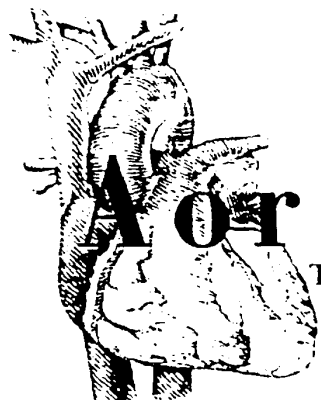


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Aorta Reporter

The Mended Hearts, Inc. Atlanta Chapter #81
Founded 1951 Chartered 1973

It's Great to be Alive and Help Others!

NADINE WALLEY, MSA

**COMMUNITY RELATIONS
SAINT JOSEPH'S HOSPITAL**

**Learn more about stress –
the good, the bad, and tools to cope with stress**

Tuesday, January 17, 2006

It's Great to be Alive—and to Help Others

Dedicated to the Memory of Dr. Paul Ambery

7:30 – 9 p.m.

SAINT JOSEPH'S HOSPITAL AUDITORIUM (ONE FLOOR BELOW LOBBY LEVEL)

FREE PARKING AVAILABLE

Drive past the hospital front entrance and watch for the Cancer Center parking deck on the left opposite the main entrance to the Cancer Center. Ring the button at the parking deck entrance and tell the attendant who answers that you are attending the Mended Hearts meeting and the gate will be opened.

**Remember – If you're reading this, you're invited!!!
(and we do it all for you; please come, learn and meet many other MENDED HEARTS)**

PRESIDENT'S NOTES

NEW YEAR'S RESOLUTIONS AND JUNIOR HIGH GIRL/BOY FRIENDS

You are probably asking yourself, "Self, what do New Year's resolutions have to do with my ex-boy friend or girl friend?" If you are like most New Year's resolutionists, you have either listed mentally or have written out your New Year's resolutions. Good for you. But wait! How long did you keep them? Did you keep that list as long as your last boy/girl friend in junior high school? Fell in love Monday morning, called him/her up Monday evening, sat next to him/her at lunch Tuesday, and found a new sweetie on Wednesday.

I have found that if you write out your goals and post them where you have to see them every day, you will keep those resolutions longer than a junior high romance. Put the list on your closet door in your bedroom or on your workstation. What you put on your list is your business, but here are some suggestions:

- Quit smoking
- Watch one less hour of television each day
- Cut your food consumption to half of what you have previously eaten
- Exercise at least 30 to 45 minutes every other day
- Write a love letter to your spouse
- Share your history with your grandchildren
- Go to your house of worship at least once a week
- Pay at least one bill on time for the next 12 months (less stress)
- Come and sign up as a Mended Heart volunteer

As you can tell, the list is endless. Good luck in making yours out. By the way, Sara, where is last year's list?

Doug Steingraber

CHAPTER NOTES

As we begin another New Year, it's a good time to remind you of our motto, "It's great to be alive—and to help others!" Sounds great; better to live by it. How about starting off the year with some resolutions that we can live by and live with? Not to be outdone, I'm starting mine off with a colonoscopy.

If you will permit me some editor's license, the following is a reprint of my article from the January 1987 Aorta Reporter (except I have made updates of the year to 2006): If you were like me during the latter weeks of 2005, now is the time, if you haven't already done so, to get back on track for the new year. It's so easy to overindulge on "goodies" that aren't so

good for the heart; and at the same time, we neglect our regular exercise routine. Let's be sure we sit down and set some realistic goals for 2006 that we should be dead serious about keeping. Some typical resolutions we, as Mended Hearts, should be setting are:

1. Taking our medicines every day as prescribed
2. Adhering to a regular exercise program
3. Learning how to relax and be patient, especially during busy periods when it is so easy to become stressed and depressed with the pressures we put, or allow to be put, on ourselves
4. Staying on the diet that was prescribed for us; or if we're not on a special diet, committing ourselves to a healthier, heartier diet
5. Not smoking
6. Being supportive and positive in helping others around us in living up to their resolutions

Nothing new there—let's take them on one day at a time.

The same 1987 issue recorded 198 hospital visits and a news brief regarding Ed Caine and I featured in the Emory University Hospital in-house paper. A photo shows us visiting a recovering open-heart surgery patient and describes the mission of the Mended Hearts. There was another article with the same photo in the *DeKalb News Sun* written by our late Helen Friese. During the same period, Helen wrote a first-page article in the Georgia Heart Association publication entitled "Good Grief...It's Santa's Heart." This time Helen's coup was an interview with Charles Schultz (Peanuts' creator) about his open-heart surgery.

Back to the future (i.e., 2006)...many thanks to our ever-reliable volunteers who helped at AHA recently: John and Dody Crosbie, Herb and Dixie Jardine, Daryl Thompson, Rudy Galistel, and Bob Fisher. Be sure to watch for volunteer dates scheduled for 2006.

We just learned of the passing of long-time member Frank Steinheimer, husband of Mary Alice. Until recent years, they were very active members who served as officers and were always helping out. If I'm correct, Mary Alice was an early president of our chapter. Our sincerest sympathy to you, Mary Alice and family. Hey there, John Crosbie...get well real soon.

Thanks to the *South Jersey Deviler*, here are a couple of thoughts to close on:

"There are a lot of people who spend so much time watching their health that they haven't time to enjoy it."

"Did you hear about the guy from Cape May that became a fisherman but he couldn't live on his net income?"

"Talk's cheap because the supply exceeds the demand."

God willing, I'll see you here again next month.

George Waterhouse

LET'S VISIT AWHILE

A wise man once said if you don't have anything to say, shut up. So... Happy New Year to all!

Herb Jardine

HOSPITAL VISITING REPORT

During the month of November 2005, we recorded 98 hospital and telephone visits at Emory University Hospital, Crawford Long Hospital, Saint Joseph's Hospital, Atlanta Medical Center, Piedmont Hospital, Grady Hospital, and WellStar Kennestone Hospital.

JANUARY CARDIO-VERSARIES

1983	Martin Espeland
1984	Esther Griffin
1987	Doris Johnston Margie Silver
1988	Samuel Barnett
1991	Edwin Foster
1993	Leroy Redmon Odell Stamey Max Weber, Jr.
1995	Luther Lindsey, Jr.
1997	Marcelene Rumble
1998	Anthony Leskavansky John Harrison
1999	Amelia Smith Ray Sigmon
2000	Jack Maddox
2001	John Newsome Joy Murray Lois Donmoyer
2002	Edward Johnston
2003	Mandy Storr
2005	Maurice Tabickman

VISITOR REACCREDITATION MEETING AND TRAINING SEMINAR

Mandated by our national headquarters

Saturday, February 11, 2006

9:30 a.m. — Noon

Saint Joseph's Hospital Classroom #1

Park in Cancer Center lot

Light refreshments and
possibly risqué videos!!

SEE YOU THERE!!

SATELLITE MEETING INFO.....

Marietta Satellite

First Tuesday of the month – 6:30 p.m.
Kennestone Hospital Rehab Center (behind the hospital)
Call Doug Steingraber at 770-926-0157 for information.

Piedmont Satellite

Meetings will be quarterly starting in January 2006
Call Joann Gorell at 404-605-3283
for dates, times, and locations.

VOLUNTEERING DATES AT AMERICAN HEART ASSOCIATION

January 12

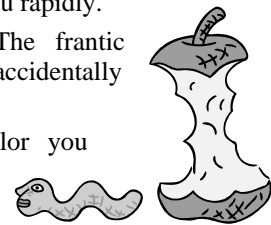
February 16

ON THE LIGHTER SIDE

The Washington Post's Mensa Invitational once again asked readers to take any word from the dictionary, alter it by adding, subtracting, or changing one letter, and supply a new definition.

Here are a few of this year's winners:

1. Intaxication: Euphoria at getting a tax refund, which lasts until you realize it was your money to start with.
2. Reintarnation: Coming back to life as a hillbilly.
3. Bozone (n.): The substance surrounding stupid people that stops bright ideas from penetrating. The bozone layer, unfortunately, shows little sign of breaking down in the near future.
4. Inoculate: To take coffee intravenously when you are running late.
5. Decafalon (n.): The grueling event of getting through the day consuming only things that are good for you.
6. Glibido: All talk and no action.
7. Dopeler effect: The tendency of stupid ideas to seem smarter when they come at you rapidly.
8. Arachnoleptic fit (n.): The frantic dance performed just after you've accidentally walked through a spider web.
9. Caterpallor (n.): The color you turn after finding half a worm in the fruit you're eating.



And the pick of the literature...

10. Ignoranus: A person who's both stupid and a pain in the rear.

AMERICAN HEART ASSOCIATION CONNECTIONS

AMERICAN HEART ASSOCIATION ANNOUNCES UPDATED EMERGENCY CARE GUIDELINES

New emergency care guidelines include dramatic changes to cardiopulmonary resuscitation (CPR) and emphasis on chest compressions, according to authors of the *2005 American Heart Association Guidelines for Cardiopulmonary Resuscitation and Emergency Cardiovascular Care*. The guidelines were published online in *Circulation: Journal of the American Heart Association*.

They provide recommendations for how lay rescuers and emergency healthcare providers should resuscitate victims of cardiovascular emergencies. Topics include CPR, the use of automated external defibrillators (AEDs) and recommendations for advanced cardiovascular life support (ACLS) and pediatric advanced life support (PALS).

The 2005 guidelines emphasize that high-quality CPR, particularly effective chest compressions, contributes significantly to the successful resuscitation of cardiac arrest patients. Studies show that effective chest compressions create more blood flow through the heart to the rest of the body, buying a few minutes until defibrillation can be attempted or the heart can pump blood on its own. The guidelines recommend that rescuers minimize interruptions to chest compressions and suggest that rescuers “push hard and push fast” when giving chest compressions.

“The 2005 guidelines take a ‘back to basics’ approach to resuscitation,” said Robert Hickey, M.D., chair of the American Heart Association’s Emergency Cardiovascular Care programs. “Since the 2000 guidelines, research has strengthened our emphasis on effective CPR as a critically important step in helping save lives. CPR is easy to learn and do, and the association believes the new guidelines will contribute to more people doing CPR effectively.”

The most significant change to CPR is to the ratio of chest compressions to rescue breaths—from 15 compressions for every two rescue breaths in the 2000 guidelines to 30 compressions for every two rescue breaths in the 2005 guidelines. The 30-to-two ratio is the same for CPR that a single lay rescuer provides to adults, children and infants (excluding newborns). The change resulted from studies showing that blood circulation increases with each chest compression in a series and must be built back up after interruptions. The only exception to the new ratio is when two healthcare providers give CPR to a child or infant (except newborns), in which case they should provide 15 compressions for every two rescue breaths.

Another guidelines change emphasizing the importance of CPR is the sequence of rhythm analysis and CPR when using AEDs. Previously, when AED pads were applied to the chest, the device analyzed the heart rhythm, delivered a shock if necessary, and analyzed the heart rhythm again to determine whether the shock successfully stopped the abnormal rhythm. The cycle of analysis, shock and re-analysis could be repeated three times before CPR was recommended, resulting in delays of 37 seconds or more. Now, after one shock, the new guidelines recommend that rescuers provide about two minutes of CPR, beginning with chest compressions, before activating the AED to re-analyze the heart rhythm and attempt another shock. Studies have shown that the first AED shock stops the abnormal cardiac arrest rhythm more than 85 percent of the time and that a brief period of chest compressions between shocks can deliver oxygen to the heart, increasing the likelihood of successful defibrillation. The guidelines also recommend that healthcare providers minimize interruptions to chest compressions by doing heart rhythm checks, inserting airway devices, and administering of drugs without delaying CPR.

The new recommendations continue to encourage greater implementation of AED programs in public locations like airports, casinos, sports facilities and businesses. The 2005 guidelines reflect results of the Public Access Defibrillation trial, which reinforced the importance of planned and practiced response to cardiac emergencies by lay rescuers. The new guidelines recommend that 911 dispatchers be trained to provide CPR instructions by phone and help callers correctly identify cardiac arrest victims. Dispatchers may walk rescuers through compressions-only CPR for most adult victims of cardiac arrest; however, instructions to do compressions and rescue breaths will be given for infants and children or adult victims of asphyxia, caused by near-drowning or other non-cardiac causes. Dispatchers also should be trained to recognize the symptoms of heart attack and other Acute Coronary Syndromes, and advise such patients to chew an aspirin while awaiting EMS.

To increase successful resuscitation, new guidelines advise EMS systems to evaluate their current protocols, shorten the response time for cardiac arrest patients, then document the impact of such changes on the number of lives saved.

The guidelines are based on the Consensus on Science and Treatment Recommendations (CoSTR), a document developed by the International Liaison Committee on Resuscitation. This group includes the American Heart Association and leading international resuscitation councils. The review of resuscitation literature reflected in CoSTR is the largest ever published. It took more than 36 months and includes input from 380 international experts. CoSTR serves as the scientific basis for many countries’ resuscitation treatment guidelines.

Vanessa G. Garrity
Volunteer and Communications Coordinator

MEDICINE & TECHNOLOGY

SAVING MONEY ON PRESCRIPTION DRUGS

Communicating with Your Doctor

It's a good idea to tell your doctors whether paying for medicine is a problem, says Edward Langston, M.D., a family physician in Lafayette, Ind., and an American Medical Association trustee. That doesn't mean physicians can fix all the problems, Langston says, but not being able to afford medication clearly affects your health.

"I think most physicians would want to help if they knew a patient won't be able to follow the treatment," Langston says. "But many patients find it a hard subject to bring up." When Langston writes a prescription, he asks patients, "Are you going to have any trouble getting this medication?"

So what can patients struggling with drug costs reasonably expect from their doctors? Patients should feel free to ask about whether a generic can be used instead of a brand-name drug or whether there is a similar drug that is less expensive. But some doctors don't know the price of drugs, so patients might have to do their own research, says Paul Hunter, M.D., a physician with Community Care for the Elderly in Milwaukee. In some cases, there may be nonprescription drugs that might work. Loratadine for allergies is a good example of an over-the-counter (OTC) medicine that is less expensive than brand-name prescription alternatives, Hunter says. Loratadine is the active ingredient in Claritin, Alavert, and some generic allergy medicines.

The doctor's office also can serve as a valuable resource for patients for such activities as informing them about the Medicare prescription drug benefit, signing application forms for patient assistance programs, and referring patients to state-sponsored services and community assistance programs. In a recent survey of 519 cardiologists and general internists, nearly all reported that doctors should consider these costs when writing prescriptions. The study appears in the March 28, 2005, issue of the *Archives of Internal Medicine*. One-third reported knowing how much patients are spending out of pocket for prescriptions. Commonly cited barriers to discussing drug costs with patients were insufficient time and concern over possible patient discomfort.

The researchers found that switching patients to a generic or a less expensive brand-name drug, the most frequently used strategy, was likely to be beneficial. But they noted that other approaches, such as tablet splitting, needed caution. Tablet splitting is done because higher-strength tablets are sometimes not much more expensive than lower-dose tablets. For example, tablet splitting involves splitting a 40 milligram (mg) tablet to get a 20 mg dose. The researchers said that while tablet splitting can reduce costs, it can also complicate prescription regimens and can be technically difficult to do.

"We don't advocate splitting pills to save money, and this isn't something patients should do on their own," says

Tom McGinnis, R.Ph., the FDA's Director of Pharmacy Affairs. "We leave it up to the doctors. If the prescriber thinks a patient could benefit from a lower dose of medication than is available or if it's the only way a patient can afford the treatment, then the doctor can direct that a patient split the tablet. Pharmacies sell inexpensive devices that help consumers easily split tablets of all shapes," McGinnis says. The major concerns over tablet splitting are that the patient may not split the pills accurately and that some tablets, such as time-release versions, should never be split.

The practice of physicians distributing free samples of brand-name drugs—another area that isn't clear-cut—was the second most likely strategy used by doctors in the study to help ease cost concerns. Hunter says he thinks free samples influence doctors to prescribe expensive, new medications, but he has also worked in clinics where patients rely on free samples to reduce their drug costs.

The intended use of a free sample is to allow a patient to evaluate side effects and effectiveness for a couple of weeks before actually buying the drug," Hunter says. "So patients can ask for free samples, but know that they are a temporary fix." Patients can't usually expect samples to provide long-term treatment. Patients who receive free samples should still ask their physicians whether a generic drug could be satisfactory.

Nicole Petersen, Pharm.D., a community clinical pharmacist at Schnuck's Pharmacy in St. Louis, says that samples aren't always the ideal solution, but sometimes they are all a patient has. When an 86-year-old woman walked out of the pharmacy without her medicine because she couldn't afford a \$70 brand-name osteoporosis drug, Petersen called the patient's doctor to see what could be done.

"There was no generic alternative, so the doctor gave her some free samples," Petersen says. "But patients have to consider how long the physician can provide the free samples and what to do when they run out."

It might make sense for patients to take free samples while they are waiting to receive drugs through a PAP, she says. "If you do take free samples, you should still let your pharmacist know so that we can stay on top of drug interactions." Also, consumers should ask their doctors for information about the sample drug's directions, side effects, and warnings.

Some doctors don't stock free samples, which are normally distributed to doctors' offices by pharmaceutical sales representatives. Billi says drug samples have been eliminated at University of Michigan clinics. "The samples are a marketing tool," he says. "They aren't intended for maintenance. Giving them out puts doctors in the position of having to act like a pharmacist because you're supposed to keep up with lot numbers and expiration dates in case there are recalls. You're also getting patients started on a more expensive drug."

Medicare Prescription Drug Coverage

Medicare Part D, the new outpatient drug coverage beginning on January 1, 2006, works like other health

insurance plans. Medicare beneficiaries will be able to choose from at least two prescription drug coverage plans. Those plans will cover drugs for all medically necessary treatments, will pay for brand-name and generic drugs, and will enable beneficiaries to get prescriptions at a pharmacy or through mail order.

The standard drug coverage in 2006 will require consumers to pay a \$250 deductible and a monthly premium of about \$35. After beneficiaries pay \$250, Medicare will pay 75 percent of a beneficiary's drug expenses up to \$2,250, with beneficiaries paying 25 percent of the costs.

After total drug expenditures reach the \$2,250 mark, Medicare's standard coverage pays nothing until the beneficiary spends another \$2,800. "It's important to know that a lot of people will never reach the \$2,250 amount," says Centers for Medicare & Medicaid Services (CMS) spokesman Gary Karr. After spending reaches \$5,100, the Medicare benefit will cover about 95 percent for the rest of the year with beneficiaries paying only 5 percent. "None of this applies to the Medicare beneficiaries who qualify for extra help because they will have no premiums, no deductibles, and no gaps in coverage," Karr says.

Some Medicare beneficiaries already get coverage for prescription drugs through union- or employer-provided health plans. If that plan is as good or better than Medicare's prescription drug coverage, Medicare will be providing new support so that coverage stays in place. "Beneficiaries should be hearing from their former employer or union this fall about their coverage options," Karr says.

Some Medicare beneficiaries also currently get drug coverage from a Medicare Advantage plan, and those beneficiaries should expect to hear from their current plan about what kind of coverage they will be offering, he says. Some plans are likely to offer coverage that is even more comprehensive than Medicare's standard drug coverage.

The first enrollment period started on November 15, 2005, and runs through May 15, 2006. For those who don't join a Medicare prescription drug plan by May 15, 2006, the monthly premium rises 1 percent a month. So for people who wait a year to join, the premium would go up by 12 percent.

People in Medicare who also receive assistance from Medicaid will get drug coverage from Medicare instead of Medicaid starting January 1, Karr says. Medicaid is the state-administered program for people with limited incomes. "If they haven't chosen a plan before January, these 'dual-eligibles' will be automatically enrolled in a prescription drug plan so that no gap in coverage occurs," Karr says. "But they will also have the ability to change plans once a month if they find a plan that better suits their needs." People in Medicaid and Medicare will be automatically eligible for the extra help, giving them comprehensive coverage with no premiums, no deductibles, and no gaps in coverage.

"We have about 50,000 people in Oregon who fall into this category," says Jane-ellen Weidanz, the MMA project manager for Oregon's Department of Human Services. "The automatic enrollment is good because we don't want people to fall through the cracks. At the same time, we will be letting people know they need to review the plan they've been assigned to see if it meets their needs, and we will be giving them assistance to help them make needed changes."

Each state will decide how its assistance programs will work with Medicare coverage. As of May 2005, at least 39 states had established or authorized some type of program to provide pharmaceutical assistance, and 32 states had programs in operation, according to the National Conference of State Legislatures (NCSL). As of June 1, 2005, 23 states had enacted laws or resolutions responding to or adjusting to the Medicare prescription drug provisions. The Medicare law allows states to "wrap around" the Medicare benefit to fill in gaps in coverage.

The Alabama SenioRx: Partnership for Medication Access program was created in 2002 to help people ages 60 and older who have no prescription insurance coverage and who live below 200 percent of the poverty level. The program helps more than 26,000 Alabama seniors receive free or discounted drugs through PAPs provided by pharmaceutical manufacturers.

We have brought in approximately 90 million dollars in free and low-cost medications in the three years we have been in operation," says Irene Collins, executive director of the Alabama Department of Senior Services. "About 80 percent of our current clients will be eligible for the low-income subsidy with Medicare Part D."

Collins says her agency continually communicates with contacts at the PAPs to find out how they will change in response to the Medicare drug benefit. "Because we anticipate changes," Collins says, "we have been working over the last several months to ensure that our clients who are eligible for Medicare savings programs are enrolled. We are also conducting many education opportunities about the changes in Medicare and providing one-on-one counseling for our clients and their families and physicians."

The Medicare drug plans starting in January 2006 are different from the Medicare discount drug cards that have been used as a temporary measure. Medicare beneficiaries who have been using the temporary discount drug cards can use those cards until May 15, 2006, or until they sign up for a plan, whichever comes first. "The card is not valid once you sign up for a plan," Karr says.

Karr says Medicare beneficiaries should read the "Medicare & You" 2006 brochure mailed in October. "This will show people what plans are available on a local level," he says.

*By Michelle Meadows
Contributed by Daryl Thompson, FDA (Ret.)*

Next month: Assistance From Pharmaceutical Companies

NUTRITION NOTES

STRESS AND THE WAIST LINE

You may have seen the recent commercials touting the weight gaining effects of stress hormones and the magic diet pills to stop them. As health professionals, skepticism always creeps in with such claims—as well it should. It is hard to know what is the truth or simply the stretching of the truth by these companies. As with most diet pills, there is some legitimacy linking stress and weight gain. Studies are showing stress does make us fat. There are two theories of why stress equal pounds.

Our stress mentally and physically wears us down; therefore, we make poor food choices and lack the energy to exercise. Secondly, there is a physiologic response of stress hormones (cortisol and adrenaline), which create a state of high-energy use and rebound hunger. The first explanation may be the most common cause. Often when we are stressed we do not make good food choices but reach for comfort or reward foods and feel too tired to exercise. This is a twofold problem. One, food usually reached for is high in sugar, simple carbs, and fat. These types of food often are nutritionally devoid and only promote the blah, listless feelings already increased due to stress. Second, by not exercising we are burning fewer calories, and the pounds quickly add up.

The other theory of weight gain due to stress is a bit more complicated. When we become stressed, the adrenal glands flood our bodies with stress hormones—including cortisol and adrenaline. These hormones are released to allow us to flee from predators or danger. However, now our stress is due to deadlines and traffic, and running away is not always the most responsible choice. Cortisol increases the amount of glucose in your blood stream, mobilizes amino acids from muscle and fatty acids from fat cells. The adrenaline increases breathing, heart rate, tenses muscles, and raises blood pressure. Most likely you sit with high blood sugar, high blood pressure, and fat flowing through your veins unable to simply run away, never using the fuel or physiologic responses to the stress. Weight gain is suspected to come from the recovery phase, when your body tells itself to refuel, therefore creating a food craving to replenish our body's stores.

So what can be done to stop weight gain due to stress? The most effective stress relief is exercise. Get moving and burn the extra calories and the stress. Getting enough sleep and choosing healthy foods can also help to lower the negative side effects of stress. Eating a well balanced diet and maintaining an exercise program are the best answers to weight loss, even though a pill sure would be nice.



*Claudia Lawson, RD, LD
Atlanta Medical Center*

THE VENT-RICLE

You know you live in Florida if...

You have FEMA's number on your speed dialer.

You have more than 300 'C' and 'D' batteries in your kitchen drawer.

Your pantry has more than 20 cans of Spaghetti O's.

You are thinking of repainting your house to match the plywood covering your windows.

Your Social Security number isn't a secret; it's written in Sharpie on your arms.

The road leading to your house has been declared a 'No-Wake' Zone.

You decide that your patio furniture looks better on the bottom of the pool.

You own more than three large coolers.

You rationalize helping a friend board up by thinking, "It'll only take a gallon of gas to get there and back."

Three months ago you couldn't hang a shower curtain; today you can assemble a portable generator by candlelight.

You catch a 13-pound redfish—in your driveway.



You can recite from memory whole portions of your homeowner's insurance policy (if you can still get insurance).

At cocktail parties, women are attracted to the guy with the biggest chainsaw.

There is a roll of tar paper in your garage.

You can rattle off the names of three or more meteorologists who work at the Weather Channel and every single newscaster and reporter at all of the major stations in town.

Someone comes to your door to tell you they found your roof.

Ice is a valid topic of conversation.

Relocating to South Dakota does not seem like such a crazy idea.

You spend more time on your roof than in your living room.

You've been laughed at over the phone by a roofer, fence builder, or a tree worker.

Having a tree in your living room does not necessarily mean it's Christmas.

The hurricane shutter guy and your roofer are driving BMW's.

You know the difference between the "good side" of a storm and the "bad side."

You go to work early and stay late just to enjoy the air-conditioning.

A battery-powered TV is considered a home entertainment center.

A chain saw, generator, or a gas grill comes as a free gift with every new Florida mortgage.

Contributed by Linda Ledford

APPLICATION FOR MEMBERSHIP

We (I) would like to join Mended Hearts, Inc., Chapter #81

Atlanta or Satellite: Marietta Piedmont

NAME _____

SPOUSE _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

PHONE _____ DATE OF BIRTH _____

DID YOU HAVE:

Bypass Surgery Balloon Pacemaker Heart Attack

Valve Surgery: Mitral Tricuspid Aortic Pulmonary

Other _____

New member family dues are \$32.00 and new member single dues are \$22.00.
Please make your check payable to:
The Mended Hearts, Inc., Chapter #81
Mail to: John Crosbie, Treasurer
3401 Winter Wood Court
Marietta, GA 30062-1247

RETIRED YES NO

DATE OF CARDIAC EVENT OR SURGERY: _____

TYPE OF MEMBERSHIP: FAMILY SINGLE

Membership covers a twelve-month period from date of enrollment and includes:

- Insignia pin
- Chapter newsletter
- Subscription to quarterly national magazine, *Heartbeat*

Aorta Reporter

A copy of *Aorta Reporter* is mailed for three consecutive months following your hospital stay or referral as a heart patient. It is our way of keeping in touch while you continue to recuperate. We enjoyed meeting you and hope you received some comfort and encouragement from us. Having lived the same experiences, we are willing to take time out of our lives because we want to share our experiences in your recovery. As you become active again, you and your family are invited to attend our Atlanta Chapter #81 or any other chapter meetings as guests. In getting to know us, we hope you will decide to join us in helping each other. Our 7:30 p.m. meetings are the third Tuesday of each month.

Mended Hearts

Mended Hearts is a nationwide support organization, affiliated with the American Heart Association, for individuals with heart disease, including persons recovering from heart attacks or open-heart surgery. Members give hope and encouragement to others by providing living proof that persons with heart disease can lead full, productive lives. Family and friends are also welcome to attend the free monthly sessions. For information, call 678-385-2062 or your local American Heart Association.

**Visit Chapter #81 at
www.mendedheartatlanta.org**

ATLANTA MENDED HEARTS, CHAPTER #81

678-385-2062

c/o American Heart Association
1101 Northchase Parkway; Marietta, GA 30067-6421
678-385-2000

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