National Vulvodynia Association

# nVA News

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Summer 2000

# Vulvar Conditions, Pregnancy and Childbirth

## *Questions and Answers with Gae Rodke, M.D., FACOG*

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*How did you become a specialist in the treatment of vulvovaginal pain?*
I have been working with patients with these problems since my residency. Upon completion of my residency in 1986, I went to Florida to study with Dr. Ed Friedrich, a true pioneer and a gentle, thoughtful physician. We collaborated on a research project with his longtime colleague, Dr. Ed Wilkinson, whose expertise in vulvar pathology was essential to our study. After my return to New York, I was fortunate to continue to learn from Dr. Burton Krumholz, an expert colposcopist, and to work for the next several years with Drs. Alex Young and Harold Tovell of the Cutaneous Vulvar Center at St. Luke's/ Roosevelt Hospital.

*Why did you create the New York Center for Vulvovaginal Pain?*
In 1987, I became interested in the use of alternative modalities in the management of pain and was impressed with some early successes; through collaboration with the Pain Center at St. Luke's, I worked with Dr. Howard Glazer to study the use of electromyographic (EMG) biofeedback in the treatment of vulvar pain patients. He and I shared many patients during subsequent years, but there were also patients who would only see one of us, even though they were likely to benefit from collaborative care. Patients who pursued both avenues simultaneously often benefitted from the combined

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# NIH Creates Web Site on Clinical Trials

Have you wondered if there are any new research studies you could participate in, but don't know where to find out about them? The National Library of Medicine of the National Institutes of Health (NIH) has developed a new web site, *www.ClinicalTrials.gov*, which contains information on more than 4,000 medical research studies involving patients that are being conducted nationwide. "If we are to continue making the giant strides in diagnosis, treatment, and cure of illness that marked the last century, we must have active participation in clinical trials by well-informed volunteers," said Donald A.B. Lindberg, M.D., Director of the National Library of Medicine.

*ClinicalTrials.gov* was initiated as a result of the Federal Drug Administration's Modernization Act, which became law in November 1997. Section 113 of the Act requires the Department of Health and Human Services, through the NIH, to establish a comprehensive database of both federally and privately funded trials on drugs and experimental treatments for serious and life-threatening diseases.

This database project is being instituted in two phases. The first phase, which is well underway, aims to provide all members of the public information on studies primarily being funded by the NIH or being conducted on the

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# LETTERS TO THE EDITOR

Dear NVA:
Fifteen years ago I married a wonderful man, only to find intimacy was so painful, it nearly destroyed our marriage. After numerous physicians suggested red wine and lubricants, a doctor at the Cleveland Clinic diagnosed my problem and recommended surgery. At that time, I was only the second woman with vestibulitis that my doctor had opted to treat surgically, so I consented to the clinic's request to use my case for teaching purposes. I even agreed to have before and after pictures of the surgery taken to help future vestibulitis patients. The surgery was a complete success and I have had a full, active life. I have been able to enjoy sexual intimacy with my husband and give birth to three children.

Today I met a woman with the same distressing symptoms that I had experienced. I referred her to the NVA because I believe that educating yourself and supporting research on this condition are essential. I hope that this letter will encourage other sufferers not to give up hope.

Sincerely,
J.P.

Dear NVA:
I cannot describe how pleased I was to read Dr. Howard Glazer's excellent article in the Fall 1999 *NVA News*. It was the first article I've seen by a health care professional that actually acknowledges the very real challenges to sexual functioning that vulvodynia and related conditions present.

Before a gynecologist finally diagnosed me with vulvodynia, I spent almost three years bouncing between two urologists who would respond to my complaints about my sex life with blank stares, embarrassment and what seemed to be, at times, genuine befuddlement. Perhaps they didn't believe that a plump, fortysomething woman had a sex life to begin with. They certainly didn't believe that it was physical pain, and not some psychological disorder, that was preventing me from enjoying one.

In spite of the fact that the symptoms I described to these physicians were the classic signs of vulvodynia (burning pain in the vulvar area that increased dramatically after sexual intercourse), neither one mentioned vulvodynia or even suggested that I consult a gynecologist. They were content to conduct exploratory surgery and prescribe major pain killers for extended periods of time even though they couldn't find anything wrong with me, urologically speaking. When it became apparent that I was being written off as a nut case, I finally consulted a gynecologist and learned about vulvodynia for the first time. The gynecologist referred me to a vulvodynia specialist and, with proper medication, I am gradually becoming symptom-free.

My personal experience has led me to the same amazement that Dr. Glazer expressed about the lack of an interdisciplinary approach by the medical profession in the treatment of vulvovaginal pain disorders. My only disappointment is that it took a person with a Ph.D, rather than an M.D., to point out this problem. When I start hearing physicians echo Dr. Glazer's views, I'll know we've made real progess in this area.

Sincerely,
B.C.

Dear NVA:
I've been reading the NVA News for several years and have never seen an article that specifically addressed the topic of clitoral pain. I have suffered from this severe type of pain for the past 10 years. The symptoms include burning, throbbing, stabbing sensations, and on occasion, uncontrollable and painful sexual arousal. I have never found a physician who has treated a case of clitoral pain and I would appreciate any ideas that you have about treatment.

Sincerely,
J. K.
*(Editor's note: The NVA has heard from a handful of women who suffer from clitoral pain. If you have clitoral symptoms and would like to be put in touch with other women who suffer from this condition, please e-mail us at mate@nva.org or send a note to the Newsletter Editor, P.O. Box 4491, Silver Spring, MD 20914. We will try to find a vulvar specialist to address this topic in a future newsletter.)* ■

# Pregnancy

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perspectives of diagnosis, and shortened the lag time between beginning treatment and improvement. Many of our patients came from out of town, and had difficulty coordinating schedules with both of us. The time spent in obtaining thorough histories, answering frequently asked questions and counselling patients precluded my personally seeing more than two or three new patients in a day, since the average patient had seen multiple doctors and tried many therapies over several years prior to seeing us. Dr. Glazer and I decided to create the New York Center so we could provide comprehensive care at one site. We integrated dedicated nurse practitioners into the program to provide better care for our patients and respond more promptly to the need for appointments and questions. Our program continues to evolve, and it has been gratifying to see that we are able to diagnose more accurately the patients most likely to benefit from various treatment options, shortening the time to recovery.

*Many vulvodynia sufferers find sexual intercourse painful. What do you recommend to this group of patients?*

I often recommend that they try to maintain levels of communication and other kinds of intimacy in their relationship, outside of intercourse. I suggest they explore ways of pleasuring one another that don't involve a lot of direct vaginal friction. In addition, some women who only have focal tenderness at the vestibule do well with topical Xylocaine. I use it in a solution rather than an ointment, because an ointment is more likely to transfer onto the partner, decrease his level of stimulation, and increase the amount of time it takes him to achieve orgasm. Such a situation can be inordinately difficult for a patient with vulvar pain. I prescribe the use of 4% Xylocaine solution on a cotton ball, placed right at the introitus, for a period of five or ten minutes before intercourse. I also tell couples to use a lot of lubrication. After intercourse vulvar pain patients should put a cold compress on the area, so that any reflex redness or swelling is suppressed before it can become a vicious cycle.

*Are there any lubricants that you recommend, and any that should be avoided?*

I tell my patients to utilize the lubricants with the least preservatives. I like Astroglide because it is water soluble, a very small quantity creates a good deal of slipperiness, and it doesn't tend to get gummy and gritty. Almond oil has similar advantages, although it should be avoided if one is allergic to nuts. Also, one should never use petroleum or oil-based lubricants when using latex condoms. I recommend either lambskin or polyethylene condoms, if one is going to apply an oil-based product. I certainly don't advise the use of commercial cold creams or other products that have perfumes in them. Many of my patients are also sensitized to spermicidal products and must avoid them.

*Many vulvodynia sufferers are of childbearing age. What do you suggest to women who want to become pregnant, but find frequent sexual relations difficult?*

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# Pregnancy

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For those women with regular cycles, calculating the fertile period is fairly simple. By subtracting 14 from the average length of the menstrual cycle the probable day of ovulation can be calculated. For example, in a 30-day cycle with day 1 as the first day of menses, day 16 would be the probable day of ovulation. The two to three days prior to day 16 would be the most fertile. Often a clear mucus discharge is noted at this time. Use of topical lidocaine solution prior to intercourse and liberal use of non-spermicidal lubricants can facilitate intercourse where possible. If penetration is not possible, manual or oral stimulation of the male with ejaculation at the introitus may suffice. The woman can then lie on her back with her knees up, which will help the sperm to travel up into the vagina and the vaginal pool near the cervix. Use of an unused vaginal diaphragm to place the pool of sperm (instead of spermicide!) over the cervix is another method commonly used to enhance the possibility of conception. Another option is to place the semen in an unused turkey baster, and insert it into the vagina. Of course we can also do inseminations in the office, but most patients don't require this procedure unless there are fertility issues such as reduced volume or number of sperm.

*Is infertility associated with vulvar disorders?*

In general, vulvar disorders are not known to increase the risk of infertility. However, some causes of infertility such as premature ovarian failure, medical conditions such as diabetes and some thyroid disorders can be autoimmune in nature. Some vulvar conditions are associated with these disorders, and may increase vulvar and vaginal discomfort through hormonal, neurological or inflammatory mechanisms. Obviously vulvar disorders can indirectly affect fertility if there is reduced frequency or impossibility of sexual intercourse. Ideally, the problem is treated, and conception becomes possible in the usual way. If improvement is slow and time is of the essence, creativity and careful planning can often help achieve pregnancy.

*How do vulvovaginal problems affect pregnancy?*

This is one of the major, often unspoken, concerns of our patients in the reproductive age group. Dyspareunia is one of the common presenting symptoms of a wide range of vulvovaginal problems including chronic vaginitis, vulvar dermatoses, vestibulodynia, generalized vulvodynia, and frequently coexistent conditions such as interstitial cystitis. At the very least, dyspareunia makes conception more of a challenge and may be disruptive to relationships, making a decision to commit to childbearing and rearing more difficult. Specifically, vulvar pain makes gynecological exams and procedures more uncomfortable. Exams during labor and manipulation to accomplish delivery are also more uncomfortable. Fear of further injury or pain has led some patients and practitioners to avoid vaginal delivery. Postpartum hormonal changes and tender scars can increase dyspareunia. Fortunately, the fetus is rarely affected by any of this. Care should be taken in choosing medications and dosages should be limited. Bacterial Vaginosis should be diagnosed and treated promptly, because it can increase the risk of preterm labor and cause infection during labor and postpartum. Urinary tract symptoms also must be investigated promptly to prevent kidney infections and preterm labor.

*What do you advise your patients who want to become pregnant but are currently taking medication to control vulvar pain?*

Fortunately, as more of our patients have had success with EMG biofeedback, this has been less of an issue. The equipment and pelvic floor exercises are totally safe to use throughout pregnancy. Used postpartum, these exercises facilitate recovery of vaginal tone and reduce urinary dysfunction and stress incontinence. For those patients using oral medications such as amitriptyline and nortriptyline, we recommend tapering and, if possible, discontinuing them prior to conception. If the patient cannot tolerate discontinuation, reduction to the minimum effective dose is prudent. Fortunately, the dosage used for vulvodynia is significantly lower than the usual antidepressant dose. With the use of home pregnancy kits, early detection of pregnancy (within one to three days of the next expected menses) is possible. Once a positive test result is obtained, it is advisable to try to further reduce or discontinue the medication, with the

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goal of at least avoiding first trimester use. Amitriptyline does cross the placenta and is excreted in breast milk. Animal studies of the impact of amitriptyline and nortriptyline on the fetus have yielded inconclusive results. Antihistamines such as hydroxyzine, which are sometimes prescribed for vulvar pain, are less problematic. Patients using topical steroid medications may be advised to decrease the potency or frequency of use. Similarly, patients should minimize the use of topical testosterone while trying to conceive, and after a positive pregnancy test, should be switched to progesterone promptly.

*Do your patients find that their vulvar symptoms change with pregnancy?*
The effect of pregnancy on vulvar symptoms is variable. Most patients find that their symptoms are no worse, and some patients improve. One exception, however, is chronic candidiasis (yeast). Pregnancy makes the vagina warmer, moister and sweeter, all of which increase the growth of candidal organisms. Dermatoses such as lichen sclerosus are often improved, probably due to increased levels of progesterone.

*What is the best treatment for a yeast infection during pregnancy?*
First, there must be an accurate diagnosis. Many women misinterpret the normal increase in vaginal discharge during pregnancy as a yeast infection. If yeast is present, it is important to ascertain whether it is of the Candida Albicans or non-Albicans variety. In the first trimester, it is prudent to withhold treatment unless symptoms are bothersome and, if needed, treat externally for symptomatic relief. If necessary, use of older agents with a long history of safety, such as nystatin (for both Albicans and non-Albicans) or miconazole (for Albicans) is preferred. It can take longer to eradicate yeast in pregnancy because of the enhanced growing conditions, so I generally treat for twice the usual duration. Neither Diflucan nor Ancobon (flucytosine) should be used during pregnancy. Because terconazole is absorbed systemically, I avoid its use in the first trimester and prescribe it later in pregnancy only if simpler agents fail.

*Do you manage the pregnancy and delivery of a vulvodynia patient differently than that of your other patients?*
Not really, but my experience caring for vulvodynia patients has affected the way I practice obstetrics for all my patients. During pregnancy, prompt attention to new vaginal or urinary complaints helps minimize the chance of increased pain or other complications. I try to minimize the number of vaginal exams during pregnancy and in labor. Fortunately my hospital has prompt continuous availability of the new "walking" epidural anesthetics which can be given earlier in labor without the drawbacks seen with the older techniques. The term "walking" epidural refers to a combined technique of regional anesthetic involving placement of narcotic medication within the spinal fluid and placement of an epidural catheter outside the covering of the spinal space. The spinal medication dose gives pain relief without loss of muscle power for the first two to four hours. Thereafter, a continuous infusion of local anesthetic through the epidural catheter keeps the patient comfortable. The rate of infusion can be adjusted and therefore reduced slightly during pushing to allow a better sense of timing and direction of the pushing effort.

Another advantage of the walking epidural is that it facilitates control of the rate of delivery. By removing the pain and overwhelming urge to get the baby out as fast as possible after crowning, it enables the practitioner to coach the patient to push steadily or intermittently with greater or lesser effort to ease the baby out without trauma. In my desire to avoid creating a new scar in an already painful area, I have endeavored to perfect techniques to promote "intact delivery" and avoid episiotomy or lacerations in vulvodynia and lichen sclerosus patients. The benefits to these patients has led me to apply these techniques to all my obstetrical patients. Recent research studies have confirmed that refraining from the use of episiotomy in "normal" patients reduces the occurrence and extent of lacerations.

*Why is it especially important for vulvodynia patients to avoid episiotomy?*
Any new scar is a focus of tenderness. In patients with vulvodynia, an episiotomy can exacerbate the

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cycle of tenderness/pain/spasm, etc. The exception would be in cases of emergency during delivery, when the few extra minutes to allow a delivery without trauma is not in the interest of the fetus, or in cases where a vacuum or forceps delivery is necessary and time is of the essence.

*But isn't an episiotomy preferable to a vaginal tear?*
The injuries incurred in "spontaneous" deliveries were a major factor in popularizing the use of episiotomy. Research has shown that when episiotomies are performed, the incisions are almost always larger than the lacerations incurred if episiotomies are not performed. They are also more likely to cause damage to the rectal sphincter and tears into the rectum.

The problem, however, is that while most lacerations are exactly where the episiotomy would have been, they are less symmetrical, and sometimes in places more challenging to repair. I find that the little extra time and attention during delivery to minimize the chance of tearing is rewarded with much less time spent sewing.

*Is there anything a vulvodynia patient can do to help minimize the trauma to the vulva during delivery?*
Some practitioners recommend perineal massage to prepare the tissues. Studies have shown varying results in "normal" women. I find that there are natural changes in the vulvar, perineal, and vaginal tissues which allow more stretch during birth than would be possible even a few days before or after. Many of my patients have pain only with touch, or exacerbated by touch, so they would find perineal massage particularly uncomfortable. To the extent that perineal massage is empowering and reassuring, I support its use. I do not feel that the advantage is sufficient to justify any significant discomfort. The two other areas in which the patient can control the situation are in choice of practitioner and in pushing technique during the second stage of labor. Finding a physician or midwife dedicated to delivering without episiotomy can be a challenge. Delivery without an episiotomy is not simply a matter of allowing spontaneous uncontrolled delivery, it is an active collaborative process between the woman and her attendant. Once the head is crowning, panting or blowing instead of pushing during the next one or two contractions can allow the tissues to stretch without tearing. The sensation of burning is often felt by an unmedicated patient as tissues stretch. So remember, "if it burns, blow!"

*Do vulvodynia patients have more pain after delivery, and is it likely to be permanent?*
Most women experience some discomfort and frustration during the postpartum phase. In addition to possible vulvar/vaginal trauma, the decrease in vaginal estrogenization that occurs with lactation can cause dryness and burning. Use of small amounts of topical estrogen cream, along with vaginal lubricants, can be helpful. It is unusual for a permanent increase in pain to occur. The stretching of the introital skin may be beneficial in reducing superficial friction when sexual intercourse is resumed. If pelvic floor exercises are performed correctly, the vaginal muscular tone can be improved, causing a net improvement in function and comfort.

*Do you ever recommend a scheduled Cesarean delivery for patients with pre-existing vulvovaginal conditions?*
Not unless there is another very good reason to perform a Cesarean delivery! As I mentioned before, with attentive care and proper exercise, sometimes vaginal delivery can even lead to improvement in symptoms and function. Cesarean delivery increases maternal risk and adds recovery from major surgery to the challenges of the postpartum period. In addition, dryness and atrophy of the vagina due to estrogen suppression during breastfeeding is more likely to be problematic for women who did not deliver vaginally. The stretching of the vaginal walls during delivery helps prevent the typical tightening (due to lack of hormones) from making tender, fragile tissues even more uncomfortable. If Cesarean delivery is necessary for other obstetrical reasons, the use of small amounts of estrogen cream and generous amounts of lubrication can help to overcome the vulvovaginal difficulties.

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## Pregnancy

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*What advice do you have for your vulvar pain patients who are afraid of pregnancy and childbirth ?*
If they want a family I encourage them to proceed. I reassure them that in most cases all goes well and that there is a chance they may even feel better afterwards. I find it personally rewarding to see my patients through this exciting and challenging time.

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# Can Acupuncture Relieve Vulvodynia?

A new study released by the Journal of the Royal Society of Medicine, reports that acupuncture may be helpful in treating vulvodynia. The researchers, Drs. Powell and Wojnarowska, speculate that acupuncture needles relieve pain through their effect on pain fibers known as *A delta fibers*; this study hypothesized that acupuncture treatment may help vulvodynia sufferers by "switching off" these overactive, malfunctioning pain fibers.

Twelve patients with vulvodynia were enrolled in the study; all of these patients had longstanding symptoms and had tried many unsuccessful therapies. All subjects had been previously treated with topical steroids and amitriptyline (tricyclic antidepressant medication), and had used self-help measures such as lubricants and removal of irritants. Eleven subjects had previously tried systemic antihistamines. Roughly half of the study population had used antifungals, local anesthetics (e.g., Lidocaine), and hormone therapy. Three subjects had tried the low oxalate diet, nerve blocks, other types of antidepressants and intralesional steroids.

The subjects attended weekly sessions for a total duration of ten weeks. Since it was impossible to establish a placebo (no treatment) group employing the acupuncture technique, the study was designed so that each woman was her own control. What this means is that each subject received five weeks of acupuncture treatment followed by five weeks without treatment. Each time a woman visited the clinic her progress was monitored by general inquiry, a pain score on a scale of 0 to 10, and a quality of life questionnaire score. This monitoring continued for five weeks after treatment ended.

During the five treatment sessions, four needles were inserted in the subject's skin at the following recognized acupuncture points: spleen meridian points 6 and 9 (located in the leg), liver meridian point 3 (located in the bottom of the foot) and large intestine meridian point 4 (located in the hand).

Two of the twelve subjects declared themselves cured after treatment with acupuncture. Three subjects experienced pain relief during treatment followed by relapse of the pain after treatment was stopped. These "short-term responders," all decided to continue with the acupuncture treatment after the study ended. Four subjects reported that acupuncture was more effective than other treatments they had tried, although their pain scores did not change substantially over the course of treatment. Only three subjects reported no improvement in pain relief and considered the treatment unsuccessful. The only side effects reported were minor bleeding and discomfort at the needle site.

Overall, the findings were that 75 percent of the study's population reported some pain relief with acupuncture treatment. The amount of pain relief reported ranged from "minor" to "exceptional." The au-

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## Acupuncture

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thors speculated that regular contact with the acupuncture specialist may have contributed to the results. A major drawback of this study was its very small sample size. The results warrant further investigation with larger sample sizes.

Reference: Powell, J. and Wojnarowska, F. Acupuncture for vulvodynia. *Journal of the Royal Society of Medicine* 1999; 92, 579-81.■

## NIH

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NIH campus. During the second phase of the project, the database will expand to include information on non-NIH sponsored trials from other Federal agencies and private industry.

The Web site does not require registration or identification, thereby ensuring confidentiality. The site allows you to do a "keyword search" for trials on specific diseases or medical conditions. You can also browse through a list of studies using either the name of the specific disease/condition or the name of the funding organization. If you locate a study of interest, the site provides information on the study's objectives, its protocol, number of participants being recruited, criteria for participation and location. Contact information for further details is listed as well. ■

# Endometriosis: An Overview

If you think back to high school biology class when you studied the female reproductive system, the uterus was described as an organ designed to nurture the growing fetus. Over the course of a month, the "endometrium" or lining of the uterus builds up in response to rising levels of estrogen. As the endometrium thickens, the uterus prepares for the implantation of a fertilized egg. If an egg is not fertilized, this lining sheds once a month during the time called the menses.

Endometriosis is a chronic, painful condition in which endometrial tissue develops outside of the uterus, primarily in locations within the abdominal cavity. Most frequently, it can be found on the ovaries, fallopian tubes, and ligaments that support the uterus; the area between the vagina and rectum; the outer surface of the uterus; and the lining of the pelvic cavity. Other sites may include the bladder, bowel, vagina and cervix, as well as abdominal surgical scars. This misplaced tissue develops into growths or lesions, responding to the menstrual cycle in the same way that the tissue of the uterine lining does. At the beginning of the cycle the tissue grows; during the time of menses it breaks down and sheds. The blood and tissue from these extra-uterine endometrial growths have no way of leaving the body, resulting in internal bleeding and inflammation. This can cause pain, infertility, scar tissue formation, and bowel problems.

According to the Endometriosis Association, endometriosis is a highly prevalent condition, occurring in 10 to 15 percent of women worldwide. Studies have reported that 40 to 60 percent of women who experience dysmenorrhea (painful periods) and about 25 percent of women with fertility problems have endometriosis. Risk factors for the disorder include a genetic predisposition, early menarche, and late menopause.

**What Causes Endometriosis?**

No one knows exactly why endometriosis develops, but several theories on its causes have been proposed.

*Retrograde Menstruation Theory* This theory suggests that during menstruation some of the endometrial tissue in the uterus is pushed backward through the fallopian tubes, implants itself elsewhere in the abdomen, and grows. According to this theory, endometrial tissue exits the end of the fallopian tube into the abdominal cavity and adheses (attaches) to organs within the abdomen, such as the bladder, ovaries, and bowel. After the tissue attaches itself to the organs, it grows in response to monthly fluctuations of circulating hormones. During the time of menses, the adhesed tissue bleeds and causes pain.

*Embryonic Tissue Theory* According to this theory, there is endome-

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# Endometriosis

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trial tissue in the abdominal cavity from the time of embryonic development. This tissue may become activated and produce symptoms many years later.

*Genetic Theory* Research evidence indicates that endometriosis is genetically linked. Women born into families in which females have the disorder are more likely to develop endometriosis, and are in turn more likely to pass it on to their daughters.

*Immune System Dysfunction* Women who have endometriosis also seem to suffer disproportionately from immune system disorders such as lupus, thyroid-related problems, and allergies. Thus, it is hypothesized that endometriosis may be the result of a dysfunctional immune system. Research comparing women with endometriosis to women without the disorder found that the immune system cells in women with endometriosis were not as effective in warding off "invader" cells.

*Environmental Causes* Studies have suggested that there may be a link between certain environmental contaminants and endometriosis. Research by the Endometriosis Association revealed that exposure to dioxin, a toxic chemical byproduct of pesticide manufacturing, was related to the development of endometriosis in animals. In this study, 79 percent of the monkeys exposed to dioxin developed endometriosis. The greater the dioxin exposure, the more severe the endometriosis. Exposure to the chemical can be minimized by using dioxin-free (unbleached) tampons, sanitary pads, napkins, paper towels and toilet paper; consuming organic meats and vegetables, and avoiding contaminated fish; and by using non-toxic cleaning agents.

**Symptoms**

The most common symptoms of endometriosis are pain before and during periods, pain during sex, infertility, fatigue, painful urination and bowel movements during periods, and gastrointestinal upset. ( For a more extensive list of symptoms, see the chart below).

**Diagnosis**

If you think you may be suffering from endometriosis, you should seek medical attention promptly. Although the condition is not preventable, the sooner it is detected, the better the chance for effective treatment. It is important to communicate all of your symptoms to the physician taking your medical history. If you experience pain at specific times during your monthly menstrual cycle, it is often helpful to keep a "pain diary." In this diary, you rate the amount of pain experienced on a daily basis on a scale from 0 to10 (no pain to severe pain). You should also write down exactly where the pain is located and whether it is always perceived in the same area or in different areas at various times during the month. As part of the initial examination, your physician will also perform a pelvic examination and palpate (feel for tender spots) inside the pelvic cavity.

A thorough medical history and physical examination can help a

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## Endometriosis Symptoms

| | |
|---|---|
| Painful menstruation | Pain during ovulation |
| Heavy/irregular bleeding | Low back pain |
| Premenstrual spotting | Bowel pain during periods |
| Painful urination | Diarrhea/constipation |
| Pain with sexual intercourse | Blood found in urine |
| Deep pain on tampon insertion | Blood found in stool |
| Abdominal bloating or pain | Constant tiredness |

# Endometriosis

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physician determine if endometriosis is a likely possibility, but the only way a definitive diagnosis can be made is through an outpatient procedure called a laparoscopy. During a laparoscopy, a small fiber-optic scope is inserted into the abdominal cavity through a very small incision made next to the navel. This enables the physician to visually inspect the pelvic organs for signs of adhesed endometrial tissue. If necessary, tissue samples may be taken from the organs or abdominal cavity to confirm the diagnosis.

**Treatment**

Upon diagnosis of endometriosis, your doctor may discuss the following treatment options with you: pain medication, hormone therapy, and surgery. The option chosen will depend on many factors such as severity of the condition, duration of symptoms, impact on quality of life, age, and hormonal status. The treatment goals are to reduce pain, shrink or slow the endometrial growths and preserve fertility.

For symptomatic pain relief, over-the-counter medications such as aspirin, Tylenol, and ibuprofen may be recommended. To control severe painful episodes, your doctor may prescribe a stronger pain reliever.

The main long-term treatments are hormone therapy and surgery. Hormonal medications taken for endometriosis simulate a state of pregnancy, i.e., they prevent ovulation by controlling the amount of estrogen in the body. For example, oral contraceptives are often prescribed to keep endometriosis under control. These hormones are taken throughout the month to prevent the patient from menstruating. The goal is to stop internal bleeding, thereby reducing pain and adhesions.

Gonadotropin-releasing hormone drugs such as Lupron, Synarel and Zoladex also are used for this purpose but they are treatment options of limited duration, i.e., they are not used for longer than six months. These types of medication decrease the amount of estrogen in the body through their action on the pituitary gland. In short, they produce an artificial menopause. Women may experience hot flashes, vaginal dryness, headaches, depression, insomnia and memory loss while using these medications.

Another short-term approach is the use of testosterone derivatives such as Danaxol. These medications also work by decreasing the amount of estrogen in the body, thereby shrinking the endometrial lesions and relieving pain. The drawback to this approach is that androgenic side effects such as acne, reduction in breast size, weight gain, abnormal facial hair growth and deepening of the voice may occur.

Laparoscopy, the surgical procedure used to diagnose endometriosis is also used to treat the condition. During this outpatient procedure, the surgeon can locate adhesions within the abdominal cavity and remove them by a variety of methods including excision, laser ablation and vaporization. It is important to have an experienced physician perform the surgery and for all of the endometrial tissue to be removed. Alternately, major abdominal surgery known as a laparotomy can be performed to remove the endometrial tissue in the abdominal cavity. Since this procedure is more invasive and requires hospitalization, laparoscopy is generally the preferred surgical method.

In addition to current medical approaches, there are several alternative treatments which women have found to be helpful in managing endometriosis. Following a diet with plentiful amounts of organic vegetables and few processed foods, and reducing intake of caffeine, sugar and alcohol is recommended. B Complex vitamins, the combined use of Vitamin E and Selenium, and Chinese herbal teas also can be helpful. Other complementary treatment options include acupuncture or acupressure, and the use of stress reduction techniques such as yoga, biofeedback, meditation and regular exercise.

*For more information:*
*If you are interested in learning more about endometriosis, you can contact the Endometriosis Association at 800-992-3636 or visit www.endometriosisassn.org.* ■

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