SAMPLE

the Connection

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Vestibular Schwannoma (Acoustic Neuroma):

The profession is not achieving its potential for early diagnosis

Charles H. Tator,MD,PhD,FRCS(C)

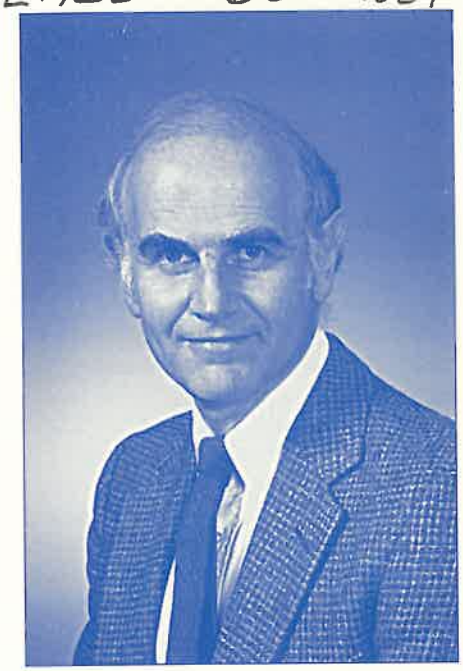
PLEASE - DO NOT REMOVE

Dr. Tator is chairman of the Division of Neurosurgery, University of Toronto; Dan Family Chairman, Neurosurgery Division, Toronto Hospital; and chairman of the Medical Advisory Board, Acoustic Neuroma Association of Canada. The following editorial, printed in the August 1993 issue of the Canadian Medical Journal, is being reprinted with the permission of CMJ.

Although this article was written and printed for the perusal of medical professionals, ANAC feels it is of importance and interest to ANAC membership. We urge you to pass it on to members of the medical profession with whom you are in contact. Copies with the reference bibliography are available upon request.

Great advances have recently occurred in the field of acoustic neuroma. There has also been a name change: to "vestibular schwannoma," a more accurate term for these tumors, which almost always arise in the vestibular nerves rather than in the acoustic nerve. Vestibular schwannomas are benign tumors for which modern medicine has developed diagnostic tests and effective therapy. Despite these advances the diagnosis is not made early enough, when the tumors are small and the morbidity is minimal. Complications such as facial paralysis, brain-stem damage and death are all related to tumor size.

The diagnosis of vestibular schwannoma is often delayed because the disease is uncommon (it has an annual incidence rate of only 10 cases per million people) and because the symptoms it gives rise to occur in other, more common conditions. Such a delay usually means that the tumor has been allowed to grow and ultimately compress and damage vital structures, including the brain stem, lower cranial nerves, and branches of the vertebral and basilar arteries; this reduces the effectiveness of therapy and increases the morbidity.



Modern technology has provided a solution to delayed diagnosis of vestibular schwannoma, but family physicians, otolaryngologists, neurologists, and neurosurgeons must alter in three ways their paradigms for diagnosing these lesions. First, they must consider this diagnosis earlier and arrange for definitive diagnostic tests. Second, they must concentrate on the tests that have greater sensitivity and specificity and discard those with less accuracy. Third, they must broaden their use of two new, highly accurate and safe technologies: the auditory brain-stem response (ABR) test and magnetic resonance imaging (MRI).

Since clinical examination is always the basis for ordering tests, the search for and recognition of certain symptoms of vestibular schwannoma are still important. The early symptoms include unilateral hearing loss, which occurs gradually and is often first noticed when the patient uses the telephone; sudden partial or complete hearing loss is less common. Hearing loss is usually followed by a gradual onset of tinnitus, which is variable and may be described as whistling, humming, machinery-like noise or bells ringing. True vertigo may occur, but a

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Acoustic Neuroma Association of Canada

Your comments, ideas, suggestions and financial support are needed and welcome.

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"The Hope is Recognition and Treatment"

Vestibular Schwannoma

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commoner symptom is a sense of dizziness, swaying or other disequilibrium. As the tumor grows and compresses the brain stem, the patient's balance becomes impaired, especially during walking, and there often is a tendency to veer to the side; this is intensified at night. With further tumor growth, facial numbness or weakness develops because of compression of and damage to the fifth and seventh cranial nerves respectively. Rarely, the patient has headaches and otalgia. As the mass enlarges in the posterior fossa, raised intracranial pressure can cause headaches, vomiting, papilledema and coma, often with hydrocephalus.

In the early 1900s patients with vestibular schwannoma commonly presented with papilledema and hydrocephalus. Fortunately, patients with such advanced symptoms rarely present today, although I have seen several during the past 5 years. A family history of von Recklinghausen's disease, cutaneous tumor, café-au-lait pigmentation, a brain tumor or vestibular schwannoma should alert the practitioner to the possible diagnosis of vestibular schwannoma because of the genetic transmission of neurofibromatosis.

Clinical signs in patients with vestibular schwannoma may be minimal or absent, which accounts for many instances of late diagnosis. Although unilateral hearing loss of the sensorineural type can be determined with a tuning fork, few physicians perform this test today. Classically, air-conduction hearing, although diminished compared with hearing with the good ear, is still better than bone-conduction hearing. Nystagmus may be present, even with small to medium-sized tumors, and thus testing the extrocular movement of the eyes is still worth while. Signs of dysfunction of the 5th, 7th, 9th and 10th cranial nerves and of cerebellar incoordination, especially gait disorder, should be sought, although these signs are only present in patients with medium-sized to large tumors. Funduscopic examination is essential to detect raised intracranial pressure, which may be present if the tumor is large.

To wait for the full-blown evolution of this condition guarantees unacceptable rates of morbidity, disability and dependence. The available technology can help in the recognition of these tumors when they are still very small and amenable to cure with minimal morbidity.

Practitioners should discard some of the older tests, which are less accurate, lack sensitivity and specificity and are costly and inefficient. These include auditory tests based on the observation that retrochlear lesions such as vestibular schwannoma produce excessive tone delay and absent loudness recruitment. Other older tests are vestibular tests, such as assessment of caloric responses and electronystagmography. Pure-tone audiometry and the assessment of speech discrimination remain useful, although they lack sensitivity and specificity. Many radiologic tests, including skull radiography, myelography of the posterior fossa and tomography of the temporal bones, have low yield. In the 1970s computed tomography (CT) was helpful, especially when combined with air cisternography, but it is no longer necessary. Some practitioners still order electroencephalography to diagnose the cause of hearing loss, although the technique is ineffective for this purpose.

With regard to the new techniques the ABR test is described first, because for several reasons it should be performed first in most cases of suspected vestibular schwannoma: it is cheaper and more readily available than MRI and generally requires the involvement of an otolaryngologist, who may be able to rule out an acoustic neuroma, and thus avoid the more expensive MRI (an ABR test costs only a few dollars, whereas an MRI test with contrast-medium enhancement, costs about $1000).

The ABR test, developed about 20 years ago, was refined during the past 10 years for use in the diagnosis of vestibular schwannoma. A sound generator is placed in one ear, and the electric response generated from the cochlea, brain stem and cerebral

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President's Corner

Virginia Garossino

Over the years, it has been encouraging to notice fewer post-surgical complications and deficits for recent AN patients. In a previous column, we asked you to write and let us know the results and experience of your treatment. We have received several letters and we thank you for taking the time to write out your story. The responses were positive and the members wrote to say they are happy with the diagnosis and treatment they have received.

The past ten years have seen great improvements in the diagnostic procedures, surgical techniques, and the time required to obtain a proper diagnosis. These are, in part, due to the work of our organization in alerting the medical community to the importance of this condition, and to heightening the awareness of the possibility of acoustic neuroma in the general public.

With a look in my crystal ball and with great optimism for continued medical advancements in the next ten years, I foresee the future outcome of acoustic neuroma treatment continually improving.

Vestibular Schwannoma

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cortex is picked up by electrodes placed on the scalp. Several hundred brief stimuli are administered, and the responses during the first 10 milliseconds are averaged by the computer. Usually five waves are identified, and a diagnosis of vestibular schwannoma is made when some of the waves are delayed or when the time lapse between the waves is lengthened. The test takes about 30 minutes to perform in both ears and has been shown to have a sensitivity and specificity of about 90%.

There have been several reports of normal ABRs in patients with vestibular schwannoma; furthermore, the results can be suggestive in patients with retrocochlear lesions due to trauma or multiple sclerosis. Nevertheless, even very small vestibular schwannomas, including those confined to the internal auditory canal that do not even touch the brain stem, can be accurately diagnosed.

All patients whose ABR test results have been indicative of vestibular schwannoma and those whose results have been negative but who have highly suspicious symptoms and signs should then undergo MRI, preferably with an intravenous injection of gadolinium-DTPA (diethylene triamine penta-acetic acid) to increase the sensitivity of the test (there have been no reports of false-negative test results with the use of this contrast medium). Most tumors, even very small ones confined to the internal auditory canal, can be diagnosed by means of this technique and medium, without gadolinium, MRI fails to detect a small number of them. There has been much less morbidity associated with the use of this contrast medium than with pneumoencephalography or CT with air or iodine-containing contrast media. Since MRI is more sensitive than plain CT and more specific than CT with air, it is the imaging method of choice for suspected vestibular schwannoma. Indeed, if the high cost and limited availability of MRI were not important factors, then all patients with suspected vestibular schwannomas would require only MRI for diagnosis, and the ABR test could be omitted.

The ABR test and MRI, especially the latter, are incredibly powerful techniques for the diagnosis of vestibular schwannoma. However, their power has to be unleashed by the practitioner who suspects this condition. Suspicion should be aroused when a patient initially presents with unilateral hearing loss and tinnitus. The rewards of early diagnosis are enormous, since the failure to diagnose a small tumor could make the difference between a patient who rapidly returns to work and one who needs state support for years. Furthermore, early diagnosis and treatment is highly cost- effective, because the outcome and cost of treatment are directly related to tumor size. Moffat, Hardy and Baguley demonstrated that the costs of lifetime care for a patient with a poor result of treatment is equal to the cost of diagnostic testing for 2568 patients with unilateral sensorineural hearing loss or of surgery for 198 patients with vestibular schwannoma.

Norman Dott, a pioneer neurosurgeon from Edinburgh, advised many years ago that "the right time to remove an acoustic tumor is when it is no larger than a grain of wheat". Today, practitioners have the tests to do this.

I thank Dr. John A. Rutka, Department of Otolaryngology, Toronto Hospital, for comments on the manuscript.

Glossary of Terms

otalgia: pain in the ear

papilledema: Swelling of the optic nerve, indicates increased intracranial pressure on the optic nerve

hydrocephalus:excess water in the brain due to blockage of cerebrospinal fluid flow, increased production, or decreased absorption

nystagmus: rapid movement of the eyeballs

funduscopic examination: eye exam to look into the back of the eye and assess it for papilledema, done by eye specialist

Bilateral Link

by Frank Fusca

Some time ago I began to feel I was losing touch with my emotions. I would come across a funny article and read it straight through without a pause for even the slightest of grins. I'd become aware of this in the middle of the next article and wonder why I did not laugh. I'd return to the original article and read it again. Yes, it sure was funny - even the second time around!! I'd force out a "ha-ha"; but it was just that - forced, artificial and unnatural, not spontaneous as it should have been. Something similar would happen if I read something sad.

What was happening? I can't laugh and I can't cry - I have known this for a long time and often wondered which was worse. Was this physical limitation making me lose the emotional feeling as well?

Enter Commander Data. Star Trek fans will recognize Data immediately. If you are not a Star Trek fan you still know Data, just think of him as a space-age Tin Man, a walking computer, a robot or more correctly, an Android.

Data lives in the future, in about 2350 AD. Aside from a slight greenish tinge in his eyes you would never tell him apart from anyone else. Data was designed to approximate human behaviour and he does this well, very well indeed. He is really super-human, quicker and stronger than any human. He does not require food or sleep and will not lie (unlike another friend of ours). He cannot age or feel pain. He can perform calculations at speeds that would embarrass today's largest computers. He reads and learns at incredible rates, is always alert, calm and logical. The only Android among his peers, Data is truly exceptional.

When someone asks Data how he is feeling, he will jerk his head slightly while he performs his self-diagnostic and say, "Functioning within the established parameters". Data has no fear, no emotions, no feelings. He does have a quest though: his quest is to become human.

Unlike the many things he can accomplish so effortlessly, he knows he will never become human. This does not stop him from trying. His powerful computer circuits have

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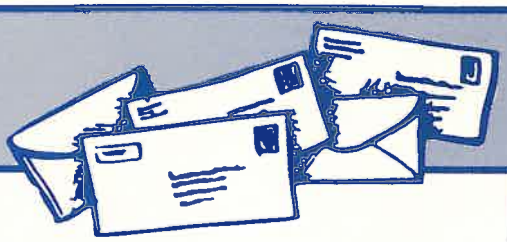
Mailbag



Mailbag letters express personal opinions and experiences only. ANAC does not endorse any product, treatment, physician, procedure, or institution. When a brand name occasionally appears it is for purposes of education. Always consult your physician before using any over-the-counter product.

Dear ANAC,

Thank you very much for your help and kindness during our telephone conversation. I received the package of information the very next day a TRIBUTE to you and your people.

The information has been very helpful as I now face the near impossible task of deciding which method of surgery to undergo. The Doctors at one hospital want to perform the 'SO' type, while the doctors at another hospital want to do the 'MF' type - NOT an easy or pleasant choice at all, and as of yet I still remain confused and undecided. Unfortunately I am already battling other major medical problems. Three years ago I was diagnosed as having a 'lupus-like undifferentiated connective tissue disease' and 'myalgic encephalomyelitis'(Chronic Fatigue Syndrome). I'm really not sure how I'm going to get through the trauma of 'neurosurgery', but I will - RIGHT???

I would like to make a special mention of your Toronto contact person, Catherine Hartwell. As per your referral, I called her. She is extremely kind and caring and spent a good deal of time with me on the phone. Needless to say, her support and understanding is greatly appreciated at this most difficult period in my life. I hope to speak with her again as time goes by.

I have enclosed a cheque for the 1994 membership year. The 'Association' is obviously well established, professional and well represented and should be fully supported by those whom are able.

In closing I would like to thank you once again for your kindness, and as time progresses I will attempt to keep in touch.

Stewart Kates
192 Royal Orchard Blvd.
Thornhill ON L3T 3E7

★★★★

Dear ANAC

The Tinnitus Association of Canada (TAC) is happy to renew its subscription to the Connection. Yours is a superb publication, both in quality of information and exceptionally handsome presentation. I always enjoy reading the letters you publish, they have great human interest even for someone who doesn't have an AN problem.

Congratulations on your tenth anniversary and on the excellent work done by you and the Board in sustaining the spirits of those with acoustic neuromas, as well as providing them with essential information.

Elizabeth Eayrs
Coordinator
Tinnitus Association of Canada
23 Ellis Park Road
Toronto ON
M6S 2V4

★★★★

Dear ANAC,

Please find enclosed a cheque to cover my 1994 membership. My successful surgery took place in July 1993 at Sunnybrook Medical Centre. I am back to work full time and managing quite well with one deaf ear. I feel I've had a fairly positive outcome and so would be encouraging for those facing surgery.

I greatly appreciate all the information I was able to gather prior to my surgery through ANAC. Keep up the good work!

Pat Poland
R.R.#2
Camlachie ON
N0N 1E0

★★★★

Dear ANAC,

Thank you so much for your support and thoughtfulness in sending the newsletter. Sorry to be so slow in getting around to enrolling as a member, but this past year has been a busy one. My recovery has been good and my concerns for the future are calmed by the stories of other patients.

I realize more than ever how fortunate a person is to have friends and relatives for support. And to still be able to drive is great!

Thanks again.

Laura McCabe
175 Marine Drive
St. Clair Beach, ON
N8N 4K2

Maybe I Can Hear

I will go to the park
To hear children talk.

As I go further in the park
A dog starts to bark.

Children laugh and play
No sound coming from
their way.

I think I can hear them play
But I am too deaf to stay.

John Kekely
3 Storey Cres.
Etobicoke ON M9B 3C7

On January 3, 1991 John had surgery for a 2 cm. acoustic neuroma in his left ear. The surgery left him deaf in both ears although previously he had hearing in both. He dedicates this poem "to all ANAC members who lost hearing during surgery".

Hats Off to Jane Hartnett

by Ed Morrisey, Halifax Chapter member

Jane Hartnett with daughter Ashley and son Michael

Jane Hartnett has been familiar with acoustic neuroma (AN) and its after-effects for many years. As the daughter of Anna Parkinson, the Halifax Chapter contact person, she has seen the difficulties with which her mother has had to cope including the surgeries for bilateral AN which have left Anna deaf! During the past three years Jane has been part of the committee forming an association called 'Acoustic Neuroma & Late Deafened Adults Support Group.'

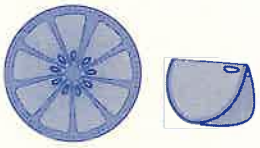
Her typing skills are appreciated at the chapter meetings since they are the core of the system developed for the deaf attendees. Jane types into a lap-top computer, through a special panel and the words are then projected onto the wall. In this manner the evening's information can be read as it develops. The talks given by the guest speakers are easily understood by everyone through this method.

Although both she and her husband, Laurie, are kept busy with their two children, she also has been employed by Shell Oil Company for the past ten years. In fact, her employer was instrumental in the chapter having sufficient funds to buy the computer.

Jane, we appreciate all the assistance you are giving to us at the meetings, as well as in other ways, and we all want to say a great big, "THANK YOU" .... Our hats are off to you.

The Lemonade Stand

Life served us lemons ... so let's make lemonade



A column of personal recipes for using the lemons of life to make something more palatable.

What helped you after your acoustic neuroma treatment? Perhaps it is still a help ... are you willing to share it with others? Send it to The Lemonade Stand - it may be just the recipe someone's been looking for!

Recipe 1: I recently spoke with two women who have overcome their inability to work outside the home because of 'shortcomings' following acoustic neuroma surgery. One started taking ceramics courses several years ago to obtain more strength and control in her affected hand. She now has a small ceramic business out of her home which keeps her whole family busy.

Recipe 2: The second one is pursuing a lifelong desire to become a seamstress and has already made three beautiful bridesmaid dresses. The accomplishment included many alterations, adjustments, and lovely compliments from the young ladies who wore them.

Recipe 3: Balance Tips shared by British ANA through brochures: Check with your Hearing Therapist or Physiotherapist, as a carefully planned exercise programme may help to reprogramme balance system by giving the brain plenty of practice with the new pattern of signals. Do not turn your head quickly, as this may upset balance. Avoid bright light and sunlight; try wearing tinted or sun glasses. Balance appears to be particularly poor when you are tired or in the dark, so walk slowly and carefully, to avoid obstacles.

"Consider how hard it is to change yourself and you'll understand what little chance you have of trying to change others."

Jacob M. Braude

"Trust your hunches. They're usually based on facts filed away just below the conscious level."

Joyce Brothers

"A general practitioner? He's a doctor who introduces you to specialists."

Making the Most of Life

Know your strengths
Acknowledge your weaknesses
Accept your strengths
Accept your weaknesses
Develop your strengths
Work with your weaknesses

L. Gray

Missing! $35,000

For the past seven years our association has been receiving sustaining grants from Health & Welfare Canada in recognition of the valuable work that we do.

As a result of government cutbacks and reviews of all social programs, we have been advised that the grant we have been receiving may, in fact, be reduced or eliminated. At best, our grant application for the coming year will be delayed pending the review of the sustaining grant program in its entirety. You can well appreciate that the delay, if not reduction or elimination, will have serious implications on our budget and will no doubt result in severe cutbacks in our operations.

In order to continue to provide the assistance and services to our members and to the medical community, this anticipated shortfall must be made up quickly. We must therefore look to each and every one of our members to assist in our fundraising efforts. We are pleased to report that membership and voluntary contributions are at record levels. The grant, however, represents the single most important source of revenue.

More contacts with potential corporate donors are needed. Please help us by identifying corporate givers with whom you are in touch, as well as the name, address and phone number of the contact person. We have learned that success in this area can only be achieved through personal contacts.

55 Shopping Days Left 'Til Christmas

Would you like to save money on your Christmas shopping, get a tax receipt for your purchases, and have all your shopping done by tonight?

Consider a contribution to ANAC - a gift made in someone's name. An acknowledgment will be mailed to the persons you select, offering them Season's Greetings and best wishes for the New Year, and will advise them that you have made a donation in their name.

Try it and I promise you will hear only the most complimentary comments from the recipients. All donations in excess of $10.00 per name will be receipted for tax purposes. The amount contributed is not indicated on the acknowledgment. Let's get together and make this the best holiday season for everyone.

We have enclosed a 'gift list' to make your shopping easier.

In view of recent developments relating to our grant or lack thereof, our slogan is even more meaningful.

Jonathan A. Kantor
Director Fundraising

Get Your Share of Fresh Air

Many of the acoustic neuroma patients who suffered severe facial nerve damage, so common only a few years ago, also have one collapsed nostril. They only breathe half of the air to which they are entitled. Sleeping on the good side aggravates the problem, particularly if the good nostril becomes even partially obstructed by a pillow or bed clothes.

However, a doctor recently recommended a simple device that guarantees a refreshing night's sleep. It is a small plastic device called a NOZOVENT. It is available at all Homecare & Surgical shops and some drugstores, and costs only $12.95. This small soft plastic device worn at night keeps both nostrils open no matter which side you sleep on, and the increased supply of air does wonders for your energy.

We urge you to try it if a collapsed nostril is a problem for you.

> "There are moments when silence has the loudest voice."
> *Leroy Brownlow*

Special Thanks to Our Contributors

December 1, 1993 to March 1, 1994

A big thank you to all those listed below for sharing in this helpful way. Contributions are tax deductible and are promptly acknowledged with an appropriate card. Gift amounts are never disclosed.

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Mr/Mrs. R. Eisen's 30th wedding anniversary
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(all proceeds go to the Facial Nerve Clinic, Jewish General Hospital, Montreal, Quebec)

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In Memory of Margaret Hargrave

The family of Margaret Hargrave, of Winnipeg, Manitoba requested that memorial donations be given to the Acoustic Neuroma Association of Canada.

Margaret had many friends and was admired for her zest for life, her courage in the face of adversity and her commitment to friends and family. In a letter Margaret's son, David, explained his mother's difficulty becoming diagnosed with acoustic neuroma...

> "My mother's case is a classic example of the need for your work. She suffered symptoms which gradually increased in severity over a period of several years. Her doctors *failed completely* to diagnose her condition.
>
> The condition was eventually 'diagnosed' by one of her elderly friends who lived 1500 kilometres away in Toronto. She sent my mother an article from *Women's Day* magazine. My mother took the article to her doctor saying 'Maybe this is what I have?'. The doctor scheduled appropriate tests, the tumor was discovered, and my mother underwent successful surgery to remove the tumor in 1987.
>
> She recovered quite well from the surgery, with the help of the Benign Tumor Support Group at St. Boniface Hospital, Winnipeg, MB. I am told that she became an inspiration to others in this group.
>
> I wish you every success in your work of educating the medical community regarding this condition."

ANAC would like to express appreciation for the support given by family and friends:

Phyllis Wotton
Jean Matthams
Dorothy Armstrong
Phyllis Johnstone
Orval Menlove
Dorothy Rodgers
Janet Carter
Joyce & Art Pigott
Ruth Walker
Maryon Seddon
Joan Emsley
Ruth Harris
Marion Bowman
Mrs. Iris Hanford
The Simmons Family
Benign Brain Tumor Support Group, Winnipeg MB
Tannis Johnston
David Hargrave
Irene Garbutt
Mrs. M.R. Forster

Communicating With A Hard-of-Hearing Person

Reprinted from a handout used by Beth Brooks, an audiologist in Vancouver BC.

If you have normal hearing and you live with, work with or socialize with a person who is hard-of-hearing, you already know that communication may be difficult at times. You may experience frustration in trying to make yourself understood. You may feel ignored when that person fails to respond.

It is difficult to understand what it is like to have a hearing loss, but you can learn about some of the problems that a hearing-impaired person faces. And you can learn to communicate more easily.

PROBLEMS FACED BY A HARD-OF-HEARING PERSON

- Whether or not he/she wears a hearing aid, he/she usually hears only part of the message.
- The 'gaps' in the message must be filled in by speechreading, knowledge of the subject, context and imagination.
- When these resources are insufficient, the hard-of-hearing person may feel frustrated and embarrassed.
- The strain of listening, watching, and piecing information together is tiring both mentally and physically.
- Trying to understand speech may be so frustrating that the hard-of-hearing person may withdraw from situations involving the spoken word.
- The hard-of-hearing person may feel left out and ignored by others.
- The hard-of-hearing person may not realize that someone is speaking to him/her unless the speaker obtains his/her attention first.
- Environmental factors, e.g. distance, background noise, lighting, room acoustics, and speaker characteristics make some situations much more difficult than others.

COMMUNICATION STRATEGIES

- **Reduce background noise.** Turn off the radio, T.V., fan; close doors, windows; avoid noisy locations; help the hard-of-hearing person find a quieter location.
- **Move closer.** Speak at a distance of between three and six feet (no greater than ten feet).
- **Get his/her attention first** by calling his/her name or by gently touching his/her arm. This helps him/her focus on what you have to say.
- **Face the hard-of-hearing person directly,** giving a good clear view of your face with available lighting on your face. This will give greater visibility of your mouth movements, facial expressions, and gestures. Don't sit with your back to the window.
- **Speak clearly and not too fast.** Use normal stress and intonation. Form your words distinctly, but do not exaggerate mouth movements.
- **Do not shout.** It makes your voice unnatural and unpleasant. It also makes the vowels louder than the consonants which can be confusing. You will also likely appear to be angry.
- **Rephrase when asked to repeat.** You will give the listener extra cues this way. For example, "I want to go shopping" is easier to speechread than "I want to go to the store".
- **Inform the hard-of-hearing person of the topic of the conversation** and alert him/her to changes in topic. Don't limit the conversation to niceties, but give the listener the information he/she needs to be able to join in.
- **Arrange furniture in a convenient manner.** No speaker/listener should be more than ten feet from any other and all should be visible. It is usually easier to hear in rooms with rugs and curtains than rooms with hard surfaces.
- **Use pen and paper** to write down key words as appropriate. Remember most hard-of-hearing people are able to speak; you are the only one who will need to write.

- **Try to be patient.** Remember that some situations are MUCH more difficult than others for the hard-of-hearing person. He/she must concentrate hard and may tire easily. Your understanding will be most appreciated.
- **Keep your sense of humour active.** Join in with the hard-of-hearing person in appreciating the humour of many confusions and situations.

Legal Decision In Favor of Gamma Knife Patient

Irma Swatogor-Arnold, ANAC Gamma Knife contact person from Ontario, recently won an appeal decision of the Divisional Court of Ontario involving out-of-province funding for Gamma Knife treatment of acoustic neuroma.

The unanimous endorsement of the Divisional Court stated that the LINAC is not at present an identical or equivalent procedure to the Gamma Knife for the treatment of acoustic neuroma and accordingly, dismissed the appeal. The result was that the Ontario Health Insurance Plan (O.H.I.P.) must reimburse Mrs. Swatogor-Arnold for the money she paid for the Gamma Knife treatment in Sweden in 1992.

Mr. Brian Somer of the legal firm, Somer & Associates, who is himself an ANAC member, represented Irma. We wish to express our gratitude to him and congratulate both Brian and Irma for their success.

It is felt that this decision might serve as a legal precedent for similar cases which are presently being appealed and stayed by O.H.I.P. In fact, this might also impact decisions of other provincial Health Insurance Plans.

Your Donation Is Special

General donations and memberships to ANAC represent the largest base of support for the organization. In these times of financial restraint your help is of even greater importance. Can we encourage you to consider giving to ANAC more than once a year?

Increasingly ANAC contributors are making 'special gift' donations in recognition of family members' and friends' special occasions such as birthdays, Christmas, Hannukah, and anniversaries. The honored person receives a card announcing the donation gift (amount not disclosed). It is gratifying for them to know their special occasion has supported a worthwhile cause personally meaningful to the contributor.

When giving Memorial Gifts, cards are also sent in acknowledgment of the donation.

All donations are listed in the *Connection*.

Remember: No One Can Help Us If We Are Not Prepared To Help Ourselves!

Never cry & never swear
When life is hard to you.
It teaches you only what to avoid
And also what to do.

If friendship breaks & knocks you down
You never cry or swear
You ask yourself, "What did I do wrong?"
This freshens up the air.

Author Unknown

Please enroll me as a member of
Acoustic Neuroma Association of Canada
Box 369, Edmonton, AB, T5J 2J6

Enclosed ❑ $20 - 1994 membership
❑ $200 life membership
❑ _____ donation

Name: _____

Address: _____

City: _____ Province: _____ Postal Code: _____

Phone: (Bus) _____ (Res) _____ Age: _____ (optional)

I am	I Agree (Please ✓)	YES	NO
❑ Acoustic Neuroma patient	to share name/address with other patients	❑	❑
❑ Family Member	to receive names of others	❑	❑
❑ Medical	to give locally help when needed	❑	❑
❑ Other	to support research	❑	❑
	to be informed of new treatment developments	❑	❑
	to participate in local functions	❑	❑

Comments: _____

_____

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