

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 2004
Issue 30

Hearing Implants – a talk by Ivy Court Manager of the Emmeline Centre, Addenbrookes Hospital

Reported by – Chris Richards

On May 15th we welcomed Ivy Court and her colleague Cay Jackson to our meeting to talk about hearing implants. Ivy also brought a number of examples of the implants used so members could look at them and ask questions.

Ivy began by explaining that the Emmeline Centre which is situated in Addenbrookes Hospital is a unit which deals with the 'high tech' end of ENT working very closely with ENT and Audiology while having it's own suite of rooms on Level One of the hospital. The Centre is named after Emmeline Waley-Cohen who was a patient of the unit in its very early days when it was based in the Old Addenbrooke's Hospital. When she died she left money in her will for the unit to have its own suite of rooms.

Ivy began by showing a diagram of the ear illustrating how it consists of three parts – the outer ear, consisting of the pinna and the canal leading to the ear drum, the middle ear which transmits sounds and the inner ear consisting of the cochlea and the hearing nerves.

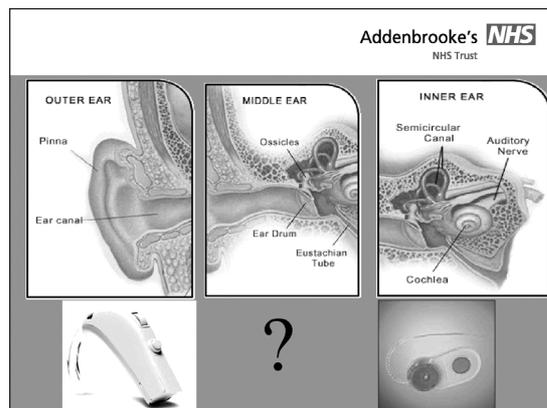


Diagram 1 The Ear

She told us that a few years ago they had started a programme with Bone Anchored Hearing Aids (BAHA) and at the moment there are 66 adults and 7 children in the programme. The main reasons for using this type of aid are:

- Chronic otitis media (a chronic infection of the middle ear which makes it difficult to use an ordinary hearing aid as it sets up an environment in which infection is most likely to occur)
- External otitis – which is infection of the outer ear
- Congenital problems such as Atresia which is lack of development of the outer ear and/or canal.

The BAHA is rather like a rawlplug being put into a wall – it encourages sound to travel through the bone rather than through the outer ear. It consists of three parts – the implant, the connector and a hearing aid.

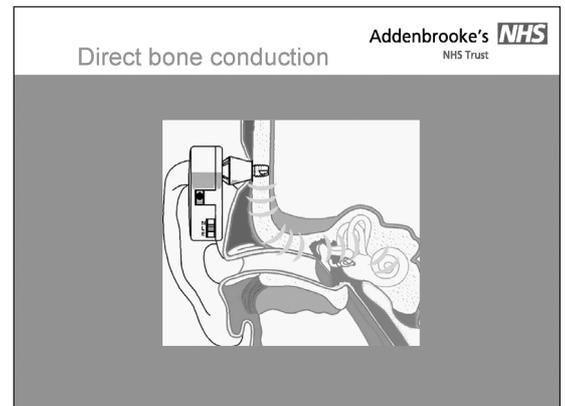
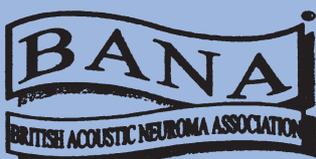


Diagram 2 Bone Assisted Hearing Aid

Before it is decided to use a BAHA the patient must be assessed to ensure that their hearing is better through bone than through the normal channels of the ear.

Next Meeting

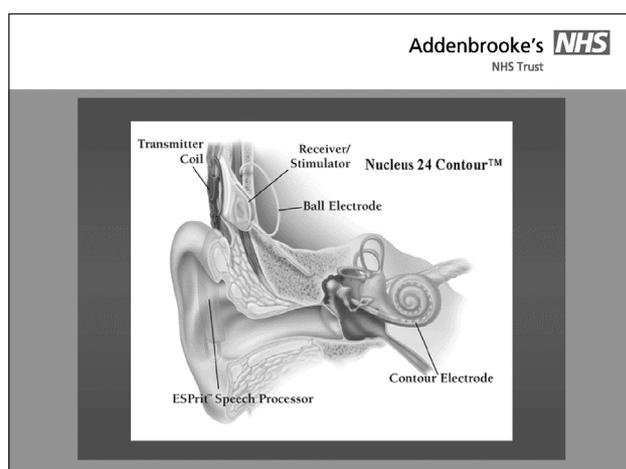
The next meeting will be held on Saturday 24th July 2004 in the Boardroom at Addenbrookes Hospital. Doors open at 13.00hrs
The speaker will be Laura Skorupa from the Royal National Institute for the Deaf.



In order to set up a BAHA the patient requires surgery to drill a small hole in the skull in order to put in the implant. This is often done as a day case under a local anaesthetic. The implant is placed 3-4 mm into the skull to enable the best transmission of sound and fits flush with the bone on the outside. A connector is attached to it which can later be fitted to a hearing aid.

There is a three month wait between inserting the implant and connector and fitting the hearing aid which allows osseointegration. As the fixture in the skull is made of titanium this, over time, integrates with the bone and becomes part of the skull, therefore giving a much stronger fixture.

Recently the BAHA has become an accepted treatment for Single-Sided Deafness (SSD). For many years it has not been appreciated that someone with a 'dead ear' had a problem. A BAHA on the deaf side will transmit sound to the cochlea on the other side. Research is being carried out into the benefits of the device and indications are that it MAY be able to give direction of sound. The device can pick up sound from the deaf side and feed it through to the other side but people may actually have to learn how to distinguish direction. Research does however indicate that the BAHA gives improved speech discrimination particularly in noisy settings. For most people with SSD the major problems are restaurants and other social gatherings and users report an improvement over no hearing at all.



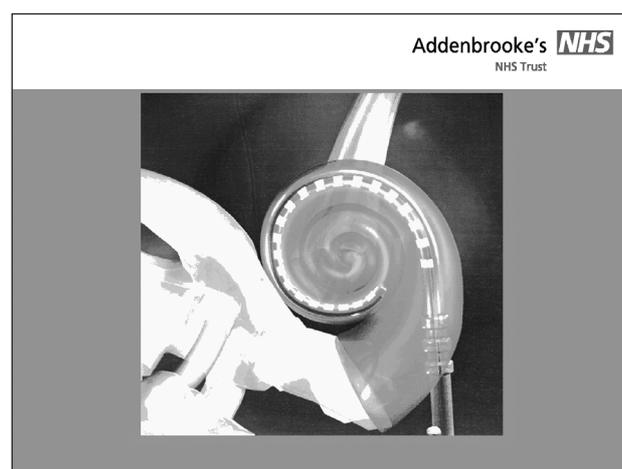
Diagrams 3&4 Cochlear Implant

Another hearing implant is the Auditory Brainstem Implant (ABI) which is attached directly to the brainstem bypassing the inner ear altogether. This will be used for patients with bilateral deafness who are not suitable for cochlear implant as they do not have intact auditory nerves. Patients with NF2 may have these implants put in at the time of removing an acoustic neuroma.

Ivy also spoke about problems with the inner ear in which **cochlear implants** are used. The centre has been running a cochlear implant programme since 1983 and now has treated 175 adults and 145 children with cochlear implants – the youngest child being 13 months and there is no upper age limit as long as hearing is poor enough and the person's general health is good enough to have surgery with a long anaesthetic. Now that all babies have hearing tests within a few hours of birth they will get referred earlier.

The implant does involve a major operation so it is important that patients are properly assessed. They need to have a profound or total deafness which means that they have less than 30% discrimination for speech. The auditory nerve must be intact, the patient must be well motivated and have realistic expectations – it does have limitations and requires work to be effective. Funding is also an issue as people get referred from other health authorities and money is always restricted leading to the need for waiting lists.

Assessment will include full auditory assessment and hearing aid trials, if appropriate, and auditory training, to ensure that a cochlear implant is really required. Patients will also have an MRI scan and Caloric testing to check their balance as this may present problems after surgery. They will have counselling and meet other patients so they have a clear idea about the equipment and what is required of them. An electrode is inserted into the cochlea which has wires which can be stimulated at different sound frequency levels and can then be transmitted to the auditory nerve.



Ivy ended her talk by describing how, early in her career she had been involved in counselling AN patients and she acknowledged the good work being done by AMNET. She then spent time with members showing them the equipment. We would like to thank Ivy and Cay for their time and wish Ivy all the best in her forthcoming retirement.

We held our AGM at our last meeting on Saturday 15th May 2004 at Addenbrooke's Hospital. Here is a record of the meeting for those who were unable to be there.

AMNET AGM held on Saturday 15th May 2004 at Addenbrookes Hospital

Apologies: Ray Maw, Jill Laurimore, Margaret and Graham Allcock, Ella Pybus

Chairman's Report

Alison reported that this year has been a steady year without much growth for AMNET. Our meningioma side has been strengthened by Ella and Caroline further establishing the Meningioma Association UK. A lot of recent enquiries have been from patients with newly discovered meningiomas whom I can direct to them. Other enquiries are from established Acoustic Neuroma patients and a few new ones.

I recently went to see Jean Hatchell, the Clinical Nurse Practitioner. She confirmed how few AN patients were now coming onto the wards. From carrying out three Acoustic neuroma operations a week in the past, there are often only one or none scheduled now. Clearer MRI scans, earlier detection and alternative treatments plus watch and wait policies along with an increase in the number of operating centres, were cited as reasons for the decrease.

While in the hospital I visited the newly smartened Audiology Department to make sure our literature is still being displayed. If you happen to visit in the future and see an empty space on the last board on the right, please let one of the committee know so we can restock.

AMNET attended CAMTAD's 25th anniversary exhibition in the heat of August 2003. We got some interest in our existence. It was also useful for AMNET helpers to look at other stalls and products.

Our speakers this year have provided us with an interesting variety of views. Brenda Elcome talked with sound and without sound about the benefits of lip reading which she preferred to call speech reading as the whole body is involved. In September we were our own speakers, sharing experiences, fears and triumphs on our journey through our altered lives. At Christmas time Mr Moffat returned and entertained and instructed us in the next instalment of **his** journey towards operating on 1000 patients.

We thank all these speakers for giving their time and expertise to inform and educate us.

My thanks to everyone who has helped AMNET during the year, particularly Roy for his continued website work and all the committee members and helpers. Their day to day work and extra flashes of inspiration keep AMNET going. Ray is now far away but still looking after our Irish members.

Treasurer's Report

Joanne reported that the accounts had been audited by Michael Bartlett. This year we had a deficit of just over £246. This is mainly due to the number of members going down and a good number of people not renewing their membership. There have been no new members in the last 12 months. Subscriptions were down by about £750, Donations were down by £2000 but expenses were also down due to a decrease in the number of newsletters. However we have spent less and there is still £4000 in the account

Joanne has applied to the Inland Revenue for Gift Aid. So far she has not heard anything from them but will send forms out when they become available. Gift Aid enables us as a charity to claim back 28p for every £1 you give provided you pay tax and this can be backdated for all the donations you have made since April 2000.

Accounts accepted Proposed by Eleanor Monk, Seconded by Bronwyn Lummis

Elections

Chairman	Alison Frank
Treasurer	Joanne See
Secretary	Tony Monk

Proposed

Joanne See	Bronwyn Lummis
Chris Richards	Eleanor Monk
Neil Bray	Thelma Pye

Other committee members will remain:

Newsletter Editor	Chris Richards
New Members	Neil Bray
Meningioma UK	Ella Pybus
Website	Roy Edgar
General	Eleanor Monk
	Jill Laurimore

Any Other Business

A question was raised about why we were not getting new members. Members were reminded that the number of operations is falling but literature is still around. Paying by standing order was suggested as a way of maintaining members and although some people don't like this it could be offered as an option.

There is a trophic stimulator available to buy.

Next meeting will be on 24th July 2004

Editorial

Dear all

Welcome to our Summer Newsletter. I hope you will find it interesting. Please note that this edition is earlier than usual as our next meeting is in July not September.

We have a report of Ivy Court's talk at the last meeting with more information about the BAHA hearing aid and I also have an article by Diana Farragher which is the first of a series she is writing for them. There is also some news of the new Audiology clinic.

I'm looking forward to sunny weather and holidays I hope the rest of you are too.

Best wishes

Chris.

Facial Rehabilitation

This is the first of a series of articles by Diana for BANA and kindly passed onto us by BANA Headlines

Diana has acted as Medical Advisor for BANA from the early days and has given talks to many of the branches. Her next talk will be at Bristol on Saturday October 16 at 2.30pm for the BANA South West Branch. This meeting will be held in the Zorab Lecture Theatre, Frenchay Centre for Medical Education, Frenchay Road, Bristol BS16 1LE.

Diana has written a self help manual called "Loss of Face" (updated 2 years ago) which many BANA members have found to be a source of strength. It is available from the Lindens Clinic for £20 + £3 post and packing.

The Lindens Clinic opened in 2000 as a centre of excellence for facial rehabilitation. Patients attend from the 4 corners of the earth as, believe it or not, facial rehabilitation is not a top priority in other countries either.

Diana received her Fellowship of the Chartered Society of Physiotherapists for her research into trophic electrical stimulation and her OBE for her work with chronic facial paralysis.

For those who would like to know more, Diana's web site address is: www.dianafarragher.co.uk

FACIAL REHABILITATION - Who needs it?

Why go to a physiotherapist to learn how to exercise your face? You can't help exercising your face it just happens".

These words were spoken by an eminent neurosurgeon when his patient asked if physiotherapy would help her facial recovery. When I was invited to contribute to the Bana newsletter I decided to expose some of the frequently aired myths about facial nerve recovery. **If you have been subject to these sorts of statements do write to Bana and let us know**

Over the next 3 editions I shall cover some of the myths heard on a daily basis in our clinic.

The Myths of Facial Rehabilitation

- 1) Facial Exercise
"Why wouldn't you exercise your face? You cannot help but use your face! Why would you need somebody to teach you?"
- 2) Synkinesis
"Nerves sometimes grow back in the wrong place. The nerve to your chin could end up in the forehead!!!"
- 3) Nerve transplants
"Wait and see, it just works by itself."
"Of course sometimes it doesn't, but there really isn't much you can do about that."

Today we will cover what you may need to be taught about facial exercise and what it involves.

I am a chartered physiotherapist and I have spent nearly 30 years exploring this question and specialising in techniques to help faces regain their previous ability to express emotion.

At the Lindens Clinic for facial rehabilitation we treat acoustic neuroma patients in different stages of recovery. Literally in one day we may assess a patient just released from the hospital after surgery and another who has been told there is no treatment for 20 + years since the event. What a dangerous myth to allow patients to go this long without intervention.

When we analyse the problems, the long term patients have, we are able to build strategies to prevent the early patients developing 'bad habits'. In unravelling 20 years of poor use and the effects on facial expression we gently guide the face to normal manoeuvres and, hopefully, expression. From this we learn how to eliminate risks and spot potential problems for the early group and in this way

we are constantly learning and developing our treatments.

In the beginning.

The facial nerve controls all the little muscles on one side of the face and the immediate response when it stops working is that the affected eye stops blinking, watering and closing. In addition when cranial nerve 5 is involved it could also stop feeling. A stray eyelash could be damaging a dry eye all day without you even noticing it. No wonder eye care is a top priority!

What else is involved?

In normal circumstances the two facial nerves right and left work as partners to produce facial expression within certain limits of symmetry.

When one partner stops working the other one ends up doing the work of two. Whilst doing all the work —having all its 'own way' it is able to influence the muscles of the good side of the face to increase their normal range of movement. Even the nose bends to the good side— the side which has been left to express all your feelings. The other side with the staring eye, the slanted mouth, the floppy cheek isn't able to pull its own weight and has only one expression, sad.

The information going to the brain about facial expression becomes very much distorted and a new facial map needs to be built up within the brain working on this new information. Fortunately it saves the original facial map, the engram for facial expression which you painstakingly built up as a baby. The engram will be accessible as soon as normal service is resumed.

Exercises What can you do?

At this stage exercise and even day to day activities only strengthen the good side and create a stronger and more distorted face map in the higher brain. If it were only possible to give the face a rest, but this is not compatible with life; we've got to carry on eating and drinking.

A physiotherapist would teach you to keep symmetrical pose as often as possible. She would also instruct you in the art of gently massaging the cheek upwards, care of the eye and how to close the eye without straining. The beginning is a stage of waiting and can be tedious but it is also a stage of convalescence and it is good to keep a record of all progress made. Each step to good health should be measured. As far as the face is concerned a good way to record progress is to use serial photographs. The last thing

you want in the beginning but you won't regret it in the long run. Have some taken today and hide them for a few months, nobody else needs to see them.

At the Lindens Clinic we use electrical testing of the nerve (emg) and the graphs obtained plot the progress of the nerve as it re-grows. It's a real boost to the ego to see how much recovery the nerve has actually made especially during those long spells when nothing seems to be happening in the mirror. We had a very exciting session in clinic last week when a lady 2 years post acoustic surgery managed to send a signal down her new nerve for the first time. She was presented with her graphs on screen as she

acted as a model for an advanced training day. Having identified the feeling associated with the increase in current flow down the nerve she was then able to intensify her efforts to such a level that an active flicker could be seen clearly by everybody in the room even her husband. Meantime she is happier to continue with her daily dose of trophic stimulation which will keep the muscle in good shape with the energy to support the growing nerve. Now she knows that the nerve is working she is in control and there is no stopping her from doing her treatment. So we now know exactly what her exercise is and she will continue to reproduce that feeling until she achieves the movement which everybody will recognise as a smile.

Meningioma Association UK

Following on to our previous advice in the last newsletter about driving after brain surgery, we thought this cheering story of how Alan succeeded in getting his licence reinstated would remind us all that a twelve month ban is not mandatory.

Driving Alan crazy

One of the problems most of us have to endure after brain surgery is being unable to drive a car. With headlamps staring glassily, the car sits in the garage, or on the front drive, a constant reminder of our lack of 'automobility' and very frustrating it can be.

When Alan telephoned us in January he was more than a little annoyed that he had been unable to drive since August last year. He thought it was unreasonable that he was faced with a long wait despite his quick recovery, and he wanted advice and help to regain his driving licence as early as possible. His meningioma had been successfully removed on October 1, three and a half months after first diagnosis. Originally, he had only gone to have a lump removed from his forehead, a cyst, he thought. It had been there for some time and had seemed to be getting bigger. It transpired that it was a meningioma tumour that had affected the bone. It was far more serious than a mere cyst. Fortunately, it was operable.

A trouble-free recovery

He was placed on anti-spasmodic medication after the op

and had had no seizures. Apart from some post-op swelling at three weeks, he made a swift recovery. Before the tumour was identified he was symptom-free and leading a busy life in retirement. The fly in the ointment now was his inability to drive, especially as he lives in a small village without so much as a shop.

Then life grew more difficult when his partner had to give up driving after an operation. By this time Alan had been taken off the anti-spasmodic meds and was attending the gym regularly to build up his strength and fitness. He felt perfectly well enough to resume driving. However, the rules seemed to be set in stone: you will not drive for at least one year. As a cricket umpire and team coach, Alan needed to get back on the road in time for the new season.

Back on the right road

With a little help from us with the wording of a letter asking his consultant to support a request for his driving licence to be reinstated, Alan was delighted to get it back on March 1, five months after his surgery. Well done, Alan.

Ella Pybus

TIPS AND HINTS

Help for Post-op Itching

Those of you who have had surgery for removal of a meningioma brain tumour may remember the itching that followed it. The itching is typically around the incision line, usually on the forehead, and it tends to develop 1 or 2 months after the surgery. This itching is due to regrowth of the nerves that had been cut during the surgery. It is a healthy sign, but, nevertheless, can be very annoying. It may last for variable amounts of time – for some people only a few weeks, for others many months. Scratching will make it only worse, as many of us find out!

My tip is to apply Eurax cream two or three times daily to the itchy areas. It is available from Boots and other chemists and does not need a prescription. It cools and reduces the itching, and is usually very effective in relieving the irritation. It is very good too for insect bites. Do not use

on broken skin or if you are pregnant, breast-feeding or have genital itching.

Numbness

Meningioma surgery involving an incision around the hairline often results in a feeling of numbness over the top of the head. This happens because nerves responsible for skin sensation were cut during the surgery. The numbness lasts for one to three months, then gradually resolves as the nerves regrow.

Free prescriptions

Did you know that if you have a chronic hormonal problem (e.g. hypothyroidism, diabetes) you are entitled to free prescriptions, whether or not this was associated with a meningioma.

Caroline Batt

Audiology: a modern and dynamic service.

This article is taken from the March edition of Addenbrookes Matters and is about the Audiology Unit which many of you will know well.

There's more to audiology than you might think: not only does the Addenbrookes Audiology Department provide care for children and adults with hearing loss, it is also home to one of the best-established tinnitus clinics in the UK and a service for patients who have problems with balance.

'The department is not just about hearing aids' says David Baguley, Head of Audiology. 'Our mission is to provide hearing and balance care for a wide range of patients aged nought to 99'.

'There is a tremendous amount that can be done for patients with hearing loss' he continues, adding that much has been done to update and improve the service. Children are now tested for hearing loss at birth, and if needed are fitted with digital hearing aids in the first months of life so that the effects of hearing impairment are kept to a minimum. 'We aim to maximise a child's potential to be the fully developed person they were intended to be' says David 'We are mindful of the needs of the family, as the diagnosis of hearing loss can be a severe blow. With a hearing impairment it's a family not an individual, with a challenge, so we work in as family-friendly a way as possible'.

Care of patients with a hearing loss continues or may start in adulthood. 'If you have a hearing loss you don't ever get discharged – it's a lifelong commitment,' explains David. He adds that the adult hearing aid service is modern and dynamic, 'We were one of the first audiology departments to fit digital hearing aids. We have 10,000 patients with fully digital devices, and they can be customised to meet the needs of the patient'. The department also offers an open access hearing aid repair service on a daily basis.

Lucy Tinker, Audiological Scientist, explains how the department works closely with the ENT (Ear, Nose and Throat) specialists who deal with the medical aspect of hearing impairment and with the Emmeline Centre for Cochlear Implants. We also liaise with hearing therapists, teachers for the deaf and speech therapists to help with the social and educational side of hearing loss. We all work in conjunction to help patients overcome their hearing loss on a daily basis'.

Patients with balance problems are also catered for by audiology. David explains 'We have physiotherapists to diagnose and treat balance problems. Many patients with balance problems can be treated successfully with customised physiotherapy ex physiotherapists to diagnose and treat balance problems'.

The tinnitus clinic offers patients modern therapeutic approaches, and its staff are active in research into the condition and training of many therapists both in the UK and in Europe. 'Previously there was little that could be done to help people with tinnitus retraining therapy, counselling, relaxation, sound therapy or hearing aids, depending on the individual', explains David 'We also have very good relations with patients partners and local tinnitus groups'.

David speaks proudly of the audiology team, the dynamic service it provides, and its hopes for the future, 'We believe it's crucial to work in a modern and effective way. In the next few years we will be building upon our achievements to make the department the internationally known and respected centre for hearing and balance it deserves to be.

Web page <http://www.addenbrookes.org.uk/service/clin/surg/audiology1.html>

Research Project into experience of skull base surgery

Dear Member

As a founder member of AMNET I am sure I am known to a number of you. I'm writing to ask if some members will consider becoming involved in a piece of research I am carrying out.

The project is the final part of a post graduate degree I have been studying for a couple of years. It will be a small project initially, but if successful I will try to expand the number of people I talk to.

The aim of the project is to try to learn more about the experiences of people who undergo skull base surgery both before and after surgery. The study will take the form of interviews in which participants will be invited to tell the story of their experience. There will be two interviews a few months apart – the second will be to discuss my interpretation of what you have said. I would carry out the interview in your own home and if you have a partner and they are agreeable I would like to talk to them as well.

The material I collect will be analysed for the purpose of my project and will be anonymised as far as possible so individuals should not be able to be identified, but my intention would be to publicise my findings, particularly so they may reach the ears of the professionals involved in care.

For logistical reasons I can only interview people within East Anglia, but if you would be interested in being involved in my research please contact me on 01954 211300 or email chris@richards2113.fsnet.co.uk

Thank you for your interest

Chris Richards
12 Sudeley Grove, Hardwick
Cambridge CB3 7XS

postbag



This is an email from David Thorne which I hope encourages you all to consider being a little more adventurous. Has anyone else got some interesting travel stories for us?

Dear Chris,

I thought some of your newer members might like to be reassured that there is life after the trauma of an acoustic neuroma.

I had my op in July 1997 following the 'usual' problems with balance, unsteadiness, and an almost total loss of hearing on one side (put down initially to my advanced age, which was then 56 !) Since then I still have some balance problems, particularly walking down narrow tow paths late at night, even when I haven't been to the pub! I also have a slightly wonky smile and of course no hearing at all on my right side. HOWEVER, since 1997 my wife and I have spent 6 weeks backpacking round Tanzania, using local buses, trains, pick-up trucks, and a lot of shanks's pony, when visiting our son teaching with VSO in a fairly remote area of the country. We were definitely the wrinkliest backpackers around, and got to many parts of Tanzania that other tourist couldn't reach.

We have also just returned from a challenging trip to Uganda to track gorillas in the Ruwenzori mountains. A tough 3 hour walk up the side of a rather large and steep 'hill' saw us achieve our objective, - where we spent an hour with the gorillas. Move over David Attenborough. We also covered just over 2500 kms on fairly dusty/bumpy dirt roads.

This isn't meant to be an advert for African Adventure Holidays Inc. but just to let people know that despite the dramatic effect of such an operation, life can still be full of excitement. It helps of course to have a caring supportive spouse, but life doesn't have to stop being full of adventure just because of an acoustic neuroma.

I am now 61 years young, by the way, and busy planning our next adventure.
Watch this space

Kind regards,
David Thorne

This is a response to Ella's article about insurance last time

Long Stratton

Dear Editor

I read in AMNET about holiday insurance. I had my acoustic neuroma removed three years ago and have had no trouble getting travel insurance. They ask me about 4 or 5 questions and charge me and extra £5 top up through the Post Office insurance and there is no excess charge. I hope this will help AMNET members to get a good cheap insurance. I would also like to say that before I had my operation my ears were very painful during flying but since I have had my op they hardly hurt at all

Keep up the good work

Best wishes
Karen Hardesty

Surfing the Net?



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:-

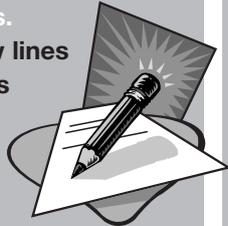
Chris Richards

12 Sudeley Grove, Hardwick

CAMBRIDGE CB3 7XS

email: chris@richards2113.fsnet.co.uk

by: 15th October 2004



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.

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.

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/>

Hearing Concern

7-11 Armstrong Road, London W3 7JL

Help Desk 0845 0744b 600

Email: info@hearingconcern.org.uk

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

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

Our next meeting will be held on Saturday 24th July 2004 in the Boardroom at Addenbrookes Hospital. Doors open at 13.00hrs
The speaker will be Laura Skorupa from the Royal National institute for the Deaf.

The Christmas meeting will be held on Saturday the 4th December at Addenbrookes Hospital. Doors open at 11.00hrs and our speakers will be Lynn Hitchin and Elizabeth Houghton who will talk about Complementary Therapies.

The Meningioma Association UK

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

Tel: 01787 374084

Email: MeningiomaUK@aol.com

Website: www.meningiomalUK.org

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

Freephone: 0800 652 3143

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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.

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