

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

Autumn 2003
Issue 27

'Lip Reading' A talk given by Brenda Elcome

Reported by Chris Richards



Brenda opened her talk by introducing herself as a lip reading teacher and saying she hoped we would enjoy the next hour and maybe feel inspired to join a lip reading class after the talk.

She explained that she had become a lip reading teacher because of her own hearing problems. Her hearing started to deteriorate about 31 years ago soon after the birth of her second daughter. She developed Meniere's disease which is a disease of the inner ear causing deafness, attacks of spinning vertigo and severe tinnitus. She was very grateful to come under the treatment of Mr Moffat who specialised in Meniere's disease at that time and after 15 years and 3 operations things improved and the vertigo and tinnitus subsided but she was left with limited hearing in both ears and wears a hearing aid on one side. However the experience did lead her to a new career.

After her third operation Brenda asked about lip reading classes and was put in touch with classes being run by the hospital. She discovered a wonderful group of deaf and hard of hearing people who met on Thursday evenings to try to improve their lipreading skills and offer each other support and friendship. She found it incredibly liberating to be with people who instinctively understood all the problems – because they were their problems too. Experiences and misunderstandings shared in

that environment became hilariously funny even if, when they happened, they had been excruciatingly painful.

She found the lip reading fun and discovered she was quite good at it as, probably like many of us, she had been doing it for some time out of sheer necessity. However she didn't really see how the class was actually going to make any difference to her lip reading ability and it took a long time before she worked it out.

After Brenda had been attending for a couple of years it was suggested that she should train to be a teacher. She has been teaching for 11 years and she admits that for a long time she had doubts about whether she was doing any more than creating a happy and supportive environment where people could get together once a week and enjoy each other's company.

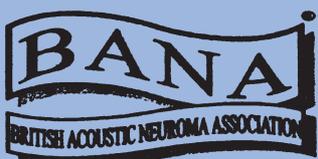
She is however now convinced that lipreading classes can and do improve communication for people with hearing loss but she would prefer not to use the term lipreading. In America it is called SPEECH READING which is far more accurate. We do not just use our lips to speak as a 'speech reader' we also need to observe tongue, jaw and even throat movements. There are also other things to look for as well. When someone makes a move towards you, you should start reading them:

- What is their body language telling you?
- What is their facial expression telling you?
- What are their eyes telling you? (It might be different!)
- How are they dressed – formally/casually?
- What are they carrying? (It might tell you where they have been)
- What do you know about the person?

The more you can anticipate the better. Only about 30% of speech is lipreadable which leaves a massive 70% which has to come from somewhere else. Brenda did an exercise in which she told a joke silently with no

Next Meeting

The next meeting will be held on **Saturday 13th September 2003** in the David Dunn Room at Addenbrooke's Hospital. The doors will open at 13.00 hrs. The topic for the afternoon will be 'Recovering from Skull Base Surgery'



expression and then repeated it with expression and body language and the audience was very aware of how much easier it was to interpret with expression.

Brenda explained that the process people were using was:

1. As far as possible they were matching speech movements to their stored knowledge of language. This is very important as you are most unlikely to be able to lipread any word which you don't already know.
2. They were using their own knowledge of language structure to fill in the gaps in what they could see.
3. They were taking further information from facial expression and body language.
4. They were using their imagination and life experience to create a plausible scenario.

We can also make use of what hearing we do have – even if it is very bad it may just give rhythm to the sounds. Lipreading is about USING EYES AND EARS TOGETHER – each can fill in the gaps for the other.

The lip reading class

Lip reading classes use various strategies to try to improve people's communication skills. One of these is to learn about different sounds of speech and how they are produced – many of them look the same. For example:

p/b/m park/bark/mark

The dog was parking badly (OR was he 'barking madly')

Another one which may cause trouble is buried/married

'My son was buried last week' – 'Oh how wonderful for you!'

w/qu water/quarter

f/v fine/vine

There are many more like this and vowel sounds are also problematic. There are actually 19 vowel sounds. Seven vowel sounds make what is called a 'jaw drop' movement:

a e u ay ie air ah

and there are the 'smile' vowels: ee/i/ear

'I'm off to the doctors. I've got a problem with my

Is it knee, ear, skin, teeth or kidneys – they all look the same?

We spend a lot of time working with these groupings in an attempt to inform the sub-conscious brain so that it can begin to develop the skill of 'moving sideways' For example the person who says her son was buried

last week looks far too happy. Stored in the brain is the knowledge that 'b' and 'm' look the same. Hopefully the adjustment can be made BEFORE we put our foot in it!

The class does exercises which are aimed at improving the use of a whole variety of skills like anticipation, concentration, mental agility, observation, use of context etc. Tactics and strategies can also be learnt such as preparing for a situation and asking the right questions in order to get an answer which can be understood. They play games, do quizzes, crosswords, have discussions on all manner of hearing related topics and of course a nice cup of tea or coffee.

Lipreading classes can be great fun and there are a lot of laughs but everything is done without voice and concentration is intense. People often go home exhausted.

Measuring Progress

Perhaps the hardest thing of all is to measure progress. However long you attend a lipreading class you will never reach a point where you can say 'I've done it. I've learnt to lipread!'

Brenda finds the most rewarding thing is to watch someone's confidence improve – and it can happen quite dramatically. The person who had begun to shy away from social situations may feel more prepared to give it a go. The person who was finding life at work almost impossible may learn strategies for coping and develop a more positive attitude. Several times she has been told that people don't feel their lipreading has improved at all but a friend or relative has said they seem to be hearing better. They know they are not, so can only assume they are actually communicating better. The benefits are hard to define but most people find the classes very enjoyable so there is nothing to be lost by giving it ago.

Brenda finished by doing an exercise using skills of anticipation and context in recognising words from a verbal description.

Questions

Brenda was asked about classes and told us that they are run at the hospital and at a number of Adult Education Centres in the area. Details can be obtained from

The Association of Teachers of Lip Reading
Box No 506
Hanley
Stoke on Trent
ST2 9 RE

Although classes usually run over an academic year people can join at any time. Brenda suggested that people should give it a try for at least a year before giving up. Fees usually have to be paid for the centre but not for the classes themselves.

AMNET Annual General Meeting

Saturday 7th July 2003 at Addenbrooke's Hospital, Cambridge

Chairman's Report

Alison presented a review of progress and growth as we reach our 7th anniversary. Liaison has continued with Jean Hatchell, the clinical nurse practitioner, during the year which has been helpful on both sides. There have been enquiries and interest from staff on the A wards as well as Clinic 10.

Our speakers have been varied, ranging from the colourful Norma Gaye last September, through the recent personal history of member, Brian Bagnall as the Mayor of Bury St Edmunds. Also in December the other speaker Philip Rundle, an archivist took us further back into the history of Addenbrooke's. In March we learned about CROS hearing aids from Judith Bird, an audiological scientist here at Addenbrooke's. Ideas for speakers are always welcome, some we need to help us learn, be entertained or move forward.

In October 2002 Chris and I went to Birmingham for BANA's 10th Anniversary get together. It felt good to be associated with it. BANA as a group has achieved a great deal in ten years. It's strength is in the diversity of the groups all over the country. They now have a strong far-sighted branch liaison officer, Bill Frost, who has conducted a quarterly review of each group.

Our success with participation in local conferences has been mixed. I mentioned last year that there was a worldwide conference on acoustic neuromas and other CPA lesions in Cambridge this July. We have made a great deal of effort to have a presence there, but despite many phone calls and letters it has proved impossible.

However we have been more successful with the CAMTAD conference from 11th - 16th August to celebrate their silver anniversary. We will have a stall of newsletters and booklets. Chris has designed a new poster to be used there and wherever appropriate afterwards.

My thanks to all the committee and helpers for their hard work over the last year.

Treasurer's Report

Joanne reported that the accounts have been audited for the last financial year and were available for perusal. It had been

a good year with a surplus of £500 mainly due to an increase in subscriptions. We now have 206 members with some new members and some people not renewing their membership this year. There is still £4000 in the account and £2000 will be transferred to a higher interest account. Members were asked for suggestions for how the money might be spent.

Proposer for accepting accounts Brian Bagnall and seconded by Thelma Pye

Election of Officers

Chairman Alison Frank – Proposed by Ros Rutter and seconded by Fiona Pyke

Treasurer Joanne See – Proposed by Jill Laurimore and seconded by Rachel Pearson

Secretary Tony Monk – Proposed by Joanne See seconded by Ros Rutter

Other committee members

Information and Library	Ray Maw
Newsletter Editor	Chris Richards
New Patient Co-ordinator	Neil Bray
Meningioma Association	Ella Pybus
General members	Jill Laurimore Eleanor Monk

Other Helpers

Web Site	Roy Edgar
Newsletter Distribution	Thelma and Bill Pye
New Patient Information	Gary and Carol Crackle

Newsletter

Chris made a plea for more contributions from members for the newsletter as there has been little recently and it should be a way of members communicating with each other.

Any other Business

Nothing was raised from the floor

Editorial

Hello everyone

Hopefully by the time you get this I shall be on holiday in the sunny Mediterranean while you may be enjoying the end of a typical British, I probably shouldn't say English, summer! I hope you find this newsletter interesting if maybe a little heavy going. I'm still waiting for some personal experiences to provide us with light relief and inspiration to everyone else.

We have, as usual, a report from our AGM and the very entertaining talk on lip reading from Brenda Elcome - how many of you have enrolled for classes in the autumn? I am also indebted to Fiona Pike for her report of the BANA AGM and the handouts from the two talks, one of which I have used to put together an article for this newsletter.

I am at present suffering from 'empty nest syndrome' as two of my children are in Australia and the other has just returned

from a trip to China. I feel as though I am missing out on something somewhere. However please don't suggest I find something to occupy myself as I already have far too much to do! I suppose I should be grateful for the respite, but at least in these days of email, mobile phone text messaging and cheap international phone calls they don't seem quite so far away! What was life like before all this communication technology - we all seem to have forgotten! However it does make life easier for organisations like ours as people can visit our web site, telephone or email us from almost anywhere. Which is a sneaky way of saying it would be easy to send me your thoughts on anything which may interest other members. Come on everyone - you don't want it all to come from me!

Best wishes

Chris.

BANA AGM held at the Cromwell Hospital in London on June 28th 2003

Fiona Pike and her husband Brian attended this meeting and have sent me their impressions along with some notes from the lectures which I will include in this edition and the next.

The morning opened with registration and coffee when everyone could mingle and chat. We spoke with people from Southend, Watford and London. The committee was surprised at the low turnout. The AGM, which is held in a different area of the country every year, usually attracts about 50 people or more but only 40 had indicated they would attend this one. The Chairman introduced Julie Moore, the new full-time paid co-ordinator who replaced Yvonne who held the post for 21/2 years and who left the organisation in March. The business part of the meeting was over very quickly. Most of the committee was willing to stand again but the secretary was standing down. As no nominations had been received the chairman suggested that the Treasurer be appointed to take on the post of Secretary too until such time as the committee could appoint or co-opt someone. This was agreed.

There were two speakers, the first was Mr Nigel Mendoza, Consultant Neurosurgeon, West London Neurosciences Centre, Charing Cross Hospital. He discussed the various options for treatment available to patients drawn from papers written by numerous specialists. He pointed out that these statistics could be very confusing. Before he started his presentation he said patients were now searching the Internet and gleaning very detailed information, hence his presentation was similar to those he would prepare for

his students. It included various slides showing different surgical approaches - his preference being retrosigmoid transmeatal. It was a most informative presentation what attracted a variety of questions from the audience.

Buffet lunch was lovely! It allowed time for everyone to mix and comment on the morning's activities. The afternoon speaker was Mr Anthony McQuillan, Research Fellow at the Raft Institute of Plastic Surgery, Mount Vernon Hospital, Northwood, Middlesex.. The title of his talk was 'Facial re-animation Options and the Mount Pleasant Experience'. He described that damage to the facial nerve can cause inability of the eyebrow to raise, inability of the eyes to close, problems with salivation on the affected side, inability to chew or swallow food in a normal manner and affects the facial expression. The aims of the treatment for the management of facial palsy were normal appearance at rest, symmetry with voluntary movement, spontaneous emotional expression, no loss of other function. He then discussed the various treatments available including Cross Facial Nerve Graft. Mount Vernon Facial Reanimation Unit is the only dedicated facial reanimation unit in the UK. The afternoon ended with him answering questions

The whole day was very enjoyable and the speakers were excellent.

Management of Acoustic Neuroma a talk by Mr Nigel Mendoza, Consultant Neurosurgeon, Charing Cross Hospital

This has been put together from the handout of the talk so it is fairly limited but there are some things I thought you might find interesting

Mr Mendoza began by tracing some of the history of acoustic neuroma from the first archaeological evidence from 2500 BC to the present day. Traced through the 19th and 20th century mortality rates were as high as 38% in 1950 but had fallen to 1% in a study reported in 2000. He recognised these advances as due to improvements in anaesthetics, monitoring during surgery, development of surgical techniques and instruments, radiosurgery and MRI imaging. He quoted an incidence (number of newly diagnosed cases per year) of acoustic neuroma as 13 cases per million of population per year. However studies of incidental findings at MRI showed 700 cases per million population suggesting that there are a large number of asymptomatic undiagnosed tumours. He

outlined the clinical presentation and investigations for AN and then went on to discuss **current issues and controversies**. He outlined these as:

- management of small incidental tumours,
- prediction of tumour growth,
- hearing preservation surgery
- the role of stereotactic radiosurgery.

The **management options for AN** are:

- Conservative management with surveillance imaging - the question being how often
- Microneurosurgical - resection either total or subtotal resection

- Radiotherapy - Stereotactic surgery or fractionated external beam radiotherapy
- Combined modality intervention

He examined evidence from a number of scientific studies which looked at outcomes from **conservative management** which showed annual growth rate at follow up of 2 - 4 years to vary between 29% and 82% in 6 different studies. From these studies he concluded that indications for conservative management were:

- Small tumours on only hearing ear
- 'Elderly' patients with longstanding stable tumours
- Incidental asymptomatic finding
- Patients who refuse treatment.

He suggested that the indications and aims for surgical management were in small tumours (<1.5cm) where the aim would be to preserve hearing, facial nerve and to prevent future growth, and in medium (1.5 - 3.5cm) and large tumours (>3.5cm) indications would be symptomatic from brain stem compression, enlarging on serial MRI, reoccurrence or patient preference.

There are three main surgical approaches - retrosigmoid transmeatal, translabyrinthine, and middle fossa.

The **retrosigmoid transmeatal** approach has the advantages of being versatile and appropriate for all tumours and can give hearing preservation, however it is an intracranial procedure which involves retraction of part of the brain and can have other risks. Results from a series of studies of operations suggest that mortality is very low (1 - 3.8%) and facial nerve preservation is between 63 and 98% with between 21 and 32% of patients having useful hearing.

The translabyrinthine approach has the advantage of not involving the brain and being surgically more straightforward but does destruct the labyrinth with hearing and balance loss. Results from three studies on this approach suggest that in between 75 and 91% there is total excision of the tumour, the mortality rate is between 0.1 and 2.6%, reoccurrence 6% and facial nerve preservation is between 96.6 and 54%. The middle fossa approach is appropriate for small tumours with preserved hearing and makes an approach above the ear. A small study of this method suggested that facial nerve preservation was 80% and hearing preservation was 59%.

He produced a summary **of complication rates of surgical treatment for AN:**

- Death - less than 1%
- Paralysis - less than 1%
- Lack of co-ordination in movement - 10%
- CSF leak - 9%

- Facial palsy - 10 - 50%
- Inability to work - 15%
- Poor quality of life - more than 15%

He outlined indications for **radiosurgery:**

- Enlarging small / medium tumour in an elderly or unfit patient
- Reoccurrence after subtotal excision
- Patient preference
- Chronic severe medical illness precluding surgery
- Bilateral tumours in NF2

A summary of results from studies of patients who had received radiosurgery showed:

- Tumour control (No growth) 92 - 98%
- Volume reduction 23 - 55%
- Hearing preservation 30 - 46%
Hearing loss related to tumour size
No loss if tumour less than 1.0 cm
- Facial nerve palsy 1.3 - 42%
Usually transient with 66% improving in 1 year
- Trigeminal neuralgia 4 - 30%
- Hydrocephalus 4%

His **conclusions** from all these studies were:

- A number of neuromas get smaller or do not exhibit growth
- Surgery can achieve total tumour removal in about 97% of patients with a mortality of 1%
- Facial paralysis is common, and a major cause of disability
- Radiotherapy can 'control' tumour growth in the short term
- There is a lack of evidence from controlled research
- No systematic study compares modalities of treatment

His **overall conclusions** were that patients had a choice:

- Small tumours (less than 1.5cm)
Conservative, Microsurgery, Surgery, Radiosurgery
- Medium tumours (1.5 - 3.5 cm)
Conservative, Microsurgery, Surgery, Radiosurgery
- Large Tumour (More than 3.5cm)
Surgery
Total excision
Subtotal plus radiotherapy

His closing comment was that if he had to choose he would probably have radiosurgery or find a very experienced surgical team!

UKBTS Summer Conference 14 - 15 July

Ella Pybus

The UK Brain Tumour Society's summer conference took place in mid-July at Nottingham University's Jubilee Campus which again provided a perfect setting. All the facilities are grouped together and everyone was able to take part and share ideas, opinions and plans. Even the technology worked - overhead projectors, video presentations and microphones all performed immaculately!.

Seeking a co-ordinated approach to brain tumour research

This year's theme was Progress through Partnership. UKBTS is calling for the formation of an alliance of brain tumour charities and support groups to enable pressure to be applied to government, NHS and research bodies for an integrated approach to scientific research and new treatments. There is, however, no intention of swallowing up smaller charities or robbing them of their names and special identities. No one forgets how many valuable and successful groups have been founded in memory of a relative or friend who has died of a brain tumour.

Rather, UKBTS envisages a coming-together of all brain tumour charities, each lending its weight and its voice to seeking more research into treatments and causes of tumours and more accurate data collection. It is no secret that in this country brain research comes a long way behind cancer as far as funding is concerned. Despite the year on year increase in brain tumours (there is a 2% increase per annum), we lag far behind the USA. In Britain only 10 research projects are being funded compared to over 700 in America.

Integrated Help - where is it?

Conferences' own experiences also emphasised the need for an integrated approach to delivering care to patients and families affected by a brain tumour. Some brain tumours, like glioma, may have a sudden onset and the need for coordinated support is urgent. One mother described how they lost their twelve year-old son only twelve weeks after diagnosis. Despite both parents having medical backgrounds, they were unable to get support or help when it was needed. There was a lack of coordinated support to provide either the equipment needed to care for him or psychological help for the family.

Their experience underlines the need for a nominated person to give support and to coordinate the patient and family needs as they change. Compared to many people, as medics, they know their way round the system and they wondered how other people would fare who were less knowledgeable than themselves. But to be told that there is a waiting time of several months in the NHS for a special bed to be supplied is shocking and unforgivable when your child or relative will be dead weeks before then — even more so when they were able to track down and hire such a bed from a private company at their own expense and have it delivered to the house within three days.

Fund-raising success

The Samantha Dickson Research Trust, set up by her parents in memory of their sixteen year old daughter, concentrates on raising funds for medical research into brain tumours. In the six years since it was founded it has raised the staggering sum of over £ 2,000,000. Yes, you read it right - over two million pounds!

Unlike other well-known charities, no part of the money goes to paying fund-raisers or administrative staff. All the money raised goes to fund research and this makes the sum

raised equal to £4 or even £5 million raised by other charities who have overheads and costs to meet.

Samantha's mother, Angela, pointed out that brain cancer has now overtaken Leukaemia in the USA, and is the second biggest killer of children after Leukaemia in the United Kingdom. She went on to point out that accurate figures are hard to come by in Britain as data collection is not coordinated as it is in Scandinavia.

Wide-ranging and fascinating topics

Over Monday and Tuesday the conference sessions offered a diversity of subjects including a presentation on the latest surgical techniques being used in neurosurgery in Germany. Dr Aurelia Peraud of the University of Munich talked about how she uses laser-guided micro-surgery to remove brain tumours. As well as giving us a detailed description of the surgery she explained what follow-up

treatments may be employed to prevent regrowth of remaining tumour cells. She and her colleagues are participating in a joint European/USA research project. After a tumour is removed, even when the whole tumour is taken, she told us that between 13 - 15 % is left behind, thus research into post-operative therapies is a very important area of ongoing study.

Beyond the Search Engines

Professor John Darling explored the subject of information sources about brain tumours on the internet. There is so much information on the net and an increasing number of us, about 10% at present, seek information via the world wide web. He drew our attention to the vast and increasing number of references available at a key stroke when using search engines like Google or Altavista. For instance, in 2002 Google offered 28,000 pages. This year, 2003, Google's number of pages on brain tumours has risen to 85,500!

He discussed the question of how well the information was organised and said that it was now more structured and

more organised than previously. The big American providers now had lists that were less random and far less confused than before.

He also praised American websites for providing reliable, comprehensive information that was easy to access and to download, such as The BT Primer and the Brain Tumour Foundation. However, vigilance is still needed to identify the dubious sites; he reminded us that not all information on the internet can be trusted and there is much that is not reliable. He recommended checking a site called quackwatch.com for the names of the cheats and snake-oil merchants who exist to prey on the unsuspecting.

Progress through Partnership in action

Nottingham was a splendid reminder that there are dedicated individuals, support groups and charities working towards finding the causes of brain tumours and how best to treat them — people with open minds who want us all to engage in the push towards getting more money and more support where it can do the most good. Write to your MP and ask for more money for brain tumour research, or start a brain tumour support group in your town or county.

My report only skims the surface of a rich and well-organised conference programme that had room for everyone, the patients and their families, the researchers, the surgeons, as well as the Neuro-oncology Nurse Specialist, the homeopathic doctor and a round-up of complementary approaches to treatment. It was the inclusiveness of this UKBTS conference which impressed me most and the fact that people had travelled from all over the British Isles and from the Republic of Ireland to play their part.

MENINGIOMA - TIPS AND HINTS

From Caroline Batt

Medical Exemption Certificate

Do you have chronic hormonal problems (whether or not due to a meningioma)? If you have diabetes mellitus, diabetes insipidus or hypothyroidism, all of which require lifelong medical therapy, you can apply for a medical exemption certificate. This means you will not have to pay for any more prescriptions. Check with your GP!

Driving with a meningioma

There is a lot of confusion about this. If you have a meningioma but no other problems (i.e. no recent surgery, no fits, no visual problems), then you should be OK to drive. After surgery for meningioma affecting the brain, you will be disallowed from driving for up to one year. This is a rather ancient regulation, based upon the possibility of having fits after brain surgery. Newer techniques make this very unlikely, but the DLA is still sticking to it. With certain types of surgery you may have a chance to appeal for a shorter driving ban; check with your surgeon. However, if you have had fits very stringent regulations apply and you probably will not be allowed to drive at all. Mind - when you have had neurosurgery for meningiomas not involving the brain (e.g., spinal cord), you will not be affected by this regulation.

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.

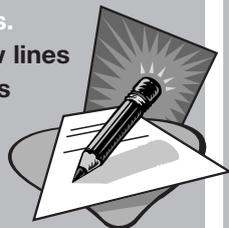
Contributions on paper and/or disc (Microsoft Word) to:-

Chris Richards

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

email: chris@richards2113.fsnet.co.uk

by: **21st October 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 held on **Saturday 13th September 2003** in the David Dunn Room at Addenbrooke's Hospital. The doors will open at **13.00 hrs**. The topic for the afternoon will be **'Recovering from Skull Base Surgery'**

The following meeting will be on **December 7th 2003** and will be our Christmas meeting. It will be held in the David Dunn Room and will start at **10.30 hrs**. Please note the earlier start. Our speaker will be **Mr David Moffat BSC MA FRCS Consultant in Otoneurological and Skull Base Surgery**

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.

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.

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.

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