnson.

Frequently Asked Questions

Alison has been asked what our members most often want to know about their condition, treatment and after effects. She has compiled a long list of which these are some. If you have any thoughts about anything you were particularly anxious or concerned about which isn't here please let us know. Otherwise I'm sure you will find it reassuring to know that others were worried as well

Before the operation

Can you get all the tumour out in one go? Will it regrow? How do you check?
Do I have to have surgery – Is there another way?
I'm worried about my family/children how do I prepare them?
I read all this stuff on the net and it's frightening who can I talk to?
I'm a Watch & Wait patient what if it suddenly grew how would I know?
How long is the operation? Will I wake up all right at the end?
I had an anaesthetic 5/10/15/20 years ago and was very sick does that still happen?
How big will the scar be? Are they stitches or something else?
Will they take off a lot of hair? Will it grow back?
Will I have a headache when I wake up?
Where will I be when I wake up – intensive care?

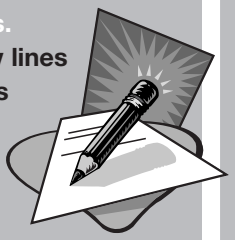
After the operation

Will I have a headache when I wake up?
Where will I be when I wake up – intensive care?
How long do I have to stay in hospital?
Will I have a bandage round my head?
When can I have a shower?
Will my family be able to come and see me on the operation day?
I live a long way away how can I get home – should I break up the journey?

Recovering

How soon will I be back to normal?
Will I be able to eat all right afterwards?
How soon will I be back to work?
Will I be able to do the same work, should I go back part time?
What will happen to my face – Will I be a freak?
If I look awful can they do anything to help me – how soon after?
Is there anything I can do to help myself?
Once the tumour has gone that'll get rid of the tinnitus – yes?
When can I start driving again?
I have balance problems now will they improve once the tumour is gone?
Can I take up my sport again?
Will I feel tired afterwards?
I live on my own is there anyone who can help me?
Can I get a hearing aid to help me?
I'm worried about my eye afterwards, will I be able to wear my glasses/contact lenses/
What bad signs should I look for after the operation?
Will my leg be troublesome? I like walking, is that a good idea?
I've got a holiday booked soon after my operation, will I be able to go? Can I fly? Can I dive?

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
email: chris@richards2113.fsnet.co.uk

by: 19th July 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

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.

Surfing the Net?

Next time you go surfing don't forget our AMNET web-page on http://www.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.

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

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

British Acoustic Neuroma Association
Oak House, Ransomwood Park
Southwell Road West
Mansfield, Notts NG21 0HJ

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

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Our speaker, following the AGM will be **Ms Johanna Beyts** who is a vestibular scientist working at the Royal National Throat, Nose and Ear Hospital in London. The title for her talk will be – **'New methods for rehabilitating patients with a balance problem'**

The autumn meeting will be on **Saturday 21st September** in the Boardroom at Addenbrooke's Hospital Cambridge and will start earlier at 11.00 hrs. Our speaker will be Norma Gaye who is style consultant and she will do two sessions showing us how to make the most of ourselves.

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