

Cambridge Skull Base Unit

Skull Base Meningioma

Introduction

Addenbrooke's Hospital in Cambridge has a specialist team (skull base) who deal with skull base meningiomas. Our team aim to help you understand about skull base meningioma, its treatment and the potential effects on you.

This information is designed to help you answer the common questions that are asked by patients after the initial consultation. It is hoped that it will help you understand your diagnosis.

Who we are

We run a skull base meeting and clinic on the second and fourth Friday of each month, and smaller clinics on Tuesday afternoons. The meeting consists of different specialists, and you may meet more than one clinician at your appointment.

The Cambridge skull base team has a great deal of experience looking after patients with skull base tumours. It is one of the largest skull base units in Europe and is happy to share its research findings with you. Our website address is <http://www.cuh.org.uk/skull-base-service>

Most of your outpatient appointments will take place in Clinic 10, on Level 2 (ground floor) of the outpatient department. It is about 5 to 10 minutes' walk from the main bus stop to the Addenbrooke's entrance.

If you are parked in the main hospital car park and need assistance with transport to your appointment, a courtesy bus is provided every 10 minutes between 07:30 and 16:00. It stops outside the main entrance to the outpatient's hall. It can accommodate one wheelchair at a time.

What is a skull base meningioma?

Meningiomas are usually benign slow-growing tumours which arise from the linings of the brain (the meninges) at the base of the skull. There are different areas that these tumours can arise from within the skull base and your surgeon or specialist nurse will give you more details about your specific tumour.

What causes meningiomas?

As with most brain tumours, the cause of meningioma is almost always unknown.

A small number of patients may develop a meningioma following radiotherapy to the brain/head. This is rare and happens many years after treatment.

Another potential but uncommon cause could be a genetic condition. If we feel that you need any further investigation for this condition, we will discuss this with you at your outpatient appointment.

How common are meningiomas?

Meningiomas are rare tumours with an incidence rate of one case for every 38,000 of the population. They can occur at any age but are more common in women and people over 40.

How fast do meningiomas grow?

Not all meningiomas continue to grow. Of those that do, the growth rate is usually very slow with an average increase of 1-2mm a year. Occasionally they can grow faster. However, the slow rate of growth of most tumours means that there is usually no urgency to treat them and many are managed simply by observation.

What symptoms do meningiomas cause?

The symptoms of a meningioma vary depending on the size and location of the tumour. These tumours can be so slow growing that they may remain undetected for years. Meningiomas can grow around nerves that control function (cranial nerves) so that for example, hearing, balance, eye sight, smell and sensation can be affected. They may also cause headaches, fits, or muscle weakness.

Some people have no symptoms at all, and the meningioma is discovered while they are being investigated for something entirely unrelated.

Are meningiomas dangerous?

Meningiomas are very rarely cancerous and do not spread to other areas of the body.

If a skull base meningioma is allowed to grow very large, it can potentially be a life-threatening condition as the tumour can press onto parts of the brain that control breathing and heart rate. However, we monitor and treat larger tumours to prevent this from happening.

How can meningiomas be treated?

There are three main ways of treating meningiomas. If the tumour is small, causing no symptoms, or if it is not enlarging then many patients prefer to undergo a period of observation (known as active surveillance, 'watch, wait and rescan', or WWR). This has no potential side effects unlike the other treatment options but you do require periodic scans to make sure that the tumour is not growing. We are able to recommend this because many meningiomas do not grow and cause few if any symptoms.

The other treatments are surgery and radiotherapy. If you have surgery, whether it is appropriate to remove the tumour completely will depend on its location, and the structures to which it is attached. As with any surgery there are risks, and the details will be discussed with you in detail. Radiotherapy is very successful at stopping the tumour from growing, even benign ones, although it does not remove the tumour.

However, in the few cases where it does not stop the growth, it can make any surgery needed later more difficult. The chances of complications with radiotherapy are generally less than those from surgery although in the long term there is a very small chance that a tumour may develop as a consequence of the treatment and very occasionally, these may be cancerous. The risk of this is around 1% for each decade after treatment. Some people find it very difficult to decide whether surgery or radiotherapy would be best for them, and the doctors, nurse practitioners and radiotherapists can help you to make the right decision for you.

Watch and wait

Why is my meningioma being observed?

You have a small tumour, which is not compressing the brain. This means that the tumour is unlikely to cause any problems in the short term. In this situation it is reasonable to observe the tumour rather than treat it by surgery or radiotherapy. The options for treatment will have been discussed with you and you have decided to undertake a period of observation to monitor your tumour.

How often will I have a scan?

At Addenbrooke's, patients undergoing observation of their meningioma are scanned six months after the original scan. If this is stable, we then:

- scan yearly for three years (for example at 18 months, 2.5 years and 3.5 years after diagnosis)
- then every two years for the following six years
- then every three years after that

If your tumour shows slight growth, you may continue to have scans every year in case any intervention is needed.

An MRI scan is the best type of scan to use for monitoring these tumours. However, occasionally a CT scan will be used instead if an MRI scan is not possible, for instance if you have any magnetic metal work inside your body. These scans are generally performed at Addenbrooke's Hospital so that your specialist can look at the scans carefully themselves. The MRI scan takes around thirty minutes and you will have an injection in your hand. The scan is painless but it can be quite loud inside the scanner. Once the scan is done, the specialist will look at the scan and write to you with the result.

Will I need to be seen again?

If you remain well and the scan shows that the tumour has not grown then we may not need to see you after this. We normally request a repeat scan when we write to you with the result of your most recent scan and will inform you when to expect the next one in your letter.

What happens if my symptoms change?

If there are any changes in your circumstances, we will be very happy to see you again and discuss any issues you may have. We will then be able to discuss the new situation with you and run through the treatment options available.

Please contact the nurse practitioners on 01223 348672 if you are concerned about a change in your symptoms.

What happens if my meningioma grows?

If the scan shows there is growth of the tumour, then we will arrange for you to come to Addenbrooke's so that we can show you the scan and discuss what should be done. If there is a small amount of growth and the tumour is not causing any symptoms, then it may be possible for us to continue observing the tumour. However, if the tumour is starting to compress the brain, then we would probably recommend treatment with either radiotherapy or surgery. These forms of treatment will be fully discussed with you so that you can make an informed decision about which type of treatment you would like.

What happens if I decide to have a different type of treatment?

You can change your mind about what type of treatment you are having at any time. If you would like to change to a different type of treatment, then please contact us and we will be happy to see you at Addenbrooke's in order to discuss this with you.

Surgical removal of meningioma

Surgery is dependent on where the tumour is. The risks of surgery are likely to vary dependent on the technique used to reach the tumour and tumour location.

If surgery is indicated, this will be discussed with you at your clinic appointment.

What is it like to have surgery?

Before your operation

You will usually be seen in our pre-admission clinic by a specialist nurse practitioner. At this clinic, we shall ask you for details of your medical history and carry out any necessary clinical examinations and investigations, such as audiology, ECG and blood tests.

This is a good opportunity for you to ask any questions about the operation, and please feel free to discuss any concerns you might have at any time.

You will be asked if you are taking any tablets or other types of medication – these might be ones prescribed by a doctor or bought over the counter. It helps us if you bring details with you of anything you are taking (for example, bring the packaging with you).

Most people who have had this type of operation will need to stay in hospital for approximately five to seven days. Sometimes we can predict whether you will need to stay for longer than usual. Your doctor will discuss this with you before you decide to

have the operation. We recommend that you have someone at home with you for the first two weeks after the surgery.

Hair removal before an operation

With this type of surgery we need to remove a small amount of hair from your head in order to see and reach your skin. We will do this by using an electric hair clipper, with a single-use disposable head, on the day of the surgery, after you are asleep and are being prepared for the operation.

Please do not shave the hair yourself, or use a razor for hair removal, as this can increase the risk of infection to the site of the operation.

If you have any questions, please ask the healthcare team who will be happy to discuss this with you.

References:

NICE clinical guideline No 74: Surgical site infection (October 2008); Department of Health: High Impact Intervention No 4: Care bundle to preventing surgical site infection (August 2007)

During the operation itself

This operation involves the use of general anaesthesia so you will not be awake during your surgery.

The incision site will depend on where your tumour is situated; and will be discussed with you in detail in your clinic appointment.

Occasionally, a small amount of tumour will be left in place if it is attached to important structures. This decision will be made if there is concern that removing the entire tumour will cause nerve damage, and in the knowledge that small remnants that are left will probably be suitable for radiotherapy should the remnant show evidence of growth. Surgery cannot restore function in nerves that have already been damaged or destroyed by the tumour.

After the operation

You will wake up in the recovery room after your operation. You will have an oxygen mask on your face to help you breathe more easily. You might also wake up feeling sleepy.

After this operation, you will have a small tube in one of the veins in their arm. This will be attached to a bag of fluid, which hydrates you until you are well enough to eat and drink by yourself. You will also have a urinary catheter; that is to say a small tube will have been inserted into your bladder to drain urine.

While you are in the recovery room, a nurse will check your pulse and blood pressure regularly. When you are well enough to be moved, you will be taken to a ward. If your operation is very long, you may stay in the neuro critical-care unit (NCCU) overnight so that you can be monitored closely.

Sometimes, people feel sick after an operation, especially after a general anaesthetic, and might vomit. If you feel sick, please tell a nurse and you will be offered medicine to make you feel more comfortable.

Eating and drinking: You can eat and drink when you feel ready, which is usually 24 hours after surgery. You may experience altered taste and a dry mouth. If this is causing you problems when you return home your GP can prescribe you artificial saliva.

The surgical site: At first, there will be a small dressing over the wound and you may have some steri-strips or stitches underneath. As the wound heals, you will have a scar but in most people this is not particularly noticeable. You will also have two small puncture wounds on your forehead due to the way your head is held in for surgery.

Getting around and about: After the operation we will try to get you up and walking as soon as we can to help prevent complications from lying in bed. The physiotherapists will help you and advise on exercises that will benefit your recovery.

When you can resume normal activities including work: Recovery from this operation is slow and steady. It will take approximately eight to twelve weeks. You should not return to work until you have been reviewed in the outpatient clinic, which will be approximately six weeks after surgery.

It can take a long time to build up your energy levels; do not be tempted to go back to work too early as this is likely to cause you to become tired, very quickly. If you have a job that allows you to resume work on a part-time basis, then take this opportunity and gradually build up to your previous hours. It is important that you do not undertake any heavy physical work for three months.

Special measures you need to take after the operation: You will be given more detailed information about any special measures you need to take after the operation. You will also be given information about things to watch out for that might be early signs of problems (for example, an infection).

Steroids

Some patients are advised to take a course of steroids to help reduce swelling around the tumour. It is important that you take this medication correctly, complete the course of tablets and monitor for any side effects. You must not stop taking this medication abruptly. We will advise you how to reduce the dose in a staged way. It might be recommended that you take medication to avoid stomach irritation. Occasionally, steroids have a serious side effect of affecting your mental health. They may make you feel depressed, or experience mood swings, anxiety or hallucinations. If you experience any of these symptoms, you should see your GP to review your medication.

Driving

You will need to inform the DVLA if you have treatment for a meningioma because it may affect your eligibility to drive, even if you have no physical ill-effects from treatment. This depends on the site of the meningioma, the symptoms it causes and the type of treatment you receive. If you have an asymptomatic meningioma that does not require treatment then it will not affect your entitlement to drive, providing that you are otherwise fit to do so. There are separate restrictions for those with a Group 2 (HGV or PSV)

licence. Please discuss this with your doctor. Your insurance company may also need to be informed – check the terms of your policy.

Flying

Travelling by aeroplane should be avoided for at least three months after meningioma surgery.

Check-ups and results: You will be given an outpatient appointment to be reviewed by the neurosurgeon about six weeks after surgery. If the surgeons have been able to fully remove the tumour and you feel well, we will then review you at one year after your surgery and again at two years following a final MRI scan to check for any residual tumour.

Serious or frequently occurring risks

The risks of any surgical operation:

- **Haemorrhage** – (less than 1%). Although the risk of bleeding is very small, when it occurs in a confined space, for example next to the brainstem, it can result in death or serious permanent neurological disability. This can include weakness or paralysis, difficulty in breathing or impaired swallowing.
- **Respiratory complications** – chest infections, which can usually be treated with antibiotics and chest exercises demonstrated/explained by the physiotherapists.
- **Blood clots** – deep-vein thrombosis in the legs, which occasionally passes to the lungs (pulmonary embolism).
- **Wound problems** – including wound infection or leakage
- **Heart** – for example, abnormal rhythm or heart attack
- **Death** – less than 1%

The risks specifically related to the surgical removal of meningiomas vary with their location and size. This will be discussed with you in detail at your clinic appointment but may include:

- **Facial weakness and/or numbness**
- **Loss of hearing and balance function on the affected side**
- **Cerebrospinal fluid (CSF) leak:** CSF bathes the brain in fluid. When the tumour is removed, the CSF pathways around the brain are opened. CSF can leak out either through the entry wound or into the ear and then down the nose. The risk of leakage is around 4%. The majority of leaks will settle down over a few days if a drainage tube is placed temporarily in the spinal fluid pathways in your back. However, some leaks will require a second small operation to repair them.
- **Infection:** The operation to remove a meningioma is long, and the ear can contain micro-organisms that can get inside the head. These can infect the cerebrospinal fluid and cause either a local wound infection or meningitis.

If there is a leakage of cerebrospinal fluid after surgery (see above) this can cause infection. The majority of infections can be treated with antibiotics. Very

occasionally, there can be serious and longstanding problems from infection inside the head. Your doctor can discuss this with you on request.

- **Stroke/major neurological impairment:** There is a very small (around 1%) risk of major neurological impairment following surgery.
- **Headache and neck pain:** It is common to experience a headache after operations on the head, particularly for the first few days. This will be controlled with painkillers.

Further information

If you require more information, please contact the nurse practitioners and they will be able to advise you or direct you to further sources of information.

Radiotherapy treatment for meningioma

What is radiotherapy?

Radiotherapy is the use of high energy x-rays to treat tumours. It can be delivered as a single treatment and this is normally called stereotactic radiosurgery. Alternatively it can be divided into 30-33 treatments (fractions) which are given daily (Monday to Friday) for several weeks; this is called fractionated stereotactic radiotherapy. Both types of treatment can be given at Addenbrooke's. To decide which form of radiotherapy is best for you involves an outpatient appointment to see you, look at your MRI scans and to assess the size of your tumour, its location and also to consider your own personal preference.

What is the aim of radiotherapy?

Radiotherapy aims to stop your tumour growing any bigger and for some patients will actually make it shrink, although this may take years following treatment. Radiotherapy will not remove your tumour.

How is radiotherapy planned?

Stereotactic Radiosurgery (SRS)/Stereotactic fractionated radiotherapy (FSRT)

Before the radiotherapy can be delivered, it is important to make a plastic mask that keeps your head very still and also makes sure that the position you lie in is the same for each visit. Before starting the radiotherapy planning process you will be shown pictures of what the mask looks like and how it is made just for you. We then need to do some scans to plan precisely where the radiotherapy needs to go. This normally means having an MRI scan and also a CT scan; the latter scan uses x-rays to form an image and helps us to plan the radiotherapy.

You will need to have your mask on when you have the CT scan, but this will only take a few minutes.

For the fractionated treatment the planning takes place on a number of visits often spread over a week.

What is it like to have stereotactic radiosurgery?

The treatment is given as day-case radiotherapy (x-ray) treatment. Stereotactic radiosurgery uses tiny beams of radiotherapy. These beams all focus on the tumour or lesion in the brain that needs treating and give a very high dose of radiotherapy in that spot, whilst giving a very low dose of radiotherapy to the surrounding brain.

This means that the tumour/lesion has the highest chance of being controlled whilst the side effects are minimised. Although it is called radiosurgery, this is not surgery. Prior to the treatment you will be prescribed medication to take on the day of treatment and the day after. The medication will be a steroid (dexamethasone) and an anti-sickness tablet (ondansetron). You will lie on the treatment couch wearing the mask and the radiographers will place you in the correct position. During the treatment the radiographers will leave the room but are watching you closely via a TV monitor. You will not feel anything during treatment but may be aware of a buzzing sound.

What is it like having fractionated radiotherapy?

The treatment is given in one of the radiotherapy treatment rooms. At each treatment you will lie on the treatment couch wearing the mask and the radiographers will place you in the correct position.

During the treatment the radiographers will leave the room but are watching you closely via a TV monitor. You will not feel anything during treatment but may be aware of a buzzing sound.

For fractionated radiotherapy the treatment is divided into several parts, called fields. The treatment machine is positioned slightly differently for each field. Each treatment field takes about a minute and the radiographers will come into the treatment room between fields. The whole treatment takes about 20 minutes.

What are the side effects of having radiotherapy?

Radiotherapy does not make you radioactive and there is no need to take any special precautions for the safety of others. The radiotherapy will not make you ill and you will be well enough to travel.

Many patients carry on their normal daily activities before and after the daily treatment session. However sometimes it can cause you to have some side effects.

Fractionated stereotactic radiotherapy – side effects (acute)

Side effects that occur during the course of treatment and in the first couple of months following treatment are called **acute side effects**. Not every patient will experience all of the side effects and if they do happen, the team looking after you will be able to provide help and advice.

Possible acute side effects include:

- **Skin erythema:** This means the skin just in the area being treated may become pink and a bit dry. This is normally very mild, not permanent and will settle about three weeks after treatment finishes.

- **Hair loss:** This is just in the treated area (normally a very small area) and for the majority of patients the hair will grow back normally three to four months after treatment has finished.
- **Increase in tinnitus:** Sometimes the noises you hear in your ear may appear to grow louder or change in tone if the meningioma is near to the hearing nerve.
- **Irritation of the treated ear canal:** You may experience some redness and irritation of the ear canal on the side being treated if the meningioma is near to this region. This may mean your hearing seems worse and you feel as if your ear is blocked. This should settle a few weeks after treatment finishes.
- **Worsening balance:** If you have a meningioma near to the organs of balance you may find that your balance is worse during radiotherapy. This is normally due to some swelling caused by the treatment and should settle a few weeks after treatment.
- **Fatigue and lethargy:** Many patients feel tired and have a lack of energy during and for a few weeks after radiotherapy.
- **Nausea:** Very occasionally patients find the radiotherapy causes them to feel sick and lose their appetite. Tablets can be prescribed if this happens to you. It is very rare to actually be sick.

Stereotactic radiosurgery – side effects (acute)

The acute side effects following SRS are slightly different to FSRT. They may occur in the days and weeks following the single treatment and include:

- fatigue and lethargy
- nausea
- headaches

Late side effects - following all forms of radiotherapy

The last group of side effects are **late side effects** and these occur years after the radiotherapy is given.

Most of these are very rare but include:

- Gradual decrease in hearing on the treated side if treatment involved the hearing nerve
- Low risk of long term facial nerve and trigeminal nerve problems if these were in the treated area. This may include facial pain, facial numbness and facial weakness.
- Very low risk of alterations in blood vessels that could lead to a stroke.
- Very low risk of causing a second tumour to develop in the area that is treated – this may be another benign lesion but could also be cancerous.
- Very low risk of continued tumour growth, which may lead to needing surgery, with increased risks.

If I have radiotherapy do I need follow-up after treatment?

Because the radiotherapy will not remove the tumour, we would recommend a follow-up schedule that includes regular MRI scans in order to check that the meningioma does not show evidence of further growth.

We also like to review you either in the skull base clinic or via a telephone consultation after each MRI.

Other follow-up while under observation, or after surgery or radiotherapy

Depending on the location of your meningioma and the side effects experienced after diagnosis or treatment for a meningioma, at Addenbrooke's we are able to offer you:

- hearing tests
- hearing aids
- single-sided hearing loss clinic
- tinnitus advice
- vestibular assessments and rehabilitation
- facial palsy/reanimation clinic
- pulsatile tinnitus clinic (specialist advice for people with rhythmic tinnitus often in line with your heartbeat)

The skull base team

- Mr Robert Macfarlane MD FRCS, Consultant Neurosurgeon
- Mr Richard Mannion PhD FRCS (SN), Consultant Neurosurgeon
- Mr Adel Helmy, Consultant Neurosurgeon
- Mr Mathew Guilfoyle, Consultant Neurosurgeon
- Mr Patrick Axon MD FRCS (ORL), Consultant Skull Base and Hearing Implant Surgeon
- Mr Neil Donnelly MSc (Hons) FRCS (ORL-HNS), Consultant Skull Base and Hearing Implant surgeon
- Mr James Tysome FRCS (ORL-HNS), Consultant Skull Base and Hearing Implant Surgeon
- Professor Manohar Bance, Professor of Otology and Skull Base Surgery, (Hon. Consultant ENT Surgeon, MB ChB, MSc, FRCSC (Canada-Otolaryngology-HNS), ABOto (American Boards))
- Mr Rishi Sharma, Consultant ENT Surgeon
- Dr Sarah Jefferies, Consultant Oncologist
- Dr Simon Duke, Consultant Oncologist
- Mr Richard Price, Consultant Plastic Surgeon

- Kate Burton, MSc (Hons), DCR(T), Consultant Radiographer
- Indu Lawes RN, Skull Base Nurse Practitioner (Neurosurgery)
- Juliette Buttimore RN BA (Hons) MSc, Skull Base & NF2 Nurse Practitioner
- Nicola Gamazo RN BA (Hons), Skull Base and NF2 Nurse Practitioner

Contact numbers

If you have any questions please contact one of our nurse practitioners:

Juliette Buttimore

Skull base and NF2 Base Nurse Practitioner (Department of ENT)

Telephone: 01223 348672 (direct line), E-mail: juliette.buttimore@addenbrookes.nhs.uk

Nicola Gamazo

Skull base and NF2 Base Nurse Practitioner (Department of ENT)

Telephone: 01223 348672 (direct line)

E-mail: nicola.gamazo@addenbrookes.nhs.uk

Indu Lawes

Skull base Nurse Practitioner (Department of Neurosurgery)

Telephone: 01223 245151 (main switchboard)

Bleep: 154-175

E-mail: indu.lawes@addenbrookes.nhs.uk

Alternatively, for patients under the care of the neurosurgeons please contact:

Havva Yilmaz, secretary to Mr Macfarlane:

Telephone: 01223 254693

Email: havva.yilmaz@addenbrookes.nhs.uk

Maria Harrington, secretary to Mr Mannion:

Telephone: 01223 586858

Email: maria.harrington@addenbrookes.nhs.uk

Susan Birtles, secretary to Mr Helmy:

Telephone: 01223 256694

Email: susan.birtles@addenbrookes.nhs.uk

For patients under the care of the ENT consultants please contact:

Bianca Saunders, secretary to Mr Donnelly:

Telephone: 01223 586638

Fax: 01223 217559

E-mail: bianca.saunders@addenbrookes.nhs.uk

Steve Potts, secretary to Mr Axon and Mr Tysome:

Telephone: 01223 256051

Fax: 01223 217559

E-mail: steve.potts@addenbrookes.nhs.uk

For patients under the care of oncology please call:
Telephone: 01223 586705
E-mail: carolyn.langham@addenbrookes.nhs.uk

Speaking to your family about your diagnosis

If you need advice or support on how to talk to your family or children about your diagnosis, then please contact one of the nurse practitioners.

Patient representatives (patient and public involvement/PPI)

If you have views about how we provide our service, the information that we give to people with meningiomas, or the facilities and environment of the hospital then we would welcome your views in person, via post, fax, phone or email. You do not have to be a patient to be a representative for the skull base service. We are keen to hear what you have to say about the service and where possible wish to involve you in service development so that we can provide the best patient-focused care possible. Please inform the nurse practitioner if you are interested in this role.

Transport and help with finances

You can get help with travel costs for NHS treatment if you receive certain benefits, or if you are named on an NHS Tax Credit Exemption Certificate. You may be able to get help with health costs if you are on a low income by completing an HC1 form (available online, from your GP, Jobcentres or the transport reception in outpatients). If you would like further information, please ask one of the nurse practitioners or contact the Citizens Advice Bureau.

Support groups and Charities

The Brain Tumour Charity

The Brain Tumour Charity was founded in 2013 and offers support and information to meningioma patients and carers affected by a meningeal tumour or tumours of the brain or spinal cord.

Telephone: 0808 800 0004

Website: <https://www.thebraintumourcharity.org/>

Email: support@thebraintumourcharity.org

AMNET

AMNET (The Acoustic Neuroma and Meningioma Network) is a registered charity established in 1996 and is the support group for acoustic neuroma and meningioma patients at Addenbrooke's and the surrounding areas.

The network was established by a group of patients who had undergone surgery and wanted to offer support and information to others going through the experience of having an acoustic neuroma or meningioma. They are supported by an advisory panel

of health professionals from Addenbrooke's, and the group consists of both former and present patients, including those on the watch, wait, rescan protocol.

AMNET hold regular meetings and have their own newsletter, AMNET news. They can offer someone to talk to, booklets, and a range of information to help people through this unsettling time.

Please contact them through their website or their Facebook group:

Website: www.amnet-charity.org.uk/

Facebook: <https://www.facebook.com/AMNETcharity>

RNID

The RNID aim to make day-to-day life better for people who are deaf or who are hard of hearing. Their website includes lots of useful information on communication equipment, your rights and help with benefits and services.

Website: <https://rnid.org.uk/>

Information line telephone 0808 808 0123

Information line textphone 0808 808 9000

Email: information@rnid.org.uk

Brain and Spine Foundation

The Brain and Spine Foundation provide support and information on all aspects of neurological conditions. They aim to reduce uncertainty and anxiety by providing clear and accurate information on topics such as dizziness and balance, migraine and brain scans. This can be found at their website.

Website: www.brainandspine.org.uk

Helpline: 0808 808 1000

Email: helpline@brainandspine.org.uk

Macmillan Cancer Support

Website: www.macmillan.org.uk

Support Line: 0808 808 0000

Email: contact@macmillan.org.uk

Privacy and dignity

We are committed to treating all patients with privacy and dignity in a safe, clean and comfortable environment. This means, with a few exceptions, we will care for you in same sex bays in wards with separate sanitary facilities for men and women.

In some areas, due to the nature of the equipment or specialist care involved, we may not be able to care for you in same sex bays. In these cases staff will always do their best to respect your privacy and dignity, e.g. with the use of curtains or, where possible, moving you next to a patient of the same sex. If you have any concerns, please speak to the ward sister or charge nurse.



We are smoke-free: smoking is not allowed anywhere on the hospital campus. For advice and support in quitting, contact your GP or the free NHS stop smoking helpline on 0800 169 0 169.

Other formats:



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<https://www.cuh.nhs.uk/contact-us/accessible-information/>

Document history

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