



Autumn 2007
Issue 41

Facial Reconstruction – Update and questions

Talk by Mr George Cormack, Plastic Surgeon at
Addenbrookes Hospital

Reported by Chris Richards



Mr Cormack introduced his talk by saying that he intended to talk about a few recent advances in surgery for facial palsy and answer questions.

Approaches to this type of surgery can be categorised into four groups – static, adjunctive, non-microsurgical and microsurgical. He discussed examples of all these approaches showing diagrams to illustrate the procedures and photographs of patients before and after surgery.

Static procedures – these procedures do not restore movement but counteract the effects of gravity. There are a number of procedures that can be carried out around the eye which can improve appearance.

Eye

A **Browlift** is performed to lift the eyebrow which may be drooping over the eye as a result of

paralysis of the frontalis muscle on the forehead. A crescent-shaped piece of skin is excised from above the eyebrow under local anaesthesia.

Tarsorrhaphy is a procedure which is more usually carried out by ophthalmic surgeons and entails joining the outer ends of the upper and lower eyelids. This supports a lower lid that may be falling away from the eyeball and provides more cover to the eye by the upper lid. This will reduce the amount of the eye exposed while blinking is not happening. It can restrict lateral vision but is easy to undo if found to be unacceptable.

Canthopexy is a procedure which tightens the tendon in the lower eyelid. The process involves making an incision in the outer part of the lower lid, inserting a suture into the tendon and then attaching the stitch to the lining of the orbital bone to give more support for the lower eyelid.

Forthcoming Meeting

The next meeting will be held on **Saturday 24th November 2007** in the Boardroom at Addenbrookes Hospital, Cambridge. Our speaker will be **Mr David Moffat BSc MA FRCS Consultant Otoneurological and Skull Base Surgeon**. Room open from midday.

This will also be our Christmas meeting and members are invited to bring a small contribution towards a shared lunch and there will be a raffle.

Lower lid support is a procedure in which an implant is placed in the lower lid to correct a tendency for the lower lid to drop downwards. This used to be done with ear cartilage but the most recent development is an artificial implant made of a thin plate of porous plastic that is inserted beneath the muscle layer in the eyelid (Medpore). Tissues grow into the device so that there is less chance that the body will reject the implant.

Mouth

To help raise the corner of the mouth and centralise the middle of the upper lip, a **static sling operation** can be performed. This involves taking a strip of fascia (a flat band of tissue lying below the skin that covers the underlying muscles) from the thigh measuring about 15cm by 2cm. This is then inserted into the centre of the upper lip and lower lip and the top end is then passed around the zygomatic arch, a part of the temporal bone in front of the upper part of the ear.



Fig. 1. A diagram showing muscles in the lower face.



Fig. 2. A Static Sling procedure.

Adjunctive procedures – these procedures do not fit into the other categories.

Gold weight lid loading – a gold weight can be inserted into the upper eyelid so that it is heavier and gravity can then assist the eye with closing. Because the eyelid lifting muscle is not affected by facial palsy, the eye can still be opened but when the lifting muscle relaxes the lid will close. These weights come in a variety of shapes and sizes and may also be made tantalum. The gold weight can be exchanged for one of a different weight under local anaesthesia at a later date if any recovery occurs in the eyelid closing muscle.

Botulinum toxin – Toxins are chemicals produced by organisms to give them an advantage in their environment – antibiotics are similar but have less of an image problem. Clostridium Botulinum is a bacterium which is often found in badly handled or processed meat products and was first isolated at the end of the nineteenth century and named ‘botulism’ from the Latin ‘botulus’ meaning ‘sausage’ and in the 1940s the toxin was isolated and found to prevent neuromuscular transmission therefore causing paralysis. The first medical use of the toxin was in 1970s to treat squints by weakening the muscle which causes the squint rather than cutting it. It has subsequently been approved for use in the treatment of spasticity in neck muscles, excessive sweating and also cosmetically to reduce wrinkles. In many cases of partial facial paralysis where there has been some recovery, aberrant reinnervation causes twitching or overactivity in certain muscle groups. For example it can be injected in the chin to relax muscles which cause the ‘dimple in the chin’ seen in partial facial paralysis. Injections around the eye can be used on the good side to weaken muscles to improve symmetry, for example to reduce frowning or crows feet on the good side to match the less dynamic appearance of the paralysed side.

Non-microsurgical muscle transfers

A recently developed operation is being used to correct the elevation of the lower lip that results from weakness of the depressor muscle of the lip. The operation uses the anterior belly of the digastric (means “two bellies”) muscle which is a muscle running between the lower jaw and the mastoid via the neck. The posterior part of the muscle is supplied by the facial nerve which is paralysed but the anterior part is supplied by the trigeminal nerve which should be unaffected. This anterior belly of the digastric muscle is detached from the posterior and passed up into the lower lip to create a downward force on the lip. With a lot of effort in front of a mirror voluntary control of this muscle may be gained. It can eventually become an almost automatic movement.

Parts of the chewing muscles (temporalis and masseter) that move the jaw can sometimes be redirected into the area around the mouth.

Microsurgical techniques

These techniques involve surgery using a microscope to join nerves or blood vessels. Nerves may be joined up in either of two ways.



Mr Cormack speaking to AMNET members.

Firstly nerve grafts taken from the leg may be used to bring nerve impulses from the good side of the face across to the paralysed side. This is called a **cross- face sural nerve graft**. Unfortunately when a nerve graft is taken out of the leg the conducting part of it disappears and the nerve acts only as a collection of empty tubes through which the conducting part of the nerve has to regrow from the healthy nerve that it is rejoined to. This process proceeds at about an inch a month, so it takes several months to get functioning nerve fibres across the face. A second operation then has to be carried out to join the graft to the non functioning nerve on the paralysed side. Unfortunately the health of the junction between the nerve and the muscle is integral to the success of this procedure and this junction undergoes irreversible deterioration about nine months after damage to the nerve.

A faster way of getting functioning nerve fibres to these critical neuromuscular junctions is by carrying out a facial to hypoglossal microsurgical union. This is a very old operation but all previous forms of this operation have involved sacrifice of some function in the hypoglossal nerve (the **hypoglossal to facial neurorraphy**). The most recent development in this field is the realisation that the stump of the facial nerve can be joined to a window cut in the side of the hypoglossal nerve. (**The facial to hypoglossal end-to-side neurorraphy**). This doesn't interfere with tongue function and is therefore the operation of choice at the moment. Nerves can get to the paralysed muscles in three to four months and maintain their health. A cross face sural nerve graft can sometimes be added in at a later date. As with other nerve graft operations the patient needs to work quite hard at learning how to make the brain control the face using tongue nerve pathways.

Muscle grafts may be used in the cheek and in this case muscle may be taken from the leg or the chest, with the artery, veins and nerve of the muscle being connected to donor vessels and nerves in the face. This is an enormous and complex subject and the muscle grafts are not always successful.

Questions

Mr Cormack answered a number of questions from the audience. He stressed that this type of surgery usually requires a series of operations in order to get the best

outcome and so is an ongoing process. He acknowledged that there was greater awareness that surgery was available but there are issues about timing of surgery. For patients with Bell's Palsy which is an onset of facial paralysis usually related to an infection, there is some degree of recovery in all but 4% of patients so surgery is not contemplated at an early stage. The health of the muscle is very important to the success of surgery and by a year after the damage to the nerve this is too great for the muscle to respond to re-innervation. While muscle cells can be kept healthy using electrical stimulation unfortunately this does not preserve the actual nerve to muscle junction which is essential for a nerve graft to be successful. The dilemma is that patients need to wait to see if the nerve is going to recover and by the time this is found not to be the case it may be too late for nerve graft surgery because by the time the graft picks up function the nerve/muscle junction has irreversibly degenerated. With nerve damage due to surgery the situation may be clear from the outset since if it is known that the nerve has been cut during surgery, then reconstructive surgery can be planned at a much earlier stage. If the nerve is thought to be intact but bruised then the tendency is not to do anything but wait and see what the outcome is. It may take many months before it is clear whether or not recovery will occur and the situation is similar to that in Bell's palsy. In this situation it can be difficult to know what is best for the patient.

There was discussion about the possibility of patients with paralysis following acoustic neuroma surgery being eligible for a face lift later in life on the paralysed side only, to improve symmetry which may get worse due to the ageing process.

There was also discussion about the use of Botox® for treatment and how often it is required. In some cases after a couple of treatments the muscle will weaken so will not need further treatment, however in some cases patients become resistant to Botox®.

There was also some discussion about the lack of availability of a physiotherapist who specialises in facial paralysis and retraining of nerve pathways. Clearly this is something that would potentially benefit patients greatly.

We would like to thank Mr Cormack for attending our meeting and for an interesting and enjoyable talk.

Brain Tumour UK Cambridge One-day Conference for Patients

Alison and I attended this extremely interesting and well organised conference on **Saturday 20th October** at **Scotsdale's Nursery and Garden Centre** in **Great Shelford Cambridge**, along with about 60 other people, most of whom had experience of brain tumours either as a patient or a carer. The setting, in a lecture room within the garden centre, was interesting and allowed for the occasional wander among a vast array of plants and other garden paraphernalia. The day was well planned with talks from medical personnel in the morning and an emphasis on living with a brain tumour in the afternoon. There was so much information it would be impossible to fit it all in here so I will provide summaries of the talks and maybe reproduce a more detailed version of some of them in later editions.

The meeting was introduced by **Jenny Baker OBE** the chief executive of **Brain Tumour UK** who welcomed everyone and said she hoped it would be the first of many such meetings. She praised the hard work of Ella Pybus, Caroline Batt and others who had organised the day and thanked Scotsdale's, a family business which does much to support local cancer charities, for the use of the room free of charge. They also provided excellent food for lunch and cakes for afternoon tea. Jenny welcomed everyone who she said all had a common interest in brain tumours and hoped Brain Tumour UK was a safe place to share experience and support each other. She also noted that it was International Brain Tumour Awareness week and there were many events being planned around the world this week. This included 70 walks 'around the world' which were hoping to clock up the equivalent of walking around the equator. She emphasised that Brain Tumour UK was about Support, Research and Education.

The day was chaired by Professor Geoffrey Pilkington, Professor of Cellular and Molecular Neuro-oncology at Portsmouth University who is medical director of BTUK.

The first speaker was **Dr Neil Burnett** Reader in Radiation Oncology/ Honorary Consultant Oncologist at Addenbrookes Hospital. His talk was entitled '**The Impact of Brain Tumours on Patients and Society**'. He emphasised the fact that although brain tumours are only a small proportion of the total number of cancers they have a large impact on individuals and society. By measuring the average number of years of life lost by different groups of cancer patients his research has shown that this was highest for brain tumour patients because a high proportion of brain tumours affect patients at a young age and cause death in a relatively short period of time. He also identified that, despite this, brain tumours are a

'Cinderella' group of cancers and attract far less funding than some of the higher profile cancers such as breast and prostate cancer. He emphasised the importance of advocacy and talked about his work with the All Party Parliamentary Group on Brain Tumours which is raising the profile of brain tumours with groups such as the National Cancer Research Institute and Cancer Research UK. He advocated increases in a number of resources that would improve care for patients and their families.

The second speaker was **Dr Sarah Jefferies** Consultant Clinical Oncologist, Addenbrookes Hospital who spoke on the topic of '**What is a Brain Tumour?**' Her comprehensive talk described the different parts of the brain and their functions and the different types of tumour that can arise in each part. She discussed the origins of tumours, their presentation, pathology and grading and how they are diagnosed.

The third speaker was **Mr Colin Watts**, Clinical Scientist and Consultant Neuro-surgeon at Addenbrookes Hospital. His talk entitled '**Brain Surgery and the Tumour Clinic**' outlined the components of contemporary neurosurgery and oncology care and the constraints on the service. He discussed the importance of patient centred care and the way in which they are working to improve the service at Addenbrookes Hospital by putting the patient at the centre of a care pathway supported by a multidisciplinary team and key workers alongside good information collection and data management. There is a focus on providing a joint neuro-oncology clinic, with a better referral system, more staff and better access to imaging. He talked about the importance of communication and including the patient in the process.

He also discussed the importance of research and that patients have the opportunities to take part in research which can give them hope for the future. He talked about his research into cancer stem cells trying to identify ways to stop cancer cells dividing.

Finally he also emphasised the importance of raising the profile of brain tumours and of patient groups and medical staff working together.

The final speaker in the morning was **Kate Burton** – Advanced Practitioner in Neuro-oncology and Radiotherapy at Addenbrookes Hospital. The title of her talk was '**Radiotherapy Explained**'. She described her role as an advanced practitioner therapeutic radiographer specialising in brain and spine tumours. She described other members of the team including diagnostic

radiographers who do the imaging such as MRI scans, clinical oncologists who prescribe and plan treatment and radiologists who are the doctors who read the scans. She presented a brief history of radiotherapy which was first discovered in 1885 and first used as treatment 10 years later. She set out to dispel some of the myths about radiotherapy and described treatments with radiotherapy. Radiotherapy is used mainly for treating cancer but can also be used for treating benign tumours. It works by damaging the DNA in cells and stopping their growth. Normal cells can be affected by radiation but are normally able to repair themselves. Radiation can be used before surgery to reduce a tumour although this is unusual with brain tumours, after surgery to treat residual tumour, on its own or before, after or alongside chemotherapy. Where and what is treated depends on the type, size, location and treatment intent of the tumour.

She described the team who are responsible for delivering radiotherapy and the different types of radiotherapy- radio-surgery which is a single dose treatment – usually for a small tumour, and fractionated radiotherapy where the dose is divided into equal parts and delivered daily usually over a period of weeks. She also described the pathway for treatment which includes, consultation, immobilisation (preparation of masks necessary to keep patient immobilised during treatment), imaging and planning and treatment.

After Kate's talk we broke for an enjoyable lunch where people had the opportunity to chat to each other, before reconvening for the afternoon session.

The first speaker in the afternoon was Elizabeth Smallwood, Community MacMillan Cancer Nurse Specialist in Priscilla Bacon Lodge, Norwich. She spoke about '**Support and Palliative Care**'. Palliative care aims to focus on quality of life, helping people think about the impact the diagnosis has had on themselves and those around them, affirming life and promoting respect and dignity. Macmillan nurses like to be involved early, soon after diagnosis, so patients can decide how much support they need as time goes on.

She identified some of the problems that brain tumour patients find themselves faced with and how they may need to steer their way through them. Their needs may be financial, physical, psychological, spiritual, or social and there are numerous people and agencies who may be able to help and support them. However they often need help from a key worker in order to steer their way through this maze to get the help they require. This person can liaise with other members of the care team but also work with the patient to focus on their quality of life and the impact the diagnosis has had on their life.

She also discussed how an altered body image can have an impact and helping patients to work towards accepting the changes they are facing. These changes may be related to

function and appearance but also may be related to changes in roles within the family which can be difficult to accept. Elizabeth also emphasised the help that is available to patients in the community from the Primary Care Team and other specialist workers.

Elizabeth Crowe, Epilepsy Action, Accredited Volunteer, spoke about '**Living with Epilepsy: the Patient's Perspective**'. She described her experience of undergoing surgery for a malformation of blood vessels which left her with epilepsy. Epilepsy can have many different effects depending on the part of the brain affected and it may result from surgery or a tumour but may also occur for no obvious reason. Getting a diagnosis may be the first problem, especially if there is no clear reason for the seizures. Response to drug therapy is very individual and patients often have to try various drugs in order to find the one that suits them. Epilepsy cannot be cured so the aim is to have 'controlled epilepsy' where a drug regime prevents any further seizures. Elizabeth said it is important to see a neurologist as they are knowledgeable about epilepsy and also the latest drug therapy. 60-70% of people with epilepsy do attain full control so it is important to keep going back until it is right. Every day 100 people in this country are told that they have epilepsy – there needs to be more understanding and less fear. Elizabeth has become an accredited volunteer for Epilepsy Action because she had so much help from the charity particularly in relation to other effects of epilepsy such as families having to cope with seizures and learning to live with the person you are now. An aim of the organisation is to 'stamp out stigma' and Elizabeth talks to groups to help them understand the effects of epilepsy and also provides one-to-one support to those who have just been diagnosed.

Epilepsy Action provides information, support and listening for individuals, carers and friends.

Website: epilepsy.org.uk Helpline 0808 800 5050

The final session of the afternoon was a more 'hands on' session. **Barbara Seagal** a Garden Writer introduced '**Sensory Plants for use and Pleasure**'. She explained that plants have been part of our lives for two million years as they like the same things as we do – water, shelter and a place to feel safe. They are air purifiers removing carbon dioxide from the air and releasing oxygen. They can be grown in gardens or just in pots on a windowsill.

She brought along a wide variety of plants including herbs such as varieties of basil and mint and flowers such as pinks to show how plants can affect all our senses. These plants can be used in the kitchen, for medicinal purposes or just to enjoy in our gardens. She passed them around the audience so we could all experience the smells and touch of the different plants.

The day closed with tea and cakes to celebrate 10 years of BTUK.

AMNET AGM Saturday 7th July 2007

Minutes

Apologies: The West Family, Brian and Fiona Pike.

Minutes of last AGM held on 16th September 2006 were accepted as a true record.

Chairman's Report

Welcome to our AGM for 2007. This year has been a bit lop-sided as we had our AGM for 2006 in September due to hosting the BANA AGM in the summer. We were intending to have our AGM in June this year but BANA could only get the venue and speakers they wanted then so we moved a little way into July. Usually we try not to clash so that AMNET members who also belong to BANA can get to both AGMs. BANA had theirs geographically close this year in Bushey Baptist Church near Watford. The speakers were excellent and broadened our knowledge further. We hope to be able to publish a report in a later edition of AMNET news. The RAFT report is available. (Restoration of Appearance and Function Trust)

Last September our friend and Advisory Board member Mr Sarkies joined us for a further update on facial palsy and the eye. It was a very enjoyable AGM and meeting with many old faces returning whom we had not seen for a while. As always there was lots of helpful chat going on, to catch up on news and reassure newer members. This fulfils one of the main purposes for which AMNET was set up.

In April Rachael Rowlingson joined us to talk about fatigue. This is sometimes seen as an afterthought symptom but it is one that can have a long term detrimental effect.

Our committee has expanded this year for which we are very grateful. Margaret Allcock has been in charge of the trophic stimulators for some time but is now also attending meetings. John Peartree has also joined us and is having an input where possible. Rachel Pearson, the author of many amusing letters to the Newsletter Editor is helping Jo to keep the members financial details up to date.

We are putting our energies into expanding the Watch and Wait role of AMNET so we will let you know how this develops.

We have reached 40 editions of AMNET News so our thanks to Chris for the very high standard she has maintained and built on from Peter Jones beginnings eleven years ago.

As ever my thanks to everyone who helps AMNET to continue to function and flourish.

Treasurer's Report

The books have been audited for last year by Michael Bartlett.

The balance at the end of the financial year, which is 31/01/07 was £3755.66.

The main expenditure for last year was the printing of the newsletter which cost £1085.13 compared with £642.00

last year. This was mainly due to the printing of an extra issue this year and printing of the outside pages which are done in bulk. The other areas of expenditure were sponsorship of an audiological scientist to attend a course and meeting expenses.

The income came mainly from subscriptions although this was reduced from last year, however donations were slightly increased. The Christmas meeting raised money through the selling of raffle tickets and other items.

Election of Officers

Office	Officer	Proposed	Seconded
Chairman	Alison Frank	Jill Laurimore	Margaret Allcock
Treasurer	Joanne See	Anne Whitelam	Bronwyn Lummis
Secretary	John Peartree	Tony Monk	Joanne See

Other Committee members:

Neil Bray	Margaret Allcock
Chris Richards	Ella Pybus
Jill Laurimore	Janice Petitt

Publicity and promotion

Chris Richards – Newsletter Editor emphasised the importance of contributions to the newsletter from members as people like to read about other people's experiences particularly people who are part of the 'watch and wait' programme or have made a decision about treatment. We would like to collect a library of people's experiences.

We are also looking for someone who has some familiarity with web pages or would like to learn, and who would be willing to keep an eye on our webpage and update it as necessary.

Brain Tumour UK and Meningioma UK

Ella Pybus reported on the work of Brain Tumour UK in the area. There are now Cancer Support Centres in Cambridge and Norwich where patients with any tumour can attend for support and advice. Brain Tumour UK has also got contacts in Cambridgeshire, Norfolk and Suffolk. She emphasised that these support services are available to all people with brain tumours.

She also reported on the Brain Tumour UK 'Walk around the World' which will take place in October.

Editorial

Dear All

We are coming to the end of another year – it does seem to go around faster each year possibly not helped by changing weather patterns! I hope you enjoy the articles in this newsletter. We have the reports from Mr Cormack's talk about Facial Reconstruction and our AGM in September and also a report on a very good day conference organised by Ella Pybus for Brain Tumour UK in October.

I have changed the appearance of the back page a little – hopefully to provide more information and also included the opportunity for readers who are not members to join AMNET.

The next event we are looking forward to will be our Christmas meeting when Mr Moffat has been invited to speak and we look forward to seeing as many of you as possible.

Best wishes

Ray Maw

We have heard from Ray who is still very happy in the wilds of Ireland where he has found that telephone and email communication is rather erratic. However, he is still willing to help people with information and if you do want to get in touch with him you can write to him at:

Toreen, Dunmanway, West Cork, Eire

New Specialist Nurse

Melanie Jackson is a new Specialist Nurse at Addenbrookes with a particular remit for 'watch and wait' acoustic neuroma patients. She can be contacted by telephone 01223 348672 Bleep 154-600 or at Addenbrookes Hospital, Box 294, Hills Road, Cambridge CB2 2QQ.

She is also usually available in Clinic 10 on Mon to Wednesday and Friday from 7.30 am.

Left and Right Ear Badges

These badges have arrived. If you have ordered one and will not be at the Christmas meeting on 24th November please can you contact Alison. The price will be £2.50 plus postage and packing.

Would you like to join AMNET?

We provide

- Telephone contact with past patients, who understand what you are going through, and have time to listen.
- A regular newsletter for members, with information about developments in treatment and living with acoustic neuroma.
- Regular meetings, providing the opportunity to listen to expert speakers and meet other members
- A library of resources, which can be hired by members.
- A detailed website, at www.amnet-charity.org.uk

If you would like to join AMNET and support our work please complete the form below and send a £15 annual subscription to:

AMNET

The Old School House, The Green, Old Buckenham, Norfolk NR17 1RR

Name

Address

.....

.....

Postcode *Tel

*Email

(* optional)

I enclose a Cheque/Postal Order for £15 for my yearly subscription to AMNET.

FORTHCOMING MEETINGS

The next meeting will be held on **Saturday 24th November 2007** in the Boardroom at Addenbrookes Hospital, Cambridge. Our speaker will be **Mr David Moffat BSc MA FRCS Consultant Otoneurological and Skull Base Surgeon**. Doors open at **midday**. This will also be our Christmas meeting and members are invited to bring a small contribution towards a shared lunch and there will be a raffle.

The first meeting for 2008 will be held on Saturday April 5th at Addenbrookes Hospital Cambridge. Speaker to be arranged.

AMNET Advisory Panel at Addenbrooke's Hospital, Cambridge

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 Booklets

BANA has produced some 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**
- Effects an acoustic neuroma can have on your memory, emotions, behaviour, executive functioning and energy**

All these booklets are available from Alison. There is a charge of £2.00 for all except for the first title.

Contributions

Please consider writing for your newsletter. It can be anything you feel will be of interest to members from a few lines to a couple of pages. It all helps to make the newsletter more interesting.

Email:
chris@richards2113.fsnet.co.uk

If you would like to make a contribution please telephone or email me.

Facial Stimulators

AMNET has some Facial Trophic Stimulators which are available to members for short term loan. There is a charge of £30 at present which includes maintenance and postage. If you would like to know more please contact: **Margaret Allcock on 01493 700256.**

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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<http://amnetcharity.org.uk/index.html>

Email: contact.amnet@btinternet.com

Telephone: 01953 860692

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Old Buckenham, Norfolk NR17 1RR

British Acoustic Neuroma Association (BANA):

Web site: <http://www.bana-uk.com>

Email: admin@bana-uk.com

Telephone: 01623 632143 **Fax:** 01623 635313

Freephone: 0800 652 3143

Address: Oak House B, Ransomwood Park,
Southwell Road West, Mansfield, Notts
NG21 0HJ

Meningioma UK:

Web site: <http://www.meningiomauk.org>

Email: MeningiomaUK@aol.com

Telephone: 01787 374084

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

Brain Tumour UK:

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

Telephone Helpline: 0845 4500 386 (10am -

1pm, Monday to Friday).

Address: PO Box 27108, EDINBURGH,
EH10 7WS

Royal National Institute for the Deaf (RNID):

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

Email: informationline@rnid.org.uk

**Information Line (including
Tinnitus)(Freephone)**

Telephone: 0808 808 0123

Textphone: 0808 808 9000

Address: 19-23 Featherstone Street, London
EC1Y 8SL

Cambridge Campaign for Tackling Acquired Deafness (CAMTAD):

Web site: [http://www.copag.members.beeb.net/
copmoc/camtad.htm](http://www.copag.members.beeb.net/copmoc/camtad.htm)

Telephone/Textphone/Fax: 01223 416141
(Mon - Fri 09.30 - 12.30)

Address: 8A Romsey Terrace, Cambridge
CB1 3NH

Also contact point for Cambridge Hard of
Hearing Club and Cambridgeshire Tinnitus
Support Group

Changing Faces:

Charity offering support for people with
temporary or long-term facial disfigurement
problems

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

Email: info@changingfaces.org.uk

Telephone: 0845 4500 275

British Tinnitus Association:

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

Email: info@tinnitus.org.uk

Telephone: 0800 018 0527

Minicom: 0114 258 5694

Address: Ground Floor, Unit 5, Acorn Business
Park, Woodseats Close, Sheffield, S8 0TB

Entific Medical Systems:

Information about bone conducted hearing aids,
particularly for single sided deafness.

Web site: <http://www.entific.com>

Addenbrookes Hospital: Neurotology and
Skull Base Surgery Unit

Web page:

[http://www.addenbrookes.org.uk/serve/
clin/surg/neurotol_skullbase1.html](http://www.addenbrookes.org.uk/serve/clin/surg/neurotol_skullbase1.html)

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