Making the Most of Life with Aphasia
Triumphant living with long-term communication challenges

Survivor Ron Hoover and wife Jane
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Stroke Connection Magazine is underwritten in part by Bristol-Myers Squibb/Sanofi Pharmaceuticals Partnership, makers of Plavix.
Help raise your protection against another stroke with PLAVIX. If you’ve had a heart attack or stroke, the last thing you want is another one sneaking up on you. PLAVIX may help. PLAVIX is a prescription medication for people who have had a recent heart attack or recent stroke, or who have poor circulation in the legs (peripheral artery disease) causing pain.

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. This can help protect you from another heart attack or stroke.

Talk to your doctor about PLAVIX. For more information, visit www.plavix.com or call 1-800-268-7205.

Blood platelets can stick together and form clots. PLAVIX helps keep blood platelets from sticking together.

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

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.
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).

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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Searching for Ancestors — A Labor of Love

I enjoyed Bob Guns’ article “Writing as Therapy” in your September/October 2007 issue. It shows me that even if you can’t work your regular job, your life can go on with a hobby that can help others.

I had an ischemic stroke in November 1995, when I was 55. I spent a month in rehab learning to walk again, which I did, but I was still very depressed. Six months later I had another stroke. That time I spent only two weeks in the hospital. When I came home, my wife bought me a computer. For about three weeks I used it to play games. Later my brother suggested I get into ancestry, which I did. Since then, I have located where my family was before Alabama, where my grandfather is buried, and I have reunited with a cousin. I also reunited with two other cousins that I’d lost contact with over 40 years ago. This search is a labor of love, and it keeps my mind clear and alert.

Ervin Hughes, Survivor
Birmingham, Alabama

Articles Improved Her Understanding

Thank you for your September/October 2007 issue, especially “Navigating the Memory Maze” and “The Right Side of Communication.” My husband of 50 years had two strokes 18 months ago, one on each side. Although he has greatly improved, there are behaviors I could not understand. Many of them were discussed in the two articles. My husband also has Parkinson’s, and I look forward to any information in upcoming issues.

Sharon Klug, Caregiver
Arlington, Minnesota

A Cornucopia of Questions

My dad had a stroke in March 2006 and is making excellent progress, thanks to my mother’s TLC and our strong advocacy skills. He is receiving cognitive therapy and occupational therapy, for which I advocated. My purpose for writing is to ask why therapy teams don’t seem to adequately tell the family what to expect when the patient is discharged. All my mom and I were told was “he shouldn’t drive and keep him on a low-salt diet.” Isn’t that a no-brainer?

Meal time is interesting. Corn on the cob presented an unusual experience. My father tried to navigate the kernels on the cob. However, once he started eating, if he was interrupted (like the phone rang), he seemed unsure where he left off on the corn. I had to point where he should begin eating. I mentioned this to his neurologist and said that it was as if (during meals and non-corn events) he had to be “jump started” to remind him how to sequence eat.

Based on my experiences negotiating the healthcare system(s) in the hospital and in rehab, I decided to pursue a graduate degree in healthcare advocacy. It is crucial that the families of stroke patients know what patients are entitled to and how to get that care. We could write a book … well, if not a book, at least a pamphlet!

I am interested in knowing if any other families could share their meal-time experiences. I wonder if some of the problems relate to visual discrimination or depth perception difficulties? But more importantly, why don’t healthcare professionals alert families to these possibilities?

Beth Rose Feuerstein, Caregiver
Long Beach, New York
Not a Relationship Success Story

Your November/December 2007 issue hit some points I think you should explore in more detail. Two letters, “As Progress Slows So Do the Visits” and “In a Lonely House,” as well as the article “3 Wheelin’ on the Road to Recovery,” all touch on the often catastrophic effects of stroke on relationships. Broken marriages, broken engagements, family and friends falling away are hugely important topics — especially for those of us who are/were loved ones trying to be caregivers.

My fiancé (age 65) and I (age 59) had been engaged for several years when he had his stroke. He made a good recovery with some deficits. The deficits are not the problem; I can deal with medical issues. His emotional issues, which he refuses to get help for, are the problem, and I am going to “give” him back to his family soon. I simply cannot live with this demanding, angry, critical, verbally and psychologically abusive person any longer. It’s the constant criticism, ranting, tantrums, name-calling and total self-absorption that are destroying what was a fairly good relationship.

I don’t recognize the person he has become, and I wouldn’t want to be around him if I were meeting him now. This is not a relationship, it’s a sentence, and I have served it for the past year and won’t do it much longer. He has a large family, but they are all “too busy” to be involved. I’m sure he’s disappointed in that, but that is no reason why I should be stuck with his hostility. I’m sorry I brought him home, but I can’t change the past. I can only go forward, but I see nothing positive to continue a relationship for. I’m a person, too. Maybe I’m too selfish to think that my own life has some value. Ours is not a success story. I’d like to read about how other people have dealt with the issues of separation, divorce and broken engagements without catastrophic results.

Name withheld by request

Editor’s Note: Thank you for your candid letter. We have an article on this topic planned for an upcoming issue.

Delivering Hope in Ottawa

The November/December 2007 issue seemed to be written for me! For example, I have had a cerebral hemorrhage (page 4), which has affected my sight in two ways: left-side hemianopia (page 12) and damage to the parietal lobe, affecting my art (“Brushstrokes,” page 26). Oh, what hope Dianne Mitchell has given me!

In retirement, I have taken life-drawing classes at our Ottawa School of Art and was devastated when I finally tried to draw two weeks ago. My rendition of a copy of a woman’s face looks most “Picasso-esque” to my husband and to me.

I found the experiences of caregivers and survivors most apt and supportive — realistic, but full of determination and hope. My husband joins me in this. We sat down on our sofa as soon as I brought the magazine from the mailroom and read it cover to cover.

Maureen Cassidy, Survivor
Ottawa, Ontario, Canada

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A hypertension vaccine could be an important alternative to conventional drug therapy because many patients take oral prescriptions inconsistently — if further research supports results from a small study testing the safety and tolerability of such a vaccine.

Despite the fact that effective drugs are available, only about one out of four people has their blood pressure successfully controlled. Many people are apparently unable or unwilling to take pills every day for the rest of their lives. A vaccine that would need to be given just every few months could achieve better control of high blood pressure.

The vaccine targets angiotensin II, a molecule that constricts blood vessels and raises blood pressure. Angiotensin II is already the indirect target of several blood pressure medications. Angiotensin-converting enzyme (ACE) inhibitors (such as benazapril and enalapril) reduce the production of angiotensin II in the blood by slowing its conversion from angiotensin I. Angiotensin receptor blockers (ARBs, such as candesartan and losartan) prevent angiotensin II from acting on these receptors, thus preventing constriction of the blood vessels.

Seventy-two patients with mild-to-moderate high blood pressure were injected with either 100 or 300 micrograms (µg) of the vaccine or a placebo. Compared with patients who received a placebo, those who were injected with 300µg of vaccine significantly reduced their daytime systolic blood pressure (the top number of a blood pressure reading, measuring pressure as the heart constricts) by 5.6 millimeters of mercury (mm Hg) and their diastolic blood pressure (the bottom number of a blood pressure reading, measuring pressure as the heart rests between beats) by 2.8 mm Hg.

The vaccine had the most striking effect early in the morning, the most dangerous time to have high blood pressure because it raises the risk of heart attack and stroke.

In the 300µg group, the typical morning blood pressure surge was blunted between 5 a.m. and 8 a.m. After correcting for baseline blood pressure levels, the 8 a.m. blood pressure was lower by 25 mm Hg systolic and 13 mm Hg diastolic than in the placebo group.

Another potential advantage of the vaccine over ACE inhibitors and ARBs is that these medications result in a large increase in renin, an enzyme that is thought to cause inflammation and is implicated in kidney failure. Vaccination induced only a low increase in renin.

The next step in developing the vaccine is another small trial to determine whether a different injection regimen will create a larger antibody response and a greater reduction in blood pressure.
The American Stroke Association partnered with leading patient and therapy organizations for a “Stop the Cap” advocacy day on Capitol Hill in Washington, D.C. on October 31, 2007. Physical, occupational and speech therapists, patients, caregivers and others participated in the event, which included visits to 78 members of Congress.

Under current law, Medicare patients who have a stroke or other debilitating illnesses and who need outpatient physical, occupational or speech therapy are subject to arbitrary limits or “therapy caps.” However, Medicare patients needing additional outpatient therapy above the $1,780 limits can receive an exception to the limits. These exceptions process, originally expiring on December 31, 2007, was extended through June 30, 2008. More than 5.4 million Americans, including 4.4 million Medicare beneficiaries, are living with the consequences of stroke, and these arbitrary limits could have a significant impact on Medicare beneficiaries who need lengthy rehabilitation. The American Stroke Association continues to urge Congress to repeal these arbitrary limits on Medicare therapy services or to at least extend the current exceptions process for an additional one to two years.

In addition to the AHA/ASA, the Therapy Cap Advocacy Day was sponsored by the American Health Care Association, the American Speech-Language-Hearing Association, the American Physical Therapy Association, the American Occupational Therapy Association, Easter Seals, and the National Association for the Support of Long-Term Care. For the latest information about the status of the Medicare therapy caps, visit StrokeAssociation.org/yourethecure and click on “Medicare Caps on Therapy Services.”

Blood Pressure Management Center offers consumers an easy, secure way to track important health data — at no cost. Consumers can enter daily blood pressure readings and track their condition over time. They can also enter the amount of physical activity they are doing, track their weight, enter updates on how they feel each day, review their readings through easy-to-read graphs and get additional health-related information via links to the American Heart Association Web site.

Consumers can print their personal reports and take this information to their physician or even log in and access the tool while at the physician’s office. They can also allow a family member who is helping manage their care access to their online records. This Web-based platform makes it possible for people to manage their health from virtually any computer and in one security-enhanced location.

Blood Pressure Management Center can be accessed at: www.americanheart.org/BloodPressureManagementCenter.
Genetic Testing May Be Useful for Fine-Tuning Prescriptions

Data provided in real-time studied in blood-thinning therapy

Genotype-guided dosing has the potential to reduce the risks associated with taking warfarin, for which doses vary from person to person and must be tightly controlled. COUMA-GEN is the first randomized, controlled trial aimed at improving patient care by tapping genetic codes to predict the needed dose of the blood thinner in individuals. This information should improve its safety and efficacy.

“The idea behind this study is that the future of medicine needs to be more personal,” said Jeffrey Anderson, M.D., lead author of the study and professor of medicine at the University of Utah in Salt Lake City. “We can use genotyping to fine-tune prescriptions based on detailed information about individuals and their metabolism, which will lead to fewer side effects.”

Warfarin is a drug used to prevent the blood from forming blood clots in persons at risk for this. It is a common therapy for stroke patients, especially those who have a heart arrhythmia called atrial fibrillation, and in other settings — but too high a dose can potentially cause excessive bleeding, while too low a dose allows clots to form, which can lead to a stroke. This means that warfarin has a very narrow therapeutic window. In other words, the dose has to be just right in order for it to work effectively and to keep the risk of unwanted bleeding down. The effective dose for an individual should only be a little lower than a dose that could increase the risk of bleeding. And this is truer for patients with some genetic characteristics than for others. “Now we can genotype patients quickly by swabbing the inside of the cheek, putting the swab in a sort of test tube and checking their DNA for liver and metabolism issues that can affect the patient’s sensitivity to the drug,” Anderson said.
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The National Multiple Sclerosis Society presented a 2007 da Vinci Award to the WalkAide for outstanding design innovation aimed at helping the disabled overcome barriers and further empower all people.

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Good Enough
Approaching life two stones at a time

When I was consulting, one of my associates shared with me a bit of research about Japanese and American consumers. Evidently the Japanese consumer is simply not satisfied with a product or service that’s “imperfect.” In America, however, the average consumer is satisfied with a product that’s “good enough” — as long as it can be repaired, if necessary, within a reasonable timeframe.

I want to draw a parallel with my life. I’m not saying it was perfect before, but it was close. Now I consider it “good enough.” Why the change? A traumatic shock to my health.

And how did “good enough” begin to make sense? Part of it was realizing I’d never be able to do certain things again or possibly do them as well. Of course, that led to the fundamental question of whether or not life was worth carrying on in this suddenly reduced capacity. Well, I didn’t spend much time on that issue.

I did spend time adjusting to my reduced capacity — for example, how to lower my expectations of myself.

Here’s an example: One day we started stacking some ornamental rocks down one side of our driveway. This was part of our driveway project (it first had to be graded and widened). So I would put two ornamental rocks in my Radio Flyer red wagon and take them down the driveway where I placed them. Then I’d go back to the top of the driveway and put two more rocks in the wagon for my wife Veronica to place later in the day after she got home from work.

“So,” you ask, “how long did that take?” Well, it took quite a few weeks, actually a long time. But then, one day there were no more rocks at the top of the driveway. I couldn’t believe it!

Never would I have imagined completing a project this way. Usually it would be done in a concentrated, stressful few hours on a weekend. So, this project did not meet my normal expectations of how to get something done. However, it was … let’s all say it together now — and loudly — IT WAS … GOOD ENOUGH!

Why was it good enough? First of all, I didn’t have the physical capacity to do much more than two rocks at a time. Second, the end product looked fine. Third, there was really no rush to get it done, it just needed to be completed — sometime. A while ago I would have looked very differently at this issue.

So, I have come to learn that good enough is … good enough.

Bob Guns, Survivor
Mooresville, North Carolina
he man stepped out of the crowd and fell into step beside my daughter Melissa.

“Are you jogging alone? Do you want company?” he asked.

Though she didn’t know who he was, she gladly accepted his offer. “Oh yes,” she said. “Thank you.”

Melissa, age 27, was struggling to finish the Vermont City Marathon in Burlington in May 2006. She was running as a member of the Train To End Stroke (TTES) program. The man jogging beside her was an American Stroke Association volunteer who was helping out during the race.

Melissa had been jogging since 8 a.m. It was now close to 1 p.m., nearly five hours later. She was hot and exhausted. Her feet hurt. This was her first marathon, and she wasn’t certain that she would be able to finish it.

When my mother had a massive stroke in July 2005, my family struggled to find a way to deal with the enormity and anguish of what had happened. Melissa and I needed to find a way to give meaning to the devastation the stroke had caused, and to ensure that my mother’s ordeal would in some way help to create awareness of the disease. I chose writing about stroke. My daughter chose to help raise funds for the American Stroke Association by jogging in TTES.

She had trained with a team of other runners, coaches and advisors for the previous four months. Their goal was to raise funds to support stroke research, education and awareness. Melissa named my mother as her stroke hero and ran in her honor.

As Melissa neared mile 17, her marathon partner began to fall farther and farther behind. Many of the other 7,000 runners who had entered the race had either finished earlier or had dropped out. The lonely streets and paths stretched, winding and endless, like an unfamiliar maze. The sun, which had risen mild mannered and warm, was singeing the midday air with 80-degree heat.

When the man stepped out to jog with Melissa at mile 24, she welcomed his company, glad of someone to help make the minutes and the miles pass more quickly. They talked.

They jogged. In his presence she found the will and determination to continue the race to its end.

That man’s presence, at that moment in my daughter’s life, was important. He stepped forward and offered to help, and in doing that, made her journey easier.

I, too, have felt the presence of people, those who have supported and surrounded me as I have begun to deal with my mother’s recent death. Without them, those first weeks and months would have been much more difficult. They gave me the time and the space to absorb some of the shock of my loss.

Looking back at our experiences during that period, I have begun to think about the meaning of presence in all of our lives; that presence is far more important than presents we receive during the holidays or at a birthday. So often, we rush about trying to find just the right gift, the right toy, the right sweater, the right book or CD. Perhaps we’ve lost sight of something so much simpler … that the best expression of our caring can be our presence, the sharing of our time, our experiences and our thoughts with our loved ones.

And yes, our presence, even to people we don’t know, does make a difference.

Just as my daughter neared the last few yards before the finish line, she heard the man say, “You’re on your own now. Go for it.”

She turned to look back at him, to thank him, but he had disappeared into the crowd.

Marsha Zeitz, Stroke Family Member
North Dartmouth, Massachusetts

Editor’s Note: The National TTES program has concluded. The program continues on a local level in Boston and at the Western States Affiliate. For more information, please contact 1-888-4-STROKE.

Marsha’s story was originally published in the New Bedford Standard Times, New Bedford, MA, December 2006.
In summer 2005, I started having difficulties breathing. My family doctor sent me to a pulmonary doctor who did a pulmonary function test and told me to quit smoking and learn to control my asthma. My problem with that was that I've never smoked in my 46 years, nor have I had asthma, yet the doctor was convinced otherwise and would not listen to me.

So I asked my doctor for another pulmonary specialist to get a second opinion. By this time I was having more difficulty breathing and within a matter of weeks I found myself living in an iron lung in the Ventilation Care Unit of Jewish Hospital in Louisville, Kentucky. A neurologist and a critical care pulmonologist determined that I had had a series of brain stem strokes that had paralyzed my diaphragm.
am a personal trainer and fitness instructor and manage two corporate fitness centers in southern California. On April 25, 2002, I was 45 years old and teaching an aerobics class when a stroke changed my life. It was an ischemic stroke that damaged the back, left portion of my brain. I immediately lost my speech, and my right side was paralyzed.

It was like a bolt of lightning: One day I was in top physical condition, and the next I didn’t know what was going on — couldn’t count to 10, couldn’t say the alphabet and couldn’t drive. I had to relearn everything that I had learned over a lifetime. The “self” I had known was injured; my personality and ability to perceive the world were altered.

My body came back slowly, but I had to go to speech therapy for eight months to learn how to speak again. I still have aphasia, so sometimes I can’t express myself very well.

I never thought I would have a stroke. I’m sure that my age and the fact that I’m in good physical condition played a large part in my recovery, but you never know. Good health is certainly not guaranteed. It’s something you should cherish.

Last spring I attended “Congressional Heart and Stroke Lobby Day” sponsored by the American Heart Association/American Stroke Association. More than 600 heart disease and stroke survivors and volunteers from around the country met in Washington, D.C. on April 24, 2007, to make a personal plea to Congress:

- Help us, our loved ones and the 79 million Americans battling heart disease and stroke by making cardiovascular disease a national priority. What an honor it was for me.
- I never thought I would celebrate my five-year stroke anniversary by speaking to senators and congressional representatives.
- I want to encourage everyone to register for You’re the Cure on the American Stroke Association Web site and participate. You can ask your lawmakers to boost funding for cardiovascular disease, help improve women’s heart health and support the regulation of tobacco products.

Diane Gonneau, Survivor
Thousand Oaks, California

Next thing I know, I have a tracheotomy and am attached to a ventilator. My pulmonary doctor found out about a device used by quadriplegics called a phrenic pacer. Basically it’s a pacemaker for the diaphragm. After more research and several consultations, we found that this device might help my situation. I had two surgeries at a hospital in Indianapolis to have both pacemakers implanted. Two months after the second surgery, I went for a test run.

We had to start out with just an hour at a time and gradually increased the time. Now I can be totally off my ventilator during the day (up to 18 hours) and then rest at night. I still have a trach, but I have left my wheelchair behind and can now move freely with little assistance.

Naturally there are days when I require more assistance than others, and there is a high risk of respiratory infections, but I feel it has all paid off. Where I was not expected to live more than one year, I am now celebrating a new beginning of a new life.

Michael Lamm Sr., Survivor
Clarksville, Indiana
there has always been something mystical about the relationship between people and horses. Many stroke survivors throughout the world have discovered that the bond that develops between a person and a horse is both thrilling and restorative. Throughout the United States and Canada there are hundreds of therapeutic riding centers designed exclusively for people with disabilities. Most of these centers are accredited by the North American Riding for the Handicapped Association (NARHA). They provide an important service, are safe and beneficial, and most are located in beautiful settings.

Stroke survivors often don’t consider the idea of horseback riding. They may deem themselves too disabled or too old. Perhaps they have never ridden a horse before, or they may not be aware of the benefits. For those who take part, the rewards are invaluable.

The Somerset Hills Handicapped Riding Center in Oldwick, New Jersey is a therapeutic riding center. Its mission statement offers a good explanation of what horseback riding can do for survivors: “Horses offer a unique combination of pleasure and therapy for the rider’s mind and body. The horse’s walk stimulates the rider’s pelvis and trunk in a manner that closely resembles the human walk. This movement causes the rider’s body to react in a three-dimensional, constantly changing pattern that results in improved muscle tone, increased stamina and improved balance.”

Kelly Lucena, a development associate at Somerset Hills, said, “The horse’s movement can be a unique and extremely effective therapy tool for individuals living with brain injuries. A specially trained speech, physical or occupational therapist can use the movement of a horse to help rehabilitate specific parts of a client’s body to counter the adverse effects of a stroke.”

In Phoenix, Stable Influence offers a similar program. Director Chris Hudson is proud that her stable brings joy and hope to people with disabilities. “As a form of therapy, horseback riding is helpful in developing balance,
HORSEBACK RIDING is not only fun, it also provides emotional value by helping the rider overcome fear and anxiety while increasing self-esteem.

coordination and strength in people with disabilities. The action of a horse has a measurable effect on the rider’s body, mind and spirit for life. In our work with stroke survivors, we find the three-dimensional patterning the horse provides increases movement and coordination that enhances any other therapies these individuals are or have been receiving.”

The Equibloom Therapeutic Riding Center in Manor, Texas, is another NARHA-approved center offering several programs. Like other centers, Equibloom uses the horse to facilitate independence. Their horses are selected for soundness and suitability. Instruction is based on many years of education and experience in the biomechanics of riding.

This type of therapeutic riding benefits every age group. Grace Finn, a young survivor, has been riding for a year. Her father shared his observations: “We noticed the biggest difference after the first three weeks of riding. Her school therapist and another private therapist asked us what we had been doing differently. People who had been working with her saw immediate changes in her gait and posture even before we told them she had started therapeutic riding. Overall, there have been significant improvements in her walking, talking, balance and confidence level.”

In addition to its therapeutic value, horseback riding is fun. It provides emotional value by helping the rider overcome fear and anxiety while increasing self-esteem. It has cognitive value as the rider learns to give commands to the horse. Speech and language skills can be practiced in this fun and challenging environment. But every rider I interviewed talked about how much fun it is to ride.

Survivor Sandy Smethers, a 46-year-old mother of two, said, “This is the first time in the seven years since my stroke that I have found something that creates peace and relaxation and is fun to do. It has been difficult for me to find something that I can do that is really fun. I feel my horse Axel is my friend, and we have a lasting bond.”

Terri Nist, a rider at Somerset Hills, had a stroke four years ago. She found out about handicapped riding when her husband was passing by the center, saw the sign and decided to inquire. She has been riding for more than a year and looks forward to it every week. For her, riding is relaxing as well as great exercise. Like many handicapped riders, Terri sometimes communicates with her horse, Skip, better than with people, and she has also developed friendships with other disabled riders. She hopes to continue riding at Somerset for a long time.

The beneficial results of therapeutic riding are absolutely the gift of the horse. Most handicapped riders would probably agree with Jonathan Swift: “Upon the whole, the behavior of these animals was so orderly and rational, so acute and judicious, that I at last concluded they must be magicians.”

So what are you waiting for? Explore the North American Riding for the Handicapped Association Web site at www.narha.org to find a riding center near you. Then pay a visit and see for yourself how riding can help you.

Photos (left to right, from far left): Grace Finn, Sandy Smethers and Terry Nist

Know THE WARNING SIGNS OF STROKE:

- Sudden numbness or weakness of the face, arm or leg, especially on one side of the body
- Sudden confusion, trouble speaking or understanding
- Sudden trouble seeing in one or both eyes
- Sudden trouble walking, dizziness, loss of balance or coordination
- Sudden, severe headache with no known cause

If you experience some or all of these warning signs, don’t wait. Call 9-1-1 right away.
An inspiring tale of love, commitment and making the most of life after stroke

by Jane Penland Hoover, Caregiver
Durham, North Carolina
We had just celebrated my husband Ron’s 34th birthday, our seventh wedding anniversary and the good news that we were to have a second child, when we learned that Ron’s aortic heart valve, damaged in childhood by rheumatic fever, was failing. “We must schedule surgery right away,” said Dr. Logue, his doctor. That year (1973), a new open-heart procedure made it possible to replace a weakened valve with an artificial one. Then three months after the surgery had returned Ron’s heart to its normal size, he suffered a massive stroke. The doctors, who hoped to avoid putting such a young man on anticoagulants and a lifetime of complicated blood testing, had to do so.

After the stroke, our doctors’ evaluations regarding Ron’s recovery were distinguished only by degrees of hopelessness. Some expected Ron to have another stroke. One even told me Ron would likely die. The speech therapist said that with expressive aphasia Ron might learn to copy spoken and written material but would not speak normally again. The physical therapist thought he would learn to walk even though he would not regain the use of his right hand and arm. All assured us that any changes would be slow.

“Medically there is nothing more we can do,” said Dr. Logue as he walked with me down the hospital corridor one afternoon. The doctor’s eyes held bewilderment, pain and kindness. Seeing his compassion strengthened my resolve for Ron to live, work, raise his children, talk again and enjoy his life.

The speech therapist taught me how to encourage Ron’s speaking by showing him word and picture cards and letting him try to say what he saw. “Point to the window and ask him to name what you are pointing at,” she instructed. “Anything in the room — get him to name everything.” As she talked, Ron’s gaze followed us; frequently he flashed us a cheery smile. Seeing that she expected this to work, I began prompting him.

For Ron, speaking was grueling work; uttering a specific word, impossible. Gradually, I learned to resist my urge to hurry. Ron shelved his anger and distress and managed to offer up patience. We settled into an awkward routine of pointing and naming. When I pointed to the window he would say “door,” and when I pointed to a comb he said “hair.” We grimaced and giggled at near misses. It was six months before Ron said “Jane.” The staccato delivery so alarmed me that I didn’t recognize my name in the sound of his voice.

After our efforts produced almost no usable language, fear, anger and a silent sadness took up residence in the space between us. We moved along like flat tires. Shuddering and fretting, we continued to bump into each other whenever he tried to tell me something, and I tried to guess his meaning with his one-word clues.
On a crisp fall day eight months after Ron’s stroke, we waved to our daughter Holly as she and her friends walked away from our house toward first grade. I found child care for our new baby Rhonda and began searching for a job. Ron and I had worked together as auditors before we married, so I imagined I could design a recovery plan. When offered an accounting job with a newly built senior housing facility, I negotiated for a second desk and permission to bring Ron to work.

As I wrote the management plan, I developed a record keeping system Ron might understand. Slowly he learned to copy using his left hand. He prepared bank deposits and recorded rent payments. To further his interactions and accounting skills, we started a newspaper route in the building. Pushing a two-tiered grocery cart my father had commandeered for him, Ron and our two girls delivered more than 100 papers seven days a week for five years. By then Ron was using a few words, calculating the payrolls, preparing monthly financial statements and insisting on driving again.

After two sessions the driving instructor told me, “Mr. Hoover is an excellent driver, likely better than you.” Ron winked my way and began driving himself to speech therapy, work and back home — early enough to arrive before Holly returned from school in the afternoon.

By the time we retired 24 years later, Ron was entering the accounting data into a computer, reconciling 14 bank statements and producing the financial reports for the two facilities our corporation now owned. Ron eventually learned to type his own reports into the computer. Although it took an entire year for me to teach him, neither of us regretted the time we gave to the endeavor.

Because our need for language, story and thought did not lessen after Ron’s stroke and aphasia, we each turned inward. Today he reads and works 1,000-piece jigsaw puzzles; I write. Sometimes he reads what I write, nodding his understanding. Each night we enjoy dinner with friends in our retirement community’s dining room. Other times we treat ourselves to movies and popcorn. Our daughters and their four (soon to be five) children visit us and invite us to their homes. We eat and swim and go for long walks. The youngest granddaughter, Olivia, climbs up on Ron’s lap and says, “Opa, read to me.” Ron points to the pictures and she calls out, “Chicken … cow … pig.” Turning the pages, they both make farm animal noises and laugh. She says, “Do it again, do it again.”

Living with limited language is challenging. I often find it difficult to articulate the confusing emotions of emptiness, pain and sometimes joy that success and failure deliver to us each day. However, we are gentler and less angry than we used to be.
used to be. Ron continues to support me with patience and bright smiles. Silence is more often sanctuary than isolation now. Our life is not easy, nor is it hard. It is as it is.

We have lived 34 years since the stroke, 10 since we retired. I can still be startled as I was recently when Ron called, “Jane!” I rushed to the sharp sound of his voice, relieved to find him standing at our lake-view window. As I stepped into the circle of his strong left arm, he whispered, “Ahh — ducks — ugh — ducks,” gesturing toward the geese flocked beneath our bird feeder. He straightened and stood taller. He was the one pointing now, pointing beyond the window and calling me to enjoy the moment. 

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**In the Shadow of Stroke… the Aftermath of Aphasia**

More than a list of nouns
Language transfers meaning
From one heart to another,
Informing, questioning,
Encouraging.

Last week
At our four-person dinner table
Our friend said, “We ate
At the best Thai restaurant
At Main and Greene.”

“I know the spot! Next door
Is a barbecue shack:
I can’t name …
Sometimes our daughter
Rhonda meets us there.”

Then he uttered
His single words,
Added gestures.

Name … SameThing … Ugh …
Charleston … Holly … Jim … Aww …
Aw … SameThing … Four … More.

When he tries to speak
I no longer want to guess.
Thirty-four years since that stroke,
Yet again, I am trying to
Fit together the puzzle
Of his thought.

Aha, I’ve got it! Sticky Fingers,
The barbecue place in Charleston
Where we ate three years ago
With our other daughter Holly,
Her husband Jim.

I say, “Sticky Fingers.”
He pushes his notepad toward me.
I write “Sticky Fingers,”
He smiles.

In his aphasia group
On Monday, he may say:
Charleston … Holly … EatIt …
Aww … Longtime … ThisOne …
SameThing … uh … eat …

Then press his fingers together,
Hold as if they will not come apart,
Hoping they will say Sticky Fingers …
Maybe not.

For one small second
I imagined
He would tell our friends tonight
About another time and place
Candlelight and music witnessing
Our soft voices and bright eyes
Focused solely on each other.

Tonight he pockets pad and pen
Then scans the room,
Flashing his cheery smile
To all who look his way.
I feel alone.

He lifts his glass,
Sips tonight’s sweet tea.
I paint a smile across my face
Straining to remember
To be grateful
For our efforts.

— Jane Penland Hoover
Aphasia rarely makes the headlines, so I was delighted last year when it led a major storyline in Lynn Johnston’s comic strip For Better or For Worse. The characters, Grandpa Jim and his spouse Iris, are learning to cope with Grandpa’s aphasia after his stroke. Both feel frustrated when aphasia makes it hard to communicate with each other, let alone with family and friends. Iris mutters, “They call this condition ‘aphasia’ — it should be called ‘confuse-ya!’”

Over time, Iris learns certain strategies, making communication more successful. She tells the family that using pictures or a pad and pen helps Jim get his message across. Iris uses different ways to communicate with Jim and educates the others about aphasia. She shows how family members and friends can learn how to be creative and supportive communication partners.

If I were Jim and Iris’ speech therapist, I’d recommend they keep a basket in an easy-to-access area of the home, perhaps the kitchen table. I’d suggest they fill the basket with maps, rating cards numbered one through 10 and family photos, etc.

To help a loved one with aphasia, your resource basket might include the tips and items below. No single strategy or resource is right for every person, situation or conversation.

- **Personal portfolio:** Create a binder to show off significant mementos like letters, photos of special events or people, newspaper clippings or anything else you want to share. Include a personal record of past achievements and personal milestones. A visual record can make it easier to share memories and inspire activities that are hard to express due to aphasia.

- **Communication book:** Create your own communication book or buy one ready-made. It can be full-sized for home, purse- or pocket-sized for trips. Start with personal, medical and emergency information. Include a list of family and friends and their photos. Use business cards from a favorite restaurant or hairdresser. You can also add pictures, words or photographs grouped by category to help with clothing, food, places, feelings, numbers, days of the week, months and so on. Include information about special hobbies, interests or highlights from the week’s activities.

- **Maps:** Collect maps of your state, the United States and the world. A smaller map of your local area or neighborhood is quite useful. Pointing to a place on a map is usually much easier for a person with aphasia than recalling the name of a specific location.

- **Picture resources:** The Wordless Travel Book published by Ten Speed Press is a great resource for everyday pictures organized by categories. Picture dictionaries also help share ideas. The Aphasia Institute offers booklets to make it easier to communicate in specific situations, such as with a doctor or clergy.

- **Resource cards:** People with aphasia may confuse related groups of words like yes/no, numbers or colors. Make a card with the words “Yes” and “No” written in large letters and paired with a drawing of a happy (YES) and sad (NO) face. Also, it’s helpful to have a number card with 1–10 on one side and 10, 20, 30, etc. on the other. Use crayons or markers to create a color card.

- **Picture scale:** Make a card with a 1–10 scale. Put a sad face over the 1, a neutral face over the 5 and a happy face over the 10. This helps a person give more than just a yes/no response. It is a great way to get an opinion, by asking the person with aphasia how much he or she liked or disliked a movie, restaurant, etc., or to get someone to describe how they’re feeling.

- **Pad & paper:** Writing or drawing offers another avenue when talking is not successful. You can draw or write key words and phrases during discussions to help someone with comprehension problems. For example, instead of giving five choices aloud, list them on a sheet of paper and encourage the person with aphasia to point.

- **Calendar/personal organizer:** Keeping track of appointments, times and details can be particularly difficult for the person with aphasia. Use a calendar updated with appointments and family events whenever you are discussing schedules. Take time to review the daily highlights together so everyone is “on the same page.”

- **Leave instructions in written form:** A person with aphasia is more likely to understand a written list of details or instructions than a long verbal message. Write a note that clearly lists the chores or information you need to convey.
• **Personalized phone message:** Taking messages can be challenging for a loved one with aphasia, and frustrating for the caregiver who needs the information. Create a phone message pad that offers multiple choices. For example, list “family, friend, medical, business” at the top so the identity of the caller can be easily circled. Leave a script of useful phrases by the phone like “Please talk slowly” or “Please spell your name” or “Please call back and leave a message.”

Recommendations for improving communication:

• **Control distractions:** Try to keep distractions and background noise to a minimum. Turn off the TV during a conversation. In a restaurant, pick a quiet booth.

• **Be a partner, not a therapist:** Don’t turn conversation into therapy by correcting the person with aphasia or asking for unnecessary repetition. Encourage all communication methods that work for them. Treat the person with aphasia as a competent adult.

• **Maximize your own communication:** Speak slowly and clearly. Try to give one idea at a time and confirm that the person with aphasia understands. Use facial expressions and natural gestures. Use resources mentioned above to help convey your message. For example, if a friend is coming to dinner, show a photo and write their name and the word “dinner” on a calendar.

• **Educate yourself and others:** Take advantage of Web sites that offer education about aphasia and guidelines for communicating. Share these resources with others. Work as a team with a speech therapist to learn which strategies are most appropriate for helping you and your family member communicate.

Pulling a map out of a basket, using gestures or referring to a communication book may seem awkward at first. Keep using these resources to support your efforts to communicate. Perhaps the most important resources of all will be humor, practice and patience.

To locate an ASHA-certified speech-language pathologist near you, go to www.asha.org and click on “Find a Professional” or call (800) 638-8255.
Growing up I often thought about becoming a police officer. In 1997 I applied and tested to become a civilian jailer for the local sheriff’s department. I had just started the application process when my then-employer gave notice that the company would be closing in 60 days. As a father of three daughters, I started to panic about how I would support my family. After completing several steps of the testing process at the sheriff’s office, I was offered a job by another company. When I arrived home after meeting with the new company, I had a message from the sheriff’s department inviting me to an interview the following Monday. I didn’t hesitate.

During my interview, the sheriff asked, “Why do you want to work for the sheriff’s office?” I told him I had always been interested in law enforcement and wanted to help people. I was offered the job and started my new adventure in March 1998.

I recall walking into the jail on my first day, not knowing what dangers were inside. I discovered that I would be placed in a unit alone with up to 36 male inmates. I often found myself asking, “What am I doing?” but goals are goals, and I convinced myself that I could, and would, do the best job I could.

After five years, I volunteered to work in an in-jail drug treatment program. This was my opportunity to work day-in and day-out with people with addictions. I felt I could really make a difference in another person’s life. It was tough at first, but as the program progressed, the inmates became accustomed to my rules and expectations, and I enjoyed working with them.

Eighteen months later, I became a patrol deputy. This position was a goal of all of the deputies who worked in the jail, so I was excited to accept the position.

My first day on patrol was in March 2005. I was tense and excited. After seeing many police shows on television, I was waiting for the worst to happen, but I completed my 10 weeks of training without any major incidents. I was assigned to work in a nearby small town that the sheriff’s office patrolled. I took ownership and pride in thinking that this was my town to protect. On several occasions I counseled teenage kids; they became aware of what I expected and started acting more like adults. I was thrilled to be doing something that I had always wanted to do.

On Jan. 16, 2006, I got home from work about 11 p.m. and was greeted by my girlfriend, Christie. We decided that ice cream sounded good, and Christie went to the kitchen to serve up the dessert. I suddenly became dizzy and fell to the floor. I had no idea what was happening. The only thing I remember is lying on the cold wood floor, looking up to the bed and thinking that I needed to get up before Christie returned with the ice cream.

Christie came into the room. Being a deputy herself, she made a quick assessment and called 9-1-1. I remember the arrival of the rescue workers and I remember telling them my Social Security number. I was loaded into a step chair, placed into the ambulance and transported to the hospital. That was
the last thing I remember for the next 10 days.

When I finally woke up, my mother and father were standing over me, which felt strange because my mother lived in California and I had not seen my father for 12 years. Someone told me I had had a stroke and that I had a craniotomy (surgical removal of part of the skull) to relieve pressure on my brain. My left side was paralyzed.

After I was medically stable, I was admitted to the Younker Rehabilitation Center, Iowa Health — Des Moines. The first time I was taken out of the wheelchair, I fell over like a wet noodle. Sitting on the physical therapy mat, I tried and tried to hold my head up. Nope, every time the therapist let go, I fell over! Once, when I was alone in my room, I decided to get up by myself and go to the bathroom, even though I had been told to call for help. When I crashed to the floor, I realized I had serious problems. How was I going to return to helping people when I couldn’t even use the restroom on my own?

When I was discharged from the rehabilitation center, I became an inpatient at a local brain injury center, On With Life (“OWL” as we liked to call it). Walking through the facility the first time, I could see that most of the other patients were in far worse condition than I was. I made a close friend at OWL and participated in a brain injury education group three times a week. I felt like I was back in a position to help people, if only by showing a positive attitude and offering my friendship to those who needed a shoulder to lean on. Six months to the day, I was released to go home.

With the help of friends and co-workers, I got a limo ride home escorted by my fellow deputies. What a trip home!

I began outpatient therapy, working with speech pathologist Paulette Wood. After two months of therapy, Paulette and I talked about doing volunteer work to get me back into the community. We found “Telecare,” a wonderful program at the hospital where volunteers call people to check on their welfare. One day a week, I call about 40 people, ask how they are doing and wish them a good day. It’s an opportunity to talk with people and offer a helping word. I am thrilled that I now have the skills to make the calls, speak clearly, keep the telephone records and work in an atmosphere with lots of distractions. I also help determine if people need assistance. If they do, Telecare has a plan in place for a friend or neighbor to call on them. In an emergency, we would call the sheriff’s office and ask them to make a “welfare check.” Once again, I am in the loop.

My second volunteer job is at a local elementary school. Once a week, I am a “reading partner” with two first-grade students who benefit from one-on-one reading time. I read well and my speech is now very clear. This is a “win-win”: I get to use the skills that I worked so hard to recover and at the same time, help children become better readers.

I had to show some initiative to arrange transportation for my volunteer jobs because I do not yet drive. I remembered that my new friend from OWL can drive, so I asked if he would be willing to drive me to the elementary school. Not only did he agree, he became a reading partner, too!

Being involved in volunteer work is very important to me and takes me back to one of my original life goals — helping people. Along my journey to recover from stroke, I can make a difference in the lives of others.

Recovery has been a long and sometimes frustrating road. There have been many days when I got angry and tired of being told what to do. I realize now that they were only trying to help, but it was just the principle of not being able to decide things on my own. I continue to have problems: weakness on my left side, especially my left arm and hand, impaired walking gait and the inability to use optimal thought processes.

Little things are now huge accomplishments, like when I did my laundry for the first time. Having a washer and dryer given to me by a friend was like getting a new toy for Christmas.

Another recent accomplishment was shoveling part of my driveway to eliminate some of the ice build-up — nothing like trying to move slush and snow with one hand! It was great exercise and I’m sure my neighbors got a kick out of watching me!

I’ve scheduled my driving test, as my next goal is to drive again.

“10-38” is the police code that we use to report that a police officer needs immediate help. I never thought that code would refer to me as it did the night of my stroke. I thank the rescue workers for their prompt response to our call that night. I don’t plan to ever give up. Life is too short to let one moment slip by without making the most of it.

“I 0-38, officer down!” … but not for long.
Has Your Stroke Left You with Limited Use of Your Arm and Hand?

If you’ve suffered a stroke or brain injury and are frustrated by the limited use of your affected hand and arm, then the SaeboFlex® might be your key to a better life. Designed by occupational therapists, the SaeboFlex® allows stroke survivors to use their affected hand in therapy and at home to relearn grasp and release.

“Watching my patient go from initially learning grasp and release with the SaeboFlex® to functional tasks without the orthosis has been a life changing experience for me. I am brought to tears when I watch my patients with the SaeboFlex®.”

– Daryl Holt, OTR/L

“To try on the SaeboFlex® was amazing! I was so excited to see my arm move, and that I could grasp and release… was amazing.”

– Mary Graham, Stroke Survivor
Which color do you like?” Marilyn asked as she held up a stack of polo shirts fanned out like a card trick. My eyeballs traveled left to right trying desperately to make a decision.

It was Sunday afternoon and we were in the clothing department of Paragon, a mammoth Manhattan sporting goods store. The place is crazy during the week, but on a Sunday when there’s a sale it’s like standing in the middle of the Plaza de Toros in Pamplona during the running of the bulls. If you linger in one spot too long you’ll get stampeded by obsessive shoppers on cell phones power walking through the store. Sometimes in order to save your life, a swan dive behind the barbell display is necessary. Definitely a dangerous maneuver, but it’s better than having the face of a crazed shopper be your final vision on the planet.

So why would a stroke survivor be in a sporting goods store that sells, among other things, barbells? I could say we had a trip planned to the French Riviera and I wanted to look buff in those tiny Speedo bathing suits that seem to be the rage over there, but I don’t think I’d be comfortable wearing something as thin and transparent as a sausage casing.

Actually I had just gotten out of the hospital and my wife thought I needed a little cheering up. We differ slightly on what constitutes cheering up. I’m of the “Great, I’m out of the hospital so what’s on TV” school. Marilyn is of the “He’s out of the hospital so let’s go shopping” school.

What’s the big deal about picking a color? Making even a simple decision after a stroke is difficult, and this is compounded by the fact that I spent an extended period of time in a decision-free environment. The hospital plans out everything … when to get up (usually with a syringe) … when to take meds … when to do therapy … when to eat … when to take more meds … and finally, when to sleep. Now I’m calling the shots with shoppers whizzing by me so close I can feel the breeze. After only seeing beige for so long, it looked like Marilyn was holding up an outfit Liberace would wear in concert. All that was missing was the piano and the candelabra. I was yanked from the womb and this was my slap on the fanny. I didn’t need a shirt. I needed a binky and a nap.

We live in an age where there are way too many choices. Here’s a frightening statistic: The average supermarket carries over 200 varieties of salad dressing! Now there’s a great place for a stroke survivor to hang out. “Hey, John, why are you bringing your sleeping bag to the supermarket?” “Because I need to dress my lettuce and it may take a while.”

Finally, when I got home, the first thing I did was grab the remote, kick back on the couch, and relax. Yeah, right! First I had to deal with the numbers: channel 2, click, 3, click, 4, click, 5, click, click, click. Then the initials: HBO, CNN, TNT, AMC, click, click, click, click, click ...

Continuing Physical Therapy at Home
by Craig Moore, PT, MS
Orlando, Florida

Many stroke survivors feel their therapy ends long before they’re ready. With that in mind, we asked physical therapist Craig Moore to suggest some things that survivors could use at home to further their recovery. Craig cautioned, “The items on this list are not for everyone, and they don’t take the place of working with a therapist. They are suggestions of products that might be beneficial to someone who has plateaued in their stroke recovery and would like to work on continued maintenance and/or progression at home. The ability of an individual to use any of these products will depend on their post-stroke limitations and/or the level of caregiver assistance they have at home. I recommend that you consult your physical or occupational therapist to see if any of these devices may be safe and suitable for you.”

A note about cost: The items on this list reflect a wide range of prices, from free or low-cost to more expensive items. We invite our readers to share their own low- or no-cost at-home therapies or adaptations that support recovery of activities of daily living. We’ll share them in a future issue. Send your suggestions to us at: StrokeConnection@heart.org or Therapy Suggestions, Stroke Connection, 7272 Greenville Ave., Dallas TX 75231 or fax 214-706-5231.

See our sidebar on page 28 for more information about where to find the aids and equipment described.

This information is provided by the American Stroke Association as a resource. The products listed are not owned or provided by the American Stroke Association. Additionally, the products have not been evaluated and their listing should not be construed as a recommendation or endorsement of these products.

Range of Motion/Stretching

Comprehensive Therapeutic Exercise Program
Most survivors benefit from continuing an exercise program after therapy has ended. Studies suggest that exercise can improve cardiovascular fitness, sensory and motor functioning and overall health — for both survivors and caregivers. Any exercise program for stroke survivors should first be discussed with their physician and therapists. Most rehab programs will provide patients with exercises that they can continue to perform independently or with the assistance of a caregiver.

Free tips for exercises can be found on stroke Web sites such as:
www.stroke.about.com/od/lifeafterastroke/p/Exercise.htm

To create your own exercise program, you can invest about $400 in a Rehabilitation Exercise Prescription Kit that provides pictures and directions of stretching techniques and exercises.

Skate Systems
Skate systems assist survivors in performing upper or lower extremity movements on a variety of surfaces. These devices promote continued range of motion with friction-free movement. Additionally, they keep you positioned so that you are not fighting against gravity to exercise. This can benefit someone with a limited, active, independent range of motion.

Prices vary from around $60 for the arm only to more than $100 for an arm and leg skate to about $270 for a skate and board system.
**Hemi-Glide**
This device promotes upper extremity range of motion in all planes in a friction-free environment. Hemi-Glide promotes independent range of motion of the upper extremity. Lightweight and easy to use. Cost ranges from around $5–$75.

**Fine Motor Exercise Kit**
An all-inclusive kit containing a variety of objects survivors manipulate with their hands, promoting fine motor dexterity and coordination. The “Yes-U-Can” kit is small and portable. $41.95.

**Electrical Stimulation**
Ranging from $200 to $995, electrical stimulators use a light electrical current to promote muscle contraction. These units are very small, can be worn on a belt clip or in your pocket, and contain preset modes for ease of set-up and use. Muscle contractions through the use of a muscle stimulator promote overall muscle tone and can be used as a technique for muscular re-education.

**Continued post-therapy exercise is important for improving overall health, both for survivors and caregivers.**

**Resistance Exercises**

**Although loss of muscle strength is common after stroke, the American Heart Association suggests strength training three times per week can improve muscle tone and overall strength.**

**Cuff Weights**
Weights vary in poundage from 0.5 lbs to 20 lbs and can be strapped to the upper or lower extremity using Velcro attachments. Cost ranges from $11 for one cuff weight to around $500 for a 32-piece set of varying poundage. For a “low-tech” means of weight training, look no further than your kitchen pantry — you can perform strength training exercises using canned goods of varying sizes and weights.

**Thera-Band®**
This is a resistive exercise product similar to a rubber band. Bands come in various degrees of resistance. The bands can be wrapped around an upper or lower extremity and then attached to a stable object (such as a door knob, bed frame or table) to perform resistance exercises. A variety of accessories such as adjustable handles or loops can also be purchased, making it easier to hold onto the band. Instructional exercise booklets may also accompany the bands. A kit of individual bands costs $13.

*Product photos courtesy Patterson Medical/ Sammons Preston*
Therapy Putty
This putty provides a variety of levels of resistance for hand, finger, wrist and arm strengthening and promotes upper extremity gross/fine motor skills.
A set of multiple resistance packages is about $17; a 12-page exercise booklet is about $10.

Endurance Exercises/Activities

The American Heart Association recommends 20–60 minutes of aerobic exercises three to seven days per week.

Pedal Exercisers
Pedal exercisers are ideal for low-impact aerobic upper- and lower-body muscle conditioning and endurance training. These peddlers can be highly portable and “low tech” or more advanced with computers and advanced resistance systems.
Portable peddlers can be as inexpensive as $60, while the more “high-tech” variety can cost up to $2,000.

Able Tripod Cane
Enough cannot be said about walking for exercise. While walking around the home is great, getting outdoors and into the community is even better. If weather prevents you from getting outside, walk in the mall or a large indoor space with adequate places for you to sit and rest. Increasing distances can really improve your overall endurance.
The type of device needed to assist survivors with walking is dependent on the severity of the stroke. If you are able to use a single-point cane, the Able Tripod cane has a larger base for balance and stability. If you drop it, the tripod portion of the cane allows you to step on one end to bring the cane back to an upright position. The cane can even be left in a vertical position independently until ready for use.
If you already have a single-point cane, replacing the tip with an Able Tripod will only cost $20. A standard cane with the Tripod attachment costs $50.

Where to find these items
The items listed on these pages are available through online retailers of rehab equipment.

Sammons Preston Rolyan: www.sammonspreston.com
or 1-800-323-5547
Rehab Mart: www.rehabmart.com or 1-800-827-8283
Active Forever: www.activeforever.com or 1-800-377-8033

Many items may also be available in your local area through medical equipment suppliers. Check your Yellow Pages under rehab equipment, medical equipment or medical supplies.

About the author...
Craig Moore is a physical therapist in Orlando. He is president of the Home Health Section of the American Physical Therapy Association.
The American Physical Therapy Association represents more than 73,000 physical therapists nationwide. Its goal is to foster advancements in physical therapist education, practice and research. You can access “Find a PT” to find a physical therapist in your area at www.apta.org/consumer.
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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If you’ve had a stroke, your chance of having another is 9 times greater.

Help raise your protection against another stroke with PLAVIX. If you’ve had a heart attack or stroke, the last thing you want is another one sneaking up on you. PLAVIX may help. PLAVIX is a prescription medication for people who have had a recent heart attack or recent stroke, or who have poor circulation in the legs (peripheral artery disease) causing pain.

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. This can help protect you from another heart attack or stroke.

Talk to your doctor about PLAVIX.
For more information, visit www.plavix.com or call 1-800-268-7205.

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

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.