Newsletter of The Acoustic Neuroma 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 2003**
Issue 26

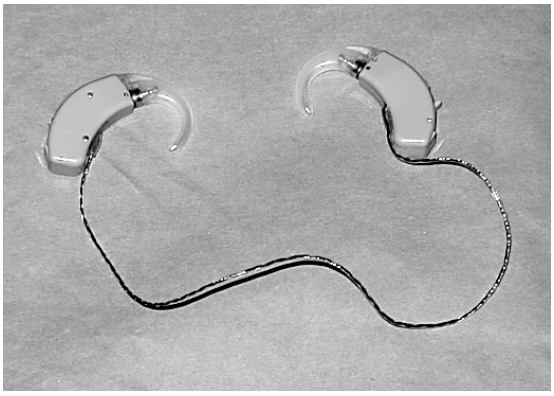
# CROS Hearing Aids

## a talk by Judith Bird, Audiological Scientist, Audiology Department, Addenbrookes Hospital

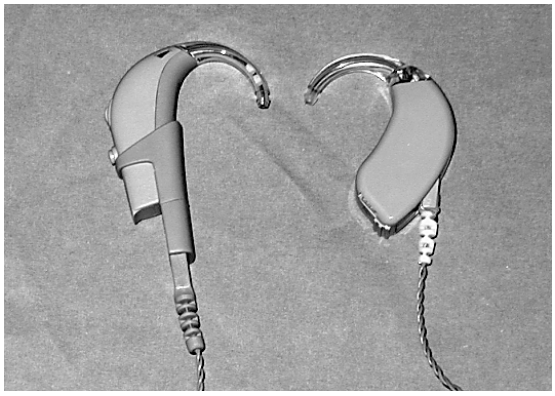
Reported by Chris Richards

Judith opened her talk by describing what is meant by a CROS hearing aid. CROS stands for Contra-lateral Routing Of Signals and is a principle rather than a particular type of hearing aid. It is any hearing aid where the sound is picked up on one side of the head and relayed into the opposite ear. Sound is usually relayed by a head wire from a microphone on one ear to a receiver on the other ear. At Addenbrooke's these aids are often custom made by a company who split the parts of a hearing aid to produce these two parts. The earpieces are kept as open as possible so that sound is not prevented from entering the good ear

**Custom built CROS aid**



**Commercially available BICROS aid**



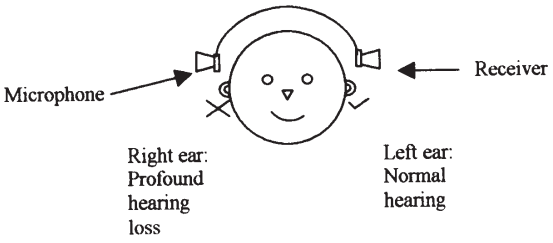
CROS hearing aids are used in a number situations:-

- Unilateral hearing loss
- Severe/profound unilateral hearing loss and mild loss on the other ear.
- Medical: when someone cannot tolerate an ear mould appropriate for hearing loss for some reason such as recurrent ear infections
- Feedback problems

There are three types of CROS hearing aids

The CROS aid is used when there is profound hearing loss on one side and normal hearing on the other side, or when the poor ear is not suitable for a conventional aid for example if recurrent infections make it difficult to tolerate a full earpiece.

**Cros aid**

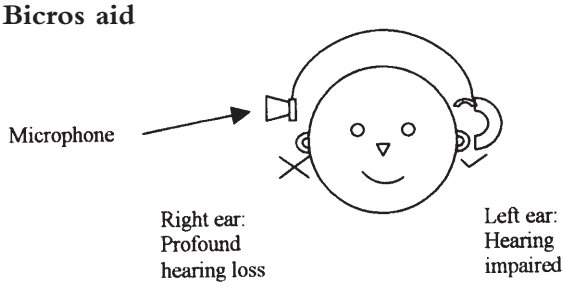



The BICROS hearing aid is used when there is profound hearing loss in one ear and some impairment in the other. It uses a microphone on the ear with profound loss and a normal hearing aid on the hearing impaired ear.

## Next Meeting

The next meeting will be our AGM which will be held on **Saturday 7th June 2003** in the David Dunn Room at Addenbrooke's Hospital. The doors will open at 13.00hrs as usual and the AGM will be at 13.30hrs. Our speaker for the afternoon will be Brenda Elcome who will speak about 'Lip Reading'.

**Bicros aid**




Multi-CROS aids are also possible and can be used when there is hearing impairment in both ears . It is effectively two hearing aids but with separate microphones and receivers which can help if there are problems with feedback. In practice, people tend to find them difficult to manage and they are therefore rarely used.

For those with unilateral hearing loss the main problems are

- Unable to hear on the bad side
- Problems where there is background noise
- Impaired ability to localise sound leading to difficulties in groups

The CROS hearing aid only provides a solution for one of these problems as it gives awareness of sounds on the bad side but it does not reduce background noise or improve ability to localise sound. There are also some problems associated with using CROS hearing aids. There is a high repair rate and they are cumbersome.

Assessment for the use of a hearing aid is very important. For people who have developed strategies for dealing with their hearing loss such as retraining the people around them to sit on the right side, attract attention before speaking and getting the right seat in the restaurant, these strategies may work better than a CROS aid. However it is difficult to assess who will benefit and who won't before they try it out.

Successful fitting is dependent on assessing a number of criteria. These include, the demands on hearing in different situations, the listening environment, how well-motivated the person is to use the aid and duration of hearing loss which will both be linked to how well they are already coping.

The process for obtaining a hearing aid involves an assessment to find the solution that will best solve the hearing problems in that individual. If the decision is made to try a hearing aid, a mould is made and then the hearing aid is fitted a few weeks later. It is very important that the patient tries it out in their everyday life in order to decide on the advantages and disadvantages. Progress with the aid is then reviewed at a follow-up appointment. Subsequently, minor problems and repairs can be dealt with at the daily open access repair sessions. A review of the fitting may be necessary at a later date if the hearing needs change. There is high demand for these reassessments and so often there may be a significant wait for an appointment.

Of all the CROS hearing aids, the BICROS hearing aids is probably the most widely used. The patient will already have one hearing aid which can be boosted by the addition of the second microphone. Digital hearing aids are not used with CROS aids as minimal amplification is given but can be used with BICROS.

In the question session the problem of background noise with hearing aids was raised. Judith pointed out that hearing aids don't filter out unwanted sounds as well as normal hearing and hearing speech in background noise often remains difficult even with the most sophisticated hearing aids. On first fitting, extraneous background sounds may seem very noticeable, but this often improves with consistent use of the aids. People tend to do better in background noise when two hearing aids are fitted when this is appropriate. Some hearing aids allow the user to switch to a directional microphone when listening in noise which can help by cutting out sound coming from behind .

Judith was asked about the advantages of digital hearing aids. She said that it does depend on the individual. The aids are more flexible and can be set to meet more precisely the needs of an individual. Judith pointed out that work in the Modernising Hearing Aid Services project has suggested that improvements to the whole process of hearing aid fitting are also highly significant in patient satisfaction with the hearing aids. This may partly be due to the increased time spent at the assessment appointment, ensuring the best solution is found to an individual's hearing problems and that there are realistic expectations of what hearing aids can achieve. People's expectations are very important in the ultimate success of hearing aids and sometimes with digital hearing aids expectations are too high. Realistic expectations are very important in the ultimate success of hearing aid use.

Judith summarised her talk by saying that CROS aids were highly successful for some people but rejected by others. It is important that people have the opportunity to try if it is appropriate. Each individual needs to assess if the advantages outweigh the disadvantages for themselves. She suggested that in general – rather like MARMITE – people love CROS hearing aids or hate them!

# AMNET AGM

*The AMNET AGM for 2003 will be held at Addenbrooke's Hospital on Saturday 7th June at 13.30 hrs*

## AGENDA

- Apologies
- Minutes of Last Meeting
- Chairman's Report
- Treasurer's Report
- Election of Officers
- Any other Business
- Close

The present trustees and committee members are willing to stand again but if anyone wishes to be nominated for the committee or wishes to nominate anyone else please fill in the form below and send it to:
Alison Frank, The Old Schoolhouse, The Green, Old Buckenham, Attleborough, Norfolk NR17 1RR

| **Present Trustees** | | **Present Committee Members** | |
|---|---|---|---|
| Chairman | Alison Frank | AMNET Library | Ray Maw |
| Secretary | Tony Monk | Newsletter Editor | Chris Richards |
| Treasurer | Joanne See | New Members Co-ordinator | Neil Bray |
| | | Meningioma Association | Ella Pybus |
| | | General Members | Jill Laurimore<br>Eleanor Monk |

**Nomination for Committee member**

I would like to nominate _____

To serve on the AMNET committee in the office of:: (tick one office)

Chairman ☐
Secretary ☐
Treasurer ☐
General Committee member ☐

Signed _____ AMNET member

# Editorial

Hello Everyone

As I write this it is beginning to feel like summer although the weather forecaster is promising cold weather and rain to come so I shouldn't get too excited!. However I would like to welcome you to our summer newsletter.

This time I have a couple of reports from speakers at meetings – a very informative talk from Judith Bird, an Audiology Scientist from Addenbrooke's, who spoke to us about Cros Hearing Aids at our last meeting. She gave some very helpful information about how useful hearing aids can be and the importance of having realistic expectations and persevering with hearing aids in order to get the best from them.

My other report is from the Christmas meeting when Phillip Rundle, the archivist from Addenbrooke's, described the history of the hospital from it's beginnings in 1766 until the present day.

We have a report from Ray Maw about some of the findings from his latest Members Survey describing some of people's experience related to returning to work following surgery. It would be interesting to put some more individual details with the numbers. Maybe some of you could write in and tell us about your own experiences when returning to work after treatment of surgery.

Finally I would like to remind you that our summer meeting is as usual the AGM. We have to re-elect our trustees and appoint the committee for the next year. As I have said in the notice our present trustees are willing to stand again but if you might be interested in being a trustee or even just a committee member we would love to hear from you. Please contact one of the committee members (numbers on the back of the newsletter) if you would like to know more. Most of us have been serving on the committee for a number of years and there is always room for new blood. It needn't be too onerous we hold about 4 – 6 meetings a year and whenever possible we try to coincide these with the quarterly meetings. So please think about whether you can help us by putting something back into AMNET so we can keep it going for future patients.

Looking forward to hearing from you with your experiences!

Regards

# ‘A History of Addenbrooke’s Hospital’ A talk from Mr Phillip Rundall the archivist from Addenbrooke’s Hospital

Reported by Chris Richards

Mr Rundall began by describing the hospital as it is today. Addenbrooke’s Hospital is on a site of 60 acres and is continually growing. It was built on 45 acres of land purchased from Sir Francis Pembleton in the1950s and now has 6.000 staff and there are 8000 workers on site including staff from research establishments, university departments and pharmaceutical companies. It has 1300 beds and a budget of £240 million. In a year there are 53,000 inpatients, 57, 000 Accident and Emergency attendances and 350,000 outpatients. There are 4500 births at the Rosie Maternity Hospital.

The hospital has 20 operating theatres, 6 miles of corridors, 3000 parking spaces, 1000 cycle spaces and a bus station. On site there are a number of other institutions – the Wolfson Brain Imaging Centre, Medical Research Council’s Molecular Biology Research building, Hutchinson building, Welcome Trust and the ACCI which includes hospital, university, Welcome Trust, British Heart Foundation and Glaxo Smith Klein.

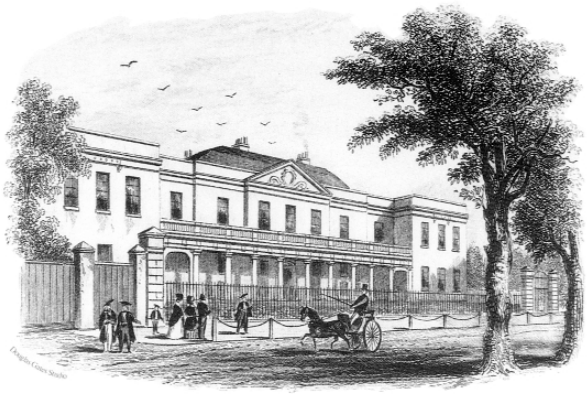
The beginnings of the hospital were much smaller. The site of the original hospital was in Trumpington Street opposite the Fitzwilliam Museum. The façade of the original 1866 building is still there but it now houses the Judge Institute of Management Studies.

The first Addenbrooke’s Hospital opened it’s doors to patients in 1766. It was built with funds from the bequest of Dr John Addenbrooke who died in 1717 leaving £4900 to be used to build a small physical hospital for poor people. It took between 1719 and 1766 to actually build the hospital as the trustees invested unwisely and were very dilatory. Eventually a house was built in Trumpington Street but as the money had run out it was set up as a voluntary hospital run with subscriptions. Some wealthy people including the Earl of Hardwick and the Bishop of Ely gave large sums.

The hospital had 20 beds with 3 physicians, 3 surgeons, 3 apothecaries The physicians and surgeons had their own practices and the work they did for the hospital was voluntary. This continued right up to 1948. There was also a matron who was responsible for housekeeping and disciplining the servants who did all the other jobs and tended to be servants who had been rejected by more fussy employers.

The minutes of hospital meetings at that time show continual problems with servants, nurses and porters.

The original hospital was expanded in the 1820s when John Bowdale gave money to build a great extension. By the 1840s the Regis Professor of Physic at that time, Hatherland, had revised the curriculum for students and made it more scientific. The introduction of anaesthetics had also made it possible to carry out more complex surgery. Paget and Hymphrey, Professors of Physic and Surgery worked in the second part of the nineteenth century to improve the status of the hospital and the medical school. The influence of Florence Nightingale at that time also lead to the hospital being rebuilt in 1866 with large nightingale wards. The first school of nursing was opened in the 1870s by Alice Fisher and at that time the nurses paid for the privilege of being trained.



In the early 20th century Clifford Albert built the first clinical laboratories with a memorial fund donated by the mother of John Bonnet and the John Bonnet Laboratory is still part of the hospital.

During World War 1 the first nurses home was built and a convalescent home was built in Hunstanton. The hospital treated many military patients and a large military hospital with 1000 beds was also built nearby.

Between the wars, to meet the needs of a growing population and improving medicine a third storey was added and two extra wings were built. These housed a private patients ward and a children’s ward.

During World War II there was increasing specialisation and new drugs making it difficult for hospitals to continue on voluntary subscriptions and the Beveridge report suggested the changes which came about with the Health Services Act in 1948. The consultants were opposed to the change but were talked around with a good financial deal.

It became essential for the hospital and university to work together so a new site was purchased and stage one of the present Addenbrooke’s hospital was opened in 1962. This consisted of outpatients, accident and emergency, neuro wards and orthopaedic wards. There were also university and research buildings.

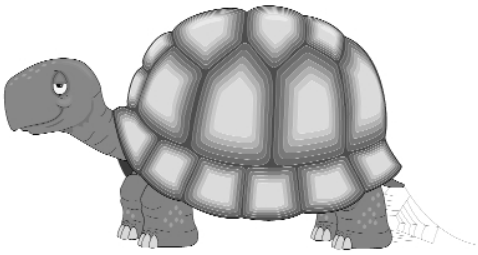
Stage 2 included the clinical school and the management were proud to announce that it was finished on time and within budget. It also included the famous chimney which can be seen from miles around. This is 220 feet high and was completed in 13 days using a continuous pouring process. Many people came to watch this but it was described by an architectural journal at the time as an ‘unlovely and inhuman mass’.

Stage 3 included the Rosie Maternity Hospital and the F and G block allowing the old site to close completely in 1984.

In 1993 the hospital achieved Trust status and since then there has been huge expansion on the site as described earlier and it will continue to grow.

# Rachel's Corner

## *Life in the Slow Lane*



*Tortoises get a bad press. Being fast is glamorous, being slow is contemptible. But there was that business with the hare …*

For the fortunate acoustic neuroma patient, the standard advice to take 3 months off work and then go back to "normal" life may be entirely appropriate. If, however, after 3 months you are still struggling to get up in the morning, it is easy to feel frightened and miserable. Have I not tried hard enough? Am I lazy? Am I letting everyone down? Worst of all, Will I ever get better?

It is of course impossible to say what will happen in individual cases. It might, however, offer a little comfort if I illustrate from my own life the possibility of improvement *after years*.

### Immediately Postoperative

Constant severe head pain. Eye sore much of the time, despite copious Lacrilube. Driving impossible.

### 3 Months Later

3 further operations for CSF leak do not cure pain. (Plumbing nevertheless eventually successful!)

### 1 Year After First Operation

Migraines 3 times per week, but minuscule amount of paid work possible. Lacrilube more adequate.

### 2 Years After First Operation

Slightly more paid work possible. Buy a car.

### 3 Years After First Operation

Can work for 3 half days per week. Housework being done more often. Can drive short distances slowly. Eye still improving. Face still improving.

### 4 Years After First Operation

Eye so much better can manage with Liquifilm twice a day. Driving 13 miles to work (on deserted tracks, but who cares?) Thanks to neck exercises head pain much more manageable and am planning to work half time.

All right, I admit it, I was always a slow learner. Took years to learn to make tea. (According to mother I still don't let it stand properly). Never understood calculus. But for all of you still having a rough time, I cannot emphasis too strongly that slow improvements are cumulative, and that even after years of pain life can improve beyond measure.

# AMNET Library: MEMBERS SURVEY 2002

## Post-operative Impact of an Acoustic Neuroma on Employment

**Once again thank you for your magnificent response to the 2002 member's survey:**
*95% from current members (173 out of 183) and 65% from a sample of former members (37 out of 57)*

This survey was primarily concerned with the *'rates of recovery'* from post-operative problems but it included a section on employment *'before and after'* an acoustic neuroma operation – an aspect about which we have no information in the AMNET Library. As this section was limited in it's scope, the findings can only be regarded as indicative of the impact of an acoustic neuroma operation upon employment.

# OVERALL FINDINGS

**Before the operation** most members were employed (62%), just under a third were retired (30%), a few were househusbands/housewives (7%) and one member was unemployed. Of those in employment about a quarter were self employed (26%), over half were in full time employment (56%) and about a sixth (18%) were working part time.

**After the operation** the number of members employed dropped by over a third to below (40%), consequently almost half are now retired (48%), househusbands/housewives are 9% and unemployed are 3%.

**Return to work:** While very few (3%) of members going back to work did so within the first month after their acoustic neuroma operation, the great majority returned within six months (50% within the second and third months and 31% within the fourth to sixth month). Most of the remainder go back within a year (12%) while 3% returned over the next two years and only one member over three years later.

**Type of job to which members return:** Well over half (63%) return to their previous job; approaching a third (29%) go back to the same type of work but change their employer; whereas 9% not only change their employer but also change their type of work.

**Time members spend working:** Over half (57%) spend the same number of hours working ; while, perhaps surprisingly, nearly a quarter (23%) work more hours than before their operation; however a fifth (20%) work fewer hours.

Significantly, where members change their employer, on average, they seem to work longer hours than if they returned to their previous employer. On the other hand, a similar number of members appear to have changed their employer in order to work fewer hours.

**Not returning to work after an acoustic neuroma:** Over a third (37%) who were in work gave up or had to give up work altogether after their operation. Most of these had been in full time employment (77%); of the remainder more had been in part time jobs (14%) compared to those who were self employed (9%). In other words, members who were self employed largely went back to work afterwards.

*Although it is not possible to draw any significant conclusions from these results it does suggest that for many of those undergoing surgery for an acoustic neuroma they are able to successfully return to their previous employment for a large minority the operation prompts a change in their working life. The reasons for this are probably very varied but would be interesting to investigate ED*

## Tips and Queries

*This is a new idea for a column in the newsletter. It is aimed at providing information and suggestions towards making life easier for all of us. It is of course dependent on people sending in their questions or suggestions so please start putting pen to paper.*
*The first tip is from Jill Laurimore.*

After five years of having to use ointment for my dry eye problem - and this after trying what seemed like every brand of eyedrop available not just here but in France and the US as well, I have recently been prescribed the answer: Minims Artificial Tears made by Chauvin. They are a preservative-free solution in clever re-sealable packaging which means one can use each little plastic phial several times within a 12 -24 hour period. I learned about these from a fellow AMNET member - an example of how useful our meetings can be in the cause of ongoing recovery. I gather these particular drops are being prescribed now at Addenbrookes but they weren't available when I had my op. Initially I had trouble getting the prescription filled and in fact wasted a year trying to use a substitute which I was assured by the pharmacist was 'just the same' - but of course it wasn't. The suitability or otherwise of eyedrops is very much down to personal choice and experience, but if you haven't yet heard of them and are stuck using ointment you might want to give them a try: they seem easily available now through Boots and other mainstream pharmacies.

*Thank you for the tip Jill and I hope to receive some more tips and questions for next time. As a charity we do have to be careful about appearing to endorse particular products or procedures so please take note of our 'Necessary Note' on the back page. Ed*

# Unrecognised Effects of a Meningioma or Acoustic Neuroma

Having a benign brain tumour diagnosed, whether it is an acoustic neuroma or a meningioma, is always a disturbing experience. The medics tell you the good news – yes, it is benign, but the consequences may be difficult to handle; usually surgery and/or radiotherapy will be required, and occasionally other forms of medical management (such as medical therapy or wait-and-see). Whatever happens, normal life is disrupted.

Following treatment, there is obviously a period in which your body has to recover. However, there are other psychological effects of illness that are often not recognised. Patients may be affected by anger, depression, loss of self-esteem, social withdrawal, relationship problems, and so on. These after-effects may have a serious impact on the way one recovers from such a traumatic experience.

Anger is a frequent reaction following an initial period of shock after having been diagnosed with any serious condition such as a brain tumour. 'Why does this have to happen to me?' It may be followed by acceptance or in some people, by depression.

In fact, all reactions described in bereavement will apply here, and depression is therefore a possibility. Having any illness can cause you to feel "down" or sad. But if the sadness is severe or long lasting, there may be an unrecognised link: clinical depression may occur at the same time as the medical condition. Clinical depression has been estimated to occur in as many as one in three people with any medical condition. Depression can cause changes in eating and sleeping patterns, problems with memory and concentration, decreased energy, and feelings of hopelessness, worthlessness, and negative or pessimistic thinking.

If you are bothered by tinnitus there is advice and support available. Not everyone is lucky in having a bearable form of this phenomenon or in being able to withstand its distressing effects.

If you are affected, discussing such symptoms with your doctor is important. First, if the depressive symptoms are part of the medical illness or side-effects of medications, treatment may be adjusted or changed. Second, if clinical depression is an additional problem, it can be treated. Such treatment is effective and can start to work within a few weeks. Treatment of depression can have a positive effect on the course of one's illness, particularly when it improves one's ability to deal with chronic problems. In addition, it can significantly enhance the quality of life.

Loss of self-esteem and social withdrawal may both occur if the illness and its treatments have led to a change in living circumstances (e.g., giving up your job, or if surgery leaves you with facial or other impairments). Often, these lead to depression. An important thing to remember here is that these things have not changed who you are, and that they are only external aspects. Making conscious efforts to retrieve your social life and if possible to resume work of any kind may be extremely helpful.

Finally, relationship problems: the people you care about and who care about you e.g. your partner, your family and friends will be affected in some way. There may be problems of rejection or feelings of guilt. Serious illness in one partner of a couple may have long-lasting effects, which eventually can have a detrimental effect upon the relationship. The healthy partner may feel exhausted after all their efforts to be supportive, disappointed about the results, or disillusioned about the relationship under the new circumstances. It can be very helpful to realise this in an early stage and to consider marriage or family therapy. Remember that after a serious condition partners and children may need help too.

To finish, let's emphasise that having a benign brain tumour, or indeed any other serious illness, does not necessarily lead to these personal consequences. It is a condition that usually can be treated effectively or managed long-term, and most people learn to live with that. However, the initial adaptation can be difficult, and you should recognise that this is OK and that help is available to assist you in dealing with it.

Caroline Batt and Ella Pybus

To celebrate CAMTAD's

**25th Aniversary**

**1978–2003**

## 'Hear This' Exhibition

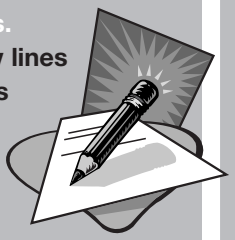
at

**St Andrew the Great Church**
**St Andrew's Street**
**Cambridge**
**CB2 3AX**

(adjacent to Lion Yard Shopping Centre)

**11th–16th August 2003**

**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: 18th July 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 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 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.

**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.changingfaces.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)
4th floor, White Building, Fitzalan Square, Sheffield S1 2AZ
Freephone enquiry line 0800 018 0527
**Web site: http://www.tinnitus.org.uk/**

**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.

## FORTHCOMING MEETINGS

The next meeting will be our AGM which will be held on **Saturday 7th June 2003** in the David Dunn Room at Addenbrooke's Hospital. The doors will open at 13.00hrs as usual and the AGM will be at 13.30hrs. Our speaker for the afternoon will be Brenda Elcome who will speak about 'Lip Reading'.

The September meeting is still to be confirmed.

### 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.