ANA/NJ Newsletter
Vol. X, No. 3, October 2006

Meeting at JFK Medical Center, April 30, 2006

Kathie Belonger introduced our speaker, Nancy Conn-Levin, a health educator, brain tumor survivor and co-founder of the Monmouth & Ocean County Brain Tumor Support Group, Inc.

Nancy's focus for our meeting was on stress management, coping techniques – and her main message was: "Find something to smile about every day! Studies have shown that simply smiling can improve your mood and have a positive impact on your overall health. Rediscover joy in your life!" She proposed that, for getting started, we all think about and answer the following five questions:

1) List three people in your life who help you smile or feel positive.
2) List three sensory experiences that bring you joy (sights, sounds, aromas, tastes, textures).
3) List three objects or possessions that are joyful to look at or to hold.
4) List memories of three experiences in your past which fill you with joy.
5) List three images of possible events in the future which are joyful to anticipate.

For continuing stress management, Nancy recommended these techniques: (a) spend time with people who make you laugh (b) clip and post favorite cartoons (c) watch the funny movies/TV shows (d) see things less seriously (e) laugh at your own mistakes (f) share funny stories (g) SMILE! Relaxation techniques (breathing exercises) were also described. Nancy cautioned that during times of stress "the worst thing to do is to stop taking care of yourself." Looking after "me" is not something to be neglected.

Nancy provided various helpful handouts: *Five Minute Stress Breaks; Ten Health Suggestions for Brain Tumor Survivors; ABC's of Coping with Stress.* Also available at the meeting were copies of Nancy's latest booklet, *Brain Tumors and Fatigue* (2005), printed with support from the Brain Science Foundation. Nancy can be reached at 732-922-9686, or email mngioma634@aol.com.

Spring Meeting, 2007

For our April 2007 meeting, we are hopeful that Morristown audiologist Elizabeth W.Cook will be available to present "Options for Better Hearing." "Liz" is chief audiologist, Morris Audiology and Hearing Center, Morristown, NJ. The next issue of the newsletter will provide details.

Notices

▪The Executive Board of ANA/NJ is pleased to report the good news that our association has resumed its affiliation as a local chapter with the national Acoustic Neuroma Association (ANAUSA). We look forward to reestablishing our relationship for the benefit of acoustic neuroma patients, and we hope to participate and assist with the ANA national symposium to be held in the summer of 2007 in Philadelphia.

▪We are happy to announce that Jon Bonesteel (Montclair) is a new member of the ANA/NJ Board of Directors. Jon has been heading ANA support group meetings for north Jersey patients.

Thank You!

The Executive Board, in grateful appreciation, wishes to acknowledge the recent special contributions to ANA/NJ. *Thank you all ~*

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Memorial Gifts
Wilma Ruskin, in memory of Fay Sosnick

Dr. Samuel Selesnick in The Spotlight ~

Dr. Samuel Selesnick does not look to the future to fulfill his plans and dreams. He is living them now. He is engaged in doing what he wants to do and is living very much in the present.

Dr.Selesnick grew up in Flemington, NJ, the youngest of three children. His father was a dentist and his mother was a music teacher. His mother died when he was only eight years old but he grew up with a deep love of music which has continued to be a part of his life. Dr.Selesnick was not pressed to enter medicine, though it was a valued and respected field and there were many medical practitioners in his family. He describes his own decision to enter medicine as being evolutionary rather than a decisive moment. Likewise, his decision to pursue neurotology evolved as he learned more about anatomy and the wide range of issues this field embraced. The value of medicine in his family is demonstrated by the fact that both of Dr. Selesnick's siblings entered the medical profession as did he. His brother became a Family Practitioner and his sister is a dental hygienist.

Dr. Selesnick went to Prep School in Lawrenceville, NJ, where he enjoyed playing hockey and other sports. As an adult he has continued to enjoy sports, to the extent a hectic schedule permits, pursuing tennis and jogging.

Dr. Selesnick chose to go to Wesleyan University feeling that it represented a broader range of thought in addition to his interest in playing ice hockey and the availability of International music there. He plays electric bass (jazz), piano and guitar for pleasure and over the years has sung with a number of choruses including NY Oratorio and the Canby Singers. He especially enjoys singing with smaller groups where his participation makes a real difference.

Dr. Selesnick met his wife Alexandria (Alex) the night before he graduated from New York University School of Medicine. It was an arranged meeting, and they then dated for five years throughout his Cornell Otolaryngology residency at Manhattan Eye, Ear and Throat Hospital. Alex is a visual artist who attended Pratt Institute and later worked in TV. They married in 1990 and have three sons, Joshua age 15, Benjamin 11 and Jordan age 10. Now that the children are older, Dr Selesnick is able to spend an hour or two with them most weekdays**.**

Dr. Selesnick did his Fellowship at the University of California, San Francisco. He said the program was new, energized and felt cutting edge. He was very impressed by the leadership of the program.

Dr Selesnick feels that the qualities that make him a good doctor are his determination and his focus on doing his best. This applies not just to medicine but to everything he does. He finds satisfaction in hands-on patient contact, in surgery, but also in being on committees that address the broader issues which will shape practice in his field. Not surprisingly, dealing with insurance is on his short list of frustrations with his profession.

Dr. Selesnick has served on the Medical Advisory Board of the NY Acoustic Neuroma Association and is currently serving in this capacity for our New Jersey association. He has received various academic and non-academic honors and has given numerous lectures and presentations here and abroad including at the international conferences on Acoustic Neuroma treatment in Paris, France, and Rome, Italy.

Dr. Selesnick likes the fact that his profession allows him the mix of clinical work, research and teaching. Since clinical work consumes the 8am to 4pm hours, his other work extends beyond these times. He devotes his surgical skills to those parts of his profession which are more complex and challenging leaving the routine procedures to others in his field. He says that the removal of acoustic neuromas is, he feels, one of the most challenging surgeries in the whole body due to the anatomy of the area. He does all three AN surgeries and has done hundreds of them. Of the three, he has done more Retrosigmoid and Translabrynth surgeries than Middle Fossa. He considers a number of factors in determining the most appropriate procedure to use, including tumor location, size of tumor, hearing status, age and patient preference. He is more inclined to go with a "wait-and-watch" approach with an older patient. For the most part he still feels that microsurgery would be his recommendation for a younger patient in most cases. He is concerned that pre-treatment patients can be overwhelmed by all of the information now available on the internet and has seen this practically immobilize some of them. Since it is difficult to separate out truth from fiction in this medium, he feels that the abundance of unscreened information can be counter productive.

Dr Selesnick has recently been training on the X-Knife which is a Linac (Linear Accelerator) so that he can provide the full range of options for his patients. Weill Cornell Medical Center has the equipment but it has been used for other procedures until now. It can be used for either single or fractionated treatments. Since NY Presbyterian/Weill Cornell Medical Center (where Dr Selesnick has worked since completing his medical education 15 years ago) is a teaching facility, Dr Selesnick is brought into the classroom setting to share his particular expertise in skull base surgery. Cornell's approach to education has changed since he graduated and students are now involved with patients from the beginning of their medical training**.** A cluster approach is utilized in which students address diagnosis and treatment from the perspective of patients with a range of symptoms. Dr Selesnick feels that although there is no evidence at this point to this being a better approach to learning, he suspects that in the long run it will prove out that doctors come away from their educations with a better ability to apply what they have learned. Dr Selesnick says that doing surgery on a patient's brain for the first time is more exciting than frightening. This is because you build up to it gradually by working with cadavers, observing, and assisting prior to actually doing the surgery.

In addition to treating patients and teaching future doctors, Dr Selesnick is involved with research. He has been the principal investigator on numerous studies including "Regional Spread of Non-Neurogenic Tumors to the Skull Base via the Facial Nerve" and "Cellular Investigations in the Growth Rate of Acoustic Neuromas." A promising area which he anticipates may offer great hope to future practice is the Gene therapy research he is now involved in. It has the potential to protect against hearing loss caused by ototoxicity such as when chemotherapy causes hearing loss. He is hopeful that there will be a practical application for this type of gene therapy as a result of this research.

Dr. Selesnick has a variety of interests and talents in his life beyond medicine but is satisfied with the fact that none of them can compete for his time with the profession he finds both challenging and fulfilling.

Interview by Kristin Ingersoll

“Hybrid”Cochlear Implants

Suppose you are experiencing age-related hearing loss. The sensory hair (nerve) cells in the spiral-shaped cochlea of your inner ear are damaged and no longer work as they should to send electro-chemical signals along the auditory nerve to your brain.

You’ve read that important and promising research on hair cell regeneration is under way – using mice, guinea pigs and zebrafish. But meanwhile, your hearing problem isn’t getting any better. The high frequency sounds needed for good speech discrimination are not being processed effectively. Turning up the volume on your new hearing aid does help somewhat for one-on-one conversations, but in crowded rooms it floods in all sorts of background noise. What to do?

As reported by Lauren Neergaard (AP) in the *Star Ledger* (March 14, 2006), a new “hybrid” cochlear implant – if approved by the FDA – may be the solution for your age-related hearing loss. The hybrid combines a regular hearing aid for amplifying low-frequency sounds handled in the deepest part of the cochlea and a shortened cochlear electrode for high-frequency sounds handled at the entrance. The electrode does not extend far enough into the cochlea to damage the low-frequency sound-processing hair cells. The shortened implant’s function is to substitute at the basal end for lost high-frequency hearing. David Gantz, an otolaryngologist at the University of Iowa, is the inventor of one model of the hybrid currently being tested at a number of medical centers in the USA.

For Audiology Online, Dr. Myles Kessler, Au.D., has written “Cochlear Implant Hybrids: Who Is a Candidate?” He notes that candidacy for the cochlear implant (CI) became less restricted in the USA after 1998 and this stimulated interest among implant manufacturers in the development of the less invasive hybrids, or EAS (Electric-Acoustic Stimulation). The target group was seen to be patients with severe to profound high-frequency hearing loss, i.e., loss above the 1500 Hz level where conventional hearing aids become ineffective. Companies such as Cochlear Corp., Med-El Corp. and Advanced Bionics began working on improved insertion tools, shortened electrode arrays and hearing aid/CI speech processor combinations. Hybrid types incorporating new advances are currently in clinical trials. A group at the University of Michigan is still working on a highly flexible, ribbon-like CI that could simplify the insertion process and help surgeons minimize damage to healthy ear tissue. The device may be available in 4 to 5 years for use in humans.

Dr. Derald Brackmann at the House Ear Clinic in Los Angeles commented favorably on the hybrid approach during an interview for Audiology Online (August 8, 2005): “[The hybrids] are really interesting to me,” he said. “There are probably a million people in the USA that are candidates for hybrids, and these devices appear to solve some of their unique problems. For example, imagine a patient with normal hearing through 1000 Hz, and then a precipitous loss at 1500 Hz and nothing after that, with 38 percent discrimination. . . . [That] might be the ideal patient. We know people with these audiograms will do better with hearing aids than without, but the hearing aids cannot impact the frequency regions in which the person has no measurable acoustic hearing. So for those individuals, the cochlear implant portion of the hybrid could deliver

high frequency sounds, and that could make an enormous difference in their quality of life."

Dr. Brackmann's interviewer then asked: "What about the issue of short versus long electrodes for that same patient? In other words, I think the hybrid devices advocate short electrodes as they only need access to the basal end of the cochlea to deliver high frequency information. . . If you were to implant a short electrode, and then if the patient loses all hearing 7 years later, you'd have to re-insert a longer electrode at that time, and that could risk further damage to the cochlea, which might make the 'traditional' cochlear implant less effective, or am I misunderstanding the argument?"

Dr. Brackmann replied: "No, you've got it, and that's the dilemma. There are good arguments on both sides and no resolution point. The determination of short versus long electrodes, and their use in hybrids and cochlear implants is a topic we need to focus on, but we haven't got enough data to really make a decision at this time. The shorter electrode is currently what is used in the hybrids, but again, this is under review and maybe it'll be resolved soon."

(For the interview, see www.hei.org, the Newsroom. See also recent articles on "Kinds of Implants" in www.healthyhearing.com)

Ototoxic Drugs

ANACanada's newsletter for Spring 2006 calls attention to an article by Orin S. Kaufman, D.O., "Ototoxic Medications: Drugs that Can Cause Hearing Loss and Tinnitus," *Hearing Rehabilitation Quarterly* vol. 22 (1997). The article provides a long list of potential troublemakers, including: Salicylates (aspirin); Anti-Inflammatories (Advil, Alleve, BenGay, Indocin, Motrin, Nuprin); Glucocorticosteroids (Prednisone); Anesthetics (Novacaine); Antibiotics (gentamicin, neomycin); Chemotherapy drugs (cisplatin, carboplatinum); Diuretics (Lasix); and Cardiac medications (lidocaine, Elavil/ amitryptiline). Dr. Kaufman notes that the likelihood that any of the most commonly used medications on the list will cause a hearing or tinnitus problem is extremely small, and problems that may develop are mostly reversible once the medication is discontinued. There is a special caution for neomycin, found in over-the-counter anti-biotic ointments. Dr. Kaufman observes that, "ironically, several drugs found to cause tinnitus are also used to treat tinnitus [e.g., Prednisone, amitryptiline]." He stresses that "the drugs with the greatest potential to cause a hearing loss are usually used only in life-threatening situations." Diuretics such as Lasix, for example, "are usually ototoxic when given intravenously for acute kidney failure." For Dr. Kaufman's complete list and brief comments, see the reprint of his article at the website of the League of Hard of Hearing**,** www.lhh.org/otology/ototoxic**.**

Just recently, a Health Today article in the *Star Ledger,* "Hearing Loss Can Follow Some Drug Treatments" (April 11, 2006) warned especially about two types of ototoxic drugs used for life-threatening conditions: chemotherapy drugs (cisplatin, carboplatinum), prescribed for cancer treatments; and aminoglycoside antibiotics (gentamicin) used for deep-tissue infections. One patient suffered irreversible inner ear damage with severe loss of balance after gentamicin was used to treat an infection that developed following back surgery. In a second case, chemotherapy with cisplatin helped to cure a brain tumor but resulted in severe one-sided hearing loss. The article reports that scientists are trying to find oto-protective agents that will prevent such out-comes. In the meantime, it's recommended that hospitals will need to monitor hearing during treatment and modify drug dosages accordingly.

Association Meeting

" Acoustic Neuroma: Open Discussion of Growth Rates, Diagnosis and Treatment Options"

Dr. Samuel Selesnick

Professor and Chairman
Department of Otorhinolaryngology
NY Presbyterian/Weill Cornell Medical Center

October 22, 2006
1 PM
Morristown Memorial Hospital
Auditorium A, Jefferson Building

Refreshments Social Time

Directions to Morristown Memorial Hospital, 100 Madison Ave, Morristown, NJ

From northeastern NJ – Take Route 80 West to Route 287 South to Exit 35/Madison Ave. Turn left at the light onto Madison Ave. Make a left at the next light to Hospital entrance. (An alternative off the Garden State Pkwy would be Route 280 West to Route 287 South)

From northwestern NJ – Take Route 80 East to Route 287 South , and follow the directions above for Exit 35.

From western NJ or PA – Take Route 78 East to Route 287 North, and follow the directions above for Exit 35.

There is a parking garage near the Hospital main entrance. Discount coupons will be available at the meeting.