



A NICE RESULT

For over two years NICE, the National Institute for Health & Clinical Excellence, has been engaged in a technology appraisal on the cost effectiveness of cochlear implantation as a treatment for severe to profound deafness and on 2nd Sept 2008, NICE published its draft Final Appraisal Determination (FAD). Readers will be aware that the NCIUA has been heavily engaged in the process of contributing to and commenting on the development of this appraisal. In close cooperation other leading organisations including CICS, RNID, National Children's Deaf Society, The Ear Foundation and LINK, the NCIUA believes



that a landmark recommendation has been achieved. In this respect our thanks go to our Chairman Nigel Williams and our Vice Chairman Tricia Kemp (pictured here) who were the only two Expert Patient Witnesses chosen from user groups to personally present the case directly to the Appraisal Committee.

The draft final key FAD recommendations are as follows:

1.
 - Unilateral cochlear implantation for all children and adults
 - Simultaneous bilateral cochlear implantation for the following groups:-
 - Children (12 months to 17 yrs)
 - Adults who are blind or who have other disabilities that increase their reliance on auditory stimuli as a primary sensory mechanism for spatial awareness
 - Sequential bilateral cochlear implantation is not recommended.
 - People who had a unilateral implant before publication of this NICE guidance, and who fall into one of the categories described above, should have the option of an additional contra lateral implant only if this is considered to provide sufficient benefit by the responsible clinician after an informed discussion with the individual person and their carers.
 - Further research into the cost effectiveness of bilateral implants vs. unilateral implants in adults for another review in Feb 2011.

We welcome the NICE recommendation supporting unilateral cochlear implantation for all adults and children and recognise that this is a huge step forward for people who cannot benefit from hearing aids but could be helped by cochlear implants. We now appeal to all Primary Care Trusts (PCTs), who provide the funding, to put an end to the agonising wait experienced by numerous patients where some PCTs flatly refuse to fund any adult implantation at all or at best limit the scale of funding that is necessary to ensure that clinical demand of both adults and children is fully achieved. The battle now to be won is to remove those barriers and the postcode lottery that still exists for unilateral implantation. We will be monitoring this situation to promote NICE's recommendation in this respect and see that it is taken seriously, and avoid offering budget-holders any opportunity to overlook this.

We are particularly glad that in future all children will be given the opportunity of receiving simultaneous bi-lateral implants. This was not one of the earlier provisional conclusions but the combined weight of all the groups

mentioned above who appealed against those conclusions finally won the day.

We are disappointed by NICE's current refusal to back bilateral implants for adults but welcome the recommendation that further research be conducted to examine the benefit of bilateral cochlear implantation compared with unilateral cochlear implantation in adults and that the whole subject should be reviewed again in Feb 2011.

This draft FAD is subject to appeal and it is expected that the Final Appraisal Guidance will be issued before the year end.

The NHS is required to provide funding and resources for treatments that have been recommended by NICE technology appraisals normally within 3 months from the date that NICE publishes the guidance so we should expect the recommendations to be operational by April 2009.

(The full FAD document can be accessed at- www.nice.org.uk/nicemedia/pdf/CochlearImplantsFAD.pdf and a resume of the appraisal can be seen on our website at www.nciua.org.uk/NICE)

RNID OFFER

The RNID is offering half price membership of that organisation to NCIUA members who have a cochlear implant. This £10 offer is also open to implant users of our Regional Groups. Application may be made at www.rnid.org.uk/CIOffer. RNID members receive its One in Seven publication six times a year. This magazine is packed with news, information and letters to help the hard of hearing, deafened and deaf people and promote the cause of access and equality.

MEDIC ALERT OFFER

The Medic Alert Foundation is offering a £5 discount off its membership fee of £20 to all cochlear implant users. Quote the code CISG in applying to www.medicalert.org.uk or by phone to 0800 581420. This is a vital life saving service in which, by wearing an Emblem engraved with one's medical condition(s), medications and next of kin details, the wearer can gain peace of mind knowing that in the event of an emergency, the key data is instantly available to ambulance professionals or other carers at hand.

RESEARCH APPEAL

Tanya Lyons, a final year student of psychology, is looking for help on her dissertation which is about deaf people who have synaesthesia. She is looking for people who have these conditions and would be willing to participate in research into synaesthesia and how the mixing of their senses occurs. Synaesthesia is a condition in which people have an addition to their senses in that they can possibly see colours when they hear/read letters/ numbers/days/months/music, taste shapes or are being touched-these are some of the conditions that exist. There are other combinations of senses that occur in synaesthesia and more information can be found at www.syn.sussex.ac.uk, the site of her supervisor Dr Ward.

"Synaesthesia is not imagined, but a very real experience that actually occurs, and happens as a normal experience for those who have it. Many people who have synaesthesia do not realise that they have it, as they tend to think that everyone experiences the same as they do! It's also not something that people often talk about due to their thinking that it is a normal experience".

Please contact Tanya Lyons - Email: tl22@sussex.ac.uk

BILATERAL VS UNILATERAL COCHLEAR IMPLANTATION FOR CHILDREN: LISTENING SKILLS & QUALITY OF LIFE

Summary of a Presentation by Rosie Lovett, University of York, at the Summer Meeting on 21 June, 2008

"In collaboration with Prof. Quentin Summerfield, we are conducting two studies to compare unilateral and bilateral cochlear implantation for profoundly deaf children. The aim of the two studies is to compare unilaterally-and bilaterally-implanted children in terms of their listening skills and quality of life.

So, what are the potential benefits of providing bilateral cochlear implants? The first potential benefit of bilateral stimulation is an improved ability to localise the position of a source of sound. This could help children to know where and to look to see who is talking and to be safe outdoors. The second potential benefit is an improved perception of speech in background noise, which could help children listen effectively in the classroom and at home. Together, localisation and speech perception in noise are known as spatial listening.

We are measuring whether these benefits are being shown by children who use bilateral implants, and/or by children who use a unilateral implant and an acoustic hearing aid. The first study compared two groups of children: 28 children who use bilateral implants and 19 children who use unilateral implants. These groups are fairly well matched in that they don't differ significantly in terms of their age, their age at diagnosis of hearing impairment, or their age at first implantation. There is also a group of 50 normally-hearing children.

We are measuring the spatial listening skills of these groups. In addition, we are asking the parents of the

implanted children to fill in questionnaires about their child's quality of life. The quality of life measurement is crucial because it forms part of cost-effectiveness calculations which can be used by policy makers such as NICE.

The first test assessed whether a child could discriminate a sound on the left from one on the right. The normal-hearing group scored an average of 92% correct, the bilateral group 80% correct, and the unilateral group 58% correct. A 50% score is one of chance or guesswork. So what's the take-home message from this test? Whilst bilaterally-implanted children, on average, performed significantly better than unilaterally-implanted children, there was a large spread of scores. Also, neither group of implanted children performed as well as children with normal hearing.

The second test assessed whether children could track a moving source of sound. The normal-hearing group scored an average of 95% correct, the bilateral group 58% correct, and the unilateral group 24% correct. On average the bilaterally-implanted children performed significantly better than the unilaterally-implanted children. Again there was a



BILATERAL VS UNILATERAL COCHLEAR IMPLANTATION FOR CHILDREN: LISTENING SKILLS & QUALITY OF LIFE cont'd

spread of individual scores. Thus, bilateral implants do not guarantee good performance.

The third test measured speech perception in noise. We measured the maximum amount of noise that the child could tolerate, whilst still understanding the speech.

Normal-hearing children performed better with noise from the side than with noise from the front, an effect known as spatial release from masking. Both groups of implanted children showed spatial release from masking when noise was shifted to the side of the child's second device. This is because the child's head shields their first or only implant from some of the noise. Bilaterally-implanted children also showed spatial release from masking when noise was shifted to the side of their first device. Unilaterally-implanted children did not. We conclude that the bilaterally-implanted group should be able to perform better in a range of noisy situations than the unilaterally-implanted group.

The conclusions from the listening tests are shown in Figure 1.

Listening skills summary

- On average, bilaterally implanted children perform better than unilaterally implanted children on tests of:
 - Left-right discrimination
 - Movement tracking
 - Spatial release from masking
- Overlap between groups – no guarantee of good performance

Figure 1

On questionnaires, the parents rated their child's quality of life using the Health Utilities Index and visual analogue scales. There was no statistically significant difference between parental ratings of the quality of life of bilaterally-and unilaterally-implanted children.

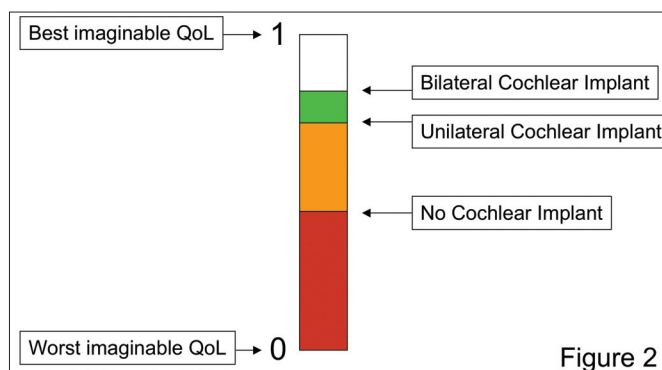
To summarise, the listening data reveal a benefit of bilateral implantation in terms of listening skills. However, according to the parents of these children, those listening skills don't or haven't yet translated into improved quality of life.

Why is there this apparent mismatch? There are two possible reasons. The first is that it takes longer for higher-order benefits to emerge, so it might be that we will see improvements in quality of life further down the line. The second possibility is that it is difficult for parents to rate the quality of life of their own children. This could be because they don't know other implanted children with whom to compare their child. Another possible reason is that

there is a very natural and proper inclination for parents to try and maximise the quality of life of their own child. Therefore, they provide rather high ratings. So in that sense, maybe it is not fair to ask parents to make this judgement.

In the second study, we asked people who are not the parents of implanted children to make judgments about the quality of life of bilaterally-and unilaterally-implanted children. This study was conducted by Georgina Batten and Hannah Bellenger. The study posed 4 descriptions of a hypothetical profoundly-deaf child. In the first description the child does not use a cochlear implant; in the second the child benefits from a single cochlear implant; in the third the child benefits from an implant and a contralateral acoustic hearing aid; and in the fourth the child benefits from bilateral cochlear implants. We asked our informants to rate the quality of life of the child in these four scenarios.

The results show that, on a quality of life scale from 0 to 1, the difference between bilateral implants and the next best alternative of an implant and a hearing aid is 0.06 (Figure 2). NICE have published estimates of the cost of bilateral implantation for children. If you use those estimates and 0.06 as the incremental gain in quality of life, then bilateral implantation for children emerges as a cost-effective health-care intervention.



So, what have the two studies shown? In our sample, the bilaterally-implanted children have, on average, better spatial listening skills than the unilaterally-implanted children. Parental questionnaires do not reveal a quality of life benefit of bilateral implantation, but if you contact other groups, then we do see a benefit in quality of life resulting from bilateral implantation.

I wish to thank Deafness UK and Advanced Bionics who sponsored the research. I would also like to thank Tricia Kemp and the Cochlear Implanted Children Support Group (CICS), the NHS cochlear implant programmes who contributed, and all the parents and children who took part in the studies."

MUSIC APPRECIATION & COCHLEAR IMPLANTS

Summary of presentation by Mary Grasmeder, Audiological Scientist, South of England Cochlear Implant Centre (SOECIC), Southampton, given at the Summer Meeting on 21 June, 2008

"Music is a very complicated sound; in fact it is not just one sound. When you are listening to music you are listening to lots of sounds all at the same time. Someone with normal hearing can pick up very, very tiny differences in notes. Not only are they able to hear lots and lots of different notes, but they can also tell if notes are not being played properly, if there is something wrong, if something sounds out of tune. Someone with normal hearing can also recognise a whole range of different musical instruments. Even instruments that sound very similar. They can recognise different chords, they can tell, for example, whether something is being played as if it sounds a bit sad, in a minor key, or if it sounds happy in a major key. And they can do all of these things at the same time.

There are a few technical difficulties when you try to listen to music with a cochlear implant. It's a difficult challenge that we pose ourselves. Cochlear implants normally stimulate only one or possibly 2 electrodes at any one time. And because of this, the information which is transmitted has got to be limited. And until recently, most of the processing strategies that we use eliminated some of the important information that you need to hear music well. A lot of the temporal fine structure of music is not processed. So because this information has been missing, people have often found it difficult to pick up small differences in notes. Recently the manufacturers have been trying to introduce temporal fine structure into the implants, and this is an ongoing process.

Recently in Southampton, we started offering interested patients an opportunity to look at how they are listening to music with their cochlear implants, which involves going through assessments and getting some feedback on how they are doing on various aspects of music. Also how they are listening to music, what kind of music they are listening to, and giving them some tips really about what is good and what is bad about listening to music with a cochlear implant. I am trying to move on from this and put together a package so that people can try it at home. This is only in its early stages but I would like to try it out on you today."

Mary then gave an interesting, thoroughly absorbing, and entertaining live demonstration of musical notes, chords, instruments, classical music, nursery rhymes, a whole panoply of music as she tested the audience's reactions and responses. Everyone was given a bleeper to signal their scores and answers to a range of questions that were posed as Mary developed and demonstrated a series of

Music Tips as follows.

- Start with music that you know well. Your memory of the music will help you to fill in any gaps in what you hear.
- Simple music is easier to hear with a cochlear implant than very complicated music. Some people start with nursery rhymes or simple folk songs, before trying more complex things. There has been a tendency for music to become more complicated over the years, both for classical and pop music. Sometimes older music is easier to listen to than modern music.
- Cochlear implants often process rhythms better than melodies. Try listening to music that includes one or more of the following:
 - .1 A simple rhythm e.g. Christmas carols such as 'O little town of Bethlehem'.
 - .2 A repetitive or predictable rhythm. Songs with choruses are often like this.
 - .3 A strong beat. Try music that you can dance to.
- Listening to one or two instruments is easier than listening to lots of instruments at the same time, even if they are playing the same tune.
- Music can be part of a social activity. Taking part with other people can make listening more fun. Try dancing for example.
- Some instruments are easier to identify than others. Broadly speaking, percussion instruments come across well (drums and piano); string instruments, especially if they are plucked, are fairly good; wind instruments can be difficult to identify.
- Some detailed low frequency information can be picked up using hearing aids. If you have some residual hearing and have a hearing aid for your other ear, try using it when listening to music.
- Background noise gets in the way! In the context of music, backing music or accompaniment can be intrusive and reduce the extent to which you can pick up the tune. Try to choose music where the accompaniment is light.
- It's easier to listen to 2 instruments that are very different than 2 instruments that are very similar. For example, listening to a trumpet and drum playing together is easier than listening to a trumpet and trombone playing together.
- Think about the place where you are when listening to music. A quiet concert hall is better than an echoing cathedral; a quiet living room is better than a noisy car.



MUSIC APPRECIATION cont'd

- If the volume of the music is very quiet, you may miss some sounds. If the volume of the music is very loud, you may not be able to hear the sounds very clearly and they might all be at the same level.
- A direct connection into your processor can help to improve the quality of the signal. Use a direct input lead if you have one available.
- A song can be easier to pick up than an instrumental piece, as the words can help you to follow the music.
- Being able to see the person who is performing will help you to hear the music. If they are singing, you will be able to lip-read them. If they are playing, the movements they make will help you to make sense of the music. Try DVDs rather than CDs or watch a live performance. Alternatively follow the words or the music to help you keep up.
- Practise makes perfect! This very much applies to listening to music with your cochlear implant. The sound will improve and become more meaningful the more you try.

In conclusion Mary thanked the audience for their contribution to the development of this project and said that the package would be put up on SOECIC's website in due course. She reviewed all the above Music Tips (see Figures 1 & 2)



UNIVERSITY OF
Southampton
Institute of Sound and
Vibration Research

Music Checklist (1)

- What kind of music are you listening to?
 - Music you know well
 - Not too complicated
 - Strong beat or simple or repetitive rhythm
 - Instruments you can identify
 - Light accompaniment
 - Volume not too soft or loud



UNIVERSITY OF
Southampton
Institute of Sound and
Vibration Research

Music Checklist (2)

- How are you listening?
 - Watch the singer or player or follow the words or music
 - Use a direct connection to your implant or use a loop system
 - Use a hearing aid as well if this helps you
 - Listen in a quiet room
 - Dance or share the music with someone else
 - Increase your microphone sensitivity if necessary
 - Practise makes perfect!

UNDERWATER FUN

I was implanted in 2001, at Southmead Hospital in Bristol. This turned out to be one of the best things I've ever done, as it improved my confidence no end.



During my first year at Cornwall University, I picked up a deaf magazine where I saw an article about Worldwide Dive and Sail (WWDAS). In it, I read that their instructor, Naomi Hayim, worked there. Naomi is a graduate of marine and freshwater biology and although deaf, speaks, lip-reads and signs and provides a one to one, unique service to deaf and hard of hearing people who want to dive. I'd always been interested in the underwater world for as long as I could remember, but after my implant, I'd always assumed that learning to dive would never be an option. On seeing the article, I thought I had nothing to lose by sending an email. Several emails later, I booked myself on a trip to Thailand! The cochlear implant means I can't go below 30 metres, but as this is the limit for most recreational diving, I wasn't missing out on anything.

So in 2005, I set out for Thailand and met Naomi for the first time and the rest of the WWDAS crew. Straight away I found that there were no barriers and this put me at ease instantly. There was a mix of deaf and hearing people on the boat, and this was never a problem and the crew were also deaf aware. With that first stride into the water, I was completely hooked. There was no going back now! A whole new world opened up to me, one where everyone was all equal, regardless of their disabilities. I loved the sensation of floating underwater. Beautiful sights included massive colourful coral, and fish both big and small, as well as the environment around me. By the time I returned to the UK, I was already planning my next trip!

I have now teamed up with Naomi and another devotee of WWDAS, Shirley, to help promote trips for D/deaf and HOH people. I want to encourage other implant users that there is a whole other world waiting to be explored. There is nothing to hold you back. We are all firm believers in making diving trips accessible for everyone and breaking down the barriers. Taking the plunge on that first trip realised a lifelong dream and subsequently changed my life, now I want to help someone else realise their dream.

We are branching out for our next trip, taking the luxurious boat Sampai Jumpa Lagi out to Indonesia. This time, we will dive in the beautiful Komodo and Sunta Islands, scheduled for September 2009. We are already taking bookings! Take a look on the website at www.worldwidediveandsail.com for more details and drop us an email to deniece@worldwidediveandsail.com

Deniece Wheatley.....Having Fun!

MANUFACTURER QUESTIONS & ANSWERS

This is a continuation of the session at the Summer meeting when a series of member questions were put to the manufacturers. This will be continued in further editions.

Advanced Bionics UK: Responded by Yvonne James

From Carole Burleigh:

I have started to experience immense discomfort from implant/processor when outside in windy weather. The noise is mechanical, a loud whirring, and I can only describe it as being "hooked up to a washing machine!" Apart from being uncomfortable and extremely irritating, it makes conversation extremely difficult. Does anyone else have this problem and can anything be done to eliminate it? Could this be another problem caused by the faulty electrodes?

Yvonne: From the description this sounds exactly like wind noise which unfortunately you are perceiving as an extremely unpleasant sound. Some users do comment on difficulty in hearing on windy days, and it may be helped by use of the T-Mic or changing the position of the T-Mic. Please contact your centre to see if anything can be done with your program. Your problems are only associated with being outside in windy weather, so I would not expect this to be associated with the faulty electrodes.

From Tim Barlow:

Are there any accessories that can help me listen to CDs of actors reading poetry? Are there accessories to help me hear speakers at meetings?

Yvonne: You should try using the Direct Connect earhook, which will plug directly into the CD player, although this is not recommended if the CD is directly connected to the mains circuit. For that you will need an isolating transformer for complete electrical safety. FM systems or using the Lapel microphone may be useful, depending on the type of meetings you are attending. I would suggest you contact your local centre and speak to the Hearing Therapist (if one is available), or whoever helps with your rehabilitation to explore these solutions.

Cochlear Europe Ltd: Responded by Clare Sheridan

From Mary Collins:

Is there any room in the massive advance in technology since 1993 when I had my implant (Nucleus 22) of which I could take advantage. As a music lover I have had to accept so far that my implant cannot be replaced/adapted to allow any enjoyment of music now. Is there anything I can do e.g. bilateral implantation, to rediscover that which has been lost.

Clare: Different people have different experiences of music with their cochlear implant and there are a range of factors which influence how they enjoy music including biological, environmental and lifestyle issues. As clinical understanding of music perception with a cochlear implant improves there are recognised strategies that can help people with their appreciation of music.

One of the most important aspects of enjoying music is to give yourself realistic expectations and also plenty of time to experience music. Music will probably not sound the same as you remember it but persistence, patience and keeping positive can go a long way to improving your overall enjoyment of music. If you can wear a hearing aid in your other ear this may well help and your audiologist may be able to give you different CI MAPs to try; different people find that different coding strategies can help. Your CI team can call our clinical helpline or speak to their Clinical Specialist at Cochlear if they would like to discuss this. You should start off listening to familiar music with a simple melody and stay away from complex orchestrated pieces at least initially. Try to listen to music played on a single instrument and listen to a range of instruments to find out which sounds the best to you, then listen to familiar pieces played on that instrument again and again. Try to describe the differences in the sounds of different instruments. You may also find that some styles of music sound better than others so try listening to a range of different types of music - country, pop, rock, folk etc. Your listening practice should be broken into short but frequent sessions. Begin by selecting music with a strong rhythm and beat, keep the volume at a moderate level and try direct input e.g. use the TV/ Hi Fi cable. If you are listening through your processor microphone then make sure you're in quite room with carpets and curtains to avoid echo or try using headphones that cover the whole of the microphone of your processor. When listening to songs start by listening to music with limited accompaniment; reading along with the lyrics can help. When thinking of music we tend to focus on listening only, however, being able to see the musician or singer can help too so try to watch DVDs of musicians and singers performing. Above all give yourself time and frequent short listening opportunities. Don't be put off trying again, even if you have had previous unsatisfactory experiences of listening to music - go on, have another go!

MANUFACTURERS QUESTIONS & ANSWERS cont'd

Cochlear Europe Ltd: Responded by Gaynor Booth

From Colin Taylor:

Why is it very difficult (impossible) to transfer the map from the Esprit to the Freedom processor?

Gaynor: Cochlear has developed and implemented a sophisticated software tool called Custom Sound which easily allows the conversion of an ESprit Map to a Freedom processor. In the rare event of a clinic or clinician experiencing difficulty with a conversion, they should contact a member of the Cochlear Clinical-Technical Team who would be more than happy to provide advice or further assistance as required.

MED-EL UK: Responded by Fiona Kukiewicz

From Lisa Midgeley:

Q1. Are there any developments to produce a splash proof or water proof implant? One that could be worn in the bath?

Fiona: To minimise the effects of day to day moisture exposure (the most common of which is generally perspiration) on electronic components, the circuit boards used in MED-EL speech processors are uniquely coated to effectively shield the electronic components. Additionally, MED-EL employs connectors that are treated with specially developed water repellent lubricants. As part of our continuous improvement process for external equipment we have improved the moisture resistance of our speech processors and feel this is reflected in the very small proportion of repairs we receive every month (less than 0.4% of processors in circulation).

Developing a truly waterproof processor (i.e. one that could be worn in the bath or submerged) presents a number of technical challenges. Some processor batteries require air to function, and a water/air-tight seal would not be possible. Current speech processors have to be able to be disassembled - to change the batteries, or connecting leads etc. Making the necessary joints watertight is difficult, but ensuring that these will remain watertight after repeated use over the years is even more challenging. Additionally, making the processor watertight might allow in water vapour (e.g. from perspiration), which could result in condensation within the electronics, which then can't escape due to the waterproofing. On balance MED-EL believes that the approach of making the processor water and moisture resistant, but not actually 'waterproof' brings the best combination of usability and reliability for patients, with the current technology available. However research and development is always ongoing, and should future advances make waterproofing more viable, this will certainly be considered.

Q2. My son (aged 23 months) has bilateral cochlear implants. Are there any plans to manufacture one battery pack to power both implants?

Fiona: MED-EL doesn't currently provide a battery pack to power bilateral implants and your suggestion has been fed back to our product development team. MED-EL's latest development in battery packs is to provide the DA CAPO, an ear level rechargeable option for the TEMPO+ and OPUS 2. This has some advantages, including a 20% reduction in speech processor weight; this may mean that small children can transition to totally ear level systems even earlier. Your CI centre will be able to show you a DA CAPO system.

Q3. It would be really useful to have both the short and long leads come in different lengths. The short lead on my son's head loops a lot between the coil and processor, making it very easy for little fingers to catch it and pull it off. Also because he is cruising around the furniture and the walls if he presses the short lead against something it causes the coil to come away.

Fiona: The MED-EL coil cable is available in the following lengths 9.5cm; 12cm; 28cm. The paediatric battery pack is available with either a short lead (12cm) or a long lead (27cm). It may be helpful for your CI team to reassess the coil strength to ensure that it is optimal.

UGANDA'S FIRST IMPLANT

In a unique set up, Dr Rowland of the New York CI centre operated on a 23 year old young man in Uganda, watched by a team of local doctors, and then later the switch on was monitored by an audiologist in New York over the Internet!

NEW CHIEF EXECUTIVE FOR THE EAR FOUNDATION

Sue Archbold will be CEO effective 1 November 2008 on the retirement of Brian Archbold this autumn.

DIARY DATES

20 November 2008

November Forum

The Ear Foundation

Nottingham

OCIS SURPRISE PARTY



Andrew with Marni Roff, a CI user

The Oxford Cochlear Implant Support group (OCIS) held a special Summer Party at Brill, Oxfordshire on 20 July to celebrate the retirement of Mr Andrew Freeland, FRCS from the Oxford CI Team this autumn. Over a hundred CI users, parents and families gathered to pay tribute to Mr Freeland and express their grateful thanks for all his work at Oxford since the CI team was formed in 1994.

Brilliantly organised by Jenny Lewis, OCIS leader, and Jane Jones, CI Coordinator, the event was a complete surprise to Andrew who thought he was attending the normal summer party gathering.



Andrew with Jenny Lewis

To the acclaim of OCIS members, Jenny presented Andrew with an engraved whisky decanter as a memento of the close relationship which he had built up with all his patients and the CI team. Andrew said he was deeply touched by the presentation and everyone's warm thanks and that he very much appreciated the tributes and the occasion.

The new CI surgeon will be James Ramsden who was trained as a Specialist Registrar at Oxford. He is currently working at The Sick Children's Hospital, Toronto, Canada.

1000th CELEBRATION PARTY

On 5th July, at the famous Manchester United football ground, the Manchester Royal Infirmary Cochlear Implant Centre team held a party for all their implant users to celebrate their 1000th patient since the unit started.



Professor Richard Ramsden, who started the programme in 1988, said: "I am delighted to be part of this exciting achievement by my team and in being the first hospital in the country to reach this milestone".

Talisha Buckley-Walsh, aged two - known as Tilly (pictured here with her Mum), was the star guest at the party. She did not speak or respond to her parents until she had the operation. Now she can hear and as her delighted mum says, she just loves to talk and has been transformed into a little chatterbox!

Mum, Chinade Buckley, 21, said: "Tilly had hearing tests after she was born so we knew she was partially deaf in at least one ear but it was only when she was a year old that we realised she was completely deaf. Her dad realised she didn't react to him clapping right next to her face unless she was looking directly at him. Having the implant so young means she will be able to catch up with other children, go to mainstream school and live a totally normal life. The hospital staff have been amazing. They have transformed all our lives."

National Cochlear Implant Users Association

President: The Rt. Hon Lord Ashley of Stoke, CH PC

***Chairman** Nigel Williams
E-mail: chair@nciua.org.uk

***Vice Chairman** Tricia Kemp
E-Mail: vice.chair@nciua.org.uk

***Treasurer** Paul Tomlinson
E-mail: treasurer@nciua.org.uk
Fax: 01305 262591

***Secretary** Dr Ray Glover
The Vicarage, 70 Sycamore Road,
Amersham, Bucks HP6 5DR
E-Mail: secretary@nciua.org.uk

***Editor** Richard Byrnes
E-mail: editor@nciua.org.uk

***Committee Members** Jenny Burdge, Alison Heath, John Hirst,
David Williamson

Disclaimer

Whilst the Association uses its best endeavours to provide accurate information on the subject of cochlear implants it does not provide medical advice or make recommendations with regard to any particular implant or equipment and no article in this newsletter should be construed as doing so.



We gratefully acknowledge the support of the TouchPaper Company of South Wales in printing this edition of our Newsletter.

Registered address:
NCIUA, 70 Sycamore Road, Buckinghamshire HP6 5DR
Registered Charity No.1073222
Web Site: www.nciua.org.uk Email: enquiries@nciua.org.uk