

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

Winter 2006
Issue 38

AMNET is 10 Years Old!

On September 16th 2006 AMNET celebrated it's 10th Anniversary. This was an enjoyable occasion with much to celebrate. There is a report of the AGM and of Mr Sarkies talk inside and here are some pictures of the event.



Chris presenting Alison with a gift to acknowledge all the hard work she has put into AMNET and the support she has provided for members over the last 10 years.



Cutting the cake



Tony and Eleanor Monk who have retired from the committee after six years were presented with a cake.



Some AMNET members enjoying the opportunity to chat.



Next meeting

The next meeting will be held on **Saturday 25th November 2006** in the **Boardroom** at **Addenbrookes Hospital** at **12.00hrs** It will be the Christmas meeting so you are all invited to bring a contribution towards lunch as usual. The speaker will be **Rachel Humphriss Clinical Scientist in Audiology** who will talk about developments in the treatment of balance rehabilitation.

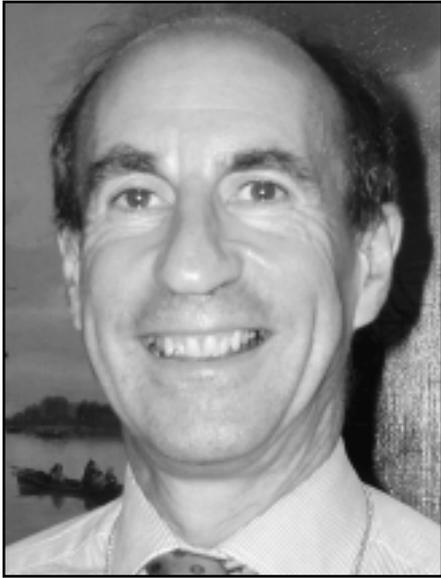
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Facial palsy and the Eye

Talk by Mr Nicholas Sarkies – Consultant Ophthalmologist
Addenbrookes Hospital, Cambridge

Reported by Chris Richards



We were very pleased to welcome Mr Sarkies to our 10 year anniversary meeting. He opened his talk by commenting that for people with facial palsy, eye problems can be an ongoing problem long after surgery. However he also commented that where he was doing 3-4 tarsorrhaphy operations (suturing the eye so that it could close more easily) 15 years ago he now does none. He is also aware of seeing less people with facial paralysis in the clinic than 10 years ago.

Anatomy of the eye and facial palsy

Mr Sarkies showed us a picture of the anatomy of the eye illustrating the nerve connections between the ear and the eye. He explained that while the 7th and 8th cranial nerves supply the face there is an extra nerve which branches off the 7th and 8th nerves – the **nervus intermedius** - which provides the nerve supply to the lacrimal gland and tear ducts as well as providing secretory, movement and sensory nerve supply to the tongue. Therefore, any trauma to the 7th and 8th nerves before the nervus intermedius branches off will mean the loss of tears in the eye. The cornea of the eye is the outside layer and provides two thirds of the refraction of light onto the retina. It needs to have a smooth polished surface and this is assisted by a film of tears which keep it moist and protect it from damage.

A number of factors can affect the facial nerve including **acoustic neuromas** and **meningiomas**,

other brain tumours such as **cholesteatomas**, and damage to the trigeminal nerve. However the most common causes are **injury** and **Bells Palsy** which is an unexplained facial palsy. In the case of Bells Palsy tear production is not usually affected, though treatment with extra tears is usually advised when the palsy is severe. There is some capacity for nerve recovery although this does depend on the nature of the injury and how much of the nerve needs to grow again. If the nerve has been cut it cannot regrow, but otherwise it may start growing again, albeit very slowly.

Examining the eye

When examining an eye affected by facial palsy Mr Sarkies described looking for a number of factors. **Bell's phenomenon** is the ability of the eye to move upwards when the eye is closed. If a person does not have this ability the cornea is more vulnerable to damage if the eye is unable to close properly. He will also examine how much of the eye is **exposed** when closure is attempted. This can be measured in millimetres, and is called lagophthalmos. He is also interested in whether there is **corneal exposure** and the degree of **tear production**.

There are two types of tear production – **reflex tears** which are produced when fluid is required to lubricate the eye because of irritation such as wind or cold, and **emotional tears** which are stimulated by a different part of the brain. These are produced in a greater quantity and have different constituents.

When the eye is examined the tear film can be seen, showing whether the eye is covered and with the use of fluorescent drops any damage to the cornea can be identified.

Treatments

The general condition of a patient is important as if they are not active and alert they may require assistance in caring for the eye. It is also important that they have access to an eye clinic in case there are any problems.

Initially most people can manage with extra lubrication and voluntary blinking.

Extra lubrication can be provided through the frequent use of eye drops or ointment, as required, to keep the eye comfortable. Lubricants used should be free of preservatives as some people have a reaction to the preservative causing the eye to become very painful. Eye drops in individual dose dispensers are the best to use.

The eye can be **taped** at night but this needs to be done with care ensuring that the eye is dry and is completely closed so that the cornea does not become damaged. Care also needs to be taken with the type of tape used as some may cause irritation.

'**Think blink**' is the process of encouraging the patient to blink voluntarily. Normally the eye will blink seven times per minute but while it is very difficult to achieve this through voluntary blinking a degree of voluntary blinking will help to keep the eye moist.

Eyelid weights may be put in to assist the eye to close. Gold weights can be sewn into the eyelid but tantalum weights can be fixed temporarily to the eyelid externally.

Eyelid surgery is considered if other measures have failed or when it is clear there will be no recovery. Tarsorrhaphy is rarely carried out now but surgery to lift the eyelid is sometimes undertaken.

Aberrant regeneration

Damaged nerves often do grow back along the path they went before the damage occurred, but

sometimes they grow along a different route and go to the wrong place. This can result in some anomalies:

Crocodile tears which are tears which occur when eating. The name is thought to be related to a belief that crocodiles cry when they are eating. This will often improve over time or people become used to it, but if it is troublesome it can sometimes be treated using botulinum toxin.

Taste sensation can be disturbed leaving a metallic taste – this again is often a temporary phenomenon.

Hemifacial spasm, caused by twitching of the nerves, may also be a problem and if severe may be treated with botulinum toxin. This treatment may be effective for facial problems but does have side effects.

Questions

Mr Sarkies took some questions from members and covered a number of areas including the problem of ingrowing eyelashes which can be treated by electrolysis or a freezing treatment of the roots.

There was also some discussion of the need to protect the eye in certain situations such as high levels of air conditioning and in aeroplanes.

Members noted that abnormal behaviour of lacrimal glands occurs in various ways, and often persists for many years after surgery.

We would like to thank Mr Sarkies for his interesting talk and for taking the time to answer members' questions.

Editorial

Dear All

Welcome to the fourth edition of AMNET News for 2006. It has been a busy year for us – particularly Alison – but also an enjoyable one with two important events. After the success of hosting the BANA AGM in July we held our own 10th Anniversary meeting in September complete with lunch and a cake. I hope you like the pictures we have included for those of you who were unable to come.

This edition also has two articles by members which is very exciting for me because I love to hear your stories – so please if there is anyone else out there with something to say – however brief – please let me know.

I hope you have all had a chance to look at our new website – see the address on the back page. We are looking for someone to help us keep the website updated. All you need is access to the internet – minimum expertise is required and help is available. Please let me know if you think you might be able to help.

All that is left is to wish everyone a very Happy Christmas and all the best for 2007!

Best wishes

Chris.

I would like to thank Elizabeth Clark for this very interesting and helpful article describing her experience, especially in relation to having a Bone Assisted Hearing Aid (BAHA) fitted at the time of surgery

How an Acoustic Neuroma Affected my Hearing by Elizabeth Clark

(12 October 2005)

Introduction

I am forty years of age, married with two children aged eight and six and work part time as a solicitor in a small firm. My tumour was diagnosed in March 2005 and was removed on 26 May during an eleven-hour operation. Prior to diagnosis I felt for some years that my hearing at the affected side was impaired, almost as if my ear was blocked with some tinnitus and hearing distortion. What I now appreciate is that as the tumour grew my hearing at the affected side in effect became less useful and indeed for at least one year prior to surgery, I could not confidently use the telephone at the affected side. It also became apparent that the tumour was distorting sounds to the other ear making hearing difficult generally in a variety of situations. I was therefore certainly aware that I could not hear as well as I thought that I should be hearing at my age. My hearing loss was one of the main reasons for seeking a medical diagnosis of my condition, in addition to other symptoms, noticeably severe face pain. If normal hearing with both ears on a scale of one to ten is 10/10, then prior to the operation, owing to the distortion and hearing loss I would say that my hearing was 6/10 or 7/10

Removal of the Tumour

My surgeon, David Moffat, Consultant in Otoneurological and Skull Base Surgery, B.S.C., MA., FRCS advised that owing to the size of the tumour as a result of the required surgery I would be deaf at the affected side. This would undoubtedly have an effect on my every day life, the options being to either rely on one ear, use cross aid hearing aids or a bone anchored hearing aid (BAHA). He explained that the procedure would entail fixing a titanium implant in the skull which acts like a 'raw plug', then there is a three-month wait to allow osseointegration (the fixture in the skull, being made of titanium integrates with the bone and becomes part of the skull to give a stronger fixture) before the BAHA, which is an amplification system by which sound is conducted to the cochlea through direct bone conduction thus bypassing the outer and middle ear. Mr Moffat mentioned that it would be possible to fit the fixture during surgery to remove the acoustic neuroma, although previously other patients had surgery at a later date for the BAHA surgery.

Having considered the matter, I decided that I would like to proceed to have a BAHA fitted at the same time as the removal of the tumour. With the help of the Emmeline Centre at Addenbrooke's Hospital (Graham Brickley), and with support from my own GP, (Richard Ansell) I was able to secure funding for the procedure and ongoing costs relating to the BAHA from East Surrey Primary Care Trust. Funding was refused by my Private Medical Insurers AXA PPP who were paying for all the other costs in relation to the surgery to remove the tumour.

Single Sided Deafness following surgery

This, I experienced for seven weeks following surgery. My head at the affected side felt empty, which in addition to the dizziness owing to the removal of the tumour, was very disorientating. I did however notice that the hearing through my right ear was much clearer and less distorted, however I was very much aware of my 'dead ear'. I certainly felt quite vulnerable, isolated, and at times panicked or frightened when I knew that I could not hear something. It is certainly very frustrating and considerably altered my awareness generally. I can only liken this to feeling as though I was inside a Perspex box, there being an invisible barrier between me and the outside world. I did not feel as confident in many every day situations and was very aware that when talking to someone I needed to be able to see their face to lip read, particularly when there was any background noise. I found myself avoiding conversation, particularly to people unknown. Everyday situations were certainly more difficult, for example I found it difficult to hear the telephone ringing and could not locate its whereabouts, difficulty in hearing the television and radio/car radio (needing this a lot louder than the rest of the family) and found it difficult to have a conversation whilst in the front of the car with passengers in the rear. I was also aware of my own voice in only one side of my head.

If normal hearing with both ears on a scale of one to ten is 10/10, with single sided deafness I would say that this is either 3/10 or 4/10. I do not therefore consider that I would have been able to return to my work without some sort of hearing aid.

Hearing with the use of digital cross aids

Having the aids fitted made a huge improvement in having a 'dead ear'. My balance appeared immediately better and I felt that my affected side was alive again. There are certainly many advantages and much to recommend, although there are also some disadvantages or difficulties.

Advantages and Disadvantages of digital cross aids

Advantages

1. Useful when watching television where there is no other background noise, although sound is a bit distorted.
2. Very useful where there is a 'loop system'.
3. Good in quiet situations or small group settings where there is no background noise. Digital aids are very neat, easy to use when needed or remove and effective immediately without surgery and with no direct infection risk.

Disadvantages/difficulties

1. The volume controls can be difficult to adjust to get the optimum setting.
2. The tone of the sound heard appears to be unnaturally high and in particular my own voice sounded very strange. I felt that singing in tune was more difficult than prior to surgery.
3. The sound was oppressive in any situation where there was background noise. I felt as though sound was being forced upon me with the loudest sound winning.
4. I had no directional distinction.
5. The use of a cross aid blocks the good ear, even with the use of an open mould, which is noticeable. I also found wearing the microphone over the ear at the affected side uncomfortable following surgery.

In summary I would say that a digital cross aid is certainly preferable to single sided deafness, with hearing improved, I would say to 6/10 or 7/10 but only where there is no background noise. In noisy situations I found it better to have no hearing aid, for the reasons stated and would say that hearing what you want to hear in these situations is as low as 3/10 or 4/10.

Hearing with a BAHA

The external connector was fitted to the implant on 12 September under local anaesthetic. Allowing time for this to heal again, the hearing processor was fixed on 3 October. The sensation and experience of this was both immediate and amazing. The sound quality is crystal clear with a much more natural, subtle tone which mimics normal hearing. My own voice certainly sounds more normal than when using the digital cross aid. I would say, without hesitation, that a BAHA is a far more sophisticated device than a cross aid, with hearing and sound quality in all situations, on a scale of one to ten certainly 9/10. My hearing is undoubtedly better using the BAHA than before I had surgery, particularly when using the Loop Telecoil which gives absolute clarity of sound through bone conduction which excludes all other background noise or echo and is clearer than through my normal, unaffected ear. I feel much more confident and am starting to distinguish directional sound, which is something that I feel would have been impossible without the BAHA. I do feel that I am, and will be able to return to my work and that my hearing impairment will not have any adverse effect in this respect. I am extremely pleased with the results of the BAHA which have, I am pleased to say, exceeded my expectations. I do consider that the BAHA has enhanced, and will continue to enhance, my quality of life.

I would summarise the advantages as follows:-

Advantages of Bone Assisted Hearing Aid

1. The BAHA compact device has a built in directional microphone which can easily be switched on and off. With the use of the directional microphone the sound is very natural and mimics the effect of a normal ear. I feel that the position of the BAHA in the skull however is important for the optimum use of this facility, which I am pleased to say in my case is I feel perfectly situated. This certainly helps with directional sound. Although I understand that the BAHA can be situated further back in the skull, I do not think that this would be as useful when using the directional microphone facility, as when this is switched off there is certainly an awareness of sound coming from around the head which is less natural and gives more of an echo in certain situations.
2. The processor is small, I found it very easy to fit and entirely unobtrusive and indeed I am unaware that I am wearing an aid.
3. Sound is natural, subtle, and clear, particularly when watching the television with or without the Telecoil.
4. The Telecoil device is easy to fit and use where there is a 'Loop' facility available. The sound using this is crystal clear.
5. Sound is not oppressive, is not distracting and I have not experienced any difficulties where there is background noise. It is almost as though my brain can pick out what sounds I want to hear.
6. My own voice sounds a more normal pitch; singing/playing guitar is easier and sounds natural.
7. Directional location of sound is much better and I feel that this is improving in the short time that I have been wearing the BAHA. I can also judge the distance of sound much better, which is particularly noticeable when I am driving and certainly makes me feel more confident.

I do not feel that in this report I wish to include a heading for 'disadvantages' of a BAHA. The only difficulty that I can foresee would be if the BAHA is forcibly knocked or pulled off the abutment unintentionally, although hopefully this would not damage the connector or the implant in the skull. I have found that I need to be careful when I am doing activity involving lying on the affected side during exercise or yoga, which causes feedback when the processor is touched. The obvious considerations of having a BAHA are that this involves surgery with a corresponding healing time and an infection risk. The attachment of the BAHA processor I found to be very simple, however may take some time for some to learn and adjust to.

Finally, I would like to say that I feel that I would already be lost without the BAHA and am extremely pleased and grateful that I have been given the opportunity, and funding to have this facility.



Thank you to Stephen West for this follow up to his article earlier in the year. We are pleased to hear everything went well and as always I am very keen to hear about your experiences.

Dear Chris

Thank you for including my article in the last newsletter. Since writing that article I have now completed my course of radiotherapy. I am feeling well and the last seven weeks seem to have gone by so quickly. My experience of undergoing the Radiotherapy treatment for my Acoustic Neuroma has been very much as I was expecting after hearing Kate Burton's talk at the AMNET meeting. Everyone I met at Addenbrookes during my treatment was very positive about the treatment and explained what was going to happen and how to deal with any side effects that might happen. Following the first few sessions I kept looking out for side effects but nothing seemed to be happening, I was a little concerned that the treatment was actually working because I couldn't feel anything happening. The Doctors assured me that it was working and that peoples reactions to Radiotherapy do vary.

By the end of my treatment yesterday the only things that I have noticed are;

- A. I got tired much quicker than usual and needed to rest when I got home after the treatment.
- B. My sense of smell seems to have been increased so that some certain smells become a bit overwhelming.
- C. My balance seems to have remained fairly good throughout the treatment but I did notice that immediately after getting up from the Radiotherapy treatment I felt a little bit unsteady but this passed very quickly after a few minutes sit down in the waiting area .
- D. I have lost a very small amount of hair behind one ear.
- E. As far as I can tell my hearing on the left side is unchanged from how it was at the start of the treatment and the Tinnitus in my left ear is also still there.

I cannot praise the work of the team in the Radiotherapy department highly enough. Although they were seeing many people each day I really felt that they were treating 'me' as a individual. They were all very meticulous in setting up the equipment to ensure accuracy each time the Radiotherapy was given. At the same time they were also making best use of the equipment available in order to avoid having lots of people waiting. Having to travel from my home in Hitchin to Addenbrookes for the 30 sessions of Radiotherapy was a bit daunting at first but once I got settled with the idea that this was effectively my 'work' for the day, I soon got into a routine and I was soon ticking off all the sessions.

I had decided to avoid using the car as much as possible during the treatment and I was pleased that I was able to continue with taking my bicycle on the train to Cambridge and then cycling to Addenbrookes. I found that it was a big benefit to have someone to keep me company on my daily journeys. Most of the time my wife was able to accompany me but when accompanied by my other non cycling friends, we were able to make use of the good bus services to and from Addenbrookes. For the last seven weeks the Radiotherapy has been dominating my life. I am now resting at home and looking forward to a well earned holiday with my family starting in a couple of weeks time. My next challenge will be to keep focused on the future and concentrate on getting my day to day life back to normality. I am also keen to explore the best way of enhancing my remaining hearing on my left side. I will have to return to Addenbrookes and see Dr Burnet for my first follow up check in eight weeks time and it is reassuring to know that the Oncology team at Addenbrookes are there for the long term management of my acoustic neuroma.

I hope that this account of what happened to me may be of help to someone about to embark on a similar treatment.

Yours Faithfully,

Mr Stephen West
25/10/2006

Rachel Humphriss is a clinical scientist in audiology at Addenbrookes hospital and AMNET supported her attendance at a course on balance. This article is her report on the course and we look forward to hearing more from her at our Chirstmas meeting

An Update on Balance

Thanks to AMNET's generous sponsorship, I had the pleasure and privilege of attending the Advanced Balance Course held by Southampton University at the end of June. Speakers included Neil Shepard, Ron Tusa and Susan Herdman, all international experts in balance.

Lectures and workshops were all of the highest quality and covered a wide range of vestibular disorders including acoustic neuroma. We were taught several new tests for a variety of conditions. For example, tests of utricle and saccule function (the part of the inner ear that detects gravity) were demonstrated, as were tests for weaknesses in individual semi-circular canals. We also practised various tests of walking and standing with a view to using these in the rehabilitation clinic.

Many of these new techniques are applicable to a wide range of vestibular disorders including acoustic neuroma and meningioma, and acoustic neuroma was discussed specifically from both diagnostic and rehabilitative perspectives. A test called Vestibular Evoked Myogenic Potentials (VEMPs) enables an acoustic neuroma to be located to a particular division of the vestibular nerve (as well as testing the function of the saccule). This test involves placing electrodes on the patient's neck and measuring changes in the contraction of the neck muscles with the patient listening to loud clicks. The response is recorded by a computer.

On the rehabilitative side, Susan Herdman (Professor of Physical Therapy, Atlanta, USA) spent a long time focussing on acoustic neuroma. She covered all the various complications of both the condition and treatments and talked about different vestibular rehabilitation strategies. We were shown video footage of a number of patients undergoing therapy, which helped to demonstrate how a patient's balance can improve if given appropriate treatment. The limitations of vestibular rehabilitation were also mentioned, particularly for patients who have other medical complications.

In summary, it was an excellent course which will help us to provide the very best care for our vestibular and acoustic neuroma patients in Cambridge. Many thanks to AMNET for their joint sponsorship without which I would have been unable to attend.

Rachel Humphriss
Clinical Scientist (Audiology)
Addenbrooke's Hospital, Cambridge.
July 2006

AMNET AGM Saturday 16th September 2006

Apologies were received from a number of members

The minutes from last year's AGM were read and accepted as a true record.



Joanne See, Alison Frank and Chris Richards (Founder members of AMNET)

Chairman's report

Ten years have passed since our exploratory get-together at the hotel in Cambridge kindly attended and paid for by David Moffat. His continuing support along with the rest of our advisory board, including new recruit Kate Burton have helped us with constructive advice when needed.

A lot of people who helped then are still working hard for AMNET now. Chris Richards began as secretary and extended into an excellent newsletter editor. Joanne See offered to be treasurer and has remained in that post keeping us financially afloat. Neil Bray has continued as new patient's officer and helps out when electronic gadgets for meetings like cameras and other audio-visual aids need attention. The other stalwarts, Peter Jones, former newsletter editor, Ray Maw librarian and Jill Laurimore all joined us later. Peter also helped us through the maze of paper to achieve our charity status. Ray is still working for AMNET from Ireland and Jill has served numerous refreshments. Eleanor and Tony Monk have been part of the committee for some years and have also given good service from behind the refreshment table.

We are always looking for new blood to bring fresh ideas to the committee and we work hard to keep our information up to date as most of us originals are more than twelve years away from our operations. Fortunately in the last few years we have had Ella Pybus join us. Ella has a wealth of knowledge, both personal and gleaned from her work with other groups, particularly Brain Tumour UK. During her time with AMNET she has also founded Meningioma UK with Caroline Batt. AMNET was originally set up to help both acoustic neuroma and meningioma patients and we were receiving many enquiries where Ella could help. It seemed logical for her to set up a separate group for meningioma patients but still maintain the strong links with AMNET.

AMNET has people working hard at specific important tasks. Margaret Allcock organises the hiring and maintaining of the trophic stimulators. Bill and Thelma Pye organise the newsletter distribution, keeping members up to date, by stamping and sending out of newsletters. This was made more difficult recently with the change of post office prices.

We have had a great variety of speakers over the years informing and challenging us to continue our recovery and keep us up to date. Some of what's on offer may need to be rejected as it does not fit in with the way we have shaped our lives, but it is useful to know of it's availability if required.

Earlier this year we hosted the BANA AGM which helped to strengthen the links with the Association of which we are a corporate member. AMNET took the decision some time ago to remain autonomous but to maintain amicable and reciprocal ties with BANA. The good turn out and friendly feel to the July meeting bore this out.

All these people in their various ways have helped AMNET complete it's first successful decade – here's to the next 10 years!

Treasurer's report

Our last financial year ran from Feb 2005 to January 2006 and at the end of the year there was £4183.14 in AMNET's account. The accounts were kindly audited by Michael Bartlett.

Subscriptions have been slightly up this year with some new members and donations stayed about the same. The newsletter expenses have been slightly reduced but in general expenses increased mainly due to donations given to departments in Addenbrookes Hospital totalling £1050.00. There was an overall deficit for the year of £488.92

Acceptance of accounts was proposed by Bronwyn Lummis and seconded by Thelma Pye

Election of Officers

Chairman – Alison Frank
proposed by Chris Richards and seconded by Joanne See

Treasurer – Joanne See
proposed by Jill Laurimore and seconded by Fiona Pike

Secretary – Jill Laurimore (standing for one year)
proposed by Joanne See and seconded by Neil Bray

Other committee members remained apart from Tony and Eleanor Monk who have resigned.

Alison expressed everyone's thanks to Tony and Eleanor who have worked for AMNET for a number of years and presented them with a cake.

Chris presented Alison with a plant, some chocolates and a card signed by everyone to thank her for all her hard work over the last 10 years. Alison has worked tirelessly to keep AMNET going, organising meetings and speakers and especially her efforts in organising the BANA AGM this year. But most of all we would all like to thank her for being the voice on the end of the telephone for so many people over the years helping them to cope at a very difficult time in their lives.

Any other business

Ella Pybus spoke and expressed how wonderful it is that AMNET has thrived over the last 10 years and how much help it has been to people. She explained that she is also working for Brain Tumour UK which is a group for people with all brain tumours and it is an area for which there is little support around the country. Ella has been asked to help in the setting up of a group locally for people with brain tumours at the Mary Wallace Cancer Centre which is situated in a house in Red Cross Lane very close to Addenbrookes Hospital. The first group meeting will be on 26th September and it will be a pilot scheme running initially for six months and will be patients and carers. Ella hoped that we would let anyone who might be interested about the group.

Within Brain Tumour UK Ella has been acting chief executive for much of this year but now there is a new chief executive. However, Ella's role has helped to strengthen the ties between Brain Tumour UK and AMNET, helping all people with brain tumours.

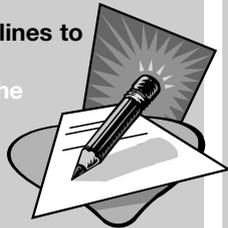
Jill Laurimore spoke on behalf of the ordinary members to say how grateful they all are to Alison, Jo and Chris who have provided so much support over the years. Before AMNET people with acoustic neuromas were alone now there is somewhere they can go and find help and support.

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: 26th January 2007

AMNET Advisory Panel at Addenbrooke's Hospital

Mr David Baguley MSc MBA
Principal Audiological Scientist

Kate Burton

Advanced Practitioner in Neuro-Oncology

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. There is a charge of £2.00 for all except for the first title.

Next time you go surfing don't forget our AMNET web-page on <http://www.amnet-charity.org.uk>

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)

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

Surfing the Net?



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.meningiomaUK.org

BANA has produced a new booklet which is available from Alison at a charge of £2:

'Effects an acoustic neuroma can have on your memory, emotions, behaviour, executive functioning and energy'

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

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Freephone: 0800 652 3143

Email: bana@ukan.freemove.co.uk

New Website: www.bana-uk.com

FORTHCOMING EVENTS

Saturday 25th November 2006 in the **Boardroom** at **Addenbrookes Hospital** at **12.00hrs** It will be the Christmas meeting so you are all invited to bring a contribution towards lunch as usual. The speaker will be **Rachel Humphriss Clinical Scientist in Audiology** who will talk about **Developments in the Treatment of Balance Rehabilitation.**

Meetings in 2007

Provisional dates for meetings next year:

Saturday April 14th 2007

Saturday 23rd June 2007 AGM

Saturday 24th November 2007 Speaker Mr D Moffat

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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