

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

Spring 2003
Issue 25

'A Year as Major of Bury St Edmunds'. A talk by Brain Bagnall Reported by Chris Richards



We invited Brian, one of our members, to talk about his experiences as Mayor of Bury St Edmunds during 2001 –2002.

Brian began his talk by describing the borough of St Edmundsbury which stretches from the borders of Norfolk on one side to the borders of Essex on the other, and includes the city of Bury St Edmunds and the town of Haverhill. It is an amalgamation of 4 councils. The mayor is chosen to be the first citizen and to represent the whole borough so he has to get around the whole area.

The mayor is chosen from the 44 councillors and when Brian was first asked he was not keen to do the job, but he reluctantly agreed and became mayor from May 2001 to May 2002. He is now spending a second year as deputy mayor.

The role of mayor is supported by a secretary and a chauffeur. The secretary is responsible for making appointments and accepting

engagements and the chauffeur is responsible for getting the mayor to where he is supposed to be. During his year as mayor Brian attended 270 engagements and he had to ask if he wanted a day off!

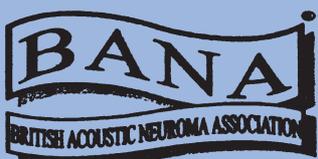
Being mayor also involves dressing up in red robes and mayoral chain and attending an engagement in full regalia is known as 'coming in chains'.

Brian showed us a photograph of himself in the regalia and this now has its place with other former mayors on the walls of the mayor's parlour. The mayor's parlour contains a number of artefacts collected over the years including a sword and two maces presented to Bury St Edmunds when it received a Royal Charter in 1606. The sword is carried in procession sheathed as 'protection' for the mayor but when the Queen visits the sword is carried unsheathed as protection for her. The mayor is the Queen's representative in the borough.

Brian has special memories of four events which took place during his year as mayor. Prince Charles visited to lay a brick on the new tower being built for the cathedral. He wanted to meet all the craftsmen and also the children who were watching. When it came to laying the brick Prince Charles did not make a good job of it, so he asked to be shown how to do it properly and a while later with his suit covered in mortar he managed to do it much more successfully. He was also very pleased to discover that the flint worker working on the

Next Meeting

The next meeting will be on Saturday 29th March in the Boardroom at Addenbrooke's Hospital. The speaker will be Judith Bird Senior Audiologist at Addenbrooke's Hospital talking about 'Cros hearing Aids' Doors open at 13.00 hrs



tower had received a grant from the Prince's Trust. Having met everyone and been charming and natural the Prince eventually left an hour late.

Bury St Edmunds sponsors a submarine called HMS Vengeance and as the submarine would have difficulty visiting the city which has only a small river, Brian was invited to visit the submarine in the Isle of Arran. They drove up there and were shown round the submarine which is very long but narrow, and taken on a trip and shown how everything works. Brian found this very interesting and enjoyable. Later in the year he attended the centenary service for submariners who had died in service at Westminster Abby.

Another exciting trip he had was courtesy of the American Air Force at Mildenhall. He was taken up in a refuelling tanker circulating in the North Sea while fighters linked into the tanker to refuel. This is done extremely quickly, taking only about 8 minutes for each plane.

Finally Brian earned himself the accolade of being a thoroughly modern mayor. In conjunction with MSN Microsoft, Bury St Edmunds became the first council to have an internet bench. The Abbey Gardens in Bury which are walled and fairly secure provided an ideal location and the bench was launched in August 2001. It had four internet connections so that people could sit at the bench and use their laptops while enjoying the gardens. As this was the first in the world it attracted a lot of media attention with camera crews from China, Japan, USA, Australia and all over Europe visiting. A friend in Singapore even sent Brian a cutting from a Singapore paper with his picture and the bench. The bench has been kept going and 129,000 contacts have been made through it. The council are now looking for new things such as possibly having a camera so people can transmit pictures. They are also looking further afield and hoping to set up a cyber cafe in the village of Hopton.

Other events he remembers from his year in office are starting an MG Rally from outside the Angel Hotel, being received by the Queen at a garden party for chairmen and mayors from councils all over the country, and receiving visitors from all over the world. As deputy mayor he now attends engagements which the mayor is unable to attend.

During his year in office Brian selected three charities to support – the Parkinson's Society, CLIC a charity for cancer and leukaemia in infants and Crossroads who are an organisation 'Caring for Carers'. He saw this as an opportunity to do something for smaller charities and he raised £3000 for these charities through the year. The fundraising included hosting a ball on New Years Eve.

Of course he also had duties in council which included being chair of the council. He aimed to stop time wasting in council meetings but found they were no shorter at the end of the year. At the end of the year there was a dinner in honour of him and his consort. His daughter had acted as consort for much of the year, but she was unable to do it all the time so Brian had twelve consorts in all and referred to them as his 'calendar' girls. He was awarded with a Past Mayors badge which he can wear at official events.

Brian was asked if he had found any particular difficulties during the year. He said that walking straight in procession was not always easy and the 'buffet' situation where there were a lot of people often presented difficulties in singling out any one conversation. He also found railway stations difficult but he also found that selective deafness can have advantages at times. In closing, he said that Mr Moffat has used him as an example to other patients that there is normal life after an acoustic neuroma.

To celebrate CAMTAD's

25th Anniversary

1978 – 2003

**'Hear This'
Exhibition**

at

St Andrew the Great Church

St Andrew's Street

Cambridge

CB2 3AX

(Adjacent to the Lion Yard
Shopping Centre)

11th – 16th August 2003

Editorial

Dear all

Spring is coming so it is time for the next newsletter. We have some very interesting items for you this time. The reports from our Christmas meeting one in this issue and one planned for the next, are on topics fairly far removed from acoustic neuroma or meningioma but, nevertheless very interesting and informative. We have some more information on meningioma from Ella and Caroline from the Meningioma Association UK – who incidentally have produced their own newsletter recently. Ella has provided information about how to get hold of a copy if you are interested.

We have an article from Jill Laurimore on her experiences with Botox –which despite it's recent bad press has been used as a medical treatment for a number of conditions for

many years. We also have Rachel's experience of learning to drive again after acoustic neuroma. Rachel has been very frank in recounting her difficulties and efforts in overcoming them. Do any of you out there have tales of overcoming problems which you would like to share to encourage everyone, or maybe your experiences in regaining a skill such as driving – please write in – I am always saying this is your newsletter so I need lots of people to contribute. Others can benefit from your experience.

Best wishes

Chris.

Acoustic Neuroma and the Mobile Telephone

This article by Brian Lloyd is taken from November 2002 edition of BANA's Newsletter 'Headline News'

On 9th July the Daily Mail printed my letter concerning acoustic neuroma and the use of mobile telephones. Some of you may have seen it. An item in the 'Mail' had explained how Robbie Walford believes his tumour was caused by heavy mobile phone use and another acoustic neuroma patient had replied airing his view that the telephone couldn't be responsible because he had an AN and had never used a mobile telephone.

Acoustic neuroma which has been recognised for many years, was notable for it's rarity and patients who had surgery 25 to 30 years ago have told me that they felt they were making medical history because acoustic neuroma was so rare, but now is it becoming more common? Or is it being diagnosed more often owing to grater awareness and improved diagnostic techniques.

Until recently we were told that there was no evidence to link mobile phone use to brain tumours. However, as more research is carried out that view seems to be changing and indications are that microwave radiation can damage tissue, hence recent health guidelines .on mobile phone use. A study carried out by Professor Lennart Hardell of Orebro University in Sweden has compared 1671 people who have been diagnosed with brain tumours with a similar number of healthy people.

Prof Hardell found that mobile phone users were two and a half times more likely to have a temporal brain tumour on the side of the head where they held the phone. In the case of tumours of the auditory nerve the risk increased to more than three times for mobile phone users

Recent research seems to indicate that digital mobile phone radiation can damage tissue in ways not previously thought of – it was assumed that digital telephones were safer than older analogue equipment – but it will take several years of study before conclusions can be made.

There has been a huge increase in mobile phone use in the UK over the last few years with around 45 million mobiles

in use. Children are considered to be particularly at risk from mobile phones radiation and it is reported that Sir William Stewart, who chaired a government sponsored report on mobile telephone health risks, will not allow his grandchildren to use a mobile phone because of the health risk.

It will be some time before the true situation is known, in the meantime there will be claims and counter claims about safety just as there was with cigarette smoking. The mobile phone is an essential tool for so many of us but we should be aware of it's possible dangers and use it cautiously. Oh yes – I still have a mobile phone but I use it sparingly.

You are invited to
A Birthday Party
To celebrate
25 years of CAMTAD
on
Saturday 5th July
3pm to 6pm
at St John's Church Hall, Hills Road
Cambridge

Botox - a personal experience

Jill Laurimore



Botox. Unless you have somehow kept yourself unsullied in a media-free zone, you must have heard of it by now. Short for Botulinum Toxin, it was for years only associated in the general consciousness with either biological warfare, or rare and usually fatal, cases of food poisoning from rogue tins of salmon. All that changed over the last few years when we heard increasingly of celebrities using it to smooth out their wrinkles - and now everyone seems to be doing it. Even Boots the Chemists is trumpeting walk-in, no-appointment-necessary botox clinics.

The first I knew of it was in the literature from BANA and AMNET when my acoustic neuroma was newly diagnosed back in 1997. Along with gold-weights and tarsorrhophy it was a suggested remedy for post-operative inability to close the eye and it sounded pretty bizarre, though subsequent familiarity has drained the apprehension from most of these procedures. Botox's unique selling point is that, in its pharmaceutically refined form, it can be used to paralyse muscle temporarily. One of its initial uses was to help patients with blepharospasm - uncontrolled blinking and twitching of the eye, and also for uncontrolled (often painful) muscle spasms in many other areas of the body, particularly the face, neck and shoulders.

I next encountered it, post-operatively, in BANA's 'Headline' journal where there was an article outlining its use at the Queen Elizabeth Hospital, Birmingham

- this time to treat the problem of synkinesis. By then I was seven months into my own recovery and had developed synkinesis myself. As we all know, even the most successful removal of an acoustic neuroma from the eighth cranial nerve may result in damage or bruising to the seventh or facial nerve. The nerve/nerves of the face may then stop 'firing' temporarily, so that the facial muscles relax and go floppy. As the nerve recovers, it may well 'go over the top', and fire uncontrollably - the muscle will flick in and out of tension making it go into spasm - a facial tic. In cases of synkinesis, when the patient attempts to move one part of the face, another part moves along with it involuntarily; the most obvious example being when the patient is asked to smile broadly, the eye on the affected side closes at the same time.

There is slightly contradictory evidence now about what exactly is causing this. The accepted surgical view is that the recovering nerve has grown in the wrong direction. The view amongst neuro-physiotherapists is that the recovering, weakened new nerve has learned inappropriate behaviour and can be retrained. This view demonstrates the idea of 'neuro-plasticity', a concept we have begun to hear more of - through American Neuroma Association, BANA and indeed from two of our own AMNET speakers, Diana Farragher, the renowned facial therapist and Dr Johanna Beyts of the Royal Throat, Nose and Ear Hospital. In very basic layman's terms the concept of neuro-plasticity is that nerves, and indeed the brain itself, have an on-going ability to change and adapt. This is encouraging for acoustic neuroma patients, though it is worth remembering that nerves which can carry on 'improving' can also change for the worse as well as the better. My own simple and very clear demonstration that change can continue well after the accepted two-year recovery span, is that I started to develop 'crocodile' tears in the fourth year after my op. The good news is that it is well worth our being informed and thus vigilant, to help our bodies in the on-going process of recovery: if it is possible to retrain inappropriate nerve behaviour then we want to know about it.

The more recent use of botox is in some ways a short-cut to this retraining. It is injected into the appropriate facial muscles and allows the twitching nerves to rest. It is not painful, takes only a few minutes and you don't even have to remove your make-up before it is done. At its very best, the calmed nerve relearns how to behave and even when the botox has worn off, it remains calm. In other cases the

area will need re-injecting to maintain the required effect. In general use the effect of botox is said to last about three months, but where the nerve has been in some way compromised, as in acoustic neuroma recovery, the effects can last longer. I have had the pulsating nerves in my chin successfully treated three times now and the effect seems to last at least six months. The botox treatment aimed at relaxing the cheek and corner of the mouth has had more mixed results. I had constant twitching of the cheek following animated conversation and that seems to have cleared up completely following the very first treatment. The result is not just aesthetically more pleasing, but the wearing 'pulling' feeling has also disappeared. The mouth though is less successful - it straightens out all right, but then goes beyond the desired effect and tends to make my top lip all but disappear on that side -(my children think this is hilarious and offer lip-tattooing as consolation). Even in the most skilled practitioner's hands there has to be an element of trial and error in the process because the

reaction of the nerve and muscle cannot be foreseen precisely. The advantage is that the effect is not permanent, one just has to wait patiently for it to wear off again.

The initial dosage should always be small, the result assessed, and the dosage increased if necessary. There are some nightmare stories of over-enthusiastic treatment for eye spasms leading to either double vision or total lid-closure lasting for months. I rejected treatment for my twitching eye a couple of years ago for this very reason, but I have recently been re-offered treatment on the NHS using small doses in the upper eye area. Ever cautious, I am first going to make myself take the time to go back and work at the physiotherapy again and see if I can re-impose some facial discipline. The process of 're-training' those weakened nerves is time-consuming and it's all too easy, indeed natural, for work and life to take precedence. If exercise fails me I may well try the eye botox route - and will report back with the results.

A LOSS OF FACE

By

Diana J Farragher OBE FCSP MSc Grad Dip Phys Dip TP

New 2nd Edition published January 2003

Diana's book is a self help book for people with facial paralysis. Over the years it has helped countless people to understand the anatomy of their face and the physiology of their palsy. It aims to help you towards educated decisions on treatment at every stage.

The new edition contains information on revised testing and treatment procedures encompassing improved technology since the 1st edition was published. It also incorporates new chapters on Acoustic Neuroma and Moebius Syndrome

Finally a very popular section, the patients stories, has many new additions and gives a remarkable insight into the strength and fighting spirit of some of Diana's patients.

Priced at £20 plus £3 post and packing
Available from: The Linden's Clinic
214 Washway Road, Sale, Cheshire, M33 4RA

ORDER FORM

Please send me copy(ies) of 'A Loss of Face'

I enclose a cheque for £....

Cheques should be made payable to 'The Lindens Clinic'

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Please send completed order form along with payment to The Linden's Clinic at the address above.

Rachel's Corner

It's driving me round the bend!



Children ride bikes. They do skateboarding. Sometimes they learn to skate or ski. Adults drive cars. Only, just occasionally, they can't. Given our poor public transport other than in cities this makes life difficult for them. And have you ever tried taking shrub prunings to the council tip on a bus?

When I was about four, according to my mother, I was the only child on the street who could fall off a tricycle. Although I learned to ride a bicycle, when other children whizzed, I wobbled. When I was seventeen my parents kindly paid for driving lessons. Driving instructors (and believe me, there were many) were driven to despair and probably drink. They and my family could not believe how stupid I was. Why did I not steer properly round bends? Why was I so terrified of cars? Why did I not accelerate?

With everyone aghast at my incompetence I was deemed a failure and after two disastrous tests was encouraged to give up. The shame of this never left me. Without telling anyone I paid for 6 more lessons when I was a student. The instructor informed me grimly that I was my own worst enemy and that I should sort myself out first. Years later I found a saintly instructor and somehow passed a test on early closing day. Many years later my husband said that I should buy a car (horror) and so I carried on desperately trying to turn myself into a Normal Driver.

Eventually after years of driving but never feeling confident I started having serious panic attacks in the car. Then I seized up before bends. As my husband was ill and later died this was all put down to stress. Finally I got myself to an ENT surgeon who took me seriously and despatched me forthwith to Mr. Moffat. The relief of learning that all my problems with steering and acceleration were due to an acoustic neuroma (it never did affect my hearing) was overwhelming.

Since my surgery I have tried to train my brain to drive all over again. It is not a very good brain and does not learn easily. The standard balance exercises helped a little with walking but not with driving. It is quite hard to find a way of learning to drive when you hold a full licence but can't do it. At first I bought a car and put P (probationer) plates on it. This just puzzled people. Now I have a home-made sign in the back window which says "Disabled Driver. Thank you for being patient". This is not a legal approach but it warns people that I may be unexpectedly slow and

stops them hooting at me so much. It also means that at a supermarket no-one parks within a mile of you if they can help it because they assume that you are likely to reverse into them.

When I am "driving" a car it is as if the road is a very choppy sea. I cling desperately to the wheel while my body tells me that the car and I are about to overturn. This also induces an emotional and physical panic response. The faster I go the worse the effect. Turning to the left (away from the neuroma side) is always harder than going to the right. This was the case before surgery. I have tried all kinds of approaches to desensitising myself to the situation, not necessarily in the following order; relaxation exercises of various kinds, having lessons at the centre for disabled drivers at Thetford, contacting acoustic neuroma groups at home and abroad to see whether they had any ideas (the delightful Australians could all drive but informed me that my computer had a virus and told me how to fix it), insuring a friend to drive my car so that he could take me to and from disused airfields, writing to Mr. Moffat and driving slowly through very gritted teeth.

When I had exhausted (in both senses) East Anglian physiotherapists, who were wonderfully kind and tried to cure my headaches when I still could not drive out of my estate, I learned through a helpful BANA member of the existence of Johanna Beyts, the vestibular scientist at the Royal National Throat, Nose and Ear Hospital in London. To my amazement my long-suffering GP gave me an NHS referral to her and this has been by far the most helpful approach to the problem. I have been seeing Jo for about 2 years now and her knowledge has led me to understand new aspects of the problem. The main difficulty is that my constant head pain and frequent severe headaches actually prevent vestibular re-training. We have therefore had to look at ways of reducing the pain. That is another story, but suffice it to say that as the pain has slowly improved so has the driving. It still has a very long way to go and every journey is still a battle fought with the road camber. However I can get myself to the nearest town and being able to go to shops, dentist, vet and so on is wonderful. Since September I have been able to manage about 12 miles on minor roads, so I can visit friends in nearby villages and take myself to what passes for work. My top speed is around 34 mph, but when I bought my car it was about 10 mph, so for me this is a triumph. But don't get stuck behind me

MENINGIOMA ASSOCIATION UK REPORT

The first issue of The Meningioma Association UK newsletter was published just before Xmas. If anyone wants a copy please see our contact details on back page. Ella Pybus

One size doesn't fit all when it comes to meningioma tumours!

Did you know meningioma tumours come in various types...?

Meningioma tumours can be divided according to their location and their type. Most meningiomas are intracranial (i.e. occur in or on the brain), but they may also be spinal (i.e. on the spinal cord). They may occur in any area, although certain locations may be more common. The location where a meningioma tumour occurs has an influence on its possible signs and symptoms. The location of the tumour also determines how easy it will be to manage/treat it (e.g. skull base meningiomas are more difficult to treat surgically).

Most meningiomas are benign, which means that they do not spread. It is very rare for meningiomas to be malignant. Occasionally, on microscopic examination meningiomas are described as 'atypical' which means that they are not totally benign, but not obviously malignant either. In that case, doctors will take extra precautions to prevent spread and/or recurrence

Caroline Batt, The Meningioma Association UK

TREATMENT OF MENINGIOMA - WHAT'S NEW

Meningiomas are almost always benign and slow-growing tumours that do not invade and do not spread. This makes them ideal candidates for surgery, because this can put a definite end to them. Small, asymptomatic meningiomas can be carefully observed and followed with serial MRI studies. Treatment is advised when there is evidence of growth or if the meningioma is large and associated with progressive symptoms over time.

Surgery

Surgical resection is indicated by the growth or size of the meningioma or the progression of symptoms. Complete resection of meningiomas is usually possible with tumours at the outer surface of the brain, but is difficult for tumours involving the skull base. Advances in microsurgical technique have made it possible to deal with meningiomas in these deeper and previously inaccessible locations such as the skull base, cavernous sinus, and around major blood vessels and facial nerves. However, even the best surgeons may not be able to remove the entire tumour in these difficult places, and meningiomas then need further radiation therapy in order to limit regrowth and prevent recurrence.

Radiation therapy

Conventional radiation therapy is used to control regrowth of incompletely removed meningiomas. This is generally given as a fractionated treatment, with multiple small doses ('fractions') administered over several weeks. This allows for higher doses to be given without side effects or damage to normal tissue.

Radiosurgery

This is the one area that has been shown to be a promising method for treatment of meningiomas. In SRT (stereotactic radio therapy) a highly focused radiation is

given, which precisely targets the tumour with little impact on healthy brain tissue. It is administered in smaller individual doses ('fractions') over a number of weeks (often 30 sessions given over six weeks). SRT therefore has fewer side effects than one big "shot" of radiation (as in the gamma-knife). It stops tumour growth in the vast majority of cases and in some people it may even cause the tumour to shrink. However, SRT is only possible if a tumour can be visualised on scans, and cannot be used in large tumours. There are very few side effects, the main one being tiredness.

Hormonal therapy

There is clear evidence that hormones and growth factors influence the growth of meningiomas. Many meningiomas have hormone receptors, predominantly for progesterone but also in some cases for oestrogen. Treatment with anti-oestrogens has not been effective thus far. Treatment with anti-progesterone drugs has shown promise, but recently completed trials with the anti-progesterone drug mifepristone (RU-486) did not show a benefit. Meningiomas may also have receptors for other hormones such as octreotide; at present this is occasionally used for diagnostic reasons (for instance, octreotide scans for diagnosis of meningioma), but not for treatment.

Chemotherapy

Meningiomas are not very susceptible to chemotherapy, since they grow slowly. In a recent report the drug hydroxyurea had some effect in reducing the growth of inoperable recurrent meningiomas, but this is still preliminary and awaiting further studies involving more patients. Furthermore, this drug has a variety of side effects as can be expected with chemotherapy, such as nausea and hair loss.

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.

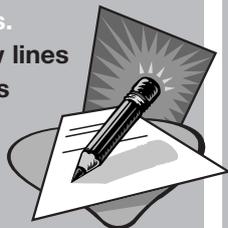
Contributions on paper and/or disc (Microsoft Word) to:-

Chris Richards

**12 Sudeley Grove, Hardwick
CAMBRIDGE CB3 7XS**

email: chris@richards2113.fsnet.co.uk

by: **17th April 2003**



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 Neurosurgeon

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

Mr N J C Sarkies MRCP FRCS
FRCOphth Consultant Ophthalmic 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 following Acoustic Neuroma

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

FORTHCOMING MEETINGS

The next meeting will be on **Saturday 29th March** in the Boardroom at Addenbrooke's Hospital. The speaker will be Judith Bird Senior Audiologist at Addenbrooke's talking about 'Cros hearing Aids'. Doors open at 13.00 hrs

Our AGM will be held on Saturday 7th June in the David Dunn Room at Addenbrookes Hospital. The speaker will be Brenda Elcome who will talk about 'Lip Reading'. Doors open at 13.00hrs

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](http://www.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.changingfaces.co.uk>

Changing Faces acts as a resource for the empowerment of people with facial distinctions. Free information packs and booklets are available.

The Meningioma Association UK

**53 Pine Grove, Brookman's Park,
Herts AL9 7BL**

Tel: 01787 374084

Email: MeningiomaUK@aol.com

Facial Stimulators

AMNET has some Facial Trophic Stimulators which are available to members for short term loan. There is a charge of £25 at present which includes maintenance and postage. If you would like to know more please contact:
Margaret Allcock on 01493 700256

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.

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.

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)

4th floor, White Building, Fitzalan Square,
Sheffield S1 2AZ

Freephone enquiry line 0800 018 0527

Web site: <http://www.tinnitus.org.uk/>

Chairman

**Alison
Frank**

01953 860692

Secretary

**Tony
Monk**

01353 778423

Treasurer

**Joanne
See**

01487 814380

Newsletter Editor

**Christine
Richards**

01954 211300

New Patients
Officer

**Neil
Bray**

01223 561234

AMNET
Librarian

**Ray
Maw**

01787 248036