



AMNET NEWS

Issue 54 Autumn 2012

Vestibular Schwannomas: Past, present and future. A talk by Mr Richard Mannion, Consultant Neurosurgeon Addenbrooke's Hospital, Cambridge on 7th July 2012



We were very pleased to welcome Mr Richard Mannion to our summer meeting and he gave us a very interesting and accessible talk about the management of acoustic neuromas over the years. Richard is a consultant neurosurgeon who works with Mr MacFarlane and the rest of the skull base team at Addenbrooke's Hospital. He is involved in surgery for removing acoustic neuromas (vestibular schwannomas) and also in the treatment of other tumours including pituitary tumours. His talk covered the management of acoustic neuromas over the last 20 years and provided a very clear picture of the way the condition is managed in the present day and some thoughts about the future.

Acoustic neuromas occur in the posterior fossa of the skull and are described as extra-axial (outside the brain), benign and occurring in adults. Acoustic neuromas occur in the cerebellopontine angle, a space between the brain and the skull where they are surrounded by a number of other structures including the nerves of hearing and balance and the facial nerve. In some case the 'lower cranial' nerves such as the vagus nerve and the glosso-pharyngeal nerves may be affected causing problems such as difficulty in swallowing. The trigeminal nerve may also be at risk as the tumour grows and increased pressure on this nerve can cause numbness and pain in the face.

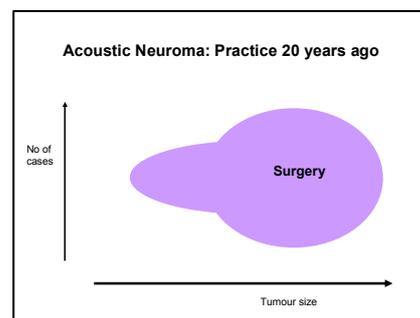
Acoustic neuromas are the most common tumour to occur in the cerebellopontine angle (CPA), meningiomas are the second most common and then there are a variety of other tumours that may occur in that area. Acoustic neuromas make up 8% of the total of intracranial tumours and 75% of those found in the CPA. They are twice as common in women as in men and are most likely to occur between the ages of 40 and 70 years. They can be associated with a very rare genetic condition called NF2 which gives rise to tumours in children and also bilateral tumours, but neither of these occurrences are likely outside NF2.

Past

In the past one of the main problems in treating acoustic neuromas was that they often presented late when they were quite large. Unilateral reduction in hearing, a common symptom, was sometimes not recognised as a symptom of a growing tumour and until 20 years ago, imaging was far less available. MRI scanning has only become routine in the last 10 years and CT scanning often missed small tumours. Diagnosis was often made late and was based on symptoms which related to compression of the brainstem (the brainstem is the centre of the physiological functions of the body such as heartbeat and breathing), or the collection of fluid in the brain (hydrocephalus) due to blockage of the drainage system for fluid caused by growth of the tumour. In these cases, surgery, as the tumours were very large, was often associated with nerve damage resulting in problems such as facial palsy and sometimes with the lower cranial nerves which may affect speech and swallowing.

Present

More recently, tumours are diagnosed when they are much smaller and may not be causing much in the way of symptoms. Access to early MRI imaging means that diagnosis



Next Meeting

The next meeting will be on **Saturday November 24th 2012** at in the **Boardroom at Addenbrooke's Hospital Cambridge**. Doors will open at 12 noon and you are invited to bring a contribution to the buffet lunch we share at this meeting.



is much easier for small tumours. A patient complaining of unilateral hearing loss will usually be referred for an MRI scan. The natural history of the tumours is becoming clearer and most of them grow very slowly (1mm per year). Regular surveillance of tumours has shown up to 50% are not growing at all, a large tumour may stop growing, but a non-growing tumour can start to grow again. Small tumours rarely require treatment, except possibly where there are growing tumours in young patients or where there are disabling balance problems.

Surveillance

Regular surveillance consists of MRI scans, the second scan after 6 months and then yearly scans for five years. After surgery an MRI scan will usually be done within 2 years and if there is no residual tumour it may not require repeating given the very low recurrence in the Cambridge series of patients. Following radiotherapy there will be yearly MRI scans as the tumours typically do not disappear but do stop growing in the majority.

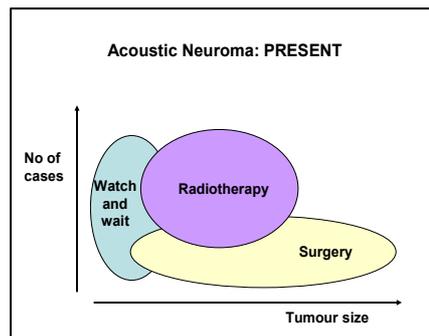
Management

Management strategies are based on the questions of when to intervene, what type of intervention and how that will be carried out. The question of when to intervene is based on a number of factors. The patient’s age is important and whether they have other medical problems that make one type of treatment inappropriate. Patient expectations are also important, some patients cannot bear the idea of living with the tumour so may opt for surgery, whereas others are very frightened by the idea of surgery and are more comfortable with the idea of radiotherapy. The size of the tumour is important and treatment is usually considered once the tumour has grown to 20mm diameter and appears to be still growing.

Service in Cambridge

There have been a number of changes to the service in Cambridge in recent years. Cambridge is now a national centre for the treatment of NF2 and auditory brainstem implants. National funding has been given to four centres around the country to manage NF2 cases, because of their expertise in treating acoustic neuromas. As these patients are often young and may have tumours on both sides, thereby losing all their hearing, the centres are also

specialised in auditory brain stem implants which aim to improve hearing for these patients. These implants are only carried out in Cambridge and Manchester. This extra funding also helps the rest of the service in Cambridge to maintain its expertise. The service is now based on multi-disciplinary meetings and where all the clinicians see patients in the same clinic. The skull base multidisciplinary team which consists of all specialities meets fortnightly on a Friday and as well as allowing patients access to all specialists in one clinic, also has video links to other clinics in East Anglia which allows cases to be discussed with specialists there, speeding up referral processes. The specialists in this team include neurosurgeons, ENT surgeons, a neuro-oncologist, plastic surgeon, hearing and balance assessment and balance rehabilitation. The skull base team is now quite large and following David Moffat’s retirement, alongside Robert MacFarlane, Richard Mannion and Patrick Axon, there are some new faces including ENT skullbase surgeons Neil Donnelly and James Tysome. The neuro-oncologists are Sarah Jeffries and Neil Burnett, the plastic surgeons Richard Price and Amir Durrani, and there are now three specialist nurses, Indu Bahadur, Juliette Durie-Gair and Sally Taylor.



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Types of radiotherapy

In the United States there are now more patients treated with radiotherapy than with surgery and there is a move in that direction in this country too. There are a number of different options with radiotherapy. Fractionated radiotherapy is favoured in Cambridge and consists of small doses of radiotherapy delivered over a period of time, usually six weeks. Stereotactic surgery or radiosurgery is a one off dose and this can be delivered by Gamma Knife or Cyber Knife. There is no evidence to suggest that one of these approaches is any better than the

	Stereotactic radiosurgery	Microsurgery
Complete tumour control	> 90% (10 year data)	97%
Facial function (HBI-II)	98%	95%
Useful hearing	75%	50% (retrosigmoid approach)
Complications	Radiation toxicity – rare Hydrocephalus 1% Malignant transformation – very rare	CSF leak 5% Infection 1%
Quality of life	Well tolerated	Worse initially

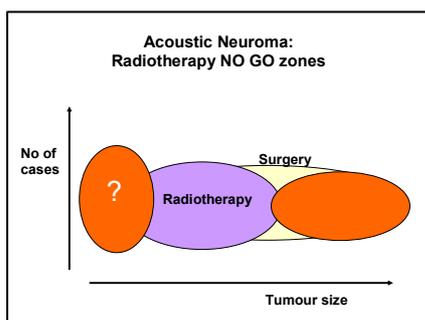
other. It has been difficult to research the effectiveness of surgery against radiotherapy as they are very different approaches and they have different risks associated with them. With surgery the risk is 'up front' at the time of the operation, whereas with radiotherapy there are less risks at the time of treatment, but may be more risks in terms of the tumour regrowing or other problems later.

Research suggests that there are various issues influencing choices related to treatment. In the case of very small tumours 'watch and wait' with no treatment but regular monitoring is usually the first choice. In the treatment of small to medium sized tumours there may be a choice between radiotherapy and surgery. As shown, radiotherapy has good results in stopping the growth of the tumour, although it is not known, in some of the studies, whether the tumours which were treated were still growing and regular imaging is still required. In larger tumours radiotherapy may not be an option as the risks to the surrounding brain and cranial nerves can be too high. Surgery provides the opportunity to remove the whole tumour but with risks which are greater for larger tumours.

Best management requires:

- Assessment of size and rate of growth of the tumour
 - All options to be discussed with the patient
- Patient choice

following discussion with each individual specialist



Questions for the Future:

Radiotherapy

The doses have been lowered over time and this helps to protect the facial nerve and hearing but long term follow up is still only up to approximately 10 years, so it may need longer to ensure there are no serious long term effects or recurrences of the tumour.

Can we treat bigger and bigger tumours safely? As the science improves and research on side effects increases it may be possible to treat tumours that are a larger size with

radiotherapy.

Greater understanding of what makes tumours grow and when they grow

Imaging studies will help to give a better idea about what makes tumours grow and when they grow, which will assist decisions about treatment. In 10-15 years time it is hoped that it will be possible to predict which tumours are likely to grow more than others and so treat them early.

Can we ever hope to treat all tumours without surgery?

Research is being carried out with a drug called Avastin which has been used in the treatment of breast cancers, bowel cancers and brain tumours. The drug acts by preventing the formation of new blood vessels and this slows the growth of tumours. Trials using the drug in a small number of NF2 patients with acoustic neuromas are at a very early stage but there have been some encouraging observations thus far. This may be good news for the future management of acoustic neuromas, however at present the drug, which is given by monthly injection, is still very expensive costing £20,000 per year and patients need to stay on it indefinitely. At present it is funded centrally, and the future of the drug for patients with acoustic neuroma will depend on results from trials across the UK and wider afield over the next few years.

Summary

Mr Mannion summarised his talk by highlighting that while there is now better understanding of the behaviour of tumours than ever before, there is still a lot to learn. However local changes to the service, such as the establishment of a multidisciplinary skullbase clinic, are offering patients a more streamlined approach to management which offers greater convenience to patients and the opportunity to discuss different aspects of their condition on the same visit.

He took and answered questions from the audience on some of the issues he discussed, including the frequency of surveillance screening for acoustic neuromas following surgery and also some further discussion about the possibilities of medical treatment for acoustic neuromas in the fairly distant future.

We would like to thank Mr Mannion for a talk which was very informative, accessible and was enjoyed by all.



Established in 1999, The Greetings Card Company is an e-commerce business which sells greetings cards, personalised cards (all occasion and Christmas), charity Christmas cards, company diaries and gift products.

You choose from a very wide selection of cards, order on line and they are delivered the following day. Profits from the cards go to your designated charity
AMNET (Acoustic Neuroma & Meningioma Network) has an account with this website and we have raised over £50 for our funds so far. So next time you need a card for any occasion visit: <http://charitycards.co.uk/>

Editorial

Hello AMNET NEWS readers.



Welcome to the Autumn 2012 Newsletter. Yes, we do have one, mostly thanks to the efforts of Chris, on this occasion! My name is Sally Hardy and I have been helping Chris with this issue. I have been a member of AMNET since Spring 2011. You may wonder about how I have become involved – I had approached Alison, as requested, before the AGM, but for understandable reasons, my name only got

mentioned ‘as showing interest in helping with the Newsletter’ at the AGM, and I was therefore not formally nominated onto the Committee.

I would like to start by expressing our immense gratitude to Chris for the outstanding job she has done in producing the Newsletter over the past 15 years. She has managed to produce very reputable, well-researched and always interesting articles. The contribution she has given so willingly over so many years will have been useful to many different people in many different ways. Stepping into her shoes is going to be a very daunting task and I am appealing to anyone interested in helping to contact me (or Chris) as soon as possible. I am certainly prepared to co-ordinate the activities as Chris suggested in her last Editorial and feel that a team effort would be a great way to proceed with the AMNET NEWS.

My background is in nursing and I was a secretary prior to having my two children. I would therefore be prepared to take notes of AMNET meetings and liaise with medical staff, to ensure they are happy with our account of their talk. What would be really useful is for someone to be prepared to search the WEB for scientific/medical and also general interest articles that might be suitable for

inclusion and also if someone else was familiar with the software Publisher, which is used in the production of this Newsletter. I currently have this on a 60-day free trial, and if someone is not prepared to step into this role, then I would need to approach the Committee to ask for Publisher (and possibly Office 2010) from AMNET funds. I retired from my Practice Nursing post in June this year and so have time to commit to AMNET, but not the funds. My e-mail address is:

Sally.Hardy3@BTinternet.com or you could telephone me on: 01954 231363 (mostly evenings), sorry but we don’t have an answerphone. In the next Newsletter, I will tell you a little about myself and the reason why I am a member of AMNET. My story is a little different to most, so more next time.

I feel passionately that the Newsletter should continue. It has been a valuable source of information for me and I am sure it must be for many of you, especially those who are unable to attend meetings, so please think what you could do to help, however small and however little time you may have to offer. From my experience so far, I can reassure you that the Committee are very friendly, lots of fun and don’t bite! It could be your chance to give something back.

We hope you enjoyed the very interesting talk by Mr Richard Mannion, Consultant Neurosurgeon at Addenbrooke’s Hospital, at the last meeting. If you were unable to attend, then please enjoy Chris’s excellent account of what he had to say. As Alison was unable to be present to give the Chairman’s Report at the AGM, she has sent a written account of what she had wanted to say, which Chris has included in this issue. I look forward to seeing as many of you as possible at our next meeting, which will be our Christmas meeting on Saturday 24th November, 2012, in the Board Room, at Addenbrooke’s Hospital. Doors open at 12.00 hrs. As this is our Christmas meeting, we will be holding a ‘bring and share’ lunch, so please bring a plate of something along. We will provide our usual light refreshment of cold drinks.

Sally

Forthcoming meetings

Due to the changes in the Committee at the last Meeting, and Alison’s recent bereavement, we do not have further dates set for meetings at the moment. Do you have any suggestions of what you would like featured in meetings, so we have a few ideas as to whom we should approach to come and talk to us? We can talk about ideas you might have at the Christmas meeting on 24th November and then let you have details in our next Newsletter.

Support for people suffering acoustic neuroma

We are hoping to go ahead with a course in the Spring of 2013, that was due to have run in November 2011 at Addenbrooke's. If you remember, Chris appealed in various Newsletters for people who might be prepared to help support people who have received a diagnosis of acoustic neuroma and have contacted AMNET. It is hoped to extend the range of people providing this support. Some members have already expressed an interest in helping or attending a course for their own interest and Alison has a record of your names to carry forward, if you still remain interested.

All of us will remember the feeling of shock when we first received a diagnosis of acoustic neuroma and possibly the difficulties of considering what to do next. For those of us who have been diagnosed in recent years there may well be different concerns to those who were diagnosed 15-20 years ago. The condition is now more widely understood, more widely documented, including the internet (which is not regulated), more easily diagnosed (due to MRI imaging) and can present difficulties to the individual who is considering treatment options. Thankfully, here in the Eastern Region, we have the benefit of the expertise, interest and dedication of the team started by Mr. Moffat and Mr. Hardy at Addenbrooke's Hospital, but sometimes people just like to speak to someone who has shared the experience.

There is no obligation to take on a role, you are very welcome to come if you are just interested in the workshop, which will be informal and everyone's contributions will be encouraged. The support we hope to offer will be by telephone, but we are open to suggestions if you think that you would have found some other means of contact or support useful when you were considering what to do next, or at any stage of your treatment, watching or waiting. We are a self-help organisation and the more interactive we can be, the more help and support we can offer each other.

If you are interested in this idea, please contact Alison, Chris or myself. We are currently looking into booking a suitable room at Addenbrooke's and formulating the programme, which is likely to be for a one-day course. We should have our usual arrangement for parking reimbursement, so please do not let this put you off.

Sally Hardy

Helpful Hints

For this column we are asking you to think about small things that you have found to be helpful, and to contact us so that we can share these precious gems of wisdom. It might be something very simple and small, but the small things in life can often be the most useful.

If we get enough of a response from you all, then maybe we can have different aspects in different Newsletters. So please think back in time. Items can include what you would have found useful at diagnosis, awaiting treatment, after effects of treatment, changes in lifestyle and relationships, or whatever else you think might be helpful.

Please send your items for inclusion to Sally Hardy (Sally.Hardy3@BTinternet.com). If you do not have a computer or internet access then please phone us, please see contact details on the back page.

To get this underway, I will include some suggestions :

- Try a glass of orange juice before eating as a helpful aid when experiencing a dry mouth:



- Try cutting pieces of tinned, sliced pineapple into bite-size pieces and storing in a bowl in the fridge. This is both refreshing and helpful if you also have a sore mouth.



- Artificial saliva is available on prescription in different flavours. One brand that I found helpful just after surgery, was Glandosane. This was especially helpful when waking in the middle of the night with a dry mouth.

- Your dentist may suggest toothpaste that contains extra fluoride, but in any case dental hygiene and check ups with your dentist are essential.



AMNET AGM held on Saturday 7th July 2012 in the Boardroom at Addenbrooke's Hospital

Present: 21 in total of which 12 were members

Apologies: Alison Frank, Margaret Allcock, Jill Laurimore

Welcome:

John Peartree welcomed everyone to the meeting. He said that as Alison's husband had passed away the previous week she was unable to attend. It was agreed to pass on condolences from the whole of the meeting. Bronwyn had got a card which she hoped all would sign.

John proposed that Chris Richards chair the meeting. This was seconded by Janice Pettitt and unanimously agreed.

The minutes:

Following a proposal from Bronwyn Lummis, seconded by Rod Slade, and agreed by the 9 members who were present last year's AGM the minutes were signed as a true copy of the minutes. A further copy was also signed to be sent to the Charities Commission.

Chairman's Report (See below)

Treasurer's Report:

Joanne reported that the accounts show a deficit this year of £613.52. This was mainly due to the Xmas meeting, when it was decided to buy refreshments rather than each bring something. The raffle made £215.70. Thanks to Bronwyn and Charlie for that.

The trophic stimulators had no income this year (the previous year they had an income of £240).

Last year showed no income from Charity Christmas cards

as they only pay out for £50 or more, so we will already have some in the pot for the coming year.

The money from Heidi was received in May so will not show until next year.

The accounts had been audited free of charge by Michael Bartlett.

It was proposed by Bronwyn, seconded by John and unanimously agreed that that these accounts be accepted.

Election of officers (see box)

Bronwyn gave a vote of thanks to the outgoing members especially thanking Jo for the sterling job she had done over the years. We are sorry to see her go but pleased to welcome Carol to the role of Treasurer. Also to Chris for all the hard work she has put in to everything over the years. We hope to see them around. Jo and Chris were presented with vouchers as a 'Thank you'.

Any Other Business:

John: In the current financial times if anyone is unable to pay their subs, please renew if you can and we do have funds that could be used to help.

Bronwyn: They will not be at the next meeting so the committee will need to find someone else to do the raffle

John: The committee can co-opt further members on at anytime.

The meeting finished at 1.45pm

Chairman's Report

Hello everyone

As we begin the 16th year AMNET has a lot to be proud of. Firstly the fact that we are still here, helping people through our newsletters, meetings, website and telephone links. All this was celebrated in style in our 15th Anniversary meeting in November 2011. Having 'booked' Mr Moffat two years ago it was marvellous to have him there to speak at and participate in the celebrations. We are grateful for his continuing support over the years since AMNET's inception. We have had a varied year with Katy Morgan, the Head of Vestibular Services talking to us in April about balance disorders that can occur and we were glad to welcome Consultant Neurosurgeon Richard Mannion to talk to us for this year's AGM.

This year had brought some changes for AMNET with some retirements. Jo and Chris have been our stalwarts right from the beginning in 1996 and we are very grateful for their hard work and support over the years as Treasurer and Newsletter Editor respectively. We are hoping the newsletter will continue to be produced and Sally Hardy has agreed to take over the role as editor. We are lucky to have Carol Clothier who has offered to take on the Treasurer's duties. Margaret Allcock is standing down from the trophic stimulator

administration which will be taken on by Janice Pettitt.

Thanks to all of you.

Bronwyn and Charlie Lummis have joined the committee and ran a very successful raffle at the November anniversary meeting. We are grateful for the continuing support of John Peartree (Secretary), Rachel Pearson (Membership Secretary), Rod Slade (Newsletter Distribution) and Janice Pettitt (Refreshments Organiser).

Funds have been raised for AMNET during the year with some generous cheques. Heidi Pratchett and her family topped the poll with their fundraising concert in February. Many thanks to you all.

To finish I would like to add my personal thanks to everyone who has helped AMNET during the year. I was unable to attend the AGM, ably taken by Chris and John. As some of you may know my husband Andrew had been ill for more than two years with COPD (Chronic obstructive pulmonary disease) and he died on June 29th. I have appreciated the phone calls, cards and emails that have been sent.

I look forward to seeing those of you that can be there on Saturday November 24th in the boardroom from midday.

Best wishes Alison.

Election of Officers and Committee:

Following a proposal by Chris Richards, seconded by Bronwyn Lummis, the following were elected en bloc:

Chairman:	Alison Frank
Treasurer:	Carol Clothier
Secretary:	John Peartree
Membership Secretary:	Rachel Pearson
General Members:	Janice Pettitt
	Bronwyn Lummis
	Charlie Lummis
	Rod Slade

Andrew Frank (1948-2012)

Although few of us actually met Andrew, many AMNET members were aware of him, as his was often the friendly voice who answered the phone and very willingly took messages for Alison. He was very supportive of Alison in her work for AMNET and I would like to offer a belated thank you from all AMNET members, and also our condolences to Alison and her family. Our thoughts will remain with you at this difficult time.



‘Specialised treatment on cognitive behaviour therapy versus usual care for tinnitus: a randomised controlled trial’

This study was carried out in the Netherlands and compared two randomly selected groups of patients who had tinnitus. One group received ‘traditional care’ which included diagnosis, prescription of hearing aids and/or tinnitus maskers when indicated and regular follow up by audiologists and a social worker. The other group received specialised care which was the same but with the addition of group treatments with a clinical psychologist, movement therapist and other therapists, focused on cognitive behaviour therapy developing techniques and therapies aimed at alleviating the tinnitus. A number of different assessments such as quality of life, tinnitus severity and tinnitus impairment, were used to measure the outcomes and these showed significant improvements in the group receiving ‘specialised care’ in comparison with the group receiving ‘traditional care’.

Cima, R et al (2012) ‘Specialised treatment on cognitive behaviour therapy versus usual care for tinnitus: a randomised-controlled trial’, Lancet, Vol 379, p1951-1959)

Research offers hope of better Tinnitus care

We would like to thank the Cambridge Evening News for permission to reproduce this article which appeared in the paper on Friday 8th June 2012. A brief summary of the study is also included.



Groundbreaking research by a doctor at Addenbrooke’s could transform care for patients with tinnitus. A new study, co-authored by David Baguley, head of audiology at Cambridge University Hospitals, shows that combining psychology with traditional treatment is more effective than the standard care given to people with the condition.

Dr Baguley, a consultant scientist, was involved in the design of the study and the interpretation of the results. It compared standard care for tinnitus – using a sound generator to mask the tinnitus – with a combination of audiology and psychology techniques.

The study found the combination worked better, and not just for people with severe tinnitus.

Tinnitus, described as a sustained ringing in the ears, affects up to 21 per cent of adults at some point in their lifetime.

Many treatments are offered for tinnitus, but there is very little evidence about which ones work best and few studies have compared treatments against each other.

Dr Baguley said: “The high quality of the research design and implementation means that we now have robust evidence that taking care and attention to address not only the hearing needs of people with tinnitus, but also their dismay and distress, results in better outcomes. “This is something we have suspected for some time, and indeed the combination care in the study was loosely based on tinnitus care at Cambridge University Hospitals.

“This will be important in underpinning decisions about commissioning future services for this important group of patients.”

The findings are published in the health journal, The Lancet.

rachel.allen@cambridge-news.co.uk

Forthcoming Meetings

The next meeting will be on **Saturday November 24th 2012** at in the **Boardroom at Addenbrooke's Hospital Cambridge**. Doors will open at 12 noon and you are invited to bring a contribution to the buffet lunch we share at this meeting.

Dates for meetings next year are still to be confirmed.

Directory

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T. 01953 860692

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British Acoustic Neuroma Association (BANA)

W. www.bana-uk.com
E. admin@bana-uk.com
T. 01623 632143
F. 01623 635313

Freephone. 0800 6523143

A. Oak House B, Ransomwood Park,
Southwell Road West, Mansfield, Notts,
NG21 0HJ

Meningioma UK

W. www.meningiomauk.org
E. support-enquiries@meningioma.uk
(Patient information & support)
meningioma@ellapybus.greenbee.net
(Meningioma UK)
T. 01787 374084

Brain Tumour UK

W. www.braintumouruk.org.uk
T. 0845 4500386 (10am-1pm, Mon-fri)
A. PO Box 27108, Edinburgh,
EH10 7WS

Royal National Institute for the Deaf (RNID)

W. www.rnid.org.uk
E. informationline@rnid.org.uk
T. 0808 808 0123 (Info line - Freephone)
Textline. 0808 808 9000

Tinnitus Helpline

T. 0808 808 6666 (Freephone)
Textphone. 0808 808 0007 (Freephone)
A. 19-23 Featherstone Street, London,
EC1Y 8SL

Cambridge Campaign for Tackling Acquired Deafness (CAMTAD)

W. www.camtadcamb.org.uk
E. admin@camtadcamb.org.uk
T / Text / Fax. 01223 416 141
(Mon - Fri 9.30am - 12.30pm)
A. 8A Romsey Terrace, Cambridge
CB1 3NH

Changing Faces

Support for people with temporary or long term facial disfigurement problems
W. www.changingfaces.org.uk
E. info@changingfaces.org.uk
T. 0845 4500 275

British Tinnitus Association

W. www.tinnitus.org.uk
E. info@tinnitus.org.uk
T. 0800 018 0527
Minicom. 0114 258 5694
A. Ground Floor, Unit 5, Acorn Business
Park, Woodseats Close, Sheffield,
S8 0TB

Entific Medical Systems

Info about bone conducted hearing aids,
particularly for single sided deafness.
W. www.entific.com

Addenbrookes Hospital

Neurotology & Skull Base Surgery Unit
http://www.addenbrookes.org.uk/serv/clin/surg/neurotol_skullbase/surgery_profile1.html

BANA Booklets

BANA has produced some booklets which may be of interest:

- A Basic Overview of Diagnosis & Treatment of Acoustic Neuroma
- The Facial Nerve & Acoustic Neuroma
- Headache after Acoustic Neuroma Surgery*
- Eye Care after Acoustic Neuroma Surgery
- Effects an Acoustic Neuroma can have on your memory, emotions, behaviour, executive functioning and energy
- Balance following Acoustic Neuroma

All these booklets are available from Alison Frank The Old School House, The Green, Old Buckenham, Norfolk, NR17 1RR

* Recently updated .

There is a £2 charge for all books.

Facial Stimulators

AMNET has some Facial Trophic Stimulators which are available to members for a 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:
Alison Frank **01953 860692**.

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.

AMNET Advisory Panel at Addenbrooke's Hospital, Cambridge

Mr David Baguley MSC MBA Principal Audiological Scientist. Kate Burton Advanced Practitioner in Neuro-Oncology. Melanie Jackson Skull Base Nurse Practitioner. Mr Robert Macfarlane MD FRCS Consultant Neurosurgeon. Mr David Moffat BSC MA FRCS Consultant in Otoneurological & Skull Base Surgery. Ella Pybus Co-director Meningioma UK and Trustee of BTUK. Mr N J C Sarkies MRCP FRCS FRCOphth Consultant Ophthalmic Surgeon.

Chairman-Alison Frank 01953 860 692.

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

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