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The WIHS Woman

The Connie Wofsy Women's HIV Study

Remembering Debbie Peterson

By Claudia Ponath, Field Manager

Our dear friend and co-worker Debbie Peterson passed away peacefully on April 4, 2008 after a long and courageous battle with breast cancer. Family and friends surrounded her in her final hours.

I believe what we all loved about Debbie was her capacity to connect with people, her ability to make a person feel welcome, her willingness to find the positive in almost any situation, her compassion, her sense of humor and her indomitable spirit, which kept her going even when times got very tough. Debbie always had a smile, a joke, a different outlook on things and somehow talking to Debbie always left you feeling better than you did before.

Debbie was born in 1957 in Chelmsford, MA, the oldest of six siblings. She moved to San Francisco in 1978 to study sociology at San Francisco State University, and made San Francisco her home. She received a bachelor's degree in sociology, then went on to study nursing at San Francisco City College, and women's health at the San Jose State sponsored EPA program, becoming a nurse practitioner. After working at St. Mary's and St. Luke's hospitals,

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and Planned Parenthood, Debbie started with the WIHS in 1995. Having always had a passion for women's health, this was the perfect job for her. She worked at the San Francisco General and Mount Zion clinics, performing physical and gyn exams, and collecting data for the study. She was also trained to be a colposcopist, allowing her to do follow up on abnormal pap smears. Beyond that, both through her clinical expertise and through her warmth and compassion, she was able to touch the lives of many study participants in positive ways. In November 2006, the recurrence of her breast cancer forced her to go on medical leave. For a long time after going on leave, she hoped to be able to come back to work. In November 2007, we dedicated our Mount Zion exam room to Debbie, in recognition of her outstanding performance with the study and participants.

In her personal life, Debbie was devoted to a large extended family and many friends and colleagues. She moved to Pacifica in 1996 with her husband Wayne and son Cody. She maintained close and loving relationships with her parents, siblings, nieces and nephews. She loved to go on road trips, hike, kayak, knit and read.

Debbie was a gifted nurse who truly cared about the welfare of her patients, a colleague who always had your back, a friend you could rely on, a loving wife, mother, sister, daughter and aunt. Many people who came to know and love Debbie will dearly miss her.

Debbie's time on this world was much too short, but she used it well, and she left it a brighter place for those of us whose lives she touched.

Things I Loved and Will Miss about Debbie

By Nancy Hessol, Project Director

The spring of 1995 was a time of great change for the Northern California WIHS site. The original participant recruitment period was halfway through, but our Bay Area site had only enrolled a quarter of the anticipated number of study participants. We had very little office space; we all shared desks and worked different hours so as not to sit on top of each other. We were desperate for clinic space, and from week to week worked at different clinic locations depending on available space. We had two study clinicians, one who worked in the East Bay and one in San Francisco, both of whom went out on disability leave. And then came Debbie!

Debbie Peterson was one of two new Nurse Practitioners we hired that spring, Debbie began working at our San Francisco clinics and Kimberly began working in the East Bay. Thanks in large part to Debbie, our recruitment numbers grew and six months after Debbie joined the WIHS we enrolled 97% of our targeted number of study participants. But that was just the beginning.

Debbie immediately developed a special relationship with both the staff members and study participants. From the participant's perspective, Debbie was gentle and kind and had extensive experience in women's health. She also had a strong desire to learn as much as possible about HIV infection and it's effect on women. From the staff's perspective, Debbie had endless energy and worked above and beyond the call of duty. She was fun to work with and yet took her job very seriously.

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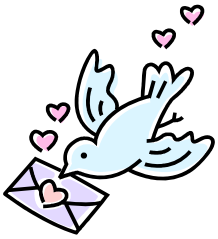
Debbie embraced all aspects of her work with the WIHS; she was a skilled phlebotomist (good at drawing blood), able to conduct the interview with ease, wonderful at performing the physical examination, and outstanding at collecting the gynecological specimens (Paps, biopsies, you name it). Debbie attended many training classes and was always able to use that information to the advantage of the study and study participants.

Fast forward to 2003, when we were all saddened to learn about Debbie's breast cancer diagnosis. Yet, Debbie's attitude was upbeat and determined. During and after Debbie's first round of cancer treatment, she continued to work and was an inspiration to us all. In the end, however, the cancer won the battle and Debbie passed away in April 2008.

We will greatly miss Debbie – our dear friend, colleague, and practitioner. We honor Debbie, Dr. Connie Wofsy, and our fellow study participants who have passed away. Our cherished memories of you live on.

Letters About Debbie



I am writing this letter to the family of Debbie. Whenever I came for my appointment Debbie always made me feel welcome. She always had a smile on her face. She never showed her illness. She always showed the strength in her soul. She loved everyone that came into her life and was always willing to help someone, despite what was going on with her. Debbie put the people that came to the hospital first because she loved her job. I'm going to miss her and her warmth, because it came from her heart. I want to send the family something. I just want the family to know that she will be alright and that God will take good care of her and that she is in heaven doing the work of God. I know what the family is going through and she is in heaven with her beautiful smile. Have faith in God. She is now an angel of God and has always been God's child

Lydia Pettaway

Thank you for offering a place to put our thoughts and feeling about someone who really mattered to so many people, Deborah Peterson.

I had the great pleasure of knowing Debbie when she first came to the Women's Study, she was this caring, spunky gal from the Boston area. I always looked forward to our bi-annual meetings. She was so comfortable to be with and was very gracious in such a personal meetings with her clients (me). Very informed in matters of health. I so appreciate and miss her. I loved how she could open up and share her life with you. Not many practitioners are as open and forthcoming as she was, so I could appreciate her also as a fellow human being. I'm so glad to have known Ms. Debbie Peterson!

Sincerely,
Nancy Callaghan

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Debbie "was" WIHS.

Each time over the last "100 years" when I was called about my "6 month appointment time" my first words were always "will Debbie be there?"

I know for the rest of my time in the study that thought will always enter my mind when I get that call from the WIHS office!

Debbie's personality reminded me of the close give friends I grew up with in Penna - kind, caring, thoughtful, fun, understanding – someone who would be your friend forever. The kind you never meet again when you leave home and move to the big city – in my case, New York.

I think there must be a Debbie in every place we all grow up. I will miss her always. She reminded me of my best friend in Penna. I know you are in heaven Debbie. When I get there I will look for you.

Love,
Donna

About Debbie

Hi there, my name is Sharon Alpert. Although most of you don't know me, I have worked with WIHS for a while.

I am the person behind the scenes of the clinic who makes sure that the clinic is supplied with all of the necessary items needed for your appointment (including juices and snacks).

I met Debbie when I started working here 10 years ago. With her East Coast accent and her warm, comical, and full of joking personality, I was immediately drawn to her and felt right at home since I had recently moved here from Massachusetts (where Debbie grew-up).

Debbie and I shared our working environment and she was always appreciative of me, which was important to me.

Not only did we share fun times together, celebratory times and dancing times, but I got to experience a very quiet and tender side with Debbie, when she discovered that I could give neck and back massages. She especially appreciated the massages during stressful times in her life. There was always a feeling of calm during these times.

There was also the many weight watcher meetings we attended. We were always yo-yoing in our weight loss and she always wanted to know what my weight was so that she could weigh less than me - we constantly teasing each other about it. There were the "2 point" lollipops that she had everyone in the office eating; that is weight watcher lingo for those who don't know. We struggled with our weight and the 6-8 cups of water that you are suppose to drink when you are trying to lose weight.

I miss the simple and fun times. I miss her laughter and her cheerful voice and upbeat personality.

I hope and pray that she is at peace.

Sharon Alpert

The WIHS Woman's Guide to Menopause

By Ruth Greenblatt, MD

What is Menopause?

Menopause is sometimes known as the *change of life* or *the change* and most women experience it. Menopause happens when women stop menstruating or having their menstrual periods for at least one year. On an average, menopause happens at age 51-52, but each woman is unique, and menopause can occur anytime from the late 30's to the late 50's. Before menopause happens, and menstrual periods stop altogether, women experience gradual changes in their menstrual cycles and sometimes other symptoms; this slow change is called *perimenopause*. Women may have difficulty getting pregnant once perimenopause begins; pregnancy does not occur after menopause is complete.

What will I Notice? Should I be Concerned about my Health?

Perimenopause is different for each woman; some women have few, and some women have many symptoms and health concerns during this time of change. *Irregular menstrual cycles* are very common; periods tend to become less frequent as menopause approaches. Some women have *hot flashes*, a sudden feeling of being hot, or flushing that usually last 2-3 minutes (but can range from 1-30 minutes), ranging from a few times to many times a day. Hot flashes are caused by a change in the way your body controls temperature, and includes dilation of blood vessels in the skin, causing a feeling of heat and redness. Hot flashes can occur for several years, but many women have them for a much less time. *Night sweats*, a symptom familiar to some women living with HIV, can occur, sometimes during hot flashes. Some women have *palpitations*, or a sense that their heart is pounding. Women often report having trouble with their sleep. Mood swings are reported by some women. As menopause approaches, and after it, many women experience *vaginal dryness* and thinning

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Why does menopause happen?

Menstrual periods occur as part of a monthly cycle that is produced by the growth of an egg follicle within our ovaries. This follicle does not just produce an egg, which may unite with a man's sperm to produce a baby, but also the hormones that are responsible for our breasts, vaginal health and other female characteristics. We are born with all the eggs our ovaries will ever have, and once we begin having periods, our ovaries lose eggs every month. Menopause happens when all the eggs in our ovaries are used up. In addition to our periods ending, and having no more eggs, our ovaries stop making many of the hormones that we have become used to having. We are still women after menopause, but we have much less estrogen and other hormones. These changes can cause symptoms and remove some of the protections women have against bone and heart disease. Menopause can be caused by medical treatments that remove the ovaries or cause follicles to stop functioning, such as some kinds of cancer chemotherapy.

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of the vagina and vulva, sometimes making sex painful.

What can I do?

While menstrual periods are usually irregular during perimenopause, you should receive regular health care, and if you experience vaginal bleeding after your periods have stopped completely, you should tell your health care provider about this. During the years women have regular menstruation, we have less high blood pressure and heart disease than men. After menopause women have increased risk of high blood pressure and heart disease. Your medical provider can do tests to determine if you have these problems or if you are at risk for them. After menopause, women tend to lose some of the mineral content of our bones. Some women experience thinning of bone and can develop *osteoporosis* or brittle bones. Women with brittle bones can have serious fractures, like a broken hip, after minor injury, such as a fall. You should check with your medical provider to determine if you need calcium and vitamin D supplements to help prevent bone loss. Other medications are available for women who are at high risk for brittle bones. The DEXA scans WIHS is doing can provide information on your bone health, or your provider may schedule tests particularly if you are a smoker, drink alcohol heavily or if you have a family history of brittle bones.

What should I do?

After menopause living a health lifestyle is more important than ever. This means a good diet, reasonable exercise and, if you are a smoker, stop smoking now. You should ask your medical provider about diet information, and they may refer you to a nutritionist to find the best diet for you. Walking, swimming and other exercises are important; check with your medical provider if you have back or joint problems or past injuries. Hot flashes and night sweats can be helped by keeping your space cool, particularly at night, avoiding hot drinks, alcohol and spicy foods. Vaginal lubricants can ease dryness and pain during sex. You should avoid using drying soaps and douches. You can also ask you medical provider about medicated vaginal creams, which can help if lubricants do not. Ask you provider about exercises that strengthen your pelvis, which can help with your sex life and to prevent urinary problems as you age.

What is HRT?

HRT is *hormone replacement therapy*, which is not a very good name, since no medication can really replace what your ovaries did before menopause. HRT includes estrogen, a woman's hormone, which is given as a vaginal cream, a skin patch, a nasal spray, an implant or a pill. HRT usually relieves the symptoms of menopause, and this is very important for the few women who have severe hot flashes, night sweats, mood changes and sleep problems. However menopause symptoms are mild, or of limited duration in most women, so HRT is not usually necessary. While HRT was commonly used 10 years ago, newer studies have shown that women who take HRT can be at increased risk for serious blood clots, breast and ovarian cancer and stroke.

Taking Care of Your Bones

By Phyllis C. Tien, MD

Taking care of your bones is very important for women and especially women with HIV. As one gets older, thinning of the bones can occur. Osteoporosis is when the thinning of the bones becomes severe enough to put you at risk for bone fractures or broken bones, especially in the hip and the arms such as the wrist. You can also get fractures in your spine even without falling or trauma to that area. Osteoporosis becomes more common during the change of life or transition to menopause, because of the decrease in estrogen levels during this transition. Osteoporosis and osteopenia (which is thinning of the bones that have not yet reached the level of osteoporosis) have also been increasingly reported in HIV-infected individuals since the introduction of effective antiretroviral therapy.

What are the causes of osteoporosis in HIV positive women?

Data from the Metabolic Study has shown that HIV-positive WIHS women have more thinning of the bones than HIV-negative women, and there is a possibility that protease inhibitor may be associated with even more thinning of the bones. So, just having HIV infection may be a factor and possibly taking certain HIV medications. Other factors that have been associated with thinning of the bones in HIV-infected people include being underweight, using corticosteroids in the past, not being physically active, and smoking.

How can I find out if I have osteoporosis?

You can find out if you have osteoporosis or osteopenia through an X-ray scan of your body. This is a special X-ray scan called the DXA scan, which stands for dual X-ray energy absorptiometry (DXA) scan. The scan provides you with a T-score and if the score is less than –2.5, then the diagnosis of osteoporosis is made. Some people recommend that all HIV-positive women should have a DXA scan done every year. In HIV-negative women, the recommendation is to have a DXA scan if you are postmenopausal and 65 or older.

How do I prevent osteoporosis?

1. Make sure you have enough calcium and vitamin D in your diet (either by taking vitamins or by eating foods rich in calcium and vitamin D such as dairy products);
2. Exercise – we should all try to exercise three times per week for 30 minutes each time;
3. Stop smoking;
4. Decrease alcohol and caffeine intake.

How do I treat osteoporosis?

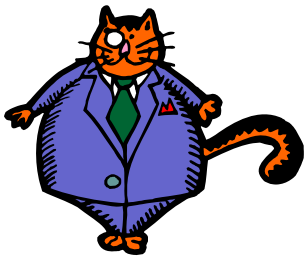
There are medications that can be safely prescribed to HIV-positive persons to treat osteopenia and osteoporosis. HIV-positive women with osteopenia, osteoporosis, or fractures should be offered bisphosphonates along with taking calcium and vitamin D. You should also exercise, not smoke and limit your caffeine and alcohol consumption to keep your bones healthy and happy.

CAB CORNER

The Spring CAB Meeting

By Heneliaka Jones, CAB Liason

Hello ladies, if you missed our last CAB meeting, then you missed an afternoon full of learning, food, and fun. Our very own, Dr. Phyllis Tien gave a wonderful presentation on Lipodystrophy, also known as changes in body fat. There were many questions on this topic and we had a lengthy discussion. Dr. Tien did a wonderful job at answering questions and talking about other illnesses common in individuals with HIV.

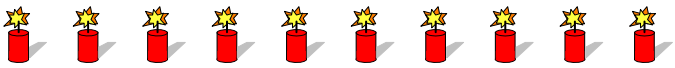


After Dr. Tien's presentation, we continued with other CAB business. I informed everyone that our next CAB event will be a Love your Liver forum in which a panel of specialist will discuss issues concerning the liver. Although we do not have a final date for this event, it will take place sometime in the fall.

We also discussed the 2008 WIHS woman of the Year. For those of you that don't know, Nilda Rodriguez won the 2007 WIHS Woman of the Year award. This year we plan to have another great slate of contestants, so please call Heneliaka "Ladybug" Jones if you would like to nominate someone for the 2008 WIHS Woman of the Year.

Lastly, we talked about the Community Advisory Board (CAB) and the role your representatives play among the various WIHS CAB groups throughout the nation, also known as the National CAB (NCAB). At our next meeting we will create by-laws and term limitations for our CAB, so I hope you all come out and let your voice be heard.

If you have any new ideas or suggestions for making the CAB more interesting and fun or if there is a topic that you would like to learn more about at one of our CAB meetings, please let me know. I look forward to hearing from you! I can be reached at 415-502-6284 or Heneliaka.jones@ucsf.edu.



ENJOY YOUR SUMMER

Ask Doctor WIHS

Q: What is Lipodystrophy and what are some of the ways in which I can manage it, particularly in my face?

Lipodystrophy has often been defined as fat gain in the belly, breast, and upper back and/or fat loss in the arms, legs, buttocks and face. Data from WIHS and other studies show that HIV infection and specific antiretroviral therapies, particularly stavudine or d4T are associated with fat loss. Fat gain appears associated with normal aging and can also occur when one regains their health after starting HAART. Eating a healthy balanced diet and exercising are effective for reducing fat gain.

In terms of fat loss, switching off stavudine has been shown to lead to some recovery of fat, but not to baseline levels. Other treatments that have been studied include rosiglitazone and pioglitazone, but it is unclear if these drugs improve the fat loss associated with HIV infection. Fat loss in the face can be stigmatizing and the FDA has approved of the use of Sculptra for treatment of HIV-associated fat loss in the face. Sculptra is a biosynthetic filler that is injected into the face usually one time per month for a total of 4 treatments depending on the severity of fat loss in the face. The filler usually lasts for about 2 years and additional treatments may be needed.

Dr. Phyllis Tien

If you would like to submit a question to Dr. WIHS , please e-mail it to Heneliaka L. Jones at heneliaka.jones@ucsf.edu or call 415.502.6284. Answers will be posted in the following WIHS Newsletters.

WELCOME

Annie Handajani

A warm *hello* to the WIHS family. I recently received the honor of being trusted as Fiscal Analyst for the grants that fund our HIV study plus other grants for our subsidiary studies. In a nutshell, I provide guidelines for study staff members to ensure that everything that we do is done in accordance with the policies set forth by the National Institute of Health, our funding source, and by the Regents of the University of California, the official recipient of the grants. I also "keep an eye" on the financial activities and make projections to determine the level of funding we require to keep our studies running. This is how I spend the majority of my "9 to 5 time".

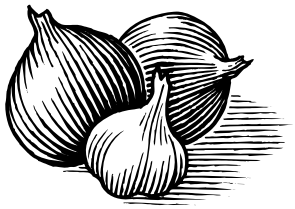
My after 5:00pm and weekend time includes walking and sightseeing, or watching good movies when it's too chilly outdoors (yes, I live in San Francisco!). Since the fall of 2007, I began swimming to my non-work activities. And I declare that swimming is my greatest achievement as it took me 15 years to overcome my fears of being in water above my knees!

I recently read the NCAB publication for the 10 Years Anniversary of WIHS and am deeply touched by how inspiring and empowering WIHS has become to women living with HIV. Learning about this makes me thankful for my job and recognize that my profession is really a wonderful vocation. The stories of transformation experienced by WIHS women bring about wisdom. I look forward to many years of growing wise with the WIHS.

Diet & Nutrition

Fruit & Veggies

*Vegetable of the Month**
GARLIC



For years garlic has been the topic of much folklore. In ancient times, its pungent odor was believed to supply strength and courage to those who ate it. Garlic has been used for numerous things including embalming, warding off evil spirits, and curing everything from the common cold to tuberculosis and broken bones.

Even in modern times, garlic is still being promoted as a health food with medicinal properties. Though garlic is a nutritious food, many of the claims surrounding it are not backed up by research.

Garlic is a member of the Allium genus and classified as Allium sativa. The garlic bulb is covered with a loose, white, crackly outer skin and comprised of individual sections called cloves. Each clove is covered in a white sheath.

Garlic is very popular in the Middle East and Mediterranean countries, India and China. In America, 250 million pounds of garlic are consumed per year and its use is growing.

Garlic is characterized by it's strong flavor and smell, stemming from its sulfur compounds. It makes a great flavoring agent for a variety of dishes.

Varieties

There are approximately 300 varieties of garlic grown throughout the world. In the United States about 90% of the garlic is grown in California and most comes in two types, early and late.

Early garlic is white or off-white in color and harvested in mid-summer. Late garlic is off-white on the outside

American: white-skinned with a strong flavor.

Chileno: a reddish-colored, sharp tasting garlic grown in Mexico

Elephant: Not a true garlic, but a relative of the leek; its flavor is very mild and it is characterized by larger heads.

Green Garlic: Young garlic before it starts forming cloves. Green garlic looks like a baby leek with a long green top and small white bulb. Its flavor is much more mild than that of mature garlic.

Italian: Mauve in color with a somewhat milder flavor.

Availability, Selection, and Storage

Garlic is available year-round frozen or fresh. When buying fresh garlic, choose from plump, dry heads that feel firm. Avoid soft, mushy or shriveled cloves. American garlic should be white to off-white. Garlic should be stored in a cool, dark place (though not a refrigerator) and can be kept for several weeks. Many people use small clay garlic holders to keep their garlic as fresh as possible. Cloves that have sprouted can still be used but they will not be as strong in flavor as fresher cloves. The sprouts themselves can be cut up like scallions and chives and used in dishes.

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Garlic Nutrition

Garlic	
Serving Size 1 clove raw (3g)	
Amounts Per Serving	**% Daily Value**
Calories 5	
Calories from Fat 0	
Total Fat 0g	**0%**
Saturated Fat 0g	**0%**
Cholesterol 0mg	**0%**
Sodium 0mg	**0%**
Total Carbohydrate 1g	**0%**
Dietary Fiber 0g	**0%**
Sugars 0g	
Protein 0g	
Vitamin A	**0%**
Vitamin C	**2%**
Calcium	**0%**
Iron	**0%**
*** Percent Daily Values are based on a 2,000 calorie diet.**	

Preparation

To remove individual garlic cloves, peel outer layers from the bulb and snap out each clove from the base. Cloves can than be peeled very easily. For a more mild flavor, whole cloves can be added (unpeeled for an even more subtle taste) to food while it cooks or marinates and than discarded before serving the meal. Another trick for imparting a mild garlic flavor in your dish is to spear a garlic clove with a fork and stir your dish with it — discarding the garlic when stirring is complete.

For a stronger flavor, used chopped, crushed, pressed or pureed garlic in dishes. The more finely garlic is chopped, the stronger its flavor will be. To chop garlic, cut in half lengthwise (remove the green core if there is one — it is bitter). Make several lengthwise cuts and than cut crosswise. A garlic press can be used also though these can be a bit tricky to clean.

To remove garlic odor from hands, use salt or lemon juice and than wash your hands with soap.

Cooking Garlic

Cooking garlic decreases the strength of its flavor making it much milder. The longer it is cooked, the more mild it tastes. Be careful not to sauté garlic too long at too high a temperature, it will brown very quickly and can become bitter. To bake garlic, place whole, unpeeled bulbs rounded side down in a shallow baking dish, drizzle with oil, cover with foil and bake for 1 ½ hours at 325°F.

Recipes

Roasted Squash with Potatoes **& Garlic**

Makes 8 servings

Each serving equals 3/4 cup of fruit or vegetables

Source: Wegmans

Ingredients

1 unpeeled acorn squash (about 1 to 1½ lbs), washed, halved, seeded and cut into 12 equal pieces
4–5 medium (about 2 lbs) butter potatoes, unpeeled, washed and quartered,
4 cloves garlic, peeled and crushed
3 Tbsp olive oil
1 large sprig rosemary

Preheat oven to 425°F. Combine squash, potatoes and garlic in 9 x 13-inch shallow baking pan. Drizzle with oil. Salt and pepper to taste. Top with rosemary sprig. Bake 45–50 minutes, turning once after vegetables are browned on one side.

Option: Squash may be peeled if desired.

Nutritional analysis per serving: Calories 176, Protein 3g, Fat 5g, Percent Calories From Fat 27%, Cholesterol 0mg, Carbohydrates 30g, Fiber 3g, Sodium 13mg.

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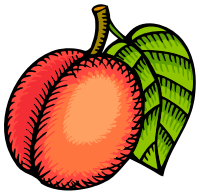
*Fruit of the Month**
NECTARINE



Commonly showcased side by side with peaches, nectarines are a similar, but yet different fruit. The best way to identify the difference between a nectarine and peach is by the lack of fuzz on the nectarine.

Nectarines, like peaches, most likely originated in China more than 2,000 years ago and were cultivated in ancient Persia, Greece and Rome. They were grown in Great Britain in the late 16th or early 17th centuries, and were introduced to America by the Spanish. Today, California grows over 95% of the nectarines produced in the United States.

Nectarines are smaller and smooth skinned golden yellow with large blushes of red. Their yellow flesh has a noticeable pink tinge, with a distinct aroma and a more pronounced flavor. There are more than 100 varieties of nectarine, in freestone and clingstone varieties. In freestone types the flesh separates from the 'pit' easily, while clingstone types cling to the 'pit.' Nectarines are more delicate than peaches and bruise very easily.

Nectarines are low in calories with no sodium or cholesterol.

Selection

Ripe fruit are fragrant and give, slightly, to the touch. If they are a under-ripe, leave them at room temperature for 2–3 days to ripen. Look for fruit with smooth unblemished skin. Avoid extremely hard or dull colored fruits and soft fruit with soft, wrinkled, punctured skin.

Storage

Nectarines keep for 5 days if stored in a plastic bag in the coldest part of your refrigerator.

Preparation

Nectarines can be used and prepared in the same ways as peaches, with no need to peel because they have no fuzz. Leave the skins on when making pies, cobblers and fresh fruit salads, etc.

Availability

California nectarines are available from late April and to late August. Almost all of the nectarines available are in California. Chilean Nectarines are available from late December through early March.

Nectarine Nutrition

Nectarine	
Serving Size ½ cup (69g)	
Amounts Per Serving	**% Daily Value**
Calories 30	
Calories from Fat 0	
Total Fat 0g	**0%**
Saturated Fat 0g	**0%**
Cholesterol 0mg	**0%**
Sodium 0mg	**0%**
Total Carbohydrate 7g	**2%**
Dietary Fiber 1g	**4%**
Sugars 5g	
Protein 1g	
Vitamin A	**4%**
Vitamin C	**6%**
Calcium	**0%**
Iron	**2%**
*** Percent Daily Values are based on a 2,000 calorie diet.**	

**Above information is taken from the Centers for Disease Control (CDC) web site: fruitsandveggiesmatter.gov*