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

Spring 2005
Issue 32

Our Christmas meeting had a complementary theme with talks from two complementary therapists from the Ely Complementary Health Centre, Lynne Hitchin and Elizabeth Houghton

Massage – A talk by Lynne Hitchin

Lynne and Liz work in a complementary health centre which provides a wide range of complementary therapies. Lynne emphasised that these therapies have been around for a long time but they are complementary practitioners working alongside medical practitioners. The practitioners do not diagnose and will always refer back to the doctor if they have concerns about a client. The practice has 12 disciplines ranging from osteopathy and chiropody to medical herbalism and hypnotherapy. The aim is to provide a holistic approach to treatment dealing with the person as a whole. This is because what appears to be one problem may affect many parts of the body. Complementary therapies deal very much with the individual and the discipline chosen for treatment needs to be right for the problem and the person. For example if massage is tried on someone who does not like being touched or acupuncture on someone with a fear on needles, this will increase stress. The individual is very important as mental attitude is related to recovery success. Sometimes therapies are combined such as using a combination of hypnotherapy, acupuncture and massage to help someone with giving up smoking.

Lynneís main discipline is massage and she described touch as the first sense developed by a baby. Therapeutic touch can be very relaxing and of huge benefit. The body needs to be balanced and a symptom such as a headache can be caused by just a small change in the balance of the body. Massage aims to redress the balance by relaxing tightened muscles, improving circulation and improving lymphatic drainage in the body. When muscles become tense they hold onto toxins and when these cannot be released they stay in the muscles changing their structure. Tension restricts the blood flow and trigger points, small concentrated areas of tension, can be formed.

Lynne demonstrated the technique for Indian Head Massage describing it as a practice which has been used for over 5000 years. It has been a strong factor in family bonding in India where the women in the family do it on each other as a way of conditioning their hair. It is also linked to spiritual belief by allowing the release of ëchakrasí which let energies out.

The technique of massage involves introducing the therapist to the muscles by gentle stroking movements to warm up the muscles, this is followed by investigation work which aims to feel what is going on in the muscle. If this produces pain it allows the therapist to identify where there are problems and then the massage can go deeper to treat tense muscles.

Lynne emphasised the fact that bad habits are related to the way muscles work and massage helps people to focus on themselves so they are more body aware. This can then help if changes in lifestyle are required.

Next Meeting and AGM

Next meeting will be on **Saturday May 7th** at **Addenbrookes Hospital** in the Boardroom. Doors will open at 13.00 hrs and the AGM will be at 13.30 hrs, followed by a talk from **David Baguley MSc MBA, Head of Audiology at Addenbrookes Hospital**.

Iridology - A talk by Liz Houghton

Liz introduced herself as a trained Iridologist as well as a Food Allergy Practitioner.

Iridology is the study of the iris which is the coloured part of the eye. As a science it can be traced back to Hippocrates and the ancient Egyptians so it is over 2000 years old.

Iridology is a diagnostic science – iridologists are not allowed to diagnose as they are not medical practitioners but they can identify possible problem areas which can then be discussed with the clientís doctor.

Modern iridology began in Germany and Eastern Europe in the nineteenth century when people began to study the eyes of bodies in the mortuary and look for signs to link with the cause of death and they began to make maps of the links between areas of the iris and other areas of the body. With the migration of many of these practitioners to America in the 20th century there has been a lot more work looking for emotional and personality traits so that maps can now make mind-body connections. The practice has some similarities to reflexology which works on the links between points on the foot and other parts of the body. The eye also has reflex points.

Originally the eye was examined in sunlight but this progressed to the use of a magnifying glass and a torch and now iridologists use head frames and bioscopes as used by optometrists, which allows them to get much closer to the eye and allows them to take digital photographs which can be downloaded onto a computer to be analysed.

The iris contains a lot of information about genetic (inherited) health – genotype and also phenotype which contains information about what has been acquired through diet, environment and lifestyle behaviour.

Iridologists examine the colour, texture and structure of the iris. The colour can range from very bright blue through grey, hazel, green, brown to nearly black. The colour is related to the density of the stroma which has layers – in blue eyes there is only one or even no layers whereas very dark eyes have four layers. Different colours are associated with different parts of the bodyís constitution. Blue eyes are associated with a lymphatic constitution so is related to immunity – the ease with which we contract infections such as coughs and colds. Brown eyes are associated with the biliary and digestive tract, green eyes with the urinary tract and brown/black eyes with the composition of the blood. There is often a strong overlap between the effects of the different colours. The different colours indicate a weakness rather than specific illness. Within the basic colours there may also be other colours such as yellow which may be seen as spots or areas of colour. These add extra dimension such as orange which indicates the pancreas which produces digestive enzymes and insulin. These spots and colours may be present from very early in life, eye colour usually settles by the age of 18, but eye colour can change due to changes in pigmentation related to toxicity. Other changes that can occur are a white ëcholesterol ringí around the eye and also signs of ageing – arcus senilis. Iridology is used to identify constitutional strengths and weaknesses and what is relevant at the time, so people can learn how best to look after themselves.

Structure in the iris varies from a very tight structure to a very weak structure the looser the texture the weaker the constitution. People with weaker constitutions are often better off than those with a strong constitution as they pace themselves rather than pushing themselves too hard.

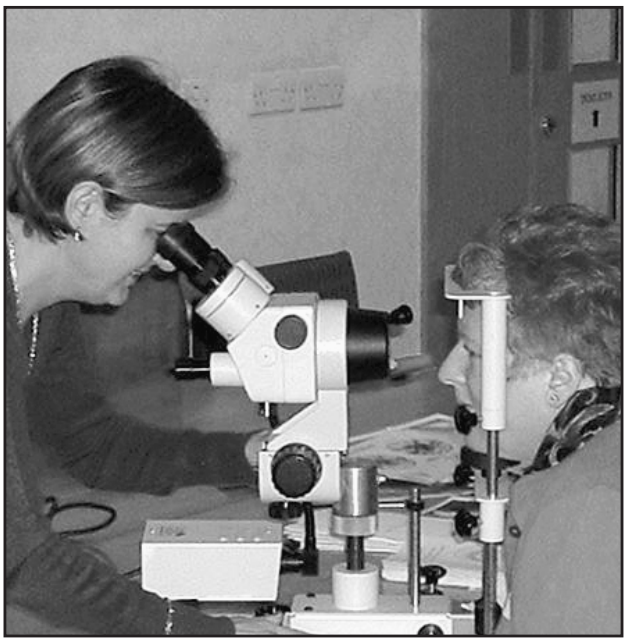
The texture can vary and may be weaker in general or just in specific areas which may indicate a specific weakness. There are also 25 to 30 signs related to the structures in the iris which may be signs of something which may be a problem. This can give increasing awareness of potential problems.

Other information can also be gleaned from irises. All irises are unique so they can be used for security. There are 200 points which can be mapped so the iris can be used for identification. The physical structure of the iris is set at 4 months and there are 28,000 nerve endings in the iris and these are all thought to relate back to physical parts of the body. Maps have been drawn indicating these connections. By looking closely at the iris through a bioscope trauma may be seen and the specific site eg one of the vertebrae can be identified.

Some signs are of acquired weakness which is passed on at the time of conception and becomes a genetic weakness.

People visit iridologists for a number of reasons but the main ones are that they have heard about the predictive nature of the examination and want to know what is there so they can look after themselves or secondly that they have had a number of tests and examinations and nothing has been found but they are convinced something is wrong. When Liz examines people she takes a very limited history before examining the iris so that she is not misled by something in the case history.

We would like to thank Lynne and Liz who both work at the Ely Complementary Health Centre, for their time and for two very interesting talks.



Meningioma Association

From Target – news from Brain Tumour UK Spring 2005

Phone Pals Launch

Brain Tumour UK is launching a new and novel 'Phone Pals' service linking people together by phone from the comfort of their own home. Two pilot groups, hosted by one of the trustees Ella Pybus- are underway and the response has been extremely positive. 'Phone Pals' provides a way for patients, their families and close friends to share support and experiences. In fact have a good old natter!

Phone Pals is a new and completely free service to help people affected by brain tumours. It involves a group discussion of about an hour managed by a host. The service is paid for and provided by Brain Tumour UK and hosted in partnership with Community Network.

To start with there will be four different Phone Pals groups: one for carers of adults, one for carers of children, one for those who have been bereaved, and one or more for brain tumour sufferers. We hope that people will be able to offer support to each other, share their experiences, make new friends and improve their quality of life.

If you are interested in finding out more about Phone Pals, or in taking part, please contact Jane Stephens on 0845 4500 386 or email: jane.stephens@braintumouruk.org.uk. Jane will take your name and number, and send you the phone pals information sheet. For Meningioma and Acoustic Neuroma Phone Pals telephone Ella on 01787 374956

United Brain Tumour Campaign

Survey of patients and carers affected by brain tumours

The united Brain Tumour Campaign charities and other brain tumour charities conducted a postal survey of patients with brain tumours and their carers. The aim of the survey was to explore the experiences of brain tumour services and to identify areas of unmet needs. A summary of the results suggested that 18% of patients waited over 24 weeks to be referred to a neurologist and that GPs can find it difficult to identify signs and symptoms which may indicate a brain tumour. Overall patients were very satisfied with the treatment they receive from their hospital, but are less satisfied with their GP. There was a feeling that not enough information and support was made easily available with 55% of patients and carers reporting that they were not given contact details of a health professional who they could speak to if they had any questions and 58% said they were not given the contact details of a charity or support organisation they could contact, despite 80% expressing an interest in attending a support group. There was also dissatisfaction with the follow-up and long term support they receive, patients and carers feel that more support should be given at diagnosis, there should be greater co-ordination between different services and that people need someone who can help them with the long term effects of a brain tumour.

The United Brain Tumour Campaign charities are : Ali's Dream, Andreas Gift, Brain and Spine Foundation, Brain Tumour Action, Brain Tumour Research Campaign, London, Brainwaves, Charlie's Challenge, Children's Brain Tumour Research Centre, Ellie Savage Memorial Trust, Hammer Out, Other charities which took part: Samantha Dickson Research Trust, Brain Tumour UK, AMNET

AMNET AGM

The AMNET AGM for 2005 will be held at Addenbrookeís Hospital on Saturday 7th May 2005 at 13.30 hrs

AGENDA

- Apologies
- Minutes of Last Meeting
- Chairmanís Report
- Treasurerís Report
- Election of Officers
- Any other Business
- Close

Anyone interested in being more involved please contact Alison or one of the other committee members.

Present Trustees

Chairman	Alison Frank
Secretary	Tony Monk
Treasurer	Joanne See

Present Committee Members

Newsletter Editor	Chris Richards
New Members Co-ordinator	Neil Bray
Meningioma Association	Ella Pybus
General Members	Jill Laurimore
	Eleanor Monk

Editorial

Dear All

Welcome to the Spring edition of AMNET News. I hope you will find it interesting.

Alongside a report of the Christmas meeting I have a couple of articles which have appeared in BANA Headlines over the last year – a further article from Diana Farragher, the third in this series will be in the next newsletter, and an article by Mr S. A. Sadiq, an eye surgeon from Manchester Royal Eye Hospital. I also have an article written for us by Doreen Sharpe who has recently retired from the Norfolk Tinnitus Association.

Please note that the meeting on May 7th will be our AGM. We will be electing the committee and would welcome interest from anyone else who would like to help us with the organisation of AMNET. If you are interested please contact Alison or one of the other committee members.

Wishing you all a warm and enjoyable summer!

Best wishes

This article by Diana Farragher was first published in BANA Headlines in July 2004 and I thank BANA for permission to publish it in AMNET News

FACIAL EXPRESSION

By Diana Farragher

"Can I realistically expect any change so many years after the event, if anything my face seems to be getting worse?"

The face is never static it is always in a state of change.

If as you claim your face is changing i.e. getting worse, then let's grasp the concept of change and train your face to work in such a way that it will always be getting better. The way in which you use your face today determines your future face it can improve.

It is never static and therefore it is totally unrealistic to accept such myths as:-

"Where you are 6 months after surgery is where you are going to stay".

"My guess is that you are likely to have to put up with the present state of affairs for life"

The above 2 statements were passed on to me in clinic yesterday. Please don't give them any credence. Before we move forward it is always necessary to let go of these concepts of rigidity.

This is certainly the case when we look at patients with "synkinesis" – this is not a disease process it simply describes the situation which exists when the movements in the face link together and it becomes difficult to move the mouth without twitching the eye etc.

"What has gone wrong?"

Nothing has gone wrong it is a natural stage in the recovery process. If the facial nerve is growing back it is impossible to get better without passing through this stage of facial inbalance. When tissues of the body heal they go through various stages of recovery and development before they achieve maturity. This is true for nerves, they grow at a rate of 1mm per day in optimum conditions but the nerve which grows is poorly formed and needs to develop a coating of fatty tissue before it can function independently or to speed.

The regeneration of the facial nerve is miraculous and pleased as you are with it the more your friends say "but you look great now", the more you realise that although it looks ok from the outside it feels very awkward and clumsy to move.

The new nerve is slow to send messages and when the brain says smile the good side wins.

The new nerve is unable to send strong signals independently down any of the 5 branches until the nerve is insulated (i.e. regrows more fatty tissue). The brain says smile and forehead, chin, neck and under eye all twitch together.

Now we reach the real catch 22 situation. To bring the nerve to maturity it needs to function but every time it functions in this immature way the brain receives distorted signals and builds up a distorted image. Long after the nerve reaches maturity the confused brain continues to send distorted messages about how to smile. "This is how we do things now" When asked to smile the eye twitches first it is getting so good at working the wrong way.

We need to work the nerve under gentle load to encourage its maturity. To do this we need to make the face feel relaxed. When it feels good it moves better and we need to bypass the distorted information by feeding in accurate information about how the face is working today. Anything which makes the face feel good will do. Many patients enjoy a facial massage or listening to a relaxation tape. Whatever works for you do more of it.

At the Lindens Clinic we achieve these goals via the following interventions.

Trophic Electrical Stimulation – is specifically applied in order to energise the muscles and gives the nerve a lighter work load. This helps to bring the new nerve to maturity without encouraging mass patterns it is also capable of switching off the unwanted reactions for progressively longer periods of time.

Massage – is used specifically to stretch the connective tissue which surrounds the little facial muscles – and tape may be applied to weak muscles in order to prevent them from straining. It is also used to make the face feel good and rebalance the asymmetries

EMG (Electromyography) and biofeedback – are used to display simple graphs on a computer screen to show the way the facial nerve is working in real time. The patient is able to correct and balance the activities in order to master the new movements.

These are the very exciting avenues of facial rehabilitation and the very reason why I enjoy the challenges on a daily basis.

So please laugh out loud when you are told "the nerves have grown down the wrong track".

Your nervous system is amazing and your recovery powers immense. Don't limit your thinking by taking on such negative concerns.

This article by Mr S. A. Sadiq a surgeon at the Manchester Eye Hospital, was first published in BANA Headlines in May 2004 and I thank BANA for permission to publish it in AMNET News

THE GENERAL AGEING CHANGES OF THE FACE

By Mr S. A. Sadiq

Anno Domini – this affects us all if we are lucky enough!

Changes due to ageing occur in all parts of the body. Those affecting the face are most noticeable. It is often impossible to say when a specific change occurs as we tend not look at ourselves in the mirror every day. However, changes are better appreciated when we look at previous photographs or meet people whom we have not seen for sometime. I find that asking a patient to bring their previous photographs is an extremely good way of documenting changes that have occurred, and photographs are also helpful in pointing these out to the person concerned.

The changes in the face are exacerbated by gravity which tends to pull the face downwards, causing general sagging of facial features. Many of these changes are further worsened in patients with facial palsy where there is loss of muscle power/strength and tone, allowing the face to sag. This is particularly seen in the area overlining the cheek bone and the area between the nose and the cheek. When deeper tissues in the eyelids (the septum) become weaker, the fat that surrounds the eyeball moves forward. This is seen as swelling or lumps under the skin of the lower and upper eyelids.

With ageing, the skin becomes less elastic and this can create wrinkling on the surface of the skin. The movements of the muscles of the face cause deeper wrinkle lines. Wrinkles are worse in those who live in sunny climates where the sun causes people to keep their eyes narrowed in brightness.

Added thinning of tissue beneath the skin often leads to the face appearing hollow, especially in the upper lid. Primarily this is due to loss of fat that tends to shrink as ageing changes set in.

The eyebrow

This has three parts;

- the tail which is at the outer part of the eye,
- the body which is above the eye,
- and the head which is at the inner corner near the nose.

The eyebrow is normally arched, although it is higher and thinner in females compared to males. With ageing, the tail of the brow drops – this is called a temporal brow droop. This can push the upper eyelid skin down and create the appearance of excess skin in the upper lid.

The upper eyelid

As the patient ages, the skin of the lid also sags, hiding the crease in the upper lid. There is a natural concavity between the eyelid and the eyebrow, called the sulcus. If the fat around the eyeball pushes forward, this can tend to fill in the sulcus. If there is shrinkage of the fat, the sulcus may be increased giving a hollow appearance.

A muscle called the levator muscle lifts the eyelid. The orbicularis muscle closes the eyelids. The opening and closing of the upper lid protects the cornea (the window of the eye) and lubricates it. If the levator muscle comes away from the fibrous tissue in the upper eyelid, called the tarsus, the upper lid droops (ptosis). When severe, this can cover the pupil and hinder vision.

The lower eyelid

The lower eyelid normally rests on the eyeball at the junction of the clear part of the eye called the cornea, and the white of the eye, the sclera. The lower lid is held against the eyeball by tension in the lid. If the lower lid becomes lax, then the eyelid can turn inwards or outwards. As the cheek falls, it makes the lower lid look thinner and makes the bone underneath the eyeball more prominent. As elsewhere, there may be redundant skin and muscle in the lower lid. Again, if the fat in the lower lid bulges forward, this can make the lower lid appear swollen or lumpy.

In the next article, I hope to look at the changes that occur in the face following a facial palsy.

Parking at Addenbrookes

You may be aware that the cost of parking at Addenbroookes has increased quite dramatically recently. The committee does not want members to stop coming to meetings because of the cost of parking. There are alternatives such as the Babraham Park and Ride but we have decided that we will offer to refund £2 of the parking charge for any members who attend the meeting. If you would like a refund please let Joanne know at the meeting.

Tinnitus – a test of character

This is an article provided by Doreen Sharpe who has just retired as the co-ordinator of the Norfolk Tinnitus Society which is now being run by the Norfolk Deaf Association in Norwich and Kings Lynn

Any change in health makes a call on our innermost resources in order to cope – from the common cold to the most serious of conditions. Personal strengths vary greatly from one person to another – where one will take to their bed at the slightest sniffle, another will carry on stoically. There is a generalisation that women tend to carry on regardless –whereas a man would be more likely to give in. (Remember the old joke about what would happen to the world if men had babies!). Pain thresholds can vary from person to person, as can tinnitus tolerance.

So it is no surprise that tinnitus has such a variation of effects on people – although we are told that the actual sounds being generated fall within a very small range – one person will be comparatively untroubled by it whereas another will be 'climbing up the walls'. It is this range of reactions to basically similar sounds, within the head or ears, which makes it hard for many GPs to understand why some patients experience such difficulties with tinnitus.

Over the ten years or so that I have been running the Helpline of the Norfolk Tinnnitus Society, I have come to the conclusion that it is not a case of gender, but more a case of genetics. Not that tinnitus in itself has any known genetic links that have been discovered so far, but individual character traits are very often inherited. This applies particularly to those people who are always anxious – about everything. I can usually detect this during the very first phone call, and if asked whether they would describe themselves as a 'anxious type', - a caller will readily agree. Ask then if someone else in their close family was (or is) an 'anxious type', you will often find this applies to one parent , and that some siblings are the same. Clearly, when this happens, it is important to point out that it is not their fault, any more than the colour of their hair or eyes! But where tinnitus is concerned it certainly going to make it more difficult to cope with the sounds, and they will have to work harder to overcome their anxiety.

There are good physical reasons why anxiety plays such a strong role in tinnitus perception. Under stressful situations the body's defence mechanisms go into action, secretions of the 'activity' hormone adrenaline are increased, releasing extra blood sugars stored in the liver, and the heart rate will increase in order to pump this extra nutrition in the bloodstream round the body to meet the demands of the emergency. In addition, the nervous senses go on 'red alert', especially the auditory system, all gearing the body up for 'fight or flight'.

Now this is all necessary for a real emergency, but where someone lives in a constant state of anxiety, to a lesser degree the same physical changes are going all the time and the auditory cortex (the area of the brain where we experience conscious hearing) will always be on 'overdrive'. If good input of environmental sounds are restricted by any deficiency in hearing, for whatever reasons, then the extra sensitivity of the auditory cortex will ensure that it picks up the sounds nearest to it, in other words, tinnitus.

This should point the way to overcome these difficulties, working on the principle of 'whatever makes tinnitus perception worse – doing the opposite will make the perception diminish'. So, if stress makes tinnitus worse, relaxation will make it better. If anxiety is making it worse, then looking at the underlying reasons behind anxiety about tinnitus, and exposing these as groundless, will make it better. If silence makes it worse, then sound enrichment will make it better.

It is not exactly rocket science is it?

Anyone who has had Tinnitus Retraining Therapy (TRT) will recognise these elements as some of the component parts of therapy, and they are things which people can do for themselves.

For relaxation – use a tape to guide you through the processes of learning to relax and breathing control, and practice every day. There are good Relaxation tapes available through Support Groups (see below) as well as Seashore sound tapes that can help with habituation. This is the desired aim of TRT when, although tinnitus is still present , it does not dominate, and there will be long periods where it is not heard. Where someone is receiving professional therapy and has a white noise generator, these tapes can be a useful adjunct.

Sound enrichment helps to diminish the perception of tinnitus, which is all too evident against a background of silence, and this can be anything from an audio tape, or radio programme, (keep the volume below that of your tinnitus). Water features, or the sounds of nature, when out and about, can also be relaxing.

As one of the possible symptoms of an acoustic neuroma, tinnitus is bound to be accompanied by anxiety about the condition and the prospect of delicate surgery. I had thought that following surgery, the tinnitus would become insignificant by comparison, but from the results of a survey which AMNET conducted a while back, it seems that this is not the case. Tinnitus remained stubbornly there, and high on the list of post-surgery problems, no doubt enhanced by disappointment that it had not gone away.

Getting help through professional therapy is undoubtedly the best option, although this is still not possible in some areas. Where that is the case it would seem sensible to help yourself by using whatever aids to achieving habituation are available.

If you are using the internet, do select information from a reputable source, preferably one run by a professional advisor or support group. Be wary of the many 'chat lines' which can be unhelpful, and don't pay any heed to the 'horror' stories which sometimes appear.

Further contacts for advice and tapes:

RNID Tinnitus Helpline Tel: 0808 808 6666 19/23 Featherstone Street, London EC1Y 8SL

'HUSH' – The Hull Tinnitus Self-Help Group Tel: Bill Howard 01482 656033 109 Southella Way, Kirkella, Hull HU10 7LZ

PS .. If you are one of those 'anxious types' do persevere! I have known many such members in the past who have overcome the distress of tinnitus. They have achieved habituation and now bear the accolade of a 'Tinnitus Manager'.

Here is some news from 'Changing Faces' taken from their new web site.

Changing Faces Changes Places

Changing faces has moved to The Squire Centre, a new purpose-designed building in central London. The building, which consists of two dedicated counselling rooms for adults and children as well as increased workshop and training facilities, will enable the charity to reach more clients and extend their programmes for teachers, employers and health and social care professionals.

Chief Executive and Founder, James Partridge paid tribute to the major donors including The Greg and Fiona Squire Foundation and the Big Lottery Fund and said, "Our new Centre is the beginning of a new chapter for Changing Faces. From humble beginnings in North London, the charity has grown in reputation and strength introducing new services and ground-breaking campaigns and building the highly-skilled team of professionals that is the charity today.

We are literally unique in what we do worldwide and the Centre presents us with a major opportunity to reach a wider community and get our message across even more strongly that living with a disfigurement is a challenge that can be successfully met.'

No quick fix

Cosmetic surgery is not a quick-fix solution says Changing Faces Chief Executive. "The Department of Health's recommendations should curb belief that cosmetic surgery is a quick-fix solution" says Chief Executive of Changing Faces

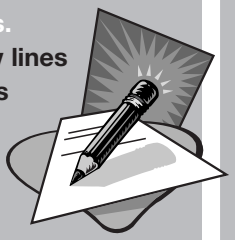
In response to the Government's report on the Regulation of Cosmetic Surgery, James Partridge, Chief Executive of Changing Faces, whose clients include people who have been disfigured as a result of mistakes in cosmetic procedures, said: "We particularly welcome that the Report's recommendation for better advice and public education about cosmetic surgery. This should mean that potential patients will be better informed to take the risks into consideration and to seek other treatments which may be more appropriate."

Dr Partridge, who sat on the Expert Advisory Group continued: "Current information and advertising greatly understates the risks associated with cosmetic surgery (in all its forms) and has a tendency to present it as just another means of beauty enhancement, when in fact any surgical procedure carries risks". As the report makes clear, cosmetic surgery is currently widely advertised in ways which would be quite unacceptable to the public and to professional ethics if they were used in relation to other surgical interventions. Changing Faces believes that some of the aggressive marketing techniques used in promoting procedures such as botox and face-lifts actually encourage people to feel insecure about the way that they look. This will change if the recommendations are put into operation because the Healthcare Commission will regulate information and advertising about cosmetic surgery.

Changing Faces is continuously contacted by people of all ages and with various types of disfigurement (including those caused by accidents, cancer, skin conditions, birthmarks) - many feel unacceptable because of the way they look. The growing popularity of cosmetic surgery and the way it is advertised as a quick-fix to achieving physical perfection and happiness can exacerbate these feelings. Cosmetic and reconstructive surgery can help patients feel better about themselves as part of a package of care which should include psycho-social interventions.

Dr Partridge added: "We also welcome the recommendations about the training of cosmetic surgeons and the proposal that all persons who advise patients about cosmetic procedures should be doctors or nurses. Changing Faces believes that this should ensure that better pre- and post-surgery assessment is conducted giving patients full information about the treatment options available. Because some people seek cosmetic surgery for reasons which are psychological and/or social in origin, counselling and social skills training should be offered as alternative or complementary treatments".

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: 10th June 2005

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

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.

Surfing the Net?

Addresses and Web sites

Addenbrooke's new website
www.addenbrooke's.org.uk

Changing Faces
(Registered Charity 1011222)
The Squire Centre,
33-37 University Street,
London WC1E 6JN
Switchboard Number: 0845 4500 275
Email: info@changingfaces.org.uk
Website http://www.changingfaces.org.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

The Meningioma Association UK

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

Tel: 01787 374084
Email: MeningiomaUK@aol.com
Website: www.meningiomalUK.org

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.

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
Email: bana@ukan.freeserve.co.uk
Website: www.ukan.co.uk

FORTHCOMING MEETINGS

Next meeting and **AGM** will be on **Saturday May 7th** at Addenbrookes Hospital in the Boardroom. Doors will open at 13.00 hrs and the AGM will be at 13.30 hrs, followed by a talk from **David Baguley MSc MBA, Head of Audiology at Addenbrookes Hospital**.

The following meeting will be held on Saturday 23rd July 2005 in the Boardroom at Addenbrookes Hospital. Chris Richards will report on her study of AMNET members and there will be an opportunity for members to discuss issues arising from the study.

The Christmas meeting will be held on Saturday 26th November 2005.

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.