After surviving a stroke, some of the toughest challenges are the ones you can't see.

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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.

**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.

If you need help paying for prescription medicines, you may be eligible for assistance. Call 1-888-4PPA-NOW (1-888-477-2669). Or go to www.pparx.org.

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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.

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

Please see important product information for PLAVIX on the previous page.
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**Blood platelets can stick together and form clots.**

**PLAVIX helps keep blood platelets from sticking together.**

**PLAVIX**

*(clopidogrel bisulfate)* 75 mg tablets

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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).

Plots 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?
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• 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:
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• 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 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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Staying Vigilant

In response to Beth Feuerstein’s article (“Stay Vigilant” in the September/October 2008 issue): My husband had a stroke in June 2003. A year later he had a seizure. His physician put him on phenytoin and checked for several weeks to get the proper dosage, 500 mg/day.

In 2007 he started having unusual symptoms. He was leaning to one side and falling down constantly. We were sent to physical therapy, and they gave him a cane, then a walker. He developed complete incontinence and didn’t care. The urologist could find nothing wrong. We were scheduled to see a neurologist to see if he was having TIAs.

He was mean and nasty, very confused, stooping over and aging right in front of our eyes. Finally, he fell and hurt himself badly enough to go to the ER. He stayed in the hospital five days, and I was told he needed to be put in a nursing home. On his last day in the hospital they told me his dosage of phenytoin was too high. Once reduced his levels would come down and the symptoms would diminish.

His physician admitted he had not checked my husband’s phenytoin level since 2005. During that time we made several trips to the doctor, including one to see if we could get an explanation of what was going on. The physician kept telling us it was all due to the original stroke.

Within seven days all the symptoms disappeared. We obviously changed doctors. Since this happened, I have become an aggressive, no-nonsense person whenever my husband has the slightest twitch.

Donna Schoffstall, Caregiver
Portland, Oregon

Tripping the Light Is Good Exercise

A friend gave me a copy of your magazine, knowing I had survived a stroke in December 2008. I found both the articles and the letters most enlightening.

I found the emphasis on exercise in your September/October 2008 issue a valuable tool. I sometimes use a cane or walker due to weakness in my right leg. There are two exercises for which I don’t need these walking aids. The first is “aqua-cise” where I can walk in the water, which I do on a daily basis. Second (and more enjoyable) is ballroom dancing. This activity not only provides emotional satisfaction, but great exercise for the leg. I find no pain or discomfort as I trip the light fantastic several times weekly.

Sam Winchell, Survivor
Boca Raton, Florida
The Comfort of Home

Home monitoring is as safe as clinic testing for patients on blood thinner

Home monitoring of clotting speed is as safe as clinic monitoring in patients taking warfarin, a common blood thinner, researchers reported at the American Heart Association’s Scientific Sessions 2008.

The researchers randomized 2,922 patients to one of the two testing methods and followed them for an average of three years. During that time, 7.9 percent of the home testing participants either experienced a stroke, major bleed or death compared to 8.9 percent of the clinically tested patients. The difference was not statistically significant, and researchers determined that once a month at the clinic seems to be just as good as weekly testing at home for most patients.

Home testing might be the better choice in certain situations such as for patients whose disabilities or distance from a clinic might keep them from appointments.

The participants were veterans being treated with warfarin at VA hospitals. They had either atrial fibrillation (AF) or had received a mechanical heart valve – conditions that increase the risk for blood clots that can travel to the brain and cause stroke.

Patients with AF or mechanical heart valves take warfarin to slow the speed at which their blood clots. However, the safe range for clotting speed is narrow. If the drug doesn’t thin the blood enough, the patient could develop a life-threatening blood clot. If the drug works too well, it could lead to hemorrhage such as a bleeding ulcer or a hemorrhagic stroke. As a result, most patients on warfarin need to have a test tube of blood drawn at a clinic each month to be sure their anticoagulation is in range. In comparison, the home monitors used just about four drops of blood.

In addition to the unpleasantness of drawing blood and the constant risk that patients may decide to skip appointments – particularly when blood draws are involved. Plus, many veterans must travel long distances to reach a clinic.

This study showed that home testing is as effective as regular clinic monitoring, the researchers concluded, and pointed out that this is a big benefit for patients where access is a problem either because of disability or distance.
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Sleep and Stroke
Too much, too little sleep increases risk in postmenopausal women

Postmenopausal women who regularly sleep more than nine hours a night may have an increased risk of ischemic stroke, researchers reported in Stroke: Journal of the American Heart Association.

Compared to women sleeping seven hours, the risk of ischemic stroke was 60 to 70 percent higher for those sleeping nine hours or more, researchers concluded.

Researchers also found that women who slept six hours or less were at 14 percent greater stroke risk than those who slept seven hours a night. Nearly twice as many women reported sleeping less than six hours (8.3 percent) than those who reported sleeping nine hours or more (4.6 percent).

The researchers theorized that the overall public health impact of short sleep is probably larger than long sleep because the prevalence of women having long sleep duration is much lower than those sleeping less than six hours. The study provides additional evidence that habitual sleep patterns in postmenopausal women may be important for determining the risk of ischemic stroke.

The findings apply only to postmenopausal women and cannot be applied to other groups, including men and younger women. Postmenopausal women ages 50 to 79 may be more susceptible to the detrimental effects of sleep deprivation than others.

After accounting for the common risk factors for ischemic stroke, the increased relative stroke risks compared to the seven-hour-sleep group were: 14 percent for six hours or less sleep; 24 percent for eight hours of sleep; and 70 percent for nine or more hours of sleep.

The researchers emphasized that the data do not imply that if women with long sleep cut their sleep hours they would be at a lower risk. The observed increase in stroke risk in long sleepers may be due to some unmeasured factors, such as undiagnosed sleep disorders.

Getting Really Relaxed
Audio relaxation program may help lower blood pressure in elderly

An audio relaxation program lowered blood pressure more than a Mozart sonata in a group of elderly people with high blood pressure, researchers reported at the American Heart Association’s 62ND Annual Fall Conference of the Council for High Blood Pressure Research.

In a study of 41 elderly participants at three retirement facilities:

- Twenty participants listened three times a week for four months to a 12-minute audio-guided relaxation training program (ATP) with background sounds of ocean waves and a calming voice.
- A second group of 21 participants listened to a 12-minute Mozart sonata three times a week for four months.
- Researchers recorded systolic blood pressure, diastolic blood pressure and heart rate before and after each session.

The ATP group lowered their:
- blood pressure from 141/73 mmHg to 132/70 mmHg and
- heart rates from 73 to 70 beats per minute.

The Mozart group also lowered their:
- blood pressure levels from 141/71 mmHg to 134/69 mmHg and
- heart rates from 69 to 66 beats per minute.

For both groups, the reduction in systolic blood pressures after intervention was statistically significant, although it may not reach clinical significance.

Higher systolic blood pressure is prevalent in the elderly population. This program may provide yet another way to help manage hypertension in conjunction with medication, lifestyle changes, exercise, diet and stress management.

Healthcare providers can use the simple program not only to help patients manage stress, but as a supplemental option to lower blood pressure. Nursing homes or senior living facilities may use this without a doctor’s order. It’s noninvasive, available and has been around for 20 years.
Is your blood pressure above 160?

Are you taking three or more medications but your blood pressure remains above 160?

This puts you at FOUR TIMES higher risk of stroke.

You may be eligible to participate in a research study for an investigational implantable device that may help you control your blood pressure.

Go to www.bloodpressuretrial.com or call 1-888-8BP-RISK and learn if you qualify.

Note: Previous stroke does not exclude you from this study.

CAUTION: The CVRx Rheos System is an investigational device and is limited by Federal (or United States) law to investigational use only.
Traveling as Therapy

After a stroke in 2006, at age 70, I took my first trip to beautiful, historic Prague. Located in the Czech Republic, Prague is said to be the city of a hundred spires. I had planned the trip with some travel buddies months before the stroke. We took a portable wheelchair, and either my husband David, a friend or tour guide pushed me around for the tours. Our guide, a young Czech professor, said three different times that I was very brave to come all the way to Prague from Houston.

Four months later I went to the southern coast of Oaxaca, Mexico, for a week’s visit with my son Steve, who lives there. I stayed in a cabana on the beach a few feet from the ocean and gazed at the turquoise waters while lying in a hammock. A friend went with me, and she helped me walk along the beach one morning and later to sit in the sand and enjoy the evening’s magic.

I had a lacunar stroke. The word lacuna is from the Latin word meaning space or little lake. It means I had a small cavity in my brain, which the doctor attributed to high blood pressure. I was paralyzed on my left side, but my mind and memory were intact, as well as my speech. I came home from the hospital with a leg brace, wheelchair and quad cane. I retired from my job as controller of an insurance business.

In 2007 I took my first cruise, four days out of Galveston, Texas, to the Western Caribbean. There was good exercise on the ship, using the stairs and walking the decks. I expended lots of energy, amidst sapphire blue Caribbean waters.

It’s been two years, and I sometimes walk without a cane. Holding on to the rail, I can climb stairs. I try to keep my stress level low and work out almost daily. Recently I joined a stroke support group. A memoir-writing class helps me tell some of my life story.

I have received two botox treatments to relax my toes so I can walk better by alleviating the pain the curling causes when I walk. It has helped, and another treatment is scheduled next month.

I recently returned from my second cruise, this time on a ship that holds around 3,100 people. Walking the stairs and decks on this very large ship helped my stamina. During a stop in Jamaica, I got in a bamboo raft with a friend and our guide, and we floated down a shallow river high in a mountain jungle. Travel forces me to cope with new situations and improve my strength and other physical abilities. It’s really therapy for me.

My friends and family are very supportive, never condescending or overly sympathetic. Recovery has been a long, hard journey and continues to confront me with tough challenges. However, travel makes the road a lot lighter.

Yvonne Lewis, Survivor
Houston, Texas
My name is LeAnn Nienow, but my friends call me LeLe.

When I met the executive director of the Sacramento affiliate of the American Heart Association in 2005 and told her I wanted to volunteer, neither of us knew that within three months, on Nov. 30, at age 40, I would experience a stroke. Of course, after that my plans changed a bit, from being a volunteer to something more. I wanted to speak, educate, mentor and, most of all, inspire. I wanted to educate those who have not had a stroke on early detection; and encourage survivors to set goals and never give up on themselves; to shoot for the stars.

Seven weeks before my stroke, I had completed the Nike San Francisco Marathon and was four days away from our local California International Marathon. I was (and am) a very fit person. The stroke left me with aphasia, which affected my speech – I now have my own set of Le-Le ebonics. I have a hard time with short-term memory and I am also challenged with multitasking, but I am getting better with time!

Two weeks after my stroke my stepfather, Gerry Lind, had a stroke. We joked who was better off: Who spent more time in the hospital? Who could read? Who could walk? Who could speak? Who could hold something? We decided we both were pretty lucky to be where we are with family and friends who have given us great support.

Six months after my stroke, I found myself standing in front of a group of Train To End Stroke (TTES) participants who were signing up to do their first marathon and looking for a coach. I announced to them that one week before I had finished Ironman Coeur D’Alene. An Ironman is a competition comprising a 2.4-mile swim, followed by a 112-mile bike ride and a full marathon (26.2 miles). At the time, I had joked with my stepdad that if he could walk when I did the Coeur D’Alene Ironman, he would cross the finish line with me. Not only could he walk, he actually ran across the finish line with me.

I took on the job of training those TTES participants. I worked with them all that winter. In 2007 I completed my fourth Ironman competition in Western Australia, on the second anniversary of my stroke.

I AM A SURVIVOR, happy and healthy!

LeAnn Nienow, Survivor
Sacramento, California
you had had a stroke and could no longer go to work every day, had two very bright, hyperactive children to rear and your husband suddenly quit his job to become a full-time student, would you think it was great? Well, that’s what happened to me.

My husband Greg’s first exposure to physical therapy was when his dad was hospitalized with pulmonary fibrosis. Despite a successful transplant, he died. Three months later I had a stroke, which gave him further insight into the world of physical therapy.

Greg’s degree is in business. After moving to the Eastern Shore of Maryland, he formed his own “caretaking” business, which was very successful. His services ranged from landscaping to overseeing homes while the owners vacationed. He checked on their properties before and after storms, for example. His clients were so fond of him that they continued to pay him while I was hospitalized, despite the fact he was not always able to make their needs a top priority.

Of course, our lives changed after my stroke. Greg was juggling so many things – his job, caring for our children and making the two-hour trip to see me in the hospital. After I was moved to the rehabilitation hospital, he was there every Wednesday because that was my physical therapy day. He was concerned whether I’d ever be mobile again. In the beginning, they concentrated on very basic things, like teaching me to hold up my head. Greg was keenly interested in every aspect of my physical therapy and even seemed to be enjoying this part of my life more that I was. As he watched my slow but steady progress, he was impressed with “what an awesome thing it is to be able help people like this.”

In the fall of 2005, six months after my stroke, Greg started the process of becoming a physical therapy assistant. In December, he decided to close his business and began taking classes so he could be accepted into the physical therapy program. In June, he began working at our local YMCA where he could have a more flexible schedule. Somehow he was able to work, go to school, maintain excellent grades, tend to the children and me, and still find time to enjoy life.

It was inevitable, however, that Greg would need to become a full-time student for two years in order to meet all the requirements. After many budget-making sessions, we decided that we would move forward with his dream. We knew that for the next two years there would be three full-time students in our home. I would soon find out how this would affect me.

Despite imperfections in our plan, there have been many good things. In particular, our daughter Anna, 13, and son Alex, 11, see the wonderful example set by their dad, who
is a very good student and takes his work seriously. They are in touch on a daily basis with the world of education and all that it entails.

Of course, there are times when all is not perfect. Like it or not, I have been forced to become the chauffeur for all school and extracurricular activities. We had to have our van outfitted to accommodate my handicap, and I also had to muster the courage to drive again. My energy level is not the same since the stroke, so I find myself tired more than before. The simplest tasks take me so much more time, which can be frustrating.

I am not always able to share Greg’s enthusiasm for all aspects of his physical therapy “life.” For example, since the stroke, I have been diligent about doing my nightly stretches before I go to sleep. You can probably imagine how helpful my budding therapist wants to be! I appreciate the concern, but let’s face it, there are times when I don’t feel like doing the “perfect” stretch.

My life has been altered in many ways by my stroke. I am not able to use my left hand at all, have aphasia and cannot hold a job outside my home as I did before. It is not always easy to be enthusiastic and cheerful about life. I do know that I am far more fortunate than many people who have experienced similar traumas, but some days are more difficult than others. At times, the cloud of depression casts its shadow on my day. Looking for the silver lining is not always easy, but I do recognize it when I see it. To think that my stroke was one of the main reasons that Greg is so driven to be a physical therapist. It appears that he was always meant to be in the “caretaking” business.

“Looking for the silver lining is not always easy, but I do recognize it when I see it.”

Greg and Rina Terry with son Alex and daughter Anna >>

FOOT DROP

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A simple solution.
Sex and Intimacy after Stroke
by Jon Caswell

Sex is a sensitive subject for many stroke survivors and their mates. Stroke can cause big changes in the lives of couples who are sexually active. Stroke-related physiological and psychological changes may affect both sexual desire and performance. The insecurity, fear and doubt that can arise from this can throw even the most open and loving couples into a tangled web of conflicting emotions: Is sex safe? Am I still attractive? Can I be both a caregiver and a lover?

Just talking about these issues may be extremely uncomfortable for some. Still, the experts and survivors we talked with believe these concerns can be overcome.
Initial concerns

“The most common concern for survivors and caregivers alike is fear of causing another stroke,” said Florence Denby, a nurse practitioner in the Stroke Rehabilitation Center at the Rehabilitation Institute of Chicago. Denby counsels couples on sex after stroke. “Very often the partner is afraid of hurting the stroke survivor or causing a second stroke. Many couples need reassurance that having sex for most survivors does not put them at risk of having another stroke.”

The experts we talked with agreed that research indicates it is very unlikely that lovemaking will cause another stroke. The heartbeat accelerates and breathing becomes heavier during intercourse, but that is normal. Making love takes about as much energy as walking up one or two flights of stairs.

Fatigue is another common problem for survivors and their caregivers. Both may require more rest time throughout the day. The best time for sex may be after resting or in the morning. “Perhaps, just to reestablish the relationship, couples should spend time together cuddling and sleeping quietly,” Denby said.

There may also be challenges with affected limbs. To avoid injury, couples may need to work on safe positioning. “I recommend that couples experiment with different positions and use pillows so both people have a comfortable experience,” said Dr. Randie Black-Schaffer, the medical director of the Stroke Rehabilitation Program at Spaulding Rehabilitation Hospital in Boston. “Oral or manual stimulation may be attractive alternatives to intercourse for some couples.”

“Hemiplegia and changes in sensation are common problems,” Denby said. “Learning what positions are the most comfortable can be challenging but also fun. I suggest that couples use pillows or props to protect the weaker side of the body. The more mobile person should assume the top position. Ask your therapist to recommend different positions. If you’re worried about urinary continence, it is a good idea for the survivor to void prior to having sex.”

Of course, the timing of when to resume sexual activity after a stroke is personal and will vary in each situation. Factors such as medical stability and availability of a partner may be an influence. Privacy may also be an issue because of additional help the spouse or partner may have in the home due to the survivor’s need for assistance with activities of daily living.

Neither partner should force the issue. You will know when you are ready. “For survivors, the personal signs would be first when they feel well enough to have sex and second when they feel the urge or desire,” Denby said. “Stroke survivors are human beings and the first step in all sexual intimacy is desire.”

What happened to desire?

Many survivors find that they don’t have much desire for sex because they are so involved in their recovery. Often there are body image concerns because of hemiplegia, drooling, facial droop or the inability to speak clearly. These concerns often cause survivors, especially younger, single men or women, to feel unattractive and unappealing to others.

For 52-year-old survivor Tracy (not her real name) of California, body image was less an issue than body sensation. “I had and have numbness. I didn’t want to be touched because it didn’t feel like me. Even when the wind blows against my skin, it feels different. And being touched by my husband reminded me of what I had gone through.”

For 51-year-old Walt (not his real name) of New York, medication prevented him from having an erection. This is not uncommon, according to both Ms. Denby and Dr. Black-Schaffer. “A number of antidepressants and blood pressure medicines can reduce libido (sexual desire) and performance,”
Dr. Black-Schaffer said. If you take pills for high blood pressure, plan sexual activity just before taking the pills. This may help you avoid impotence caused by medication.

It is extremely important never to stop taking a medication without consulting your physician first. In consultation with their healthcare providers, survivors may use medications to treat impotence. However, men should avoid erectile dysfunction drugs if they are taking medications for angina. Men should discuss this with their physicians so that treatment can be optimized.

**Talk about it first**

Walt, who had his stroke at age 43, found it difficult to talk to his wife about sex. “It was a year before we had intercourse,” he said. “I feared that our sex life and intimacy would not return to normal, and that was hard to talk about because I had a lot of anxiety. It takes courage to address this issue. Open communication is key, but very difficult.”

Tracy and her husband were never able to communicate with each other effectively after her stroke, and ultimately decided to end their 21-year marriage. “He was sensitive at first, but after awhile, he wanted business as usual, but my life was changed, and I couldn’t respond to him. He expected me to be my old self and wouldn’t give me room to adjust. He wanted to start where we’d left off, but I wasn’t the same person. It’s an adjustment just to walk or climb stairs, much less make love.”

**Getting started**

Returning to sexual activity requires patience and the loving support of your mate. A spouse or partner may not bring up the subject unless the survivor does. And everyone we talked with agreed that it is important not to measure success by past performance. Both partners are faced with major changes, and adjustments will most likely have to be made to accommodate those changes.

Start slowly, perhaps just by being close and cuddling. Explore what feels good to you now that sensation on one side of your body may be different. Tell your mate what pleases you – he or she cannot read your mind. Intercourse may not happen at first, so just relax and focus on the intimacy that you are building together. Add intercourse only if and when you both feel ready.

**Location matters**

Where the stroke happens in the brain determines how the survivor is affected. “If a stroke occurs in the frontal lobe, the survivor may be less aware of socially appropriate behavior and feel less inhibited,” Denby said. “Or if it occurs in the temporal lobe, the survivor may have decreased sexual arousal, genital arousal and libido. If the stroke occurs in the left brain, the survivor may be more depressed, which can also affect desire.”

It is even possible, though rare, that a stroke may result in an increased sex drive. “If a stroke occurs in the bilateral temporal lobes, the survivor may become more hypersexual and be inappropriate in their approach to sex,” Denby said. “Like in any act of inappropriate behavior, caregivers should remember that this is a result of the stroke. The spouse or partner needs to redirect the survivor into more positive behavior. You have to set boundaries. It takes a lot of patience and a lot of love.”
What about depression?

As in so many other areas of recovery from stroke, depression has an impact. “Depression often reduces libido, and drugs for depression may also reduce libido,” Dr. Black-Schaffer said. “There may also be cognitive changes – reduced ability to pay attention or short-term memory loss that may adversely affect the performance of many focused activities, including lovemaking.”

Those problems can be extremely frustrating for your mate and may alter your sexual relationship more than paralysis does. If you have problems with memory, depression or focus, ask your doctor to recommend someone who can help in behavior management and rebuilding your relationship.

Careful grooming and attractive clothes can help you feel good about yourself. While this may take extra effort at first, you’ll feel more attractive. A satisfying and intimate relationship also helps you accept your new self and regain confidence.

What about aphasia?

Communication is a key ingredient in a satisfying sex life, and both our experts agreed that survivors with aphasia can still enjoy sex. “The survivor with aphasia and their partner may need to learn other ways to communicate their sexuality and their sexual needs,” Denby said. “Touching and caressing are wonderful ways to show your love for another person and can aid in healing.”

“Verbalization is often not necessary for satisfactory sexual intimacy. Touch, gesture, tone of voice — which are frequently preserved in patients with aphasia — may be entirely sufficient,” Dr. Black-Schaffer said.

Role reversal

Both experts and the married survivors pointed out the difficult position the caregiver spouse is in. “The couple’s life has suddenly changed, and this is not an easy adjustment,” Denby said. “It’s not easy to change roles, to be a caregiver one minute and then be a lover. But many couples report that they have been able to adjust, adapt to the changes caused by stroke and their relationships have gotten even stronger.”

If switching roles is difficult, it may help to hire someone to help provide some of the day-to-day physical care. Also, it is important for the caregiver spouse to have breaks from her or his responsibilities without feeling guilty. Both partners need time to themselves.

Sexual attractiveness and intimacy are augmented by simply having fun together. Playfulness in your leisure time goes a long way in maintaining an adult-to-adult relationship. “If you’re interested in restoring your sexual relationship, you don’t want your mate to become like your parent!” Denby said.

“My wife and I found that improving our non-sexual intimacy – hugging, laughing, having fun – really improved our sexual intimacy,” Walt said. “It’s important to focus on what you have, not what you have lost.”

Birth control

Women of childbearing age should talk to their physicians about family planning. Generally birth control pills are not recommended for stroke survivors because they increase the possibility of blood clots. However, other forms of contraception may be appropriate – discuss them with your healthcare provider.

“If a stroke survivor does get pregnant, it will most likely be considered a high-risk pregnancy,” Denby said. “You will need to be followed closely by your obstetrician.”

Sex after stroke can be complicated, but for many couples sex was complicated before a stroke. Both of you are likely to be nervous, so give yourselves time. And don’t dive into disappointment because it’s not like it used to be. A learning curve is likely.

“Just as you may have to relearn other functions such as mobility and self care after a stroke, you may have to relearn how to have sex,” Denby said. “Reviewing photo albums and happy memories may help to remind you of the love you share. As a couple you need to be patient, loving and keep humor in the relationship. It is good to set aside a special time for intimacy and sex. Do things that make both of you feel sexy and attractive. Create a loving atmosphere with music, soft lights, candles and by giving compliments to each other. Having sex is not just about vaginal penetration as much as touching, caressing, kissing and just showing appreciation for your mate. These things help solidify your relationship.”

Getting Help

If you are interested in seeking professional help, the American Association of Sexuality Educators, Counselors and Therapists may be able to help you identify a therapist specially trained to help persons with disabilities. Send an e-mail with the subject “Referred by Stroke Connection Magazine” to aasect@aasect.org, and ask if they can help find a specialized therapist or counselor in your area. For general information, visit www.aasect.org.
Diabetes has major negative consequences for the cardiovascular system. People with diabetes have two to four times the risk of developing cardiovascular diseases (CVD) like coronary artery disease, heart failure and stroke. They are more likely to die from CVD than any other illness. So for people who already have CVD, like stroke survivors, it is especially important to keep diabetes in check.

“If someone is diagnosed with diabetes, as emphasized in the various national guidelines, we actually consider them to have CVD,” said Dr. Prakash Deedwania, chief of cardiology at the VA (Veterans Affairs) Central California Health Care System and professor of medicine at the University of California, San Francisco School of Medicine program at Fresno.

Diabetes damages the inner lining of blood vessels (endothelium) and also increases oxidative stress, which occurs when the body produces molecules called “free radicals,” which also have detrimental effects on vascular health. Diabetics commonly have high blood pressure, which also increases the risk of vascular dysfunction. Diabetes is generally associated with obesity and high blood pressure as well as low levels of HDL (good) cholesterol. All these risk factors together increase the risk of CVD in those with diabetes.

Diabetes seems to be equally common in men and women (7.4 percent of adult males and 8 percent of adult females in the United States have diagnosed diabetes). The most common risk factors for developing diabetes are family history and obesity.

Although it is critical for diabetics to control glucose levels through diet, physical activity and medication, tight control of glucose levels has not been shown to reduce CVD risk. “This is not to say a person with diabetes should not control their glucose, because glucose control benefits other problems, like vision and kidney problems,” said Dr. Deedwania.

To reduce the overall risk of CVD in diabetics, control of other associated risk factors such as high blood pressure and cholesterol abnormalities is essential.

“This is what people need to be aware of with this disease, once you have it, you are destined to have CVD, so you need to control your other CVD risk factors – cholesterol, weight, physical activity and smoking – very aggressively. You can’t just focus on diabetes.”

This is doubly true for stroke survivors. Get control of your cholesterol through diet and medication, if necessary; get active anyway you can to burn calories and lose weight – as little as 10 lbs can have a beneficial impact. And if you’re still smoking, quit.
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.
Finding Quality Care

Every stroke family is concerned with finding quality care, whether it’s acute care, secondary prevention, rehab or long-term care facilities. While the Internet can make the search easier, it can also feel overwhelming. Sometimes it can be hard to distinguish between quality information and marketing hype. The following Web sites provide reliable information.

**Primary Stroke Centers**

Most metropolitan areas have at least one primary stroke center. These centers implement the guidelines for stroke treatment put out by the American Stroke Association and Brain Attack Coalition. They are accredited by the Joint Centers for Accrediting Health Organizations. For a list of certified facilities, go to [www.qualitycheck.org/consumer/searchQCR.aspx](http://www.qualitycheck.org/consumer/searchQCR.aspx). Type your state and city in the appropriate boxes to find the primary stroke center in your area.

**Recognized Physicians**

Finding an effective, reputable doctor in your area can seem like hit or miss. The Recognized Physician Directory at the National Committee for Quality Assurance (NCQA) can be a big help with their directory of physicians who meet specific performance criteria for providing excellent heart disease and stroke preventative care. To access the directory, go to [www.ncqa.org](http://www.ncqa.org) and click on “Report Cards” in the lefthand column. On that page scroll down to and click on “Recognized Physician Directory,” select your state from the menu and select “Heart/Stroke Recognition Program” in the second box. While at the NCQA Web site you can also find assessments on health plans as well as other healthcare organizations.

**Rehab Facilities**

Of course, quality rehab is of the utmost importance to stroke families. The Commission on the Accreditation of Rehabilitation Facilities (CARF) is an international nonprofit accrediting body that provides accreditation in the human services field — focusing on the areas of rehabilitation, employment and community, child and family, and aging services. To access their directory, go to [www.carf.org](http://www.carf.org) and click on “Search for a Provider” in the lefthand column. Select “Medical Rehab” in the first dropdown box, select the type of program you are looking for in the second box and select your state in the third box.

**Editor’s Note:** The three programs listed above may be accessed via the American Stroke Association Web site – [www.strokeassociation.org](http://www.strokeassociation.org). Type “Receiving Quality Care” in the search box.

**Long-Term Care**

Sometimes stroke families have no choice but to move a survivor into a long-term care facility. This can be a scary and confusing choice. For reliable consumer information on evaluating and choosing long-term care facilities, go to [www.longtermcareliving.com](http://www.longtermcareliving.com). This is a comprehensive Web site that can help educate you on the issues and problems in finding long-term care for your loved one. It is jointly sponsored by the National Center for Assisted Living ([www.ncal.org](http://www.ncal.org)) and the American Health Care Association ([www.ahcancal.org](http://www.ahcancal.org)), a consumer advocacy group on long-term care issues. They also have a Web-based tool to help you locate long-term care facilities in your area. The AARP Web site ([www.aarp.org](http://www.aarp.org)) is also a good resource for this purpose.
Assessing a Rehab Facility

Make photocopies of this handy checklist, and ask these questions when you’re touring a facility. Make special note of items that are must-haves or deal-breakers for you. And don’t just talk to the staff during the tour — seek out patients and their family members to find out what they like or don’t like about the facility and the rehab program.

Name of Facility ___________________________   Address _________________________________
Phone Number ___________________ Date/Time Visited ____________   Name of Tour Guide _______________________

Quality of Life

Y  N  Does the facility look like a hospital?
Y  N  Does the facility look like a fancy hotel?
Y  N  Is the furniture in patient rooms and common areas worn-looking?
Y  N  Are carpets and floors clean?
Y  N  Does the facility smell good — neither antiseptic nor dirty?
Y  N  Are the meals nutritious and appetizing, and are the menus varied?
Y  N  Are special medical or religious dietary needs accommodated?
Y  N  Are patients who need help with feeding given privacy instead of eating in a common dining room?
Y  N  Can patients take meals in their rooms, if they are not feeling up to communal dining on a particular day?
Y  N  Are patients dressed in street clothes, or are they still in their nightclothes in the middle of the day?
Y  N  Are there group activities, such as card games, bingo and movie nights?
Y  N  Are there grounds or gardens patients can stroll or navigate in a wheelchair so they’re not cooped up indoors all the time?
Y  N  If you want to stay with the patient 24/7, can an additional bed be placed in the room?
Y  N  If you want to stay with the patient 24/7, can you pay an additional fee and eat your meals at the facility?
Y  N  Do the patient rooms have adequate storage for clothing, medicines, toiletries and personal items, such as family photos?
Y  N  Do the patient rooms have a private toilet?
Y  N  Do the patient rooms have a private shower?
Y  N  Does the facility offer transportation to and from doctors’ appointments?
Y  N  Are all staff members a patient may come in contact with upbeat, smiling and pleasant?
Y  N  Do some residents appear to be in bed all day long, or left alone for long periods?

Quality of Care

Y  N  Is the facility licensed by the state or accredited by the Commission on Accreditation of Rehabilitation Facilities?
Y  N  Does the facility specialize in stroke rehab?
Y  N  Are the therapists full-time staff members or contract employees from an agency?
Y  N  How often are residents checked on? When do regularly scheduled rounds occur?
Y  N  Is there a doctor at the facility 24/7 to handle medical emergencies?
Y  N  Is the facility near a hospital in the event of a medical emergency?
Y  N  Is a psychiatrist or neurologist at the facility daily to address behavioral or neurological issues that may impede rehab progress?
Y  N  Are patients bathed at least twice a week?
Y  N  Is there a barber shop/beauty salon on the premises?
Y  N  Are bed linens changed daily?
Y  N  Are rooms cleaned daily?
Y  N  Are nurses available 24/7 to give a patient his or her meds on schedule?
Y  N  Are nurses available 24/7 to help turn a patient in bed or help a patient go to the bathroom?
Y  N  Are patients given physical therapy, occupational therapy and speech therapy daily?
Y  N  Are the therapists licensed or certified in the type of rehab they are providing?
Y  N  Are there programs to help family members learn how to look after a patient who will soon be discharged to home care?
Y  N  Will a social worker or discharge planner help you find and coordinate appropriate home care for the patient, such as skilled nursing or in-home rehab therapy?
Y  N  Are support groups available to patients, family members and caregivers?
Y  N  Is outpatient therapy available at the facility after patients are discharged?

Adapted from the American Heart Association’s May 2008 Heart Insight Magazine
Hey Good Lookin’ Whatcha Got Cookin’?

“Do you Marilyn, take John to be your lawfully wedded stroke survivor till death — which could be any minute with this guy — do you part?”

“And John, do you take Marilyn to be your lawfully wedded caregiver till God forbid?”

OK, not our actual wedding vows, but they should have been. We got married on Oct 24th, and I had the stroke nine days later when I ended up in a hospital ER. Not exactly the intensive care I was looking forward to after my wedding.

I needed to make amends for the worst honeymoon on record. When our 10th anniversary rolled around I wanted to go back to “Gus’s Place,” the neighborhood Greek restaurant where I proposed. Unbeknownst to me, their lease had expired and Gus packed up his souvlaki and vanished like the boiling water in a kettle of grape leaves.

I opened the fridge and spied all the ingredients to make a Greek salad. Perfect! No stove, no cooking.

OK, here goes...

First, clean and dry the lettuce. Our salad spinner was stashed on the top cabinet behind stuff that could kill me if it fell on my head. So I tapped each romaine leaf against the sink like a peasant woman washing her sari on the banks of the Ganges.

Next, cut the tomatoes. The best way to slice these babies one-handed is to use a very sharp knife and create a place to start by gently stabbing it. Gently is the operative word here. The Tony Perkins “Psycho” shower scene approach may be more satisfying, but I’m not a disgruntled assembly line worker at the Contadina factory wearing a plastic smock.

The vinaigrette dressing: Here I get to use tools like a measuring cup, a whisk, and of course, my trusty Spill-Not Jar Opener to hold the cup. Without this you can launch the whole works through a window by vigorous one-handed whisking.

Finally I dice a red onion. Easy to do and critical, because with any luck I’ll still have tears in my eyes when Marilyn gets home — a handy device if this meal backfires. Crumble the feta, toss in some olives (I refrain from arranging them in a smiley face), chill the champagne, dim the lights (not for ambiance but for camouflage), cue up some “Zorba,” and “BAM!” one anniversary dinner.

Marilyn flashed a big Cheshire cat grin as she walked through the door. Ah, success! Then again she could have just been hungry. We toasted and made a pact to avoid any condition that has the word “survivor” after it. As we savored the moment she requested another Chez Kawie spread for the upcoming stroke anniversary. Hey, do I look like Julia Child?

Quick, move to plan B. A romantic candlelight dinner cooked by yours truly! Me. By myself. No caregiver assistance. How special is that?

I entered the kitchen with more trepidation than Neil Armstrong had when he stepped on the moon. I realized it had also been a decade since I worked with burners, an oven and anything with the name Farberware on it. But there was no turning back. I opened the fridge and spied all the ingredients to make a Greek salad — in honor of Gus. Perfect! No stove, no cooking. A shot of Ouzo, and we’re in downtown Athens. Not the most passionate meal, but there was no time for anything fussy. Think “Iron Chef meets Stroke Survivor.”
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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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 offers protection. 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.

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

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