NHS
The Leeds Teaching Hospitals
NHS Trust

Surgery for an Acoustic Neuroma

Information for patients

This leaflet aims to explain what will happen before and after your surgery for an Acoustic Neuroma. Please also see the general surgical information in the leaflet 'Acoustic Neuroma'. There are two surgical approaches. The first is called a translabyrinthine approach, this involves accessing the tumour by making an incision in the scalp behind the ear and removing the bone and hearing apparatus in order to gain access to the acoustic neuroma. The second is called a retrosigmoid approach, this involves making an opening in the skull called a craniotomy to gain access the acoustic neuroma. The skull is replaced and secured at the end of surgery.

Pre-assessment

Before your operation you will receive a pre-assessment appointment. The team will take your personal details, medical history and make sure you have had the right tests performed before your operation. These include blood tests and routine MRSA swabs, you may also require an ECG (a heart tracing).

The day of the operation

You will be sent a letter with the details of your surgical admission which will include what to bring into hospital with you and fasting instructions. You need to wear a gown and surgical stockings (to prevent blood clots in the leg) which the ward will give you. You will be seen by an anaesthetist and your surgeon who will obtain your consent for the operation.

After surgery

You will wake up in the theatre recovery room. When ready, you will be transferred to a critical care ward; this will be the Neurosurgical High Dependency Unit (NHDU) or Neurosurgical Intensive Care Unit (NICU) for close monitoring.

You will stay there until you are well enough to be transferred to the Neurosurgical ward which will usually be after one day.

Other surgical considerations (translabyrinthine approach only)

1. Using fat in wound closure

Fat is usually taken from your thigh in order to pack closed the wound behind your ear. This means you will have a wound on your thigh which may initially feel tender.

2. Lumbar drain insertion

A lumbar drain is a soft, thin tube which is inserted into your lower back once you are under anaesthetic, this allows drainage of CSF (cerebro-spinal fluid). This decreases the risk of a CSF leak while the wound is healing. Please see CSF leak section for further information.

Potential issues following surgery

There are issues which can affect patients following surgery and these are covered below. Remember not all these may apply to you and can depend on the size of the tumour you have had removed.

Hearing and Tinnitus

As a result of the surgery you will completely lose your hearing in the affected ear. Some patients will continue to suffer with tinnitus even if all their hearing is lost.

Balance

Dizziness, vertigo and nausea are common feelings after this surgery. Usually these symptoms settle down as the brain adjusts. For a few days movement of the head may cause nausea and sickness, medication can be given to improve these symptoms.

If there are issues with your balance the physiotherapy team will work with you while you are in hospital and arrange outpatient follow up as required after discharge.

Headaches

Headaches immediately after surgery are common but when you leave hospital these should have started to reduce if they have not disappeared completely. Some people do suffer with nagging headaches after surgery and simple painkillers can help. If you have headaches even with painkillers, if the light hurts your eyes, if you have a stiff neck or if you are vomiting with headaches then please seek medical attention.

CSF Leak

CSF is fluid that circulates around the brain and bathes the brain. In an operation on the brain and the inner ear this fluid can leak from the brain into the middle ear. The Eustachian tube connects the ear and nose. CSF can therefore leak from the brain to the back of the nose.

While the fluid leaking is not a major issue as it is continually being made, infection can spread up to the brain from this open passage and could cause meningitis (infection around the brain). It is very important to tell your doctor if you have any fluid leaking from the nose. A CSF leak requires medical management. This is more likely to happen when straining such as lifting heavy objects or while straining on the toilet.

Facial weakness

The facial nerve is responsible for movement of the muscles of the face.

After surgery you may have one or more of the following:

- some facial weakness
- your eyelid may not close all the way
- the wrong movement of some muscles of your face
- a dry eye or too many tears
- a change in your sense of taste

This is because the facial nerve lies alongside the vestibular nerve and so is manipulated during surgery. As you recover from the surgery any symptoms should slowly improve, although this can sometimes take many months and sometimes these changes can be permanent.

The physiotherapist/speech and language therapist will give you some initial advice about management of facial weakness and refer you on for outpatient follow up as required.

Facial weakness can occur up to a few weeks after surgery so it can happen after you go home.

It can take a long time for the facial nerve to begin to work so please be patient. Improvement can continue for up to two years.

Eye care

If you have facial weakness after your surgery you may have difficulty closing your eye.

Depending on the amount of difficulty you have, you might need to see the eye specialist before being discharged home. Even if you don't see the eye specialist after your operation, it is very important that you take great care of your affected eye. If your eye does not close properly it is at increased risk of injury and infection. It might also become dry as tears may not be produced. If needed, we will prescribe eye drops and eye ointment for you to take home and you should use these to keep the eye moist:

Eye drops should be used to keep the eye moist during the day and before bed.

Eye Ointment should be used at night. It can be used during the day, but it can blur vision. Put the ointment in after the drops otherwise the drops wash the ointment out!

If the eye does not close properly it may be necessary to cover with an eye patch or tape it closed at night.

If your eye becomes red, sore or irritable then ask early advice from your GP or ophthalmologist as this could be the start of an eye infection, and it may need to be treated.

Double vision

There is a risk of double vision in surgery for very large tumours. This is because two of the nerves which control the muscles for eye movement can be affected at the time of surgery. Rarely are these nerves irreversibly damaged and full recovery is expected by 12 - 18 months. Prism lenses in glasses can be used to help this problem.

Altered taste and dry mouth

Some patients find that after surgery they have a strange taste and a dry mouth. This is because part of the facial nerve controls the sensation of taste. This should improve if the facial nerve is working at the end of the operation.

Swallowing

The nerve controlling swallowing also lies close to the acoustic nerve and can be affected but this is rare. This will mean that the ability to swallow may be difficult for a few days after the operation. Until the swallowing reflex returns you may need to be fed through a tube from the nose to the stomach, to avoid food or liquids going the wrong way and into the lungs.

Fatigue

Feeling particularly tired after your surgery is quite usual as you have had major surgery. Towards the end of your hospital stay you may feel less tired however once you return home, you may find that you become tired again. This is usual as there is more to do at home. You may find it useful to have a

rest in the afternoon until your energy returns. Try to avoid sleeping for longer than 30-45 minutes as it may disturb your sleep at night.

It is very important that you do not do too much when you get home. A slow, gradual increase in your activity level will help you to recover and will avoid the side-effects of immobility. If there is a particular event or activity that you want to do, and you feel able to, then try. Where possible try to plan and pace activities, taking regular breaks to avoid becoming exhausted. If you become tired then stop, and if you are exhausted the next day then rest and recuperate.

The length of recovery from fatigue is variable and is based on your individual circumstances.

Advice and support can be obtained within the occupational therapy service should you continue to have issues with this.

You may have sex when you feel able to do so.

Going home

You will be able to go home as soon as your doctors, nurses and therapists are happy with your progress; this will usually be about seven days after surgery. Your wound/s will be checked to make sure there are no signs of leakage or infection. If you have had a translabyrinthine surgical approach you will most likely have a wound on your thigh where some fat will have been taken in order to close the wound behind your ear.

Informing your GP

The ward will send a typed letter that summarises your stay in hospital. This will inform your GP of the details of your surgery

and any tablets, drops or ointments that we have prescribed for you. You do not need to make an appointment to see your GP unless they have specifically asked you to do so or you have any problems.

Out-patient follow-up

You will be followed up in the acoustic neuroma Clinic approximately 2 months after you go home. This appointment will be sent to you in the post.

Returning to work

It is usual for people to remain off work for 2-3 months following this surgery. It can take a long time to build up your energy levels. Do not be tempted to go back to work early as this is likely to cause you to become very tired very quickly. If you have a job that you can go back to work on a part-time basis, then take this opportunity and gradually build up to your previous hours. Only you will really know when you feel able to go back to work.

Flying

Travelling by aeroplane is best avoided for about six weeks after acoustic neuroma surgery.

Driving

It is advised you inform the DVLA that you have had surgery. The DVLA's advice is that you do not return to driving until fully recovered from the surgery. The main thing to be aware of is your co-ordination.

This varies enormously between patients and depends on your ability to perform an emergency stop, being able to glance in

your mirrors and being able to look from right to left without feeling sick and dizzy. Once you feel able to do these, you can start driving again. Begin by driving in daylight on simple routes that you know well. Occasionally patients with large tumours may have other complications causing an epileptic fit. If this happens you must not drive and you must tell the DVLA.

Meet the team

- **Mr Sanjay Verma** - Consultant ENT Surgeon
- **Mr Kenan Deniz** - Consultant Neurosurgeon
- **Mr Nick Phillips** - Consultant Neurosurgeon and Gamma Knife Specialist
- **Ms Mariam Iqbal** - Multi-Disciplinary Team (MDT) Coordinator.

Tel: **0113 392 2183**

Contact for administrative inquiries including referrals and appointments.

Contact numbers and visiting information

Ward L26

Phone Number: **0113 392 7426**

Admissions Unit. No visiting. Old Site, LGI.

Ward L24

Phone Number: **0113 392 7424**

G Floor Jubilee Wing, LGI.

Ward L25

Phone Number: **0113 392 7425**

G Floor, Jubilee Wing LGI.

Ward L02

Phone Number: **0113 392 7402**

High Dependency Unit, C Floor, Jubilee Wing LGI.

Ward L03

Phone Number: **0113 392 7403**

Intensive Care Unit, C Floor, Jubilee Wing LGI.

Please contact the wards directly for details of their visiting hours.

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