Reclaiming Self-Esteem

Emotional recovery after stroke takes time and effort.
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After surviving a stroke, some of the toughest challenges are the ones you can’t see.

If you’ve had a stroke, you may be facing a major risk of having another. You may also be at increased risk for having a heart attack.

**PLAVIX** is the only prescription antiplatelet medicine that helps protect against both. Recovering from a stroke can be difficult and you’ve worked hard to make progress. If you’ve recently had a stroke, you should know PLAVIX can help protect against another stroke or even a heart attack. PLAVIX may be right for you. Be sure to talk to your doctor to find out.

**IMPORTANT INFORMATION:** If you have a stomach ulcer or other condition that causes bleeding, you should not use PLAVIX. When taking PLAVIX alone or with some other medicines including aspirin, the risk of bleeding may increase, so tell your doctor before planning surgery. And, always talk to your doctor before taking aspirin or other medicines with PLAVIX, especially if you’ve had a stroke. If you develop fever, unexplained weakness or confusion, tell your doctor promptly as these may be signs of a rare but potentially life-threatening condition called TTP, which has been reported rarely, sometimes in less than 2 weeks after starting therapy. Other rare but serious side effects may occur.

You are encouraged to report negative side effects of prescription drugs to the FDA. Visit www.fda.gov/medwatch, or call 1-800-FDA-1088.

PLAVIX offers protection. PLAVIX is proven to help keep blood platelets from sticking together and forming clots, which helps keep your blood flowing. Since clots are the leading cause of strokes and heart attacks, PLAVIX helps you stay protected.

Talk to your doctor about PLAVIX. For more information, visit www.plavix.com or call 1-800-905-1921.

Please see important product information for PLAVIX on the following page.
WHO IS PLAVIX FOR?
PLAVIX is a prescription-only medicine that helps keep blood platelets from sticking together and forming clots.

PLAVIX is for patients who have:
• had a recent heart attack.
• had a recent stroke.
• poor circulation in their legs (Peripheral Artery Disease).

PLAVIX in combination with aspirin is for patients hospitalized with:
• heart-related chest pain (unstable angina).
• heart attack.

Doctors may refer to these conditions as ACS (Acute Coronary Syndrome).

Clots can become dangerous when they form inside your arteries. These clots form when blood platelets stick together, forming a blockage within your arteries, restricting blood flow to your heart or brain, causing a heart attack or stroke.

WHO SHOULD NOT TAKE PLAVIX?
You should NOT take PLAVIX if you:
• are allergic to clopidogrel (the active ingredient in PLAVIX).
• have a stomach ulcer
• have another condition that causes bleeding.
• are pregnant or may become pregnant.
• are breast feeding.

WHAT SHOULD I TELL MY DOCTOR BEFORE TAKING PLAVIX?
Before taking PLAVIX, tell your doctor if you’re pregnant or are breast feeding or have any of the following:
• gastrointestinal ulcer
• stomach ulcer(s)
• liver problems
• kidney problems
• a history of bleeding conditions

WHAT IMPORTANT INFORMATION SHOULD I KNOW ABOUT PLAVIX?
TTP: A very serious blood condition called TTP (Thrombotic Thrombocytopenic Purpura) has been rarely reported in people taking PLAVIX. TTP is a potentially life-threatening condition that involves low blood platelet and red blood cell levels, and requires urgent referral to a specialist for prompt treatment once a diagnosis is suspected. Warning signs of TTP may include fever, unexplained confusion or weakness (due to a low blood count, what doctors call anemia). To make an accurate diagnosis, your doctor will need to order blood tests. TTP has been reported rarely, sometimes in less than 2 weeks after starting therapy.

Gastrointestinal Bleeding: There is a potential risk of gastrointestinal (stomach and intestine) bleeding when taking PLAVIX. PLAVIX should be used with caution in patients who have lesions that may bleed (such as ulcers), along with patients who take drugs that cause such lesions.

Bleeding: You may bleed more easily and it may take you longer than usual to stop bleeding when you take PLAVIX alone or in combination with aspirin. Report any unusual bleeding to your doctor.

Geriatrics: When taking aspirin with PLAVIX the risk of serious bleeding increases with age in patients 65 and over.

Stroke Patients: If you have had a recent TIA (also known as a mini-stroke) or stroke taking aspirin with PLAVIX has not been shown to be more effective than taking PLAVIX alone, but taking aspirin with PLAVIX has been shown to increase the risk of bleeding compared to taking PLAVIX alone.

Surgery: Inform doctors and dentists well in advance of any surgery that you are taking PLAVIX so they can help you decide whether or not to discontinue your PLAVIX treatment prior to surgery.

WHAT SHOULD I KNOW ABOUT TAKING OTHER MEDICINES WITH PLAVIX?
You should only take aspirin with PLAVIX when directed to do so by your doctor. Certain other medicines should not be taken with PLAVIX. Be sure to tell your doctor about all of your current medications, especially if you are taking the following:
• aspirin
• nonsteroidal anti-inflammatory drugs (NSAIDs)
• warfarin
• heparin

Be sure to tell your doctor if you are taking PLAVIX before starting any new medication.

WHAT ARE THE COMMON SIDE EFFECTS OF PLAVIX?
The most common side effects of PLAVIX include gastrointestinal events (bleeding, abdominal pain, indigestion, diarrhea, and nausea) and rash. This is not a complete list of side effects associated with PLAVIX. Ask your doctor or pharmacist for a complete list.

HOW SHOULD I TAKE PLAVIX?
Only take PLAVIX exactly as prescribed by your doctor. Do not change your dose or stop taking PLAVIX without talking to your doctor first.

PLAVIX should be taken around the same time every day, and it can be taken with or without food. If you miss a day, do not double up on your medication. Just continue your usual dose. If you have any questions about taking your medications, please consult your doctor.

OVERDOSAGE
As with any prescription medicine, it is possible to overdose on PLAVIX. If you think you may have overdosed, immediately call your doctor or Poison Control Center, or go to the nearest emergency room.

FOR MORE INFORMATION
For more information on PLAVIX, call 1-800-633-1610 or visit www.PLAVIX.com. Neither of these resources, nor the information contained here, can take the place of talking to your doctor. Only your doctor knows the specifics of your condition and how PLAVIX fits into your overall therapy. It is therefore important to maintain an ongoing dialogue with your doctor concerning your condition and your treatment.

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PLAVIX® is a registered trademark.
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PLAVIX is a prescription-only medicine that helps keep blood platelets from sticking together, forming clots that can block blood flow and cause a heart attack or stroke. These clots form when blood platelets stick together, forming a blood clot. If the clot becomes large enough, it can block blood flow to the brain, causing a heart attack or stroke. PLAVIX is for patients who have:

- had a recent stroke.
- are allergic to clopidogrel (the active ingredient in PLAVIX).

You should NOT take PLAVIX if you:

- have another condition that causes bleeding.
- are pregnant or may become pregnant.
- are breast feeding.
- have another condition that causes bleeding.
- have another condition that causes bleeding.

Bleeding: You may bleed more easily and it may take you longer than usual to stop bleeding. There is a risk of more bleeding when taking PLAVIX, which can be serious or life-threatening. These warning signs, don’t wait. Call 9-1-1 right away.

If you experience some or all of these warning signs, don’t wait. Call 9-1-1 right away.

**WHAT SHOULD I TELL MY DOCTOR BEFORE TAKING PLAVIX?**

- a history of bleeding conditions
- kidney problems
- liver problems
- stomach ulcer(s)
- have another condition that causes bleeding
- are pregnant or may become pregnant
- are breast feeding
- have another condition that causes bleeding

**WHAT SHOULD I KNOW ABOUT TAKING OTHER MEDICINES WITH PLAVIX?**

- aspirin
- heparin
- other medicines

**OVERDOSAGE**

As with any prescription medicine, it is possible to overdose on PLAVIX. Be sure to tell your doctor if you are taking PLAVIX before starting any new medication.

**FOR MORE INFORMATION**

For more information on PLAVIX, call 1-800-633-1610 or visit walkaide.com.

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**Speech and Language Recovery**

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High-quality videoconferencing can increase patient access to stroke specialists, especially in rural or other underserved areas, according to a scientific statement published in Stroke: Journal of the American Heart Association. The statement says a remote exam using high-quality videoconferencing equipment is as effective as a bedside stroke evaluation. Physicians must quickly evaluate stroke patients to determine if they’re eligible for time-sensitive treatment such as tPA that can save brain function and reduce disability. Stroke and brain imaging specialists are often required to perform the evaluation. However, the United States averages only four neurologists per 100,000 people, and not all of them specialize in stroke.

Telemedicine, or telestroke, uses interactive videoconferencing via webcams connected to a TV or computer screen. This allows the patient, family and the bedside and distant healthcare providers to see and hear each other in full color and in real time.

Telestroke is coupled with teleradiology, which allows remote review of brain images. This technology can broaden the reach of neurologists in a cost-effective and time-efficient manner.

“Telemedicine is an effective avenue to eliminate disparities in access to acute stroke care, erasing the inequities introduced by geography, income or social circumstance,” said Lee Schwamm, M.D., lead author of a scientific statement and policy statement on telemedicine, and associate professor of neurology at Harvard Medical School and vice chairman of neurology at Massachusetts General Hospital.

Schwamm also noted that to be effective, there needs to be changes in how telemedicine activities are reimbursed. For that, policy recommendations were released along with the scientific statement. The policy statement recommends:

- Deploying telestroke systems to supplement resources where around-the-clock local, on-site acute stroke expertise is insufficient.
- Increasing Medicare reimbursement for telestroke assessment, diagnosis and approval to use tPA to reflect the increased upfront costs of implementation.
- Developing a mechanism for uniform, streamlined credentialing for telestroke providers and uniform national telemedicine licensure by state medical boards.
- Increasing funding sources for stroke telemedicine programs, which could include designating support from the federal American Recovery and Reinvestment Act of 2009.
**TIA Revamped**  
TIA now defined by injury rather than time

A statement from the American Stroke Association attempts to redefine transient ischemic attacks (TIAs), which have been referred to as “mini” or “warning” strokes. The authors noted the risk of stroke after a TIA is higher than previously thought. Therefore, they re-defined the condition to urge immediate action and thorough testing — much like the exam after a full-blown stroke.

“We think a TIA should be treated as an emergency, just like a major stroke,” said J. Donald Easton, M.D., writing chair of the statement and professor and chair of the Department of Clinical Neurosciences at Alpert Medical School of Brown University and the Rhode Island Hospital in Providence, R.I. “Because we know the high risk of a future stroke, this is a golden opportunity to prevent a catastrophic event.”

The traditional, clinical definition of TIA, which dates to the mid-1960s, is “a sudden, focal neurological deficit of presumed vascular origin lasting less than 24 hours.” (Focal means focused or localized, not involving the whole brain.)

In the new statement, the definition is changed to “a transient episode of neurological dysfunction caused by focal brain, spinal cord or retinal ischemia, without acute infarction.” Infarction is tissue death, the main distinction between TIA and stroke. Infarction can be determined by magnetic resonance imaging (MRI).

“Research around the globe has shown that the arbitrary threshold based on duration of symptoms was too broad, because up to half of TIAs defined this way actually caused sustained brain injury according to an MRI,” Easton said. Medical advances have made it easier to tell whether a patient has had a TIA or stroke, so an MRI is key to diagnosing a TIA.

According to the paper, 10 to 15 percent of TIA patients experience a stroke within three months of a TIA, with half of those strokes occurring in the first 48 hours after TIA.

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**Window Opened a Little Wider**  
Time window for clot-busting drug may be expanded for some stroke patients

Giving stroke patients a clot-busting drug within three hours of the start of symptoms is a long-established guideline, and recent research demonstrates that extending that treatment window by an hour and a half could still benefit some patients, according to a new American Heart Association/American Stroke Association advisory published in *Stroke: Journal of the American Heart Association*.

The clot-buster recombinant tissue-plasminogen activator (rt-PA) is approved by the U.S. Food and Drug Administration for use within three hours of symptom onset in eligible patients. The scientific advisory reaffirms this guideline. Not every stroke patient is eligible for rt-PA. Patients with a hemorrhagic (bleeding) stroke, people with certain medical conditions (such as bleeding disorders) or those patients who take medications that make the blood less likely to clot (e.g., warfarin) do not receive rt-PA.

The advisory notes that some patients were treated successfully up to 4.5 hours after symptoms began in a 2008 European study. The advisory updates the current guidelines to recommend treatment in select patients in the three- to four-and-a-half-hour window.

The results of ECASS 3 study confirm the need to treat patients within the three-hour window — according to the guidelines — to reduce disability from ischemic stroke, the kind caused by blood clots in the brain.

The study also identified patients that could be treated within three hours who should not be treated during the wider treatment window, including those:

- Older than 80 years
- Having a severe stroke
- With a history of stroke and diabetes
- Taking oral anticoagulants (anti-clotting drugs)

“Every second counts with ischemic stroke because the likelihood of permanent damage increases with each passing moment,” said Gregory J. del Zoppo, M.D., chair of the advisory writing committee and professor of medicine and adjunct professor of neurology at the University of Washington School of Medicine in Seattle. He pointed out that once stroke patients arrive at a hospital they must undergo imaging tests to rule out hemorrhagic stroke so that clot dissolvers can be given if appropriate.

“There has always been a notion that there are patients who could be successfully treated outside the three-hour window, but there has been no confirmation of that, although we seem to be getting closer to the answer,” del Zoppo said.
My Garden of Independence

After my stroke in March 2005, I was in a medically induced coma in a neurointensive care unit, and my family didn’t know if I was going to live, let alone how much of me they would get back.

When I was transferred to a rehabilitation facility, I resisted therapy. According to my family, the first two weeks there I refused to open my eyes because I did not want to participate in rehabilitation.

I have regained my speech and now effectively communicate with both familiar and unfamiliar listeners. However, I was not able to be independent in my gardens. Gardening has always been a hobby of mine, but I didn’t have the energy to get up and down in order to work in my gardens. I wear a large brace on my right leg and cannot sit on the ground and get up on my own easily. It was a danger for me to be working without someone around, in case I needed assistance getting up off the ground.

Knowing my love of gardening, my husband Larry came up with the idea for a garden deck leading to a patio that would suit my needs and disability. He took his design to the contractor and explained his idea. It only took about 10 days for the deck to be built. Once it was finished, I found myself ready to take on the challenge of managing a garden on my own. It was very exciting, and I realized my husband knew me better than I thought. The garden was evidence that I was regaining independence. Not only that, but I believe it gave Larry a sense that he could help me.

The garden consists of four separate triangular sections. One section is filled with all pink flowers, another section contains a small tree, and my favorite section is filled with a variety of grasses. I like this section the most because I have so many types of grasses and they have filled in very nicely. The last section, which I dedicated to my husband, has many different plants and colors.

The reason this design meets my needs is because I can reach each section by either standing on the ground or sitting on the benches of the deck. It allows me to work with plants without assistance. The steps leading to the gardens are only two inches high so I can climb them without my cane. Each section has a bench that I can sit or lie on and allows me easy access to the garden area. All of these elements allow me to garden for hours at a time without any help.

The deck design not only allows me to be independent when gardening, but this independence also carries over into all aspects of my life. I have more confidence when interacting with others. I can easily share the story of my gardens and I am more willing to jump back into social situations. I know that I am fully capable of making significant improvements in the recovery process. My gardens motivate me to keep moving forward in life.

Marcia Rosenberg, Survivor
Toledo, Ohio
In 2005 I was busy taking care of my 78-year-old mother who had just broken her hip in an automobile accident, and was then diagnosed with dementia. I was commuting from Boise, Idaho to Las Vegas, Nev. every week to be with her in the hospital during her surgery and later in rehab. Eventually, I had to sell her home, pack up her belongings and transport them and her to Boise, where I had picked out an assisted living facility. By the time I finally had her moved in, I was exhausted.

I was looking forward to getting back to work, but when the day came, I wasn’t feeling well so I called in sick and slept a little longer. When I woke up, I tried to talk, but the right words wouldn’t come out. Later that day when I tried to order something at a store, the salesperson looked at me like I was speaking a foreign language. My daughter Laura had to help me.

At work the next day, I was still having a hard time talking and it took me forever to compose an e-mail because I kept typing the wrong words. When I heard a number, I couldn’t write it down. I could not visualize the number as I heard it nor remember what I heard long enough to write it down. Although I knew something wasn’t right, I was too busy to worry about it.

After almost a week of this, one of my employees suggested I might have had a stroke and should see my doctor. The doctor was convinced my issues were caused by the high stress levels I had been experiencing with my mother and prescribed an antidepressant.

Another week and things did not improve. I made another appointment with my doctor, who sent me for an MRI. She called me at home two hours later to tell me that I had had an ischemic stroke. I immediately started taking low-dose aspirin. For the next several months, I received outpatient speech and occupational therapy.

The next year, my mother had a hemorrhagic stroke. Because of her age, her recovery was much longer, and she has since suffered seizures due to the scar tissue. She will never be the same.

Four years after my stroke, I am certain that my mental capacities are not what they were. I still have difficulty finding the right words, still have problems writing and remembering numbers. I still have short-term memory issues, and get easily overwhelmed and confused when fatigued or ill. I don’t think people notice, nor do they realize how much of a struggle it is to appear normal and keep things straight. But it is a daily effort to compensate. I have learned to rely on writing things down, getting more rest, allowing myself to make mistakes and finding humor in the things that have changed.

Although it saddens me that I am not the same person I used to be, I am grateful for the ability to walk, talk and be independent. I’m a single mom with a busy career, two teen-age daughters and an aging mother. I can’t afford to be down for too long.

I believe that everything happens for a reason. After my recovery, and then my mother’s, I looked to find meaning in what happened. I contacted our local American Heart Association/American Stroke Association and got involved. I’ve been an active volunteer ever since. I’ve researched stroke treatment and prevention resources in our state, represented Idaho in the 2008 “You’re the Cure” Lobby Day in Washington, D.C., and provided leadership for our local Heart Walk. Strokes are life-changing events, but they don’t always have to be life-ending. I’m living with less…but appreciating it more!

Jere Burch, Survivor
Boise, Idaho
Getting My Language Back

Although a stroke can warp your identity, I am grateful that my body’s physical functions are intact. I still bicycle and hike on the Appalachian Trail. I used to be a professional journalist, and aphasia devastated my brain. In the 1990s I worked as a correspondent in Moscow and was fluent in Russian. My 2006 stroke assaulted both my Russian and native English. I cannot conduct a normal interview or even a social conversation. I cannot produce a written paragraph without grammatical mistakes – in contrast with my old fanaticism for perfect grammar.

Providentially, my beloved wife Lynn and I live in the Shenandoah Valley. Before 2006 we were aware of the renowned (and nearby) Woodrow Wilson Rehabilitation Center, but it was irrelevant to our personal lives. My stroke then radically changed those lives. Thanks to Virginia’s taxpayers, the kindly specialist Beth Laughlin gave me intensive speech therapy.

Beth told me that survivors often experience big improvement during the first year after a stroke – but then slower improvement. During the first days after my stroke I could not remember the full alphabet. In 2007 I joked that if I could continue to improve at the same rate in my first post-stroke year I would eventually become another Einstein.

The good news: In 2007 I managed to publish a freelance article in the Christian Science Monitor. With help from my patient wife, who teaches at the University of Virginia, my draft avoided howlers. The bad news: Since then I have experienced a series of rejections from various periodicals.

My scholarly drafts have turned out to be especially frustrating. In research I would read a book apparently with comprehension, but by the time I had finished reading its last chapter, I had forgotten the first chapter’s names or ideas. I also feel that my insightfulness is now more shallow and clumsier. My narrative or argument no longer has the power to captivate readers. Now I just am not a good writer.

I am now concentrating on writing short op-eds rather than more ambitious projects. I am also concentrating on trying to recover my grammatical skills. If you are a stroke survivor with a similar problem, I recommend that you look at the Internet’s many Web sites for ESL (English as a Secondary Language) adult students. Every day I practice on interactive quizzes, especially on prepositional phrases and definite or indefinite articles.

If, like me, you find that listening to words is harder than reading, listen to a classic story while simultaneously reading the same text. In recognizing names and other proper nouns you may find, like me, that your oral skills improve – alas, slowly.

Lawrence A. Uzzell, Survivor
Fishersville, Virginia
The average person spends 80,000 hours building assets during their lifetime, yet less than 4 hours planning what their heirs will receive. Even more unsettling is the fact that 7 out of 10 Americans die without a will — leaving the distribution of all they have worked for to chance or to the state’s discretion. The number one reason people fail to make a will is the belief that it is a complex and expensive process. Not true. Now, in less than one hour, you can begin creating a plan that will protect your hard-earned assets and ensure your wishes are known and followed. Our will and estate planning kit, Matters of the Heart, can help you save time, money and hassle with forms that quickly organize everything you own into an inventory.

To get your free copy, simply complete and submit our electronic form, or call 888-227-5242. You can also e-mail us at plannedgiving@heart.org or visit us at americanheart.org/plannedgiving.

We advise you to seek your own legal and tax advice in connection with gift and planning matters. The American Heart Association does not provide legal or tax advice.
When a stroke survivor is diagnosed with diabetes, they may feel confused and overwhelmed by the demands of a condition that requires consistent monitoring. These resources have valuable information about diabetes and how to manage it:

**The Heart of Diabetes™** (www.HeartofDiabetes.org)
This program’s Web site is for people who want to know more about type 2 diabetes and the lifestyle changes it may require. It includes:

**MY DIABETES HEALTH ASSESSMENT:**
This risk assessment tool provides diabetic patients with their 10-year risk of heart attack and stroke.

**INTERACTIVE GLOSSARY:**
This helps you understand new terminology you will hear as a result of your diabetes diagnosis.

**FAMILY HISTORY TREE:**
This tool helps you track how diabetes has affected your family.

**HEART360:**
This online resource helps you track health factors including blood pressure, glucose, cholesterol and physical activity. Monitoring these different health factors helps you control them.

**QUIZZES:**
Not only do these quizzes test your knowledge, they also help fill in the blanks in areas where your knowledge may be incomplete.

**RECIPES:**
So much of controlling diabetes has to do with eating right. These recipes will help you get started.

**ENROLL TO RECEIVE A FREE COOKBOOK AND MONTHLY E-NEWSLETTER:**
Recipes for a Healthier Life is full of diabetes-friendly recipes. The monthly e-newsletter has heart-healthy tips, events and programs, news, recipes, promotions and more.

**ANSWERS FROM EXPERTS:**
Experts answer frequently asked questions from people who have been newly diagnosed with diabetes.

**ACCESS THE HEART OF DIABETES FACEBOOK COMMUNITY:**
Get the latest updates from the American Heart Association plus a forum to connect with other patients and access discussion boards at www.heartofdiabetes.org/facebook.

**American Association of Diabetes Educators**
is a strong supporter of The Heart of Diabetes program. Their Web site (www.diabeteseducator.org) offers many helpful resources.

As helpful as these Web sites and their information are, it is vitally important to remember that managing diabetes requires a multidisciplinary approach. “A joint effort, almost camaraderie, between you and your healthcare provider is often required to successfully manage type 2 diabetes,” said Dr. Daniel W. Jones, a past president of the American Heart Association. “Your healthcare provider will monitor your health, set goals for you and help determine if prescription medication is needed for those goals to be reached.”

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**AT THE HEART OF THE HEART OF DIABETES**

The American Heart Association created The Heart of Diabetes program to raise awareness of the connection between type 2 diabetes and cardiovascular disease. The program encourages patients living with type 2 diabetes to get regular physical activity, eat healthy foods and work with a healthcare provider to develop a comprehensive treatment plan. By reaching these goals, people can better manage their type 2 diabetes and reduce or delay associated risks, including heart attack or stroke. Visit HeartofDiabetes.org to enroll.
Some things can be a challenge.

Managing your type 2 diabetes doesn’t have to be.

Living with type 2 diabetes can be a challenge, but managing it doesn’t have to be. By enrolling in The Heart of Diabetes™ program, you can access tools to help you get one step closer to setting and reaching your treatment goals. Enroll today by visiting www.IKnowDiabetes.org and learn how you can better manage your type 2 diabetes.
Reclaiming Your Self-Esteem
by Jon Caswell

How you think and feel about yourself may make a difference in your recovery.
Self-Esteem

Stroke can affect self-esteem the same way fire ants can impact a picnic: disastrously. Self-esteem is the way people regard, think and feel about themselves. Some of that is a matter of temperament, but most of our self-esteem has its genesis in what happens to us. When a stroke happens, its consequences, in the form of deficits, settle on a spectrum of disability that can range from slight fatigue to locked-in syndrome. Where stroke leaves its survivors on that continuum determines its impact on their self-esteem.


For example, survivors of right-hemisphere strokes may be fairly oblivious to their deficits, and their self-esteem may be relatively preserved—at least in the early days of recovery. Survivors of left-hemisphere strokes, in contrast, have a greater tendency to become depressed and regard themselves negatively. “Survivors of left-hemisphere stroke are going to react more to their strokes and experience a consequent diminishment of self-esteem,” Dr. Jacobs said.

“Generally speaking, the greater the disability, the lower a survivor’s self-esteem,” said Art Gottlieb, a survivor of 28 years who has facilitated a stroke support group in his hometown of Long Beach, Calif. for many years. He is the author of *Stroke, an Owner’s Manual*. “Any disability that diminishes the functions of an individual that were most highly prized by that person takes a greater toll than lesser types of damage. For example, the electrician who enjoyed high earnings by the use of his skilled hands may feel useless if he loses his fine motor skills. Injuries that affect the ability to communicate can literally wipe out a survivor’s self-esteem.”

A cycle with bruising consequences

Stroke can affect self-esteem in a cycle. Survivors feel devastated in the first few days after the acute event. Their feelings do not improve when they are told they will be slow to recover. When they actually start to recover, their self-esteem improves. “But when recovery slows or plateaus, and they are faced with living with these deficits,” said Dr. Jacobs, “their dream of a complete recovery vanishes, and there is a big loss of self-esteem.”
Gottlieb said it’s important for survivors to understand that recovery is a slow, painstaking process. “That way there may not be any lowering of esteem related to time alone. Failure to understand or accept the slow pace may cause a lessening of esteem. But generally speaking, the personality of the survivor before the stroke is the key to all of this. The tigers often turn into lions; the meek may fall into self-pity.”

Of course, a stroke’s effect on the survivor’s ability to work can have a major impact on self-esteem. “When people feel they have lost what they did for a living, it is much harder to focus on what they still have, and much easier to focus on what they have lost, which has very negative consequences,” Dr. Jacobs said.

For Art Gottlieb, communication disorders can be one of the most emotionally damaging outcomes of stroke. “Injuries that affect the ability to communicate have a huge impact. People with aphasia who struggle to be understood often end up defeated with obvious feelings of failure and shame. In our group we demand patience from and for each other so that no one feels he is a lesser person because he can’t communicate.”

**Self-esteem affects recovery**

Self-esteem issues have a dramatic impact on recovery, largely because of their effect on social isolation and reintegration. Stroke rarely improves your social life. Part of this is logistics—movement may be difficult and not every place is handicap accessible. But part of it is psychological: “Survivors become self-conscious because of a wheelchair or walker or some other deficit,” Dr. Jacobs said. “They become aware that others are looking at them differently. They imagine others are looking at them with pity. When people have feelings like these, it becomes an impediment to getting out.”

Survivors often feel diminished by the deficits they are left with, and seek safety and familiarity to avoid humiliation and ridicule. “In this society we talk about standing on your own two feet,” said Gottlieb. “Imagine the chagrin of being in a wheelchair or needing a quad-cane or the steadying arm of a caregiver. That’s a far cry from being independently balanced on your own two feet.”

When a person’s self-esteem is high, they are more likely to take risks and get out among people. “By not getting out, survivors are setting a limit on what they can achieve because by not getting out, they recover less, and that really compounds the disabling effects of a stroke,” Dr. Jacobs said. “Social isolation impedes recovery because isolation leads to depression. People who feel isolated feel bad about themselves, which makes therapy more difficult and it makes it more difficult to accept the life they have now.”

Gottlieb also believes in the power of human contact. “The company of others is perhaps the most important element in stroke recovery. Isolation can lead to depression and any number of negative feelings, plus it reinforces feelings of being different. But stroke disabilities are not shameful and don’t need to be hidden.”

Of course, for many stroke survivors “getting out” is easier said than done. Many face physical barriers and negative judgments, and they may feel like they are imposing on others by asking for their time or help. “Some people would rather stay home than feel like a burden,” Dr. Jacob said.

And there’s the rub: How does a person with diminished self-esteem and who feels like a burden reintegrate into a society that is not always accepting of people with disabilities? And how does a caregiver encourage their survivor to get out without becoming a nag?
our experience with stroke may have altered how you view yourself. You may be feeling discouraged and down. You have a choice to feel positively or negatively about yourself.

Just as you can rehabilitate your body after a stroke, you can raise your self-esteem (how you feel and think about yourself). You can choose to nurture yourself, affirm yourself with positive statements and change those thoughts that are unrealistic and limiting. Then you can begin to develop to your full potential.

High self-esteem is a quiet, comfortable feeling of total acceptance and love for yourself as you are. It is respecting and valuing yourself as a human being, honestly seeing your good and not-so-good qualities. It is taking care of and nurturing yourself so you can become all that you are capable of being.

Steps to Improve Your Self-Esteem

Start with the following exercises. They are equally helpful for stroke survivors and caregivers.

Go at your own pace. Once you choose to nurture yourself, you are on your way to inner fitness, greater self-awareness and higher self-esteem.

• Keep a journal. Writing down your thoughts, feelings and reactions to people and situations lowers your stress level and balances you. It is a good way to solve problems and to get to know yourself better. Write for 20 minutes a day for a few weeks. Don’t worry about spelling and grammar.

• Become aware of your true needs and wants. Begin choosing to meet those needs that you can.

• Change your negative self-talk. Everyone has a voice inside their head that is continually commenting. Negative, critical, hurting comments need to change. Begin listening to what you say about yourself and then talk back to negative self-talk with the truth. Affirm yourself every day.

• Visualize what you want to create in your life. Picture what you want. For example, picture yourself feeling confident in a new situation or progressing in rehab.

• Take time to be alone daily. It is important to take time every day just to think, read, journal, pray, meditate. Make yourself a priority.

• Nurture yourself. Take care of yourself physically, emotionally, mentally and spiritually.

The Acorn Analogy

• Deep inside you know how to be you, as an acorn knows how to be a mighty oak.

• The acorn does the best it can do at each stage of growth along its life path.

• Even if the early start was less than perfect, the eager oak accelerates its desire to grow every time it has nurturing from nature: sunlight, rainwater and soil nutrients.

• You are like the acorn, doing your best under the conditions in which you are growing.

• Add a little awareness, acceptance, self-respect and nurturing, then watch yourself grow towards your full-potential self!

Thought Restructuring: Changing Negative Self-Talk

“If you think you can, you’re right. If you think you can’t, you’re right.” — Henry Ford

Change your thoughts and you can change how you feel, which influences the choices you make. Thoughts form your belief system, the structure upon which you view the world. Many of your beliefs were adopted as a child and are not always accurate. Some of the things you believe may be false and be limiting your experience of life.

To feel better about yourself, your relationship and your life requires a deep look at your inner structure to determine which beliefs need upgrading. Some of you may find it is easy to make shifts in your thinking. It usually takes time, however, to assimilate updated beliefs, even when you know they are beneficial.

For example, you may believe you must be totally competent and almost perfect in all that you undertake. Mistakes are shameful and to be avoided at all costs. This is an example of a limited guiding belief. You can update this limiting belief by saying, “I will do my best, correct my mistakes and learn from them.”

How you feel about yourself is completely within your control. You can work on your self-esteem every day by being aware of how you talk to yourself. Take the time to nurture yourself.

About the author...

Suzanne Harrill is a counselor in Houston, Texas. You can find more information about improving self-esteem on Suzanne’s Web site, InnerWorksPublishing.com.
Stroke support groups

For Art Gottlieb, the answer is easy: Join a stroke support group. “I believe support groups are essential to recovery,” he said. “The meetings are great for social interaction, in addition to being a place to learn from others who have experienced what you are experiencing.”

Support groups can help survivors rebuild wounded self-esteem. “I believe that the majority of us feel worthy in direct proportion to the degree those about us honor our achievements,” Gottlieb said. “We see ourselves in the mirror of others’ eyes. I know that survivors in our group feel a boost in esteem when their achievements are acknowledged. All the members react with some form of congratulations when another member shows evidence of a gain. Applause is a wonderful shot in the esteem.”

Gottlieb defines his support group as an extended family. In addition to monthly meetings, a series of outings involve the entire family. Activities include boating, playing one-armed golf, visiting the aquarium, even taking a vacation cruise on an accessible ship. “Once a year we have a huge picnic, where food and fun is the order of the day,” Gottlieb added.

In addition to support groups, many survivors turn to their churches or synagogues for compassionate support. “To defeat social isolation, stroke families have to come up with a purposeful plan to join a support group or church group so that they can get out of the house and socialize,” Dr. Jacobs said.

If you can’t get out of the house because of mobility issues, find an online support group or social network. “This meets social needs to a certain degree. Sometimes it is hiding out, but it’s also reaching out. Using online resources is better than nothing, but it’s not as good as going out,” Dr. Jacobs said.

The caregiver’s role

Caregivers have an important role to play, sometimes as a cheerleader and sometimes as the gadfly who persists in encouraging a survivor to participate in life no matter how they feel about themselves. It is important to include survivors in all the activities of the family, insisting that they participate when possible. “That’s a form of tough love to prevent the survivor from hiding in a dark corner,” Gottlieb said. “Explain to relatives and friends that there is nothing ‘wrong’ with the survivor and suggest the importance of dealing with that person as a normal person who has been hurt, but is recovering. Educate others about the most beneficial ways to help: having patience with someone who has difficulty talking; not speaking for that person; and not hovering.”

Dr. Jacobs noted that caregivers must tread a difficult path. “They must encourage their survivors to take risks and make them aware that socialization is good for their recovery. Too much encouragement, however, becomes nagging, and that sets up resistance. Caregivers have to set a balance between encouragement and respecting the survivor’s own decisions.”

Acceptance

Ultimately the psychological goal of recovery is acceptance, which is the beginning of becoming whole. “I tell my stroke patients the best way to change is to accept who you are as a result of stroke,” Dr. Jacobs said. “I share this metaphor with them: Your life was a whole loaf; stroke has left you with half a loaf. Can you accept that and make a life out of it, or would you rather have no loaf? Many people would rather not live if they can’t be who they were. Others will work hard to make something out of the half a loaf they have been left.”

Gottlieb said those who grow from their misfortune experience the greatest changes. “A small handful of survivors come to a time when they say with conviction, ‘I’m glad this happened. I’m a better person for it.’ These are the ones whose hearts have grown because of and in defiance of other parts of their capabilities that are gone. They find it difficult to pass a disabled stranger without offering some words of comfort and hope. They are the first to greet new group members, take them by the hand and assure them things will get better. They now cry, not for their losses but for the losses of others. That, to me, is the meaning and essence of ‘acceptance.’”

Says Gottlieb, “a small handful of survivors come to a time when they say with conviction, ‘I’m glad this happened. I’m a better person for it.’ These are the ones whose hearts have grown...”
When I pressed the remote’s power button the other night the TV immediately fired up to our local PBS station. For the most part their programming is smart and entertaining. I wish I could say the same about “Pledge Week.” It’s not that we don’t support PBS. We do. But their blatant targeting of the boomer generation with hours and hours of oldies doo-wop music turns me off. Tunes I didn’t like that much in the first place. Well, tonight they were doo-woping’ and shoo-bee-dooin’ away.

I endured it long enough to catch The Monotones. Now there’s a great name for a group. It literally means: no variation in harmony and pitch. They should have just called themselves The Blands. They performed their 50’s mega hit “Book of Love” to thunderous applause. (Hey, what do I know?) I thought if there’s a Book of Love, then maybe there’s a Book of Rehab and it might go something like this… (Don’t worry, this isn’t my column’s version of Pledge Week, but if you want to send me a check my last name is spelled K-A-W-I-E and I’ll send you a tote bag.)

Chapter 1: Hope

This is where you get the outpatient rehab facility tour. The physical therapist who shows you around is gentle and understanding as she explains the state-of-the-art equipment. You notice the PT room has an eerie resemblance to a torture chamber you saw on a PBS documentary about the Spanish Inquisition. You don’t care because visions of you getting back to your prestroke self are swirling in your head like the dance of the sugarplum fairies. You grab a handful of pamphlets and highlight sentences with phrases like “epic recovery,” “awesome success rate” and “cutting-edge techniques.”

Chapter 2: Pain

This is where you actually get to work with that gentle, understanding PT. You’re confused because you don’t remember her wearing a monocle and speaking like Colonel Klink, but you chalk it up to a stroke thing.

“I vill be all over you like a hobo on a ham sandvich, ya?”

“And strap you into zee auto ambulatory machine until I have broken you, ya?”

“No pain no gain, ya?”

Chapter 3: Gain

Ah, it’s happy time! Things are looking up! This is where you start to see the results of your hard work. You’re walking better and becoming more independent. This is the best you’ve felt since the hospital gave you five Ativans for an MRI. Stroke survivors have been known to start twirling their canes during this period, and it’s not the antidepressants they’re taking.

Chapter 4: Plateau

This is a word you will start to hear from your insurance company. Translation: We’re tired of paying for your rehab. Of course, if you can do a triathlon they’ll continue to pick up the tab. This is when you wish you had those five Ativans.

Chapter 5: Sayonara

This is where the insurance company pulls the plug. Now you’re on your own. So you join a yoga class but you’re afraid “downward facing dog” may give you another stroke.

Chapter 6: Invasion of the Body Snatchers

Your wife insists on taking over your rehab. All of a sudden she’s wearing a monocle and speaking like Colonel Klink.

“Zis is easy. I can do zis one handed. Vie can’t you? I tell you vie. You are lazy!”

The PT room bears an eerie resemblance to a torture chamber from the Spanish Inquisition.
When the Word Escapes

by Janet Patterson, Ph.D., CCC-SLP
Member, American Speech-Language-Hearing Association

Being unable to find the right word happens to everyone. When it happens to people who don’t have aphasia it’s called “Tip of the Tongue Phenomenon.” After searching our brains for a cue or clue, such as the first letter, the word eventually comes.

When it happens to us as we age, we may call it a “Senior Moment.” We may turn to friends or family to help us find the cues as we search our minds to find the word we want.

When it happens to people with aphasia it is called anomia, or word-finding difficulty. Anomia is common with aphasia. It can make conversation difficult as the person with aphasia and their communication partner struggle to find the words and ideas they want to share.

There are many causes for word-finding problems for people with aphasia. It might be that the aphasia has blocked access to the semantic system, which stores the meanings and relationships of words we know. In this case a person with aphasia may not be able to complete a task that requires understanding word meaning. They may not be able to name a picture, identify a family member or understand what a gesture means.

On the other hand, the person may have problems getting to the lexical phonologic system. This is where what we know about the sounds of words and how to combine them is stored. In this case a person with aphasia may know the meaning of the word and recognize it if they hear it or see it in print. However, they may not be able to find the sounds to say the word when naming a picture, reading aloud or saying a word when given the definition. Or a person may make a “slip of the tongue” and find almost the right word. For example one might call a friend “Jane” when her name is really “Sue” or say “fife” when they mean “knife.” Understanding why a person has a word-finding problem is important when planning treatment.

“I know what I want to say, I just can’t find the word!”
There are two ways to treat anomia:

1. **Restorative treatment** focuses on improving the impaired systems (semantic or lexical phonologic). Examples include matching words and pictures, rehearsing the name of an item, answering yes/no questions or putting pictures into categories.

2. **Substitutive treatment** focuses on helping the person find ways to communicate even when they can’t find the words. Substitutive treatments use a person’s language strengths and abilities. For example, the person types the first letter of a word into a computer. The computer then makes predictions about the target word and the person picks the desired word. Other examples are gesturing and pantomime, drawing, or pointing to letters on an alphabet board.

**Lost and found: Finding the words you need**

Here are some tips for finding the word you want to say:

- Pause and give yourself time to think.
- Take a deep breath before trying a word-finding strategy.
- Close your eyes and think of a visual image of the word or item.
- Say the first letter of the word.
- Go through the alphabet letter by letter if you can’t think of the first letter.
- Think about the physical features of what you are trying to talk about and use that to describe it:
  - Size (Is it big or small?)
  - Shape (Does it have legs? Is it round? Is it long or short?)
  - Color (Is it one color or different colors?)
- Describe the use of the word (if it is a noun) or who does it (if it is a verb).
- Say any information you know about the word. For example, if you can’t think of the word “dog,” you might say “the thing that barks.” This is called *circumlocution*.
- Think of a word that rhymes with the target word.
- Write letters or other information about the word.
- Gesture to pantomime the word.
- If you know the topic of conversation in advance, write some key words that you may want to say or that may give you cues to other words.
- Tell your communication partner that you have aphasia and may need some help finding words.

You may benefit from some of these cues sometimes, but not all the time. Be gentle with yourself and know that sometimes the word will come and sometimes it won’t. Either way, continue to communicate with your family and friends.

**Help your conversational partners help you find words**

Conversational partners can help or hinder word-finding problems. But when a conversational partner quickly jumps in to find the word, it can hinder communication rather than support it. By using techniques of supportive communication they can help the person with aphasia find the word they want and thus maintain quality conversation between them. The most important tip is to be sensitive to the needs of the person with aphasia and place value on the shared experience of communicating ideas.

- Give your partner with aphasia time to respond.
- Ask yes/no questions—just like the game of 20 Questions.
  - Be strategic in how you ask, not random
  - Ask questions about whatever you were talking about before your partner started having trouble. Don’t start off with a question about food if you were talking about a television show.
  - Ask questions that close in on what your partner wants to say. Don’t ask “Is it in the house?” if the person just said it was an animal and you don’t have animals in the house. A better follow-up would be “Is it a pet?” or “Did we see one today?”
  - Devise a consistent pattern, such as always asking about size first.
- Use pen and paper to write your cues, such as letters or a drawing.
- Listen to your partner’s naming attempts to see if you can find a pattern to help you ask questions.
- Use gestures as you ask questions.
- Paraphrase or provide key words to be sure you understand.
- Use props, if appropriate, such as photographs, photo albums or personalized communication binders.
- Give information or ask questions in a supportive and non-demanding manner.
- Provide emotional support to acknowledge that you know that your communication partner knows what he or she wants to say.

[Editor’s Note: To find an ASHA-certified speech-language pathologist near you, go to asha.org and click on “Find a Professional” or call (800) 638-8255.]
One-handed Solutions

by Elin Schold Davis, Practice Associate
American Occupational Therapy Association

Hand hygiene, dental care, hair styling, applying cosmetics and shaving are difficult to manage with one hand. Grooming requires precise movements while handling small objects. For stroke survivors, this can be frustrating and lead to feelings of helplessness. Here are some suggestions for making your grooming routine less trying:

• Change to a “wash-and-wear” hairstyle to avoid the need for blow dryers and curling irons. Or treat yourself to a weekly visit to the beauty shop for professional styling. Ask your hairdresser for advice on a no-fuss look.

• Use a lighted, angled magnifying mirror when applying makeup with a non-dominant hand.

• Use an electric shaver to reduce the risk of nicks and for better control over hard-to-reach areas.

• Use mounted dental floss or “floss picks,” which require only one hand.

• Experiment with styles of toothpaste caps and other container tops to find ones that are easiest for you to manage. Look for those with extended lips, ridges or other features that help with manipulation.

• Keep caps and lids loose or permanently removed for ease of dispensing their contents. Or, ask a friend or a store clerk to help loosen lids, puncture caps and remove plastic wraps and inner seals so your supplies are ready to use.

• Use travel-size bottles or other small containers that can be held in the palm of your hand while twisting or prying the lid that seals it. Use the thumb and fingers of the same hand to accomplish this.

• Review the grooming tasks most important to you with your occupational therapist. He or she may have other ideas to help make things easier for you. Suggestions may include buying adaptive aids such as wash mitts, mounted nail clippers and other items designed for one-handed use.

About the AOTA...

The American Occupational Therapy Association (AOTA) represents more than 140,000 occupational therapists, assistants and students nationwide. For more information, visit aota.org/Consumers.aspx.

About the author...

Elin Schold Davis, OTR/L, CDRS, has worked in the field of occupational therapy for more than 25 years and is currently practice associate at the American Occupational Therapy Association.
WHO IS PLAVIX FOR?
PLAVIX is a prescription-only medicine that helps keep blood platelets from sticking together and forming clots.

PLAVIX is for patients who have:
- had a recent heart attack.
- had a recent stroke.
- poor circulation in their legs (Peripheral Artery Disease).

PLAVIX in combination with aspirin is for patients hospitalized with:
- heart-related chest pain (unstable angina).
- heart attack.

Doctors may refer to these conditions as ACS (Acute Coronary Syndrome).

Clots can become dangerous when they form inside your arteries. These clots form when blood platelets stick together, forming a blockage within your arteries, restricting blood flow to your heart or brain, causing a heart attack or stroke.

WHO SHOULD NOT TAKE PLAVIX?
You should NOT take PLAVIX if you:
- are allergic to clopidogrel (the active ingredient in PLAVIX).
- have a stomach ulcer.
- have another condition that causes bleeding.
- are pregnant or may become pregnant.
- are breast feeding.

WHAT SHOULD I TELL MY DOCTOR BEFORE TAKING PLAVIX?
Before taking PLAVIX, tell your doctor if you’re pregnant or are breast feeding or have any of the following:
- gastrointestinal ulcer
- stomach ulcer(s)
- liver problems
- kidney problems
- a history of bleeding conditions

WHAT IMPORTANT INFORMATION SHOULD I KNOW ABOUT PLAVIX?
TTP: A very serious blood condition called TTP (Thrombotic Thrombocytopenic Purpura) has been rarely reported in people taking PLAVIX. TTP is a potentially life-threatening condition that involves low blood platelet and red blood cell levels, and requires urgent referral to a specialist for prompt treatment once a diagnosis is suspected. Warning signs of TTP may include fever, unexplained confusion or weakness (due to a low blood count, what doctors call anemia). To make an accurate diagnosis, your doctor will need to order blood tests. TTP has been reported rarely, sometimes in less than 2 weeks after starting therapy.

Gastrointestinal Bleeding: There is a potential risk of gastrointestinal (stomach and intestine) bleeding when taking PLAVIX. PLAVIX should be used with caution in patients who have lesions that may bleed (such as ulcers), along with patients who take drugs that cause such lesions.

Bleeding: You may bleed more easily and it may take you longer than usual to stop bleeding when you take PLAVIX alone or in combination with aspirin. Report any unusual bleeding to your doctor.

Geriatrics: When taking aspirin with PLAVIX the risk of serious bleeding increases with age in patients 65 and over.

Stroke Patients: If you have had a recent TIA (also known as a mini-stroke) or stroke taking aspirin with PLAVIX has not been shown to be more effective than taking PLAVIX alone, but taking aspirin with PLAVIX has been shown to increase the risk of bleeding compared to taking PLAVIX alone.

Surgery: Inform doctors and dentists well in advance of any surgery that you are taking PLAVIX so they can help you decide whether or not to discontinue your PLAVIX treatment prior to surgery.

WHAT SHOULD I KNOW ABOUT TAKING OTHER MEDICINES WITH PLAVIX?
You should only take aspirin with PLAVIX when directed to do so by your doctor. Certain other medicines should not be taken with PLAVIX. Be sure to tell your doctor about all of your current medications, especially if you are taking the following:
- aspirin
- nonsteroidal anti-inflammatory drugs (NSAIDs)
- warfarin
- heparin

Be sure to tell your doctor if you are taking PLAVIX before starting any new medication.

WHAT ARE THE COMMON SIDE EFFECTS OF PLAVIX?
The most common side effects of PLAVIX include gastrointestinal events (bleeding, abdominal pain, indigestion, diarrhea, and nausea) and rash. This is not a complete list of side effects associated with PLAVIX. Ask your doctor or pharmacist for a complete list.

HOW SHOULD I TAKE PLAVIX?
Only take PLAVIX exactly as prescribed by your doctor. Do not change your dose or stop taking PLAVIX without talking to your doctor first.

PLAVIX should be taken around the same time every day, and it can be taken with or without food. If you miss a day, do not double up on your medication. Just continue your usual dose. If you have any questions about taking your medications, please consult your doctor.

OVERDOSAGE
As with any prescription medicine, it is possible to overdose on PLAVIX. If you think you may have overdosed, immediately call your doctor or Poison Control Center, or go to the nearest emergency room.

FOR MORE INFORMATION
For more information on PLAVIX, call 1-800-633-1610 or visit www.PLAVIX.com. Neither of these resources, nor the information contained here, can take the place of talking to your doctor. Only your doctor knows the specifics of your condition and how PLAVIX fits into your overall therapy. It is therefore important to maintain an ongoing dialogue with your doctor concerning your condition and your treatment.

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PLA-OCT07-B-Aa
After surviving a stroke, some of the toughest challenges are the ones you can’t see.

If you’ve had a stroke, you may be facing a major risk of having another. You may also be at increased risk for having a heart attack.

**PLAVIX is the only prescription antiplatelet medicine that helps protect against both.** Recovering from a stroke can be difficult and you’ve worked hard to make progress. If you’ve recently had a stroke, you should know PLAVIX can help protect against another stroke or even a heart attack. PLAVIX may be right for you. Be sure to talk to your doctor to find out.

**IMPORTANT INFORMATION:** If you have a stomach ulcer or other condition that causes bleeding, you should not use PLAVIX. When taking PLAVIX alone or with some other medicines including aspirin, the risk of bleeding may increase, so tell your doctor before planning surgery. And, always talk to your doctor before taking aspirin or other medicines with PLAVIX, especially if you’ve had a stroke. If you develop fever, unexplained weakness or confusion, tell your doctor promptly as these may be signs of a rare but potentially life-threatening condition called TTP, which has been reported rarely, sometimes in less than 2 weeks after starting therapy. Other rare but serious side effects may occur.

You are encouraged to report negative side effects of prescription drugs to the FDA. Visit www.fda.gov/medwatch, or call 1-800-FDA-1088.

**PLAVIX offers protection.** PLAVIX is proven to help keep blood platelets from sticking together and forming clots, which helps keep your blood flowing. Since clots are the leading cause of strokes and heart attacks, PLAVIX helps you stay protected.

**Talk to your doctor about PLAVIX.** For more information, visit www.plavix.com or call 1-800-905-3430.

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Please see important product information for PLAVIX on the previous page.