

Dizziness and Its Relationship to Acoustic Neuroma



by Toni R. Winder, M.D., F.R.C.P.C.

Dr. Winder, Director of the Alberta Dizziness Clinic, Adjunct Professor Neurosciences Research Group University of Lethbridge, Lethbridge, Alberta is a qualified Neurologist who completed two years of sub-specialty training in Neurology at the University of California, Los Angeles on an Alberta Heritage Foundation for Medical Research Scholarship. Since returning to Alberta, Dr. Winder has continued to develop and expand his interest in patients with vestibular disorders.

Dizziness is a non-specific term that describes a sensation of an altered orientation in space. Patients often have great difficulty describing this subjective sensation and it often represents several different types of sensations that overlap. Because the investigation and management for all of the different causes of dizziness vary quite markedly, it is extremely important that the family physician or specialist, obtains a very detailed history in order to be able to

determine that individual person's form of dizziness before undertaking any diagnostic studies.

At the Alberta Dizziness Clinic, all patients are asked to complete, in their own words, a detailed questionnaire where they have ample opportunity to describe exactly the nature of their symptoms. Once this questionnaire has been completed, the task of the evaluating physician is to go through and verify with the patient what they mean by each of their symptoms, so that it is clear to the physician what the patient has in terms of dysfunction and disability.

When diagnosing patients with Acoustic Neuroma (AN), it is critical to evaluate all the symptoms that patients report.

The patients are encouraged to describe, in their own words, the sensations they experience and how these sensations interfere with their daily activities. For example, vertigo is often used as a descriptor but its strict definition is that of an illusion of movement of the environment and always indicates an imbalance within the vestibular system. What it does not indicate is whether the imbalance arises from the inner ear or whether it arises from the brain which needs to be determined by the physician with detailed questioning and on the examination. Sometimes patients describe dizziness as a light-headed

sensation often associated with an unsteady feeling on their feet as if they may fall. This usually is associated with decreases in blood flow to the entire brain and is not a sign of inner ear or brain dysfunction. Other patients describe symptoms associated with hyperventilation and chronic anxiety-states that cause a feeling of light headedness, imbalance, faintness or giddiness. All of these type of symptoms are associated typically with patients reporting frequent sighing, air hunger, numbness and tingling around the mouth, fingers and toes, as well as commonly a lump in the throat or tightness in the chest.

Some patients report dizziness which may be part of anxiety disorders, such as panic attacks and agoraphobia. Again, unless the patient is actually to use their own words to describe what happens, the dizziness can be misleading for the examining physician. Patients also sometimes report a feeling of dizziness, confusion, trouble thinking and concentrating along with heart palpitations, sweating and tremors

continued on page 2



**Acoustic Neuroma
Association
of Canada**

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

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Dizziness and its Relationship to Acoustic Neuroma...

continued from page 1

due to hypoglycemic episodes where the blood sugar falls. The most common cause of hypoglycemia is insulin treatment for diabetes although there are some patients who have hypoglycemic reactions secondary to alcohol consumption, inadequate food intake or, rarely, insulin secreting tumors.

Dizziness can also be a sign of a drug intoxication and it is very important that during the history specific questions are directed to the patient as to what medications they are taking and the daily dosage, as often in the elderly population multiple medications can lead to significant side effects - one of which is disequilibrium or dizziness.

Sometimes dizziness may be related to changes in a patient's visual system, particularly in the elderly population when there is advancing cataract formation or new prescription changes. Patients with bifocals or trifocals who report feeling off balance and having dizziness, in fact have changes in their visual system not their vestibular system. It is, therefore, important to inquire about any changes the patient may have had with regards to their prescription or operations on their eyes for cataracts.

When diagnosing patients with acoustic neuroma (AN), it is critical to evaluate all the symptoms that patients report. The most common complaint is that of hearing loss. Typically, it is a loss that occurs gradually over months or years as a high frequency unilateral sensory neural hearing loss. They have poor speech discrimination and as a result have great difficulty hearing conversations in crowded rooms with many people talking.

The vestibular symptoms that AN patients present with are not that common. In fact less than 20% of patients with documented ANs actually have vertigo as a symptom. This appears to be primarily because the tumor is so slow growing that the brain is able to compensate for the gradual unilateral loss of vestibular function. However, in any patient with a history of hearing loss who

does report vertigo, physicians are obliged to rule out the possibility of an acoustic neuroma underlying these changes.

Most patients with ANs, in fact, present with an ill-defined sense of disequilibrium rather than true vertigo. They state feeling off balance and don't feel secure on their feet when moving quickly. Other symptoms commonly reported are headache, which increases in incidences as the size of the tumor increases; and with large tumors, patients have significant nausea, vomiting and sometimes visual disturbances often reported as a blurring of their vision.

Just as each patient has different symptoms and signs that vary according to the size of their tumor and location, the usefulness of diagnostic tests also depends upon tumor size and location.

The audiogram still remains the most important test for evaluating patients with ANs, as 94% of patients have an abnormal audiogram with asymmetrical sensory neural hearing loss, especially in the high frequencies. Auditory brainstem evoked responses (ABR) and acoustic reflex testing have also been used as screening tests but they have a relatively low specificity. Detailed vestibular testing with ENG's often have a relatively small part to play in diagnosing patients with ANs because of the test's lowered sensitivity relative to some of the newer radiographic tests that are available.

Currently CT and MRI scans with intravenous contrast agents are the most useful investigative procedures available. They are able to detect small tumors ranging between 3 to 5 mm in size previously missed completely with conventional radiographic and tomographic studies. With more MRI units throughout the country CT scans are rapidly being replaced as the investigative procedure of choice for ANs. MRIs are also non-invasive, and have the added advantage of no radiation exposure to the patient.

Once a lesion had been detected at the cerebellar pontine (CP) angle,

other conditions that need to be considered as potential causes for the growth include meningiomas, epidermoids, arachnoid cysts, lipomas as well as metastatic cancer spread. All of these only account for about 10% of CP angle tumors with the vast majority of lesions, the remaining 90%, being ANs.

Following surgery on the tumor, symptoms of hearing loss that were present beforehand may improve. In fact, with current surgical techniques, hearing is usually preserved in 12 to 65% of patients following surgery. The disequilibrium and vertigo symptoms usually improve over time; it is felt that compensation begins within a few weeks and continues over a period of months and years. Some patients, however, do report some long term disequilibrium following the surgery.

Patients with disabling equilibrium after surgery often have the added complaint of muscle contraction tension headaches which can be relieved by symptomatic measures including physiotherapy and relaxation exercises.

In general, patients who have had ANs are encouraged to go into a vestibular rehabilitation program with specific exercises aimed at enhancing remaining vestibular function. Specific balance and gait training is recommended for those who have significant disability after surgery to try and improve central compensation. No specific dietary recommendations have been made in terms of foods that may improve or inhibit the recovery process.

AN's are found in all areas of the world without any predilection for any particular ethnic group. They constitute about 8 to 10% of all intracranial tumors. Their incidence has been reported at approximately 1 per 100,000 per year, and as a result physicians who have an interest in neurology are continually on guard for patients who may present with this relatively uncommon but potentially treatable cause of dizziness and imbalance.

"THE HOPE IS RECOGNITION AND TREATMENT"

President's Corner



by Shirley Entis

Dear Friends,
Change is in the air – whether we ask for it or not. In Montreal we are finally starting to see a hint of Spring, we are ready for this change.

Change can also be frightening, but if we can be involved in directing the change then it can be enlightening.

The voluntary organizations in Canada, ANAC included are at a crossroads. We have recently sent to Health Canada a Transitional Assistance grant application which we hope will allow us the time to become financially self-sufficient.

In previous President's Corners I have discussed the Phase II Change Challenge workshop that Linda, Tom and I attended. We identified the necessity of two changes imperative for the Association: a) restructure of the organization b) strategic financial planning.

I am deeply heartened by the Directors and the Local Leaders involvement to develop the necessary action. Leading this action is a new Executive Director who knows the

Association, who has undergone treatment for acoustic neuroma herself, who has experience in fundraising, and who is motivated to direct our Association for the future. Welcome, Wenda Deane.

I am pleased to report that the Local Leaders from across Canada have had their first conference call which allowed them to share and exchange ideas, problems, and regional plans. They are looking forward to speaking with you at the local meetings.

I ask you to contact your Local Leader to see what you can do to help in our Change Challenge. Also, please call 1-800-561-ANAC (2622) to offer your suggestions and support to the national office.

I look forward to the future. I look forward to a strong and vibrant Association.

...Positive Change Is The Air!

ANAC Supports Treatment Choices

by Irma Arnold, ANAC Director for SRS

Most of you were very happy with Ruth's and Mike's personal Gamma Knife stories published in the December Connection. There were however some surprising comments made regarding ANAC 'finally accepting Gamma Knife as a treatment option for acoustic neuromas' which I would like to address.

As early as 1991 I was very fortunate to have Dr. Charles Tator, Toronto Hospital (Western Division), as my physician. He felt that in my particular circumstances the Gamma Knife was the right treatment for me.

Even though my treatment date of Feb. 18/92 was clearly stated in the application, I did not hear from OHIP (Ontario Health Insurance Plan) denying funding until after my return from Sweden. I had, however, the option to be heard before the Appeal Board. With help from my member of parliament's office as well as Larry McLean, funding was granted. It was when OHIP in Oct/92 decided to appeal the Board's decision in Divisional Court, that Dr. Tator suggested I get in touch with ANAC Head Office in Edmonton.

ANAC then sent a letter to every member of parliament in Ontario stating the importance of each person having the right to the treatment of their choice, if decided on in consultation with their physician.

ANAC also approached several Ontario lawyers, who were ANAC members and AN patients, asking if they would be willing to support my case in front of Divisional Court.

Again I was fortunate, and Brian Somer of Somer & Associates, Bay Street, Toronto offered his help. With Brian's expertise we won the case. Following that decision all out-of-country Gamma Knife treatments for acoustic neuromas were funded to the end of 1995.

Hopefully those of you who have felt ANAC unaccepting of the Gamma Knife treatment know now that the support for those of us seeking it has been there for many years. As both patient and Director of ANAC I have always found the Board of Directors and national office supportive of their members. We encourage all patients to research the various treatment options and to talk with other patients. When choosing a treatment the decision should always be made in consultation with your physician.

When considering Gamma Knife as the treatment of choice, remember that we are one of the very few countries in the developed world where the patient has to fight for funding, not always successfully. Patients in Ontario are currently in the appeal process. A British Columbia lawyer and AN patient, Wenda Deane, has just won funding for 3 patients who were treated in Seattle and Rhode Island.

Congratulations! Nova Scotia and New Brunswick have been denied funding and patients are exploring possibilities for appeal.

I would like to thank all those who have kept in touch during their decision-making regarding stereotactic radiosurgery, and after their treatment. I would like to stay in contact with all people who have had this option so we (ANAC) can keep abreast of new information in this area - personal experiences, medical centres, costs, reimbursement, etc. Your experience and history will be a tremendous help to future people wishing to pursue this treatment.

I look forward to hearing from you.
Irma Arnold

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PS: As a footnote to Mike's Story, he would like to say that Dr. Charles Tator was the only specialist he found willing to help in his decision making process and who provided him with the necessary referral for Gamma Knife treatment.

Statement on the Use of Stereotactic Radiosurgery for Acoustic Neuromas - January, 1997

by Charles H. Tator, MD, PhD,
FRCS©

Professor & Chairman of
Neurosurgery, University of Toronto
and The Toronto Hospital
Past Chairman, Medical Advisory
Board, Acoustic Neuroma
Association of Canada

My first Statement on the Use of Stereotactic Radiosurgery for Acoustic Neuromas (AN) was published in *the Connection*, the newsletter of the Acoustic Neuroma Association of Canada (ANAC) in May, 1992. Since then, there has been further information and experience with radiosurgery, and many more Canadians have been treated with this method of management. As the former Chairman of the Medical Advisory Board of ANAC, I am aware of the major interest in this method of management on the part of Canadian patients with ANs and their families. I am pleased to provide the following update concerning this important topic based on recent information and further personal experience with Canadian patients who have been treated.

It is now approximately 28 years since the first patient with an AN was treated by the Gamma Knife in Sweden. Since then, approximately 5,000 patients with ANs have received this treatment world-wide. Of these patients, more than 50 have been from Canada and most have been treated in either Sweden or in the United States. I have had personal involvement with approximately 25 of these Canadian patients and have been impressed with the effectiveness and safety of this method of management.

Although there are approximately 75 centres around the world involved in delivering Gamma Knife treatment, there is no centre for Gamma Knife treatment in Canada at this time. In my experience, the treatment is effective in approximately 90% of patients and provides either a shrinkage of the tumor or cessation

of growth with the tumor remaining approximately the same size. The complication rate is low. I have been impressed with the very careful follow-up provided by the Gamma Knife centres, and thus the information about effectiveness and safety is very reliable. It is important to have long-term follow-up because the AN is a very slow growing tumor and sometimes, the effects of radiation therapy do not become apparent for several years. In general, I have recommended stereotactic radiosurgery for specific groups of patients, such as those with tumors less than 3 cm. in diameter and those with bilateral tumors. Also, the treatment is particularly well suited to patients who have other serious conditions such as heart disease or who are at an advanced age. Patients with tumors larger than 3 cm and those who may have rapidly growing tumors and significant compression of the brain with increased intracranial pressure still require standard surgical treatment. There is still considerable uncertainty about microsurgery or radiosurgery for the majority of AN patients who fall into the younger age groups, are in good health, and have a unilateral tumor less than 3 cm. in diameter.

Of the 25 patients or so whom I have personally followed after Gamma Knife radiosurgery, one patient has had to have surgery because of continuing significant growth of the tumor and two required CSF shunts because of worsening hydrocephalus. It should be noted that shunts may be required after standard surgical therapy, and there is no evidence that stereotactic radiosurgery increases the risk of hydrocephalus.

The Gamma Knife is not the only method of delivering stereotactic radiosurgery. The linear accelerator (Linac) is another method which has received increasing attention during the past few years. The Linac is a method of giving virtually identical radiation to the Gamma Knife, but the methods of generating and focusing the radiation are totally

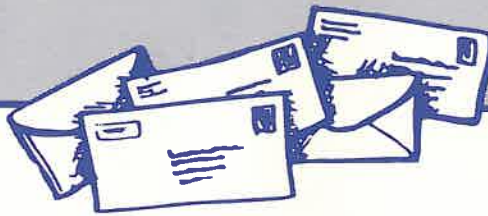
different. Although there is good long-term follow-up of patients treated with the Gamma Knife, there is no similar large body of information available on the effectiveness or safety of the Linac for patients with AN. It will probably be several years before quality information will be available concerning the effectiveness and safety of the Linac for AN patients. Indeed, I would estimate that it will be another 10 years or so before the same level of confidence can be built up for the Linac. Thus, when I recommend stereotactic radiosurgery for ANs less than 3 cm, the Gamma Knife is always recommended. Recently, I have recommended a fractionated system of stereotactic radiosurgery with the Linac for 2 patients with very large or bilateral ANs (well over 3 cm), but it will be quite some time before the effectiveness of this method of management can be substantiated precisely.

Currently, in North America, approximately 50% of patients with ANs are being treated with microsurgery, and approximately 50% with stereotactic radiosurgery, mainly with the Gamma Knife. During the past ten years, there has been a gradually increasing number of patients treated each year with stereotactic radiosurgery.

Oops!

A printing error was discovered in the April 1996 issue (Vol.9 Issue 1) of the *Connection*. In the article 'Doug's Story: A Spouse's Point of View', Doug and Eleanor Flood's phone number was published as (514)652-4317 (TDD & voice). **The correct number is (514)652-3417.** We apologize for any inconvenience this may have caused.

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.

The following are comments written by ANAC supporters on their 1997 ANAC Membership Invoice. Thanks to all who have renewed so quickly, and to those who also included an extra contribution to help ANAC continue its 1997 Program of support and public awareness.

...Really like this invoicing system! Great for forgetful types like me.

...Thank you for the excellent information on post surgery. It has made a world of difference for my family & for myself. It gave us some much needed guidance, hope & direction. You've been wonderful.

...I am very pleased to support the Association - for your excellent work & dedication. Thank you.

...I would like only to be informed of up-to-date medical procedures pertaining to this affliction.

...Thought very highly of the symposium held in Vancouver, June/96. Came home feeling very positive.

...I am now 76 - use a cane for the imbalance but am happy to talk on the phone, enjoy the Connection.

...I attended the North American Facial Therapy Study group last year and was very impressed by all the good work your Association does!

Dear ANAC,

I am very fortunate in that I came through the surgery with minimal side effects. I think the Association is a very worthy organization. I enjoy receiving "the Connection" and most of the letters make me realize how lucky and fortunate I am to have only headaches as a result of the surgery. No matter how severe the headaches I know there are a lot of people out there who were not as lucky as I was. I would be pleased to offer my name and address to anyone who wishes to contact

me to discuss their AN, or a shoulder to cry on, even just an encouraging word from a former patient. My surgery was July 5/93
Coreen Clarke, RR2, Meaford, Ont.
N4L 1W6, (519)538-5160

To the ANAC Team,
I wish to thank you for your continued good work in keeping us veterans informed with the latest medical information and providing a line of communication with other members and patients.

I had my surgery 4 years ago in Edmonton and my life is pretty much back on course.

As so many of your correspondents mentioned in their letters, the problems of headaches, fatigue and memory loss remain. However, these problems can be reduced if we just go at a slower pace.

Walter Berg, 690 Eastwood St.,
Prince Albert, Sask, S6V 2T5,
(306)764-2117

Dear Shirley:

Please express my sincere gratitude to the Acoustic Neuroma Association of Canada for the reception in my honour (November/96). In my remarks that evening, I said how much I enjoyed being Chairman of the Medical Advisory Board. It is hard to believe that these 11 years have gone by so quickly.

The organization has grown considerably and plays a very important role in the lives of so many individuals. The support provided to so many people by the Association is indicative of the importance with which it is held, and also indicative of the hard work and good will of so many individuals including yourself. Shirley, I am sure that

under your leadership, ANAC will play an even greater role in the future.

In addition to providing much needed support to individuals with acoustic neuroma and their families, ANAC also plays an important role in advocacy and research. In an era of governments withdrawing their support for health care and related matters, it is more important for organizations such as ANAC to continue to function and grow. ANAC can be an important force in letting the governments know what is necessary for providing excellence in care and for providing funds for research. This latter aspect of ANAC's role is extremely important because it is only through research that greater gains will be made.

There have been enormous gains in our ability to treat patients with acoustic neuroma over the past 11 years, and I am sure that there will be even greater gains over the next 11 years. ANAC can push the frontiers of knowledge even farther by promoting research. Research has brought us incredible improvements such as magnetic resonance imaging, auditory brainstem evoked responses for diagnosis; surgical microscope, ultrasonic aspirators and electrophysiological monitoring equipment for preserving nerve function. Even greater "miracles" lie ahead if we promote research.

I was so pleased and indeed honoured by your presence at the reception last week. Thank you very much for coming and presenting me with such a wonderful gift. The inscribed silver platter looks wonderful in our dining room and our family will cherish it.

Yours sincerely,
Charles H. Tator, MD, PhD, FRCS(C),
Professor and Chairman Neurosurgery,
Toronto Hospital
December 10, 1996

A HUG FOR ALL REASONS

by Kathleen Keating

(Reprinted in part)

Hugs are not only nice, they're needed. Hugs can help relieve pain and depression, make the healthy healthier, the happy happier and the most secure among us even more so. Hugging feels good... overcomes fears... eases tension... provides

stretching exercises if you are short... provides stooping exercises if you are tall... Hugging also does not upset the environment... saves heat... is portable... requires no special equipment... makes happy days happier... makes impossible days possible.

**A HUG MAKES YOU
FEEL GOOD ALL DAY.**

Funny Bone

"What kind of job do you do?" a lady passenger asked the man traveling in her compartment. "I'm a naval surgeon," he replied. "Goodness!" said the lady, "How you doctors specialize these days."

.....
The resident began his examination of a distraught man by asking him what brought him to the hospital. The man replied "an ambulance."

Lindsey's Story

Lindsey Oss is an active member of the ANA & Late Deafened Adults Support Group in Halifax, Nova Scotia. He has written for 'the Connection' his personal experience with the partial removal/monitoring treatment for acoustic neuroma.

As with most Acoustic Neuroma (AN) patients, my introduction to it was one of surprise and frustration. I hope that by recounting my story I may be able to shed some light on an experience that holds many uncertainties for the patient and anyone close to them.

I was first concerned that I had a problem when, after fighting off a bad cold in March, 1994 I noticed I just could not unblock my right ear. Along with this, I noticed I was having trouble keeping my balance, and my vision wasn't very stable. 20/20 hindsight now tells me these are the classic symptoms of AN and I should have seen a specialist right away. A combination of my stubbornness to even think something more serious might be wrong, and my doctor's misdiagnosis of the symptoms, lead to several very frustrating and worrisome months for me, not to mention those of my family.

I continued going to my doctor every couple of weeks through to September of that year. He kept telling me my ear was still blocked and continued to prescribe more decongestants and nasal spray. After I had become quite a pest I was finally referred to an Ear, Nose and Throat specialist, Dr. Keith Walling.

Upon my first visit to Dr. Walling, it was immediately determined there was no fluid in my ear. He sat down with me and explained he would run some audiology tests to determine the extent of any nerve damage. Finally, I felt I had some professional concern. It was basically a process of elimination culminating with a CT Scan at the end of October. Just knowing something might be so wrong that you have to have a CT Scan is unnerving enough, but waiting a couple of weeks for the results can cause uncomfortable times.



Lindsey Oss

I was due to drive to Montreal for a vacation in two weeks, and rather than speculating all through my vacation what the results of the Scan were going to be, I decided to call Dr. Walling's office. When I introduced myself to his secretary she asked me to hold. I figured, "Great, my results are in!" but when she asked if I could come into the office the next morning I got a sinking feeling it was a little more than the original hypothesis of 'just a viral infection'.

My mind really wasn't on work that morning and I knew it wouldn't be until I saw the good doctor. At 10:30am I drove to Halifax with my head spinning with every possible scenario, or so I thought.

I was only in the waiting room for 5 minutes when Dr. Walling invited me to have a seat in his office. We said our greetings, sat down and without beating around the bush Dr.

Walling came right out and said, "Lindsey you have a brain tumor."

A numb feeling came over me. All I could think of asking was, "How large is it?" and, "Is it cancerous?" I was doubly worried because my Uncle Richard was in a hospital in Montreal dying of cancer of the brain, so I was obviously thinking "Not me, too!"

As difficult as it was, for the remainder of the day I managed to avoid answering my colleagues question of "So what did they tell you?"...except for my boss. Out of the public eye, I was finally able to release the tension I had been holding inside. I also asked if he could keep my predicament from my work mates until I left for Montreal because I didn't know how to face them.

My first visit with the neurosurgeon was the week I returned from Montreal. I was still unclear of the severity of my situation because whatever Dr. Walling had said to me after the first 5 minutes of my last visit was a blur. The neurosurgeon was going to be able to give me the prognosis and I was going to be sure to hang onto every word he was about to say.

Inside his office he showed me my CT Scan and told me that because of its size my only option was total excision of the tumor. He told me I had an 80% chance of facial paralysis and he probably would not be able to save any hearing in my right ear. When I asked about radiation therapy (I knew next to nothing on the subject) he told me that not enough was known about it and recommended against it.

At the time all of this was happening I was 29 years old, a Sales Representative for MacMillan Bloedel, and single - all of which would weigh heavy on what I was going to do.

That evening I had some very deep discussions with my mother and father who had returned from Montreal with me to give some well needed support. Over the previous few months my parents had talked to many doctors at the Montreal Neurological Institute to pursue all available options for my dad's brother, Uncle Richard, who has since passed on. We decided I had nothing to lose by going to Montreal to see if they had some more favorable options. The 80% risk of facial paralysis was really not sitting well with me as I felt it would hinder my career in sales, ie: customers uneasiness with a physical handicap... and I was still searching for Miss Right, whom I hope I have found.

My parents immediately began doing all the leg work to get a referral to the Montreal Neuro so I could get my mind off things and back on my normal routine. This was very important for me because by finally resolving that it was ultimately out of my hands, and that my fate was to be determined by professionals, I was able to continue going to the gym and, after the initial shock, not make myself sick by worrying about it.

I went for my MRI and consultation in Montreal just before Christmas. I was admitted over the weekend for a series of necessary tests prior to the MRI on Monday. On the day of my MRI, Drs. Jean-Guy Villemure, Jean-Paul Bahary and Ted Roman decided my tumor was too large for radiation therapy and would have to be removed surgically. They scheduled surgery for February.

Due to the high risk of facial paralysis that would result from total excision, Dr. Villemure decided to proceed with a subtotal excision of the tumor. Dr. Villemure described my tumor as an orange, and to avoid damaging the facial nerve surrounding it he would scope out the inside of the tumor leaving the 'orange peel' or shell of the tumor. This would reduce the size of the tumor and remove the pressure it was exerting on my brain stem. The pills in the shell were less likely to grow but I would have to have periodic MRIs to gauge if there is any growth.

My surgery on February 4, 1995 was only 4 hours as opposed to the 8-10 hours estimated for total excision. The next morning I was out of Intensive Care with no complications and, with my two brothers' assistance, walking around the wing letting the staff know how grateful I was for their support while I was with them.

I have no facial palsy and no dry eye. I recuperated for 3 months before going back to work. Three weeks after the surgery I returned to the Mount St. Vincent University gym where I had been working out for the past two years. Ruth Vesterback and the rest of the staff helped ease me back into a routine that did not exert too much pressure on my head but that would help get back some of my strength and energy.

I can thankfully say I am feeling very healthy once again, and people who don't know of my surgery cannot believe it once they are told. I can very easily live with the tinnitus and hearing loss for all that I saved.

I have had three MRIs since my surgery and all have been very positive. If everything continues to be positive at my next MRI in May, I will only have to go once a year - a trivial price to pay with all things considered.

If the tumor ever grows I will have the option of radiation therapy, but until then I have at least bought myself some time and hope that science will have made significant advances if the time ever comes.

In closing, I want to say it is important to maintain a positive attitude before, during and after treatment. This is not only maintained by the individual but requires the support of family and friends. Our AN Support Group Network is also vital to any existing and future AN patients. We must use the vastness of our network to bring more awareness to the existence of AN so that improved treatments may be found and misdiagnosed tumors will be a thing of the past.

UPCOMING EVENTS

5th Annual Information Day on Brain Tumors

**Saturday, April 12, 1997
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**Hotel: \$89/night, regist'n must
reach hotel by June 20.**

For information contact
Chris Van Arsdel (972)985-0424
VanArsdel@aol.com

Daryl Holloway (972)252-8074

'Sharing Hope' Symposium July 18-20, 1997 American Brain Tumor Association

**Hyatt Regency O'Hare
Chicago, Illinois**

A wide variety of general and breakout sessions for patients, survivors, families and health care professionals.

**Contact ABTA office (800)886-2282
for information.**

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December 15, 1996 to February 28, 1997

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I Agree

- to share name/address with other patients
to receive names of others
to give locally help when needed
to support research
to be informed of new treatment developments
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