

# 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 2005  
Issue 34

## Presentation of funds raised by AMNET members for Audiology and Ward A3



On September 27th Alison Frank and Chris Richards visited Addenbrookes to present two cheques on behalf of the members of AMNET. The money which has been raised through fundraising efforts of members and their families was presented to Clinic 10 and Ward A3.

David Baguley received the cheque on behalf of Clinic 10 and said the money will be used to update leaflets for patients and Louise Maris on behalf of Ward A3 said the money would be used to produce laminated information sheets on eye care which can be taken home by patients.

### Next Meeting

The next meeting will be our Christmas meeting and will be held on **Saturday 3rd December at Addenbrookes Hospital** in the **Boardroom**. The doors will be open at 11 o'clock and as usual we invite everyone to bring a contribution of food so we can enjoy a social get – together and the committee will arrange some entertainment.

## Editorial

Dear All

Welcome to the autumn newsletter which I am writing with threats from the media of bird flu and an extra cold winter. I'm hoping it is all hype and we will have a relatively warm and uneventful winter. We are hoping to see as many people as possible at our Christmas meeting. As usual this will be a social occasion and we invite members to bring a contribution to our communal lunch. We are not sure what the entertainment will be as yet, but the committee will arrange something interesting!

I could not do a report of the last meeting as I had

already written the article for the last newsletter but I have asked Alison to write down some thoughts about the meeting. So, the newsletter this time draws heavily on BANA Headlines, for which I am grateful to Julie and Adrian, and I hope you enjoy the articles from Mr Moffat's team and from Mr Sadiq in Manchester.

So here's hoping the winter is better than it is being promised.

Best wishes



# postbag



*I'm sure everyone will be pleased to hear that we have a letter from Ray Maw who has now been in Ireland for two years. He reminds us that he is still very willing to help members.*

Dear Editor

I have been made aware that members will presumably have no idea how to contact me if they want Vislube or information.

I have had no contacts from AMNET members since I came to Ireland, however a few BANA members living in Ireland have contacted me as I have agreed to be BANA's Irish contact.

In case anyone is wanting Vislube eye drops or seeking information my phone number is 00353 2356719 and my email is raymaw@utvinternet.com

I find life in Ireland is great.

Regards

Ray

## Snippets



### Earplugs

For anyone wanting further information about the ear plugs David Baguley was describing at the meeting in May there is a web address below

[http://www.advancedmp3players.co.uk/shop/product\\_info.php?products\\_id=209](http://www.advancedmp3players.co.uk/shop/product_info.php?products_id=209)

### Tinnitus

The RNID have a book available called 'Understanding tinnitus – managing the noises in your ears and in your head' It can be ordered through their website [www.rnid.org.uk](http://www.rnid.org.uk).

## Disability Discrimination Act 2005 (DDA)

From CAMTAD Newsletter there is some information about this act which is a later version of the Disability Discrimination Act 1995. In the past the DDA has responded to complaints about discrimination but from December 2006 all public bodies such as prisons, hospitals, police forces, local authorities, schools and some theatres will have to act proactively to prevent discrimination and harassment related to disability and promote equality. They will have a new duty to promote positive attitudes towards disabled people and public authorities have a responsibility to consider providing additional services to enable deaf and hard of hearing people to be active members of their communities.

## **The side-effects and complications of acoustic neuroma surgery: How do we avoid them?**

**Stephen E. M. Jones**, Fellow in Skull Base and Otoneurological Surgery

**David A. Moffat**, Consultant in Skull Base and Otoneurological Surgery

Addenbrookes Hospital, Cambridge

---

### **Introduction**

The removal of an acoustic neuroma is a highly complex operation which carries a significant number of risks and possible side-effects. It is our job as surgeons to ensure that these risks are minimised as far as possible and to manage the complications which may arise appropriately, to reduce the disability and handicap they might cause.

The adverse consequences of surgery may be considered by virtue of the anatomical proximity of important structures which are inevitably at risk from the surgery. These structures include the Vestibulocochlear nerve, responsible for hearing and balance; the Facial nerve, carrying fibres to the facial muscles and tear glands, and fibres from the tongue providing the sense of taste from the front two thirds of that side; the Trigeminal nerve which supplies sensation to the face; the Abducent nerve which supplies the muscle which causes the eye to turn outwards; the Glossopharyngeal and Vagus nerves which supply sensation in the mouth and throat, swallowing and movement of the vocal cord; the Accessory nerve, which supplies muscles which move the shoulder upwards; the dural covering of the brain which contains the cerebrospinal fluid surrounding the brain; and the brain itself.

The avoidance of side-effects can be subdivided into prevention and treatment.

### **Prevention**

Many people who initially come to the attention of their doctor with an acoustic neuroma visit them because of hearing loss or tinnitus. Although they may have some hearing to loud sounds they often have no socially useful hearing and cannot use the telephone on the affected side. We may adopt a surgical approach which precludes hearing preservation if this approach has important advantages in other respects. Loss of residual hearing is expected in a large proportion of the patients we see in

Addenbrooke's Hospital as the greater proportion who have surgery have no useful pre-operative hearing and are operated on via the translabyrinthine route, meaning that the balance and hearing nerves are necessarily divided. Our research has shown that it is better to have no hearing at all than a small island of distorted hearing preserved. In patients who have socially useful hearing but who need to have their tumour removed we may use a different route for access, if it is possible, which may allow us to preserve some hearing.

We minimise the other complications of surgery by carefully preserving the other nerves (the trigeminal, abducent, facial, glossopharyngeal, vagus and accessory nerves) and handling them as little as possible or not at all depending on the size and degree of adherence of the tumour. We also need to take care in closing the wound to ensure that it is watertight and does not allow cerebrospinal fluid leak which is an inevitable but small risk and if it occurs may predispose to meningitis. Meningitis may also occur from infection acquired during surgery. We are meticulous about the preparation in the operating theatre and we also give everyone undergoing surgery antibiotics as a preventative measure. We have a very low rate of meningitis after surgery because of the routines we follow.

Epilepsy is occasionally seen in people who have undergone tumour removal via the middle fossa approach where the temporal lobe of the brain is retracted upwards to provide good access to the site of the tumour. The risk of epilepsy is very small (less than 1%) and is reduced by minimising the amount of retraction. Very rarely patients may suffer a post-operative fit. In this case the DVLA recommends that patients do not drive until they have been free from seizures for one year. We would also put these people on a drug to prevent the occurrence of epilepsy. There is no risk of post-operative epilepsy in patients undergoing surgery via the translabyrinthine (through the mastoid) or retrosigmoid (behind the mastoid) approach.

When our patients come with normal facial nerve function we would expect that it will function normally after their surgery in the majority of patients, although sometimes it is weak in the immediate post-operative period and recovers over the subsequent 18 months. We grade facial nerve function according to the House-Brackmann grading system, grade I being normal and grade VI being no function at all. We have found that 93% of patients with small tumours and grade I function prior to surgery have a satisfactory (grade I or II) afterwards. In medium sized tumours this drops to 91% and to 78% for large tumours. The other problems related to facial nerve function are due to damage to two small nerves which joins the nerve in the region where acoustic neuromas are found. These problems are caused by new nerve fibres regrowing incorrectly causing the eye to water when eating, a dry eye and also an abnormal sense of taste affecting the front two-thirds of the tongue. These symptoms are unlikely to occur in patients with normal facial nerve function post-operatively. We use a nerve monitor during the operation which has been shown to help the final outcome of facial nerve function and helps the surgeon minimise the risk to the facial nerve during the operation.

Injury to the glossopharyngeal, vagus or accessory nerves mentioned above will usually cause hoarseness and swallowing difficulty. This is very rare but when it does occur it is usually very transient and improves over the first 1-2 weeks post-operatively. At 3 months following surgery we have seen only 4% who have had some brief period of swallowing difficulty or hoarseness and by 12 months this had completely settled in the vast majority.

The risk of leaving residual acoustic neuroma is very small indeed. Rarely the tumour is very adherent to the facial nerve and a decision must be made between complete removal of the tumour and damage to the facial nerve. In these cases a tiny amount of the tumour capsule may be left behind in order to minimise the risk to the facial nerve. These minute pieces of tumour have lost their blood supply and when we observe them with MRI scans in the subsequent years we usually find that they do not grow at all. In the many years Mr. Moffat has been operating on acoustic neuromas in Addenbrooke's Hospital there have been 5 patients who have been found to have a possible area of residual tumour after their MRI scan at 2 years from a total of 883 who have had operations performed. This amounts to a risk of 0.5%. None of these patients have needed further surgery as the scans have not shown any

significant change in size of the remaining tiny morsel of tumour over many years.

## Treatment of complications

The vast majority of patients are neurologically intact, with no or minimal symptoms, and enjoy an excellent quality of life. 87% of patients return to their previous occupation.

Most patients have no socially useful hearing pre-operatively and even in those that do the loss of the residual hearing does not increase their hearing handicap. If they have poor hearing in their other ear we must make the most of this and a hearing aid fitting is arranged if necessary. Some people find that the loss of hearing on one side is a cause of handicap and we therefore try a CROS type hearing aid, where sound is picked up by a receiver on the affected side and transmitted to the other ear. The other possibility for single-sided deafness is the fitting of a bone-anchored hearing aid where a titanium screw is placed in the skull on the affected side which permits the placement of a hearing aid. This allows the sound from this side to be transmitted to the better ear via the bone of the skull.

In patients with no tinnitus prior to surgery there is a risk of developing it afterwards. In our patients 77% who had none before still had no tinnitus post-operatively and it was mild in the majority of those who did develop it. In 42% of patients who had mild tinnitus pre-operatively their tinnitus was abolished by surgery, and it remained roughly the same in a further 41%. For those patients who do have tinnitus many learn to cope with it very well. For the majority it is mild (61% of those with tinnitus). Severe tinnitus is unusual (less than 1% of patients at 3 months after their operation). We have an international expert in tinnitus at Addenbrooke's Hospital, and a tinnitus clinic where patients can be assessed and helped with strategies to minimise the effect of tinnitus on their lives. Many local services also have tinnitus clinics which would also be able to offer advice and support.

The gradual loss of balance function on one side occurs in any case as the tumour arises on the balance nerve. Although patients may be a little unsteady in the first few days after the operation this soon settles. We give drugs initially to stop the sense of the room spinning round. As this settles, and as soon as people are able to get out of bed safely, we ask the physiotherapists to see to them. We are fortunate to have experienced physiotherapists who help to get our patients back on their feet and give advice on the balance rehabilitation exercises. These exercises aim to help the brain

compensate for the loss of balance function on the operated side. As the brain compensates so the world stops spinning and the drugs can be stopped. We ask our patients to continue these exercises once they are home. The process of compensation can take a long time and these exercises will speed it up. By roughly one week after the operation the balance has improved enough that most people are able to go home. In the long term 53% of patients have clinically normal balance, 30% are a little unsteady when the balance system is stressed, 12% are unsteady in the dark and only 5% complain of persistent unsteadiness.

Good facial nerve function is important to quality of life. If patients have a minor degree of weakness (grades II to III) we often do not need to give any treatment at all. This may recover spontaneously up to 18 months after surgery although it may not recover fully. The results from surgery are generally excellent as already described. If the weakness in the post-operative period is more severe we do a test which shows in the majority of patients that the nerve will recover satisfactorily with time. We need to make certain that other complications, such as eye injury due to poor closure of the lids and dryness, do not arise because of facial nerve weakness and we give patients lubricants for the eye during the day and night. An ophthalmic surgeon will usually make an assessment at 1 week post-operatively. It is rarely necessary to place a temporary stitch in the outer third of the eyelids to improve their closure and to protect the eye while the nerve is recovering. This is a minor operation performed under local anaesthetic called a tarsorrhaphy. Patients with significant weakness twelve months after surgery, when the nerve will have finished recovering as far as it is going to, would be referred to our plastic surgical colleagues to consider whether any further treatment would be helpful. There are various different surgical treatments which might be used for this, depending on the patient's wishes. If the facial nerve has been lost during the operation it might be possible to gain length and stitch the ends together during the first operation and wait for its subsequent recovery. If this is not possible grafting the nerve with a nerve from the neck or joining the nerve to the nerve to the muscles of the tongue may be undertaken. These procedures may restore some tone and movements to the facial muscles but will not restore facial movement to normal. If these are not possible then static procedures may be performed, such as a gold weight in the upper eyelid to improve closure, or a sling of tissue beneath the skin to pull up the corner of the mouth, will improve the appearance of the face at rest.

The complications of abnormal sense of taste, dry eye and watering eye on eating may be difficult to help, but rarely trouble patients unduly and many who suffer from these symptoms find that they recover without any treatment.

Injury to the glossopharyngeal, vagus, accessory or hypoglossal nerves is extremely rare following acoustic neuroma surgery. If hoarseness and swallowing problems do arise they are almost always transient and helped by speech and language therapists.

Cerebrospinal fluid leak is a rare complication (3%) in our hands which generally occurs early but is an inevitable small risk. It may rarely occur up to a year following surgery. Clear watery fluid may drip from the nostril on the side of the operation, made worse by bending down. We would insert a drain into the back called a lumbar drain to reduce the pressure of the cerebrospinal fluid. This will allow the leak to seal spontaneously within a few days in 1% of patients. In the remaining 2% it is necessary to take patients back to the operating theatre to close a leak such as this.

## Conclusion

With modern anaesthetic and surgical techniques the results from acoustic neuroma excision have been transformed in the last four decades. Major complications and neurological damage are now very rare. None the less this is major surgery and cannot be performed without some risk. When we operate on an acoustic neuroma we preserve the hearing when there is socially useful hearing prior to the operation and if it is possible to do so. We carefully dissect the tumour from the facial nerve, preserving it intact and we remove the tumour entirely in the vast majority of patients. The risk of damage to other surrounding nerves and blood vessels is very small. We take precautions to avoid post-operative infection and we make certain that we close the operation site effectively so that there is no leak of cerebrospinal fluid after the operation.

After patients have woken following their operation we make sure that any nerve injury is identified early so that we can monitor it and offer any treatment needed as early as possible.

By doing all of these things we do our best to minimise the risk of post-operative handicap and subsequent deterioration in quality of life. Our aim is total excision of the tumour with preservation of life, normal facial nerve function and, although more difficult to achieve, to try to preserve hearing in the small number of patients with socially useful hearing pre-operatively if the size and shape of the tumour permits.

## **CHANGES IN THE EYELIDS IN FACIAL PALSY**

**Mr S A Sadiq D.O.M.R.C.Ophth FRCS**

**Consultant Ophthalmic Surgeon, Manchester Royal Infirmary**

---

For a healthy, moist, comfortable eye, several muscles and different nerves controlling these muscles, must function normally.

Firstly, a nerve called the facial nerve controls muscles of the face and eyelids. These muscles lift the eyebrow and help close the eyelids, protecting the front of the eye. With a facial palsy, the facial nerve for some reason stops working. Consequently, there is reduced or absent movement of these muscles. The facial nerve also supplies a circle of muscle around the eyelids. Movement of this closes the eyelids over the front of the eye to protect it and to keep it lubricated with the natural tears. In facial nerve palsy, the eyelids are unable to close or are only able to partially close. In the upper eyelid there may be unrivalled action of the levator muscle that is responsible for lifting the upper eyelid. This can result in the upper eyelid being too high so that more of the front of the eye is open and exposed. In the lower eyelid, the loss of muscle tone leads to loss of support of the lower lid so that it is not held against the eyeball. The eyelid becomes lax and pulls away from the eyeball. In cases of a mild palsy, there is some movement of the eyelids, but the blink and closure maybe incomplete. Such patients do have better function and fewer problems.

Secondly, the eyelids perform many functions such as forming a barrier to damage and drying of the front of the eye. They also stop bacteria from sticking to the front of the eye. As well as lubricating the eye, tears wash away these organisms and help kill the bugs with their many antimicrobial substances. Unfortunately, on occasions, surgery for acoustic neuromas may damage the nerve to the gland that produces the tears (lacrimal gland), and this can add to the problem of reduced eye closure.

During surgery for acoustic neuroma, the facial nerve may have to be sacrificed. In this case, the facial palsy will be permanent. On other occasions a facial nerve may only be swollen due to the surgery and so there is a good chance for full or partial recovery given

time. In my experience, if there is little recovery six months following acoustic neuroma surgery, then there is less chance of a full recovery. However, nothing is ever 100% and I have rarely seen patients achieve recovery even several years following surgery.

Thirdly, if the nerve responsible for giving sensation to the eye, the trigeminal nerve, is also damaged, drying or damage may occur to the eyeball and affect vision as any damage is usually presented to a doctor late on as patients often have no pain.

Many other factors also affect the extent to which a facial palsy impacts a person. For instance, the age of a patient influences the cosmetic appearance. Younger patients have stronger tissue and better support for the eyebrow and lower eyelid. However, in older patients there is a loss of strength in the facial tissues that allows the brow and lower eyelid to sag. This is compounded by the loss of muscle tone and increased thinning of the tissues of the eyelids in patients with a facial palsy, as well as due to effect of gravity when standing.

Contraction of the muscle of the forehead, under the control of the facial nerve, is responsible for the arched and high position of the eyebrow. In facial nerve palsy, the eyebrow tends to fall and covers the skin of the upper lid. The eyebrow is relatively bulky and can also push down the skin of the upper lid.

As well as changes to the eyelids, a facial palsy can have serious psycho-social effects on the patient. The facial nerve supplies muscles of facial expression, and when these are not working fully or at all, then the ability to express ones feelings by facial expressions is lost. Indeed the asymmetry caused by a facial palsy can often be very embarrassing. This can curtail a person's social activities and reduce their chance of continuing or gaining employment.

In the next article, I hope to look at the treatment of eye problems that occur in a facial palsy.

# July meeting

*As the article for July's meeting has already been written I asked Alison to write a short piece describing her reaction to the talk – Thanks Alison*

It was interesting to hear and see the results of Chris's successful post graduate degree course concerning AMNET members continuing recovery from acoustic neuroma surgery. I feel however far away from the surgery we are, our recovery is still evolving and growing stronger. Yes, we can put it behind us and move on but it will always have happened.

The original adjusting to the confirmation of a benign tumour instead of the vague 'well something might be wrong' sends ripples out into your own understanding and your wider circle of friends, family, work and daily life. I found I had to go a long way inside myself to cope, adjust and begin to recover before I could emerge changed but stronger. While listening to Chris at the meeting I looked at our audience and there was a lot of nodding of agreement as the slides appeared.

Our thanks to Chris for using us as a resource and sharing the results with us and to the Addenbrookes professionals for us all to learn and grow.

---

## Interesting websites

*In a new series of occasional articles I have decided to do some surfing and write a report on some websites which I feel members may find interesting and useful. If anyone out there would like to write a short review on a website they have seen, or on a book they have read which they may feel members would find helpful please send it to me. Any length will be gratefully received! My chosen website for this edition is the Royal National Institute for the Deaf (RNID)*

### **Royal National Institute for the Deaf (RNID) ([www.rnid.org.uk/](http://www.rnid.org.uk/))**

The home page of this website is headed '**Changing the World for the deaf and hard of hearing**' and has links to the various parts of the website. There is a news page which this month highlights the risk of a particular drug used in the treatment of cancer causing deafness, particularly in children and calls for the pharmaceutical industry to increase research into drugs which block this side effect. Another item is that they will be offering discounts on Deafness and Disability Training Courses for businesses who have to ensure they are complying with the Disability Discrimination Act.

In their 'How we Help' section they describe their support to deaf and hard of hearing people by providing free information via their helplines, running vital services, supporting scientific and technological research, and running the RNID Typetalk telephone relay service. They also help other organisations to provide better services to their deaf and hard of hearing employees and customers.

You may remember me writing about their 'Don't Lose the Music' campaign and this has been picked up by Richer Sounds, the hi-fi specialists who are joining forces with RNID to promote the 'Don't Lose the Music' campaign to its staff and customers. They will be displaying posters and giving out free earplugs with purchases in all their stores during October. Some top bands have also pledged their support to the campaign so don't forget to highlight it to your children and grandchildren! We all know the difficulties associated with tinnitus and hearing loss!

RNID also run campaigns to improve access to services for the deaf and hard of hearing and to combat discrimination.

Their information pages have factsheets on everything from deaf awareness, benefits and services, tinnitus, hearing aids, education and employment. There are copies of all the factsheets which can be printed out for personal use.

Finally the shop has many useful items from flashing door chimes – one of their biggest sellers – to telephones, amplifiers and tinnitus aids.

This is a well organised and attractive site which you should find worth a visit on

<http://www.rnid.org.uk/>

Chris Richards

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.

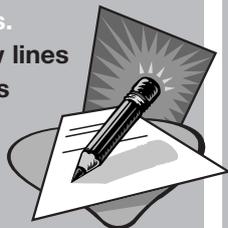
Contributions on paper and/or disc (Microsoft Word) to:-

**Chris Richards**

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

**email: [chris@richards2113.fsnet.co.uk](mailto:chris@richards2113.fsnet.co.uk)**

**by: 12th February 2006**



**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](http://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](mailto: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

# Surfing the Net?



Tel/Textphone 0115 942 1520

For further information:

**Email: [tinnitushelpline@binternet.com](mailto: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](mailto: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

## The Meningioma Association UK

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

Tel: 01787 374084

Email: [MeningiomaUK@aol.com](mailto:MeningiomaUK@aol.com)

Website: [www.meningiomalUK.org](http://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.freeseve.co.uk](mailto:bana@ukan.freeseve.co.uk)**

**New Website: [www.bana-uk.com](http://www.bana-uk.com)**

## FORTHCOMING MEETINGS

The next meeting will be our Christmas meeting and will be held on **Saturday 3rd December at Addenbrookes Hospital** in the **Boardroom**. The doors will be open at 11.00 hrs and as usual we invite everyone to bring a contribution of food so we can enjoy a social get - together and the committee will arrange some entertainment.

The following meeting is to be arranged

## 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**

00353 23 56719