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January 2004

Welcome to the January issue of StrokeNet. We wish you a Happy New Year. StrokeNet staff looks forward to bringing you news this year that helps your journey.

This month we want to introduce the newest member of StrokeNet staff. The new Website Reviewer is Janice Rodriguez, a non-practicing lawyer, who had a stroke in Sept 2000. Be sure to read her first website review, which appears in this newsletter. Welcome Janice!

Steve reflects on 2003. David Ray shares two New Zealand Christmas menus. Joe Flasher writes about chronic pain and management aids. Dez Crawford reports on pet regulations for visiting hospitals and rehab centers. Innovation and Research in Intervention Radiology's Stroke Meeting is announced. Janice Rodriguez reviews a group of websites, which cover several issues including Patent Foramen Ovale (PFO), hole in the heart. Dennis Galindo and Jim Weir share their biographies.

Have a good read.

Lin Wisman, Editor
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Organization Highlights

By Steve Mallory

I want to begin by saying that I hope your holidays have been the best that they could be! The year 2003 was a good one for our organization and I have a strong feeling that 2004 will be even better. We have matured more than many thought we would and established our roots deep in the non-profit family.

I have to thank the staff for their hard work! This has not been the best year for health for me but thanks to the fantastic volunteers we have helping make this site a success we can all enjoy this on-line resource of stroke support.

Our accomplishments are something to be proud of and let me reiterate some of the things that stand out:

- Our organization remains very liquid!
- All sites of the network have been redesigned.
- The Organization has gone from a confusing three point to a one point registration system.
- We have a new and highly user friendly message board and chat room.
- Chat has become a daily activity and much needed source and type of on-line support.
- Again, our membership has doubled and stands well above the thousand mark.
- We donated 2 brand new computers to the stroke ward of a stroke rehab hospital. We hope to begin something called Stroke Therapy.
- Our Second Annual Golf Tournament fundraiser was a complete success and guarantees that our organization will remain free for several more years!

Steve Mallory
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Life in New Zealand with a Stroke

By David G. Ray

Today, as I prepare this message, it is Christmas Day. I can recall many such days in past years when it has been warm and sunny. After our Christmas Church service and exchanging presents, we have gone to the beach for a day of playing, swimming and enjoying the company of our family before returning home and preparing for

the Christmas feast. We prepared and ate the usual Christmas fare such as roast turkey or lamb and ham accompanied by roast potatoes, kumera, green peas straight from the garden and fresh red carrots, also picked from our garden.

This would be followed by steamed pudding and hot custard, fruit salad and ice cream. The meal would be supplemented with New Zealand wine or orange juice followed by coffee and nuts. What a feast. In latter years things have changed in our household. Instead of hot roast meals we have cold meats, no heavy steam pudding, instead we have Pavlova, with plenty of cream and strawberries and/or raspberries. But today, in what is supposed to be summertime, I think we will be returning to the old days.

Our Stroke Club has finished for the year and will not re-commence until February. My own situation has changed and I have not been well but I am now making a recovery from the Raynards Disease, which had me in hospital for 6 days. Raynards affected the fingers of my left hand, the hand unaffected by my stroke. I am still required to take a mountain of medication each day but, except for one, these will cease very soon. Recently my wife and I went to a healing session given by a Catholic Priest and since then I have been making very fast progress towards a full recovery. I am still recovering from my stroke but even now I am walking much better and longer distances than before.

We are now looked forward to the New Year and all it will bring. Our programme for the club year has been mapped out and will consist of the usual mix of education, entertainment and bus trips about the Wellington/Lower Hutt area. Some of our members are more or less housebound and really look forward to the variety of activities that we arrange. I hope that all readers have had a great holiday and are looking forward to a new year full of happiness and very good health.



Managing Chronic Pain

By Joe Flasher

In my last article on mild to moderate pain, I said I would be focusing on chronic pain and those methods used to control it. As you recall one of the differences between acute and chronic pain is that chronic pain generally lasts longer than six months. You may not be aware of the source of your pain or you may have found out it's fibromyalgia, arthritis

or any number of other conditions but you know it's chronic.

Knowing the source isn't enough to alleviate your discomfort. There often aren't any quick fixes for chronic pain. There is only so much your doctor can do and often it's up to you. If you want your life to improve then you must learn to manage your pain.

Managing chronic pain isn't about making the pain disappear. It's about keeping your pain at a tolerable level. It's about enjoying life despite your pain. Being in charge of your pain doesn't mean that we can't or shouldn't look for help from others.

A doctor can be especially helpful when you have questions or need assistance. Make sure it's a doctor who communicates well with you and understands your condition. It may be a specialist overseeing your condition, your family doctor, or a pain control physician. You can usually get a referral from your family doctor.

To make managing your pain easier, learn all that you can about your condition and your pain. There is much information to be found on the internet and also at your local library in medical dictionaries and books on pain control.

Understanding your treatment is especially important when your physician recommends specific treatments. Find out why these treatments are being recommended, what are the risks and the benefits and if there are any alternatives. Be careful of medications or injections being offered, without being aware of what each entails. Any intervention brings a chance of both benefits and complications. Talk to your doctor to make sure the balance is in your favor.

I covered OTC (over the counter) medications in my previous article. In this issue we will talk about those drugs used in pain control which require a prescription. There are many classes of medications used. Let's begin with anti-seizure medications.

Some of the most effective and commonly used medications to control pain are those drugs that were developed to treat other conditions. Anti-seizure (anticonvulsant) medications were developed primarily to control epileptic seizures, but they also help control stabbing or shooting pain from nerve damage. These drugs seem to work by quieting damaged nerves to slow or prevent uncontrolled pain signals

Anti-seizure medications used for chronic pain include:

Carbamazepine (Carbatrol, Tegretol)
Divalproex sodium (Depakote)
Lamotrigine (Lamictal)
Oxcarbazepine (Trileptal)
Topiramate (Topamax)
Clonazepam (Klonopin)
Gabapentin (Neurontin)
Phenytoin (Dilantin)
Tiagabine (Gabitril)
Valproic acid (Depakene)

These medications can cause dizziness, drowsiness, nausea and lack of balance and coordination, but most people are bothered only minimally. More severe, but less common, side effects include blood and liver disorders. To reduce your risk of side effects, your doctor will likely start you off on a small amount of the drug and gradually increase the dose while monitoring.

COX-2 INHIBITORS

These medications can cause dizziness, drowsiness, nausea and lack of balance and coordination. But most people are bothered only minimally. More severe but less common side effects include blood and liver disorders. To reduce your risk of side effects, your doctor will likely start you off on a small amount of the drug and gradually increase the dose while monitoring you.

COX-2 inhibitors include:

Celecoxib (Celebrex)
Valdecoxib (Bextra)
Rofecoxib (Vioxx)

In addition, COX-2 inhibitors do not thin your blood like aspirin and other NSAIDs. If your doctor has prescribed aspirin for a heart condition, don't use COX-2 inhibitors instead.

INJECTIONS

Instead of prescribing pills to control your pain, your doctor might inject medication. Injections typically don't cure pain, but they may help you through an initial period of intense pain or a flare-up of severe pain. Injections are most effective for joint, muscle or nerve pain that's confined to a specific location. Injected medications may be an anesthetic to control the pain, a steroid to reduce inflammation or a combination of the two. In addition, a substance that improves joint mobility is also sometimes injected. One benefit of injections is that the medication works primarily in

a limited part of your body. By targeting a specific area, injections may reduce the amount of medication needed and the number and intensity of side effects.

NON-STEROIDAL ANTI-INFLAMMATORY DRUGS (NSAIDS)

I covered this class of drugs in my previous article. The basic difference between the prescription and OTC tablets is the strength of the drug. The prescription tablets have more drug in each tablet than the OTC products but there would be no problem taking more of the OTC drug to equal the prescription strength. You must be careful to monitor the effects on your stomach.

OPIOIDS (Narcotics)

Opioids are prescription medications and are regulated as controlled substances by the Drug Enforcement Administration. Opioids are often used to relieve pain from cancer, terminal illness, severe injury or surgery. Pain control after surgery is especially important. The sooner you're active, the less the risk of complications due to inactivity, such as pneumonia or blood clots.

Opioids, sometimes called narcotics, come in several forms. Some are natural compounds derived from the opium poppy, which are called opiates. There are also synthetic opioids that work in similar ways. Opioids include both these natural and synthetic forms and are the preferred term.

Frequently prescribed opioids include the following:

Codeine
Hydrocodone
Levorphanol (Levo-Dromoran)
Fentanyl (Duragesic)
Hydromorphone (Dilaudid)
Meperidine (Demerol)
Methadone (Dolophine)
Oxycodone (OxyContin)
Propoxyphene (Darvon)
Morphine (MS Contin, Oramorph SR, others)
Oxymorphone (Numorphan)

Side effects of opioids include mild dizziness, drowsiness, sedation, and unclear thinking. These can make it unsafe for you to drive or operate machinery.

I am giving you just a short overview of these drugs. Each of these drugs is a book all by itself. If you want more information ask your doctor, go

online, go to your library or email me. I'll answer what I can.

TOPICAL MEDICATIONS

Topical medications are creams or gels that you apply to your skin. These drugs act on the surface of your body or are absorbed. Pain relief ointments can occasionally help relieve nerve pain and inflammation just below the surface of your skin. Three types of topical medications are available. They are local anesthetics, analgesics and counter-irritant products.

Local anesthetic is a prescription pain relief cream made from two topical anesthetics - lidocaine and prilocaine. Your skin becomes numb within an hour after application, and the benefits are greatest 2 to 3 hours following application.

Lidocaine patch is a patch (Lidoderm) which may be prescribed for relief of pain associated with neuralgia and nerve pain.

Over-the-counter products - Several OTC topical medications are available for pain relief. They include dibucaine (Nupercainal), lidocaine (Xylocaine, Zilactin-L), benzocaine (Lanacane, Solarcain) and pramoxine (Prax, Itch-X).

ANALGESICS

Capsaicin - This nonprescription drug is made from the seeds of hot chili peppers. You rub capsaicin (Capzasin-P, Dolorac, Zostrix) on your skin, typically three or five times a day. It usually takes up to 1 to 2 weeks before you begin to feel noticeable pain relief. Capsaicin is most effective for temporary relief of arthritic pain in joints close to your skin's surface, such as your fingers, knees and elbows. It may also help relieve pain after shingles (neuralgia), pain from diabetes (diabetic neuropathy) and chronic pain near healed surgical scars.

COUNTER-IRRITANT PRODUCTS

These nonprescription medications (ArthriCare, BenGay, Icy Hot) stimulate your sensory receptors of heat or cold to cover up or counter pain.

TRAMADOL

Tramadol (Ultram) is a prescription pain medication that works in two ways. Like an opioid, it interferes with the transmission of pain signals. Tramadol is used mainly to relieve moderate to severe acute pain. Its effect in treating chronic pain hasn't been well studied. Because it's not a true opioid, risk of physical dependence and addiction is less. Side effects from tramadol can include dizziness, sedation, headache, nausea, constipation and seizures.

TRICYCLIC ANTIDEPRESSANTS

Some of the more effective and commonly used medications for chronic pain are drugs that were developed to control other conditions. Among these are tricyclic antidepressants. In addition to relieving symptoms of depression, these drugs interfere with certain chemical processes in your brain that cause you to feel pain.

The tricyclic antidepressants most commonly used for pain management are amitriptyline (Amitril, Elavil) and nortriptyline (Aventyl, Pamelor). Antidepressants don't cause dependence or addiction. However, tricyclic antidepressants can make you drowsy. Therefore, it's generally recommended that you take the medication in the evening before bed. In addition, these drugs may cause dry mouth, constipation, and weight gain, difficulty with urination, and changes in blood pressure.

I will be covering antidepressants in a future article. It is a fascinating subject and especially pertinent to us "stokers".

There are so many aspects to "pain control" that it is impossible to cover in a couple articles. There are alternative therapies to drugs that could be explored (ie: acupuncture, biofeedback, etc). If you would like to have me go into these alternatives in greater depth, please let me know.



Visiting Pets at Hospitals and Rehab Centers

By Dez Crawford

Regardless of the nature of their illness, it has been demonstrated that hospitalized patients can benefit tremendously from contact with a beloved pet. Even patients whose communication is severely limited often respond profoundly to a visit from a friendly animal, whether it is their own pet from home or a "visiting pet" brought to the hospital by local volunteers working for a visiting pet program.

Many hospitals and live-in rehab facilities today allow "visiting pets" to cheer and comfort the patients in their care. Some of these animals arrive in the hands of volunteers from local humane societies, who bring specially trained, gentle animals for patients to stroke and cuddle.

A number of facilities also allow family pets to visit the patient, provided the family complies with sensible guidelines governing the pet's health, demeanor and level of cleanliness.

When my husband, David, was in the rehab hospital post-stroke, visits from our family cats made a tremendous difference in his comfort level. He sorely missed his cats, and looked forward to a daily visit from each of our pets.

You might be able to bring the same happiness to your own friend or family member by bringing their beloved dog or cat for a visit.

Before you consider bringing a pet to visit, consider the following:

Does the patient want to see the pet? For some patients, visits from a pet may be more stressful than not seeing the pet at all. A pet visit may be too confusing for some patients; others may be more saddened than cheered by brief visits from a pet they cannot have at their side all the time.

The hospital will be a new and unfamiliar environment to the pet. Does your pet do well in unfamiliar situations, or does it become nervous and irritable? Remember that some of the same scents and sights found in a hospital, such as disinfectant, bright lights, and humans wearing medical scrubs, may be reminiscent of a trip to the vet's. Your pet's behavior at the vet's office may be a good indicator of its possible behavior in a hospital situation. Be cautious of bringing a pet to a hospital if it becomes nervous or irritable at the vet's.

Likewise, your pet will be around unfamiliar people. A pet that doesn't like strangers is a poor choice for a hospital visit.

Ask yourself:

If the pet is a dog: is it friendly to strangers, is it obedience trained, and does it handle well on a leash?

If the pet is a cat: is it friendly to strangers, and is it calm in most situations? A cat who runs from strangers, or who spends most of her time hiding under the bed at home, is very unlikely to relax in new surroundings. For most hospitals and live-in rehab facilities, which allow visiting pets, the following requirements apply:

1. At most facilities only one animal visitor is allowed at a time.
2. Pet must be healthy, free from fleas and other parasites, and up-to-date on rabies shots and other vaccinations. Be sure to bring printed

information on the pet's health and vaccination status along.

3. In most cases, the pet must have been bathed at least within the last 72 hours. Some facilities require bathing within the last 24 hours. Be sure the pet is freshly brushed so it does not shed hair in the hospital.
4. Pet must be restrained. This means a collar and leash for dogs, and a harness and leash for cats.
5. Some facilities allow other pets, such as ferrets or birds, if their health can be verified. Bring this information with you. Because birds, primates, reptiles and certain other pets can sometimes carry zoonotic diseases (diseases transmittable to humans), some facilities do not allow them to visit. Ferrets must be restrained on a leash and harness. Birds should have their "fly feathers" trimmed to restrict flying. Transport birds and ferrets to and from the facility in a cage or carrier.
6. The animal handler must have complete control over the animal at all times.
7. Cats and small dogs are best transported to and from the facility in a pet carrier.
8. Be sure to "bathroom" the dog shortly before you enter the facility. For cats, bring a large, covered, plastic shoebox with some kitty litter in it, and place it in a private corner of the room with the lid removed while you visit.
9. Be certain that the person bringing the pet is able to completely control the animal without assistance from others. A large dog that is not obedience trained, who jumps up on people, or who is not accustomed to walking on a leash, does not make a good visitor. At all times, make sure the pet does not get underfoot in a situation where it could trip the patient.
10. Trim your pet's claws or nails before your visit.
11. Most importantly, NEVER bring an excitable or nervous pet, or a pet that has ever bitten a human being.

Call the hospital or rehab center before your visit to make sure you are in complete compliance with their visiting pets policy -- specific policies may vary from one facility to another. Some facilities, for example, allow only small pets. Some allow the

patient's personal pet to visit only the patient, while others allow the pet to be "shared" by other patients. And some facilities do not allow certain breeds, which are generally perceived to be aggressive, such as Rottweilers and pit bull dogs. If your specific pet is not allowed inside the facility, you might ask if the patient may visit the pet outside, in a patio or parking area.

When you enter the patient's room, do not immediately plop the pet into the patient's lap. Allow the patient time to acknowledge that the pet is there. Likewise, allow the pet time to adjust to its new surroundings. Dogs will want to sniff around for a few minutes. Allow a cat a few minutes to check out the situation before you remove it from the pet carrier. Make sure the patient is seated or in bed when the pet is presented, especially if it is a medium-to-large sized dog. You don't want a large dog to jump up on a standing patient whose balance is poor.

Bring the pet to the patient slowly. Allow the patient time to stroke and touch the pet while you hold the animal. Assist the pet and patient with more intimate contact as desired, for example, lifting the pet onto the patient's lap. Keep the pet's leash in your own hands at all times. Don't expect the patient to control the pet if it gets excited and jumps off the patient's lap.

Both pets and patients get tired. When either the pet or patient shows signs of fatigue, irritability, anxiety or restlessness, either kennel the pet for the duration of your visit, or bring it directly home.

If you plan to "share" your family pet with other patients, follow the same guidelines. Be especially certain that a "shared" pet is completely comfortable with strangers before you offer a visit. Remember that pets whose personalities are too intimate or "licky" may not be welcome by other patients. Your own family member may love to be licked by your slobbering St. Bernard, but other people may not find this level of affection appealing.

It's also a good idea to bring paper towels, a plastic bag and a squirt bottle of sanitizer in case your pet has an accident inside the hospital. A water bowl is a must if the visit will last more than a few minutes, and a having small amount of pet treats handy is helpful. By following a few simple guidelines, you may be able to provide a great deal of joy and comfort to your family member by bringing a pet for regular visits. Like visits from human family members and friends, visits from a pet bring familiarity, comfort and love to the

patient who is trapped in a strange and sometimes frightening environment.

My husband, Dave, says: "When you are hospitalized for a stroke, it is like getting slammed into a program, without any preparation. After being hospitalized awhile, I realized that my cats were what I missed the very most from home. Being able to see them was a great relief. I was glad to see them and they were glad to see me."

Please feel free to e-mail me at <mailto:dez Crawford@hotmail.com> for further information.

CIRREF Conference

The Cardiovascular and Interventional Radiology Research and Education Foundation (CIRREF) will be holding its second annual IR² meeting, January 30-31, 2004 at the Hyatt Regency in Bethesda, MD. The focus of the meeting will be on topics related to stroke interventions. The meeting will consist of four basic modules over a day and a half: carotid and extra cranial atherosclerotic disease and interventions, intracranial atherosclerosis, ischemic stroke, and hemorrhagic stroke. Special focus will be given to basic science, clinical practice, and imaging techniques. Please also be aware that CIRREF is currently accepting abstracts for poster presentation at the meeting. Detailed information for meeting registration and abstract submission instructions can be found at www.CIRREF.org, or email us at info@CIRREF.org.



Website Review:

By Janice Rodriguez

This is my first website review for StrokeNet. I think that the Internet is a wonderful resource for stroke survivors, caretakers, loved ones and friends. It was a great help to me when I had my stroke! I am going to do something different on the format of this review - the way people usually find information on an interesting topic. It will be a series or chain of sites on a topic about stroke. But as you know, some of the information on the Internet is old, incomplete, and just wrong! So be skeptical and **always** check with your doctor or therapist!

The first topic is multipart - young stroke survivors (any person under 55 - it is great to called "young" at my age!), cryptogenic stroke (an unknown cause), and heart defects causing strokes. Or another way to say it: Why do healthy young people have strokes? Of course, the entire lingo in this article will be defined as we go. The first website is called "Generation-S: Young Stroke Survivor" - the story of Bernie, a 29 years old man who had a stroke. He was diagnosed with a PFO (Patent Foramen Ovale) and then finally, diagnosed with atrial fibrillation. At the left of the Generation-S website, there are links to some terrific articles, health topics, survivors stories and new research and techniques - you can browse the links for hours!

But back to the topic -- this is paraphrased from another enjoyable website, "Harlan Stockman's "You're Kidding?" Stroke Page": the definition of PFO in laymen words and great graphics: *A patent foramen ovale (PFO) is a hole between the upper chambers of the heart. Before birth, the hole is "intentionally" open before birth. After birth, the hole is supposed to be closed by a flap of tissue. In about 25-30% of adults, a surgeon's probe can be pushed through the hole, and there is no tissue that forms a complete blockage. In about 5 % or so of adults, the hole is "open" all the time.*

Now, I'm going to quote and paraphrase in a medical journal site (don't be afraid!) "Contemporary Management of PFO." "Assuming an annual incidence of 750,000 strokes in the United States, about 600,000 will be ischemic" (from clots). "Of these, about 200,000 will be cryptogenic, and of these roughly 70,000 will be associated with a PFO." Why a PFO? Go back to Harlan: *When a PFO exists between the upper chambers of the heart, there is the possibility that clots or bubbles will pass from the right chamber, to the left, and from there, directly to the brain causing a stroke.* OK, back to the journal: *About 21% (42,000) of ischemic strokes that have no known cause in people under 55 years old may be caused from a PFO .* Wow! But what can they do?

"In 2000, the CardioSEAL device (NMT) and in 2002, the Amplatzer PFO Occluder (AGA) became available for PFO closure." Got it! A new device to repair PFOs and other heart defects to prevent strokes. More information on these devices can be found on many sites: "NMT Medical," "The CardioSeal and StarFlex Devices," "The Stroke-inducing Hole in the Heart," and "Spencer Vascular Diagnostic Services." All the websites mentioned are listed below. So if you are interested, browse

these sites. Have fun and I will see you next month on a different topic.

"Generation-S: Young Stroke Survivor"
<http://www.orgsites.com/pa/generation-s/index.html>

"Harlan Stockman's "You're Kidding?" Stroke Page"
http://users.viawest.net/~hwstock/stroke/stroke_main_hws.htm

"Contemporary Management of Patent Foramen Ovale", Circulation 2003, AHA
<http://circ.ahajournals.org/cgi/content/full/107/1/5>

"NMT Medical"
<http://www.nmtmedical.com/index.html>

"The CardioSeal and StarFlex Devices" from Children's Hospital Boston - for full disclosure purposes, I had a CardioSeal implanted in 2001, part of the High Risk Trial clinical research program.
<http://web1.tch.harvard.edu/cardioseal/DataTrials.html>

"The Stroke-inducing Hole in the Heart" from Johns Hopkins
<http://www.hopkinsmedicine.org/hmn/W03/medrounds.cfm#stroke-inducing>

"Spencer Vascular Diagnostic Services"
<http://www.spencervascular.com/specializedexams.htm>



Biography: Dennis Galindo

I am a 55 year old brain stem stroke survivor. My stroke occurred over three years ago. At first I could only "blink my eyes." I was paralyzed from the neck down. I had a neck trachea, and a stomach tube. They are both gone now. I breathe on my own and feed myself. I'm content. I had surgery to correct a severe drop foot. I can walk with a walker. All the doctor's said the prognosis was poor. They are just interested in keeping me alive. With help of my wife, family, and friends I have some "quality of life." I live in a noosing home, but someday I will go home. See more picture of Dennis, his family and friends at

<http://aolsvc.pictures.aol.com/NASApp/ygp/Start?event=DirectView&shareInfo=esv4e+9w77kBI6wgrd+3eSeAfDkfoH59jR1APa5Yzo6/jFCnkV3ciA==&pageName=AlbumViewFromEmails>



Biography: Jim Weir

I just recently had my first stroke. The week of May 26th I seemed to be feeling extremely tired and very

stressed. I could feel pressure at the base of my neck and my left eye. I would come home from my office and just want to go to bed and try to sleep. I have been using a C-Pap machine for sleeping for over eight months and was also wondering if maybe I might need some adjustments for better rest. My wife had been out of town for a speaking engagement and was coming home on Sunday June 1st. She called me to let me know that she had decided to come home on Saturday instead and cut her meeting short which turned out to maybe a lifesaver for me.

On Saturday May 31, 2003 I woke to find that I was extremely tired with pain in my left eye and a bad headache. My wife returned home around 4pm and we had a nice dinner at home. I cooked on the grill and we enjoyed the evening. Some good friends called around 8pm and we both spoke to them but I do not remember the conversation or even talking with them. I still had my headache and my wife thought that I was rather short and very quiet. I told her around 10pm that I was going inside to take a shower. After about ten minutes she came in to check on me and found me lying face down in the dressing area outside the shower room.

I had taken a shower and walked into the dressing area where she found me. She immediately called 911 for assistance. She could see that the left side of my face was drawn and I was unconscious. She also called my son who lives in the area. Both my wife and my son work for Saint-Luke's Hospital here in the Kansas City area. The hospital is one of eleven nationwide that has the Stroke Team and

the TPA procedure. I also have had a pacemaker for the past six years and they both wondered if it could be a combination of stroke and heart attack. My wife has medical schooling and is a director at the hospital and my son manages a division of the hospital so both have medical knowledge.

I was taken to Saint-Luke's and the Stroke Team was able to administer the TPA procedure. I remained unconscious for almost 28 hours and the stroke was at the base of my brain stem, which they informed my family had a 80% mortality rate unless treated. After gaining consciousness I had weakness on the left side of my body both with my arm and leg. I left the hospital in four days time and began physical therapy both in the home and outpatient. After eight weeks of therapy I was able to return to half days at my office and have recovered almost 90%. I still get very tired and come home around 3:30pm for a nap of around 2 hours daily. I use a cane if I am going to be out for a long period only for support as needed. Otherwise you would never know that I had a stroke.

I am doing well and should be back to 100% within the next four or five months. I owe my recovery to the quick thinking of my family and the fact that I was taken to Saint-Luke's Hospital and received the TPA treatment. I am trying to make everyone in my office as well as my friends the signs and awareness of stroke and the quick action necessary to reverse the effects if medical attention is received within the first few hours. I still have fears of the possibility of another stroke and know that this is common. I am thankful for the stroke network and being able to talk and share with others. This is most important in the complete healing process.

The Stroke Network is a registered 501(3)c non-profit organization. We are an on-line stroke support organization and is available to everyone worldwide. Since 1996 we have provided stroke support and information to nearly 10,000 people and to thousands of visitors to the site. The Stroke Network is the homepage for a network of several other smaller web sites owned by The Stroke Network Inc

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