female HEALTH TODAY

Stay energized at menopause tips from Raquel Welch

Hormone therapy: Is it right for you?
How to make an informed decision

Finding a plastic surgeon
Advice from Extreme Makeover's Garth Fisher, MD

The official publication of the Foundation for Female Health Awareness

Foundation for Female Health Awareness

Letter from the Founders

The Foundation for Female Health Awareness is a not-for-profit, 501(C)(3) organization dedicated to improving women's health by supporting unbiased medical research and educating women about their health from adolescence to menopause and beyond.

Women are the heart of the health care system within the family, as they make over 80% of health care decisions in this country and spend 8 of 10 health care dollars. Our goal is to encourage women to become advocates for their own health by giving them access to the most up-to-date information provided by leading physicians and researchers. Our independence from any health care system, pharmaceutical company, or other outside resource allows us to present women's health issues in a nonbiased fashion. We intend to reach women of all ages, economic groups, educational levels, and geographic locations so that they can become advocates for their own health and well being. Our educational process will extend beyond simply providing written information on disease states. It will educate women on prevalence, predisposing factors, prophylactic measures, and how and who can best treat their problems. The information we intend to provide is comprehensive, objective, and supported by a scientific advisory board made up of the nation's leading researchers, clinicians, and surgeons.

Mickey and Mona Karram

Although the Foundation intends to address all aspects of female health, specific emphasis will be placed on disease states dealing with the reproductive tract and gender-specific medicine. The last decade of research has focused on women's health problems and shown how normal human biology differs between men and women and how these differences affect or should affect diagnosis and treatment of disease. Our main focus is prevention of disease and promotion of healthy lifestyle choices, with the ultimate goal of significantly improving quality of life for women.

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HORMONE THERAPY: IS IT FOR ME?

Publicity surrounding recent study results (The Women's Health Initiative) led many women to discontinue hormone therapy.

What should you do?

When first reported in 2002, the results of The Women's Health Initiative (WHI) caused panic. Headlines stressed the potential dangers of hormone therapy. Millions of women stopped using hormone therapy and experienced severe hot flashes, sleep disruptions, and other menopausal symptoms that kept them from enjoying life to the fullest.

If you're menopausal (or approaching menopause), this article will help you assess the risks and benefits of hormone therapy, particularly in the presence of menopausal symptoms that reduce your quality of life. Author Leon Speroff, MD, is an internationally recognized expert in the field of estrogen therapy for women. He'll help you work with your physician to determine what's best for you.

BY LEON SPEROFF, MD

WHAT IS THE WOMEN'S HEALTH INITIATIVE?

The Women's Health Iniative (WHI) was the study that received tremendous media attention, which led many women to stop taking hormone therapy. The study specifically evaluated the use of estrogen alone (in women who had had hysterectomies) and the use of estrogen/progestin (in women who had not had hysterectomies). The goal was to determine if hormone therapy reduced the risk for cardiovascular disease, as had been suggested by many earlier studies. Let's take a look at the decision to stop the study.

WHY WAS THE STUDY STOPPED?

Studies such as the WHI have a built-in safeguard to protect the health of participants. The safeguard is the Data and Safety Monitoring Board, which is an independent advisory committee that meets periodically to review interim results and determine (1) if the treatment is producing any harm that outweighs the benefits or (2) if the benefits are so great that it is no longer ethical to have patients continue to take a placebo. If either situation is reported, the study is canceled.

In May 2002, the Data and Safety Monitoring Board ruled that the section of the trial that used estrogen/progestin had to be canceled three years early because of an unacceptable level of harmful effects. The estrogen-only arm continued until March 2004, when it was discontinued because the data showed that estrogen by itself did not increase or decrease heart disease.

WHAT WERE THE REAL RESULTS OF THE WHI?

At first, physicians accepted the preliminary results from the canceled part of the WHI without question. However, slowly but surely, physicians began to look critically at the study's conclusions. They began to see that those conclusions may not apply to all postmenopausal women. Let's review the final data from the study and what they mean to the individual woman.

PHYSICIANS BEGAN TO LOOK CRITICALLY AT THE STUDY'S CONCLUSIONS

Negative results of the estrogen/progestin arm of the WHI. This arm was cancelled, mainly because of a small increase in invasive breast cancer, combined with an increase in heart attacks and strokes. The risk of venous thrombosis—a rare event in which blood clotting in veins occurs—doubled; however, venous thrombosis was already known to be associated with postmenopausal hormone therapy.

What does this mean? If the results of the WHI are accurate, they indicate that for every 10,000 women on hormone therapy an additional seven heart attacks, eight strokes, eight cases of breast cancer, and 18 cases of venous thrombosis would occur each year.

Positive results of the estrogen/progestin arm of the WHI. Fractures due to osteoporosis can cause disability or death and place a heavy financial burden on women. Even though the estrogen/progestin arm was stopped earlier than planned, women on hormone therapy demonstrated major reductions in osteoporotic fractures (a 35% reduction in spinal fractures and a 33% reduction in hip fractures). This was particularly important because the study group was already at a low overall risk for fracture. The risk for colorectal cancer was reduced by 37%; significantly, colorectal cancer is the third most common cancer in terms of prevalence and mortality in women.

Results of the estrogen-only arm of the WHI. The final data from this part of the WHI were inconclusive. In the estrogen-only arm investigators reported a total of 12 additional fatal and nonfatal strokes, six additional cases of venous thrombosis, and five fewer cases of coronary heart disease compared with the placebo group. Also, they reported one additional case of colorectal cancer, seven fewer cases of breast cancer, and seven fewer cases of all cancers. The risk for bone fracture was reduced: 11 hip fractures were reported in the estrogen-alone arm compared with 17 cases in the placebo group.

WHI FINDINGS IN PERSPECTIVE

Clearly, the positive results of the WHI were not widely reported. Still, the question remains for the individual woman: What does this mean for me? I'll review my conclusions concerning the risk/benefit profile of the study to help you work with your physician to assess your own risks/benefits.

THE CARDIOVASCULAR RESULTS

The critical question is: Were the small increases in cardiovascular problems tied to hormone therapy or do other explanations account for the reported results? When dealing with such small increases, just a few patients with cardiovascular problems can change the conclusions.

What about the patient population? Women with significant menopausal symptoms were not included in the study to avoid a high dropout rate in the placebo group. The average age of participants was 63. The average participant had been menopausal for 18 years.

Risk for coronary heart disease. The risk for coronary heart disease increases after menopause. Because study participants had been menopausal for many years before the study began, a significant amount of coronary heart disease could be assumed. It was already known that hormone therapy does not prevent cardiovascular problems in women with established disease.

The WHI investigators noted similar differences in cardiovascular problems in treated and placebo populations when age was considered (that is among women in their 50s, 60s, and 70s). However, the amount of time since the start of menopause remains the critical factor in assessing risk for heart disease.

How were diagnoses made? The initially published results from the canceled arm of the WHI used cardiovascular diagnoses made "in the field." Later, after definitive review, 10% of the diagnoses for myocardial infarction (heart attack) were changed. In the final tally, the actual increase in cases was not significant.

Were specific groups of women more vulnerable to heart disease than others? The final report showed only women who were 20 or more years past menopause had an increased risk of coronary heart disease with hormone therapy. When these patients were subtracted from the rest of the participants, no difference in coronary heart disease prevalence was observed in treated and placebo groups. It is inappropriate to conclude that hormone therapy increases the risk of heart disease in all postmenopausal women.

Unanswered question from the WHI? An important question remains unanswered: Will postmenopausal hormone therapy begun at or near the time of the menopause and maintained for a relatively long period of time provide protection against coronary artery disease? The WHI cannot answer this question, but it remains a possibility.

BREAST CANCER FINDINGS

For nearly a decade, physicians and researchers have noted the lack of conclusions in more than 60 studies on breast cancer and postmenopausal hormone therapy. Therefore, investigators have concluded that any effect of hormone therapy on breast cancer must be small. The WHI results do not change this. The most important unanswered question is whether hormone therapy initiates the growth of new breast cancers or affects preexisting tumors. Important observations favor the latter. Key points are summarized below.

- Epidemiologic studies have detected a small increase in breast cancers within just a few years of hormone-therapy use. However, it takes about 10 years for a malignant breast cell to grow to a clinically detectable size.
- Studies have found uniformly that past hormone-therapy users have no increase in risk.
- Most research indicates that breast cancers in hormone users are small and less virulent than those found in nonusers. As a result, hormone users who develop breast cancer actually have a reduced risk of dying of breast cancer compared with nonusers.
- The WHI, in contrast to other studies, reported that the breast cancers were slightly larger and less localized in the hormone users. But remember: The trial enrolled an older population

Does it matter when hormone therapy is started?

I believe an important theme has emerged from the confusion of the past few years: Healthy tissue is necessary to allow effective response to estrogen. The most benefit is gained when hormone replacement begins near the time of menopause. A very good recent study indicated that reducing the risk of Alzheimer's disease requires that long-term treatment begin at least 10 years before the symptoms of dementia appear. As blood vessel cells become involved with atherosclerosis and brain cells become affected by the processes leading to Alzheimer's disease, the ability of the cells to respond to estrogen diminishes.

more likely to have pre-existing occult tumors that are larger and more prone to respond to hormonal stimulation than tumors in younger women.

QUALITY OF LIFE, DEMENTIA, AND THE WHI

The WHI reported that postmenopausal hormone therapy had no beneficial effects on quality of life; however, the study did not include women with significant menopausal symptoms. In fact, participants were a relatively similar group of women with a fairly good quality of life.

If the objective is to study quality of life, it's important to enroll a reasonable number of participants whose quality of life is impaired.

The WHI also reported that hormone therapy increased the risk of dementia, although this was observed only in women who were age 75 or older when they started treatment. Unfortunately, the media reports failed to make these distinctions.

WHO SHOULD USE HORMONE THERAPY?

Postmenopausal hormone therapy remains the most effective treatment for menopausal symptoms, especially hot flushing, vaginal dryness, and difficulty sleeping. Negative publicity has led many to conclude that hormone therapy should be used for the shortest possible period of time to treat menopausal symptoms. However, this creates an immediate conflict for the woman who wishes a benefit that requires a lengthy period of treatment (for example, prevention of osteoporotic fractures).

The following judgments are my own, based upon the large body of research accumulated over the last 20 years.

- Postmenopausal hormone therapy should not be recommended for women with existing heart disease in the anticipation of preventing future cardiovascular events.
- Postmenopausal hormone therapy increases the risk of venous thrombosis, mostly in the first year or two of treatment. This risk is reduced with the use of cholesterol-lowering drugs and aspirin, although it is not known whether these drugs would protect completely against increased risk. Appropriate prophylactic anticoagulant treatment is recommended when hormone users anticipate immobility with hospitalization. Hormone therapy should be stopped four weeks prior to major surgery.
- Postmenopausal hormone therapy is associated either with a small increase in the risk of breast cancer or an effect on pre-existing tumors. Even a small increase in risk for breast cancer is frightening to contemplate; however, the reported risk of breast cancer with hormone therapy is even smaller than that associated with recognized factors such as having a positive family history, being overweight after menopause, and using alcohol. The evidence strongly indicates that a positive family history of breast cancer is not a reason to avoid hormone therapy.

Additionally, long-term postmenopausal hormone therapy is not precluded by the results of the WHI. We have good reason to believe that benefits associated with treatment include improved quality of life beyond the relief of hot flushes, maximal protection against osteoporotic fractures, a reduction in colorectal cancers, maintenance of skin turgor and elasticity, and the possibility of preventing Alzheimer's disease. Of course, this should not detract or subtract from efforts to apply proven therapies such as cholesterol-lowering drugs and beneficial lifestyle modifications.

INDIVIDUALIZED HORMONE THERAPY IS STILL APPROPRIATE FOR MANY WOMEN

THE CHALLENGE FOR THE FUTURE

The challenge is for physicians and scientists in the field to find the middle ground regarding hormone therapy. In the meantime, let me suggest a logical and reasonable approach.

When the treatment is properly individualized, postmenopausal hormone therapy is still appropriate for many women. To decide whether it is appropriate for you, discuss your specific goals and objectives with your physician. You may be interested only in relief of menopausal symptoms; or you may be most interested in preventing osteoporotic fractures or Alzheimer's disease; or you may want to aim for a combination of these objectives. Once your goals have been identified, you can review the many treatment options with your doctor each year and make updates as new information becomes available. When your treatment is approached in this way, "short-term" and "long-term" limits become meaningless—instead, you and your doctor together will be making decisions about your goals each year.

Getting pregnant isn't easy

BY TOMMASO FALCONE, MD

Fortunately, some of the risk factors for infertility can be managed

INFERTILITY, DEFINED AS THE INABILITY TO CONCEIVE AFTER ONE YEAR OR MORE of unprotected intercourse, occurs in about 10% to 15% of couples trying to conceive. In this article, Tommaso Falcone, MD, Department of Obstetrics and Gynecology at the Cleveland Clinic Foundation, discusses key risk factors—those you can't change and those you can—and strategies to improve your odds of conceiving.

Age matters

Fertility naturally decreases with age, simply because women are born with a fixed number of eggs (oocytes), and they are depleted over time (menopause). Women younger than age 25 have a pregnancy rate at six months of 60% and at one year of 85%. At age 35 and older, the probability at one year is 60% and at 2 years, 85%; the probability declines even more significantly thereafter.

The risk of miscarriages also increases with age; at least 40% of women over the age of 40 who become pregnant will have a miscarriage.

Although advancing age also dramatically affects male reproductivity, men in their 60s still have adequate sperm numbers and function to father a child. The average age of childbearing has increased over time.

Modifiable risk factors

Lifestyle habits, diet, and weight all have an impact on fertility.

- Smoking can accelerate the age-related process of egg depletion. It's also associated with increased miscarriage rates and poorer pregnancy outcomes.
- Overweight or underweight women more often have difficulties achieving pregnancy than do normal-weight women. Underweight women (body mass index, or BMI < 20) have ovulatory dysfunction. Obesity substantially contributes to infertility as well as to pregnancy complications, such as diabetes and hypertension. The scientific evidence is clear that weight reduction to the normal range increases pregnancy rates and improves pregnancy outcome. A proper diet and sufficient exercise are critical.
- Sexually transmitted disease is a major cause of infertility. Using condoms when you are not trying to conceive can help reduce the risk of contracting a sexually transmitted disease and protect your fertility.
- While alcohol consumption during pregnancy is to be avoided, the association of moderate alcohol intake and fertility is not clearly defined; some studies do show that fertility is improved with total abstinence.
- The association between caffeine intake and infertility or miscarriages is not clearly defined; however, caffeine intake should be limited.
- The "typical" stress of life may result in a temporary dysfunction of ovulation but is not the sole factor responsible for infertility. Excessive exercise by competitive runners, for example, can result in disruption of the menstrual cycle. Moderate exercise improves fertility by maintaining an ideal body weight. Women or men with medical conditions such as diabetes or thyroid disease should have these under excellent control before attempting to conceive.
- Antenatal vitamins that include adequate amounts of folic acid are recommended.

Diagnosis and testing

Your physician will screen for disorders associated with infertility and ask about

Most common causes of Infertility

Women

- Anovulation (lack of ovulation)
  - Polycystic ovary syndrome
- Tubal infertility (damaged Fallopian tubes)
- Endometriosis

Men: Sperm disorders

- Cryptorchidism
- Previous testicular infections
  - Mumps
- Trauma
- Occupational
  - Metals (lead, cadmium, mercury)
  - Pesticides

- Previous pregnancy problems
- Previous methods of contraception
- Past medical problems or surgical procedures
- History of sexually transmitted disease
- Current and past medication
- Occupation
- Use of alcohol, tobacco, drugs
- Family history of birth defects, mental retardation
- Symptoms that may be associated with hormonal disorders or endometriosis.

A complete physical examination should then be performed. The initial diagnostic work up includes tests to document that ovulation has occurred, that no tubal damage exists, and that no sperm disorders are involved.

A semen analysis includes an evaluation of motility, count, morphology, and possibly the presence of antibodies.

The tubes and uterus are evaluated by a hysterosalpinogram (HSG), in which a contrast (dye) is injected into the uterus.

Ovulation can be documented by any of the following tests:

- Basal body temperature curves
- Urine ovulation predictor kits (LH)
- Blood test for progesterone
- Transvaginal ultrasound
- Endometrial biopsy

For women older than 35 or those who have had ovarian surgery, a test for "ovarian reserve" should be performed by measuring day 3 follicle stimulating hormone and estradiol or by a clomid challenge test, in which blood is taken on day 3 and then taken again after completion of a course of clomid for 5 days. A normal test result does not mean that pregnancy will occur, but an abnormal result is associated with a drastically reduced fertility rate.

Treatment options

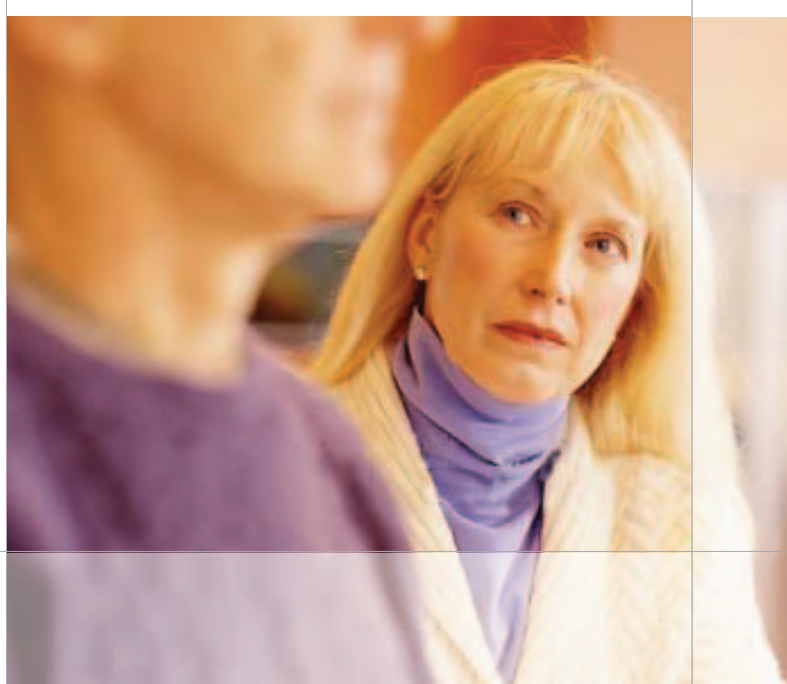
Treatment for infertile couples essentially consists of three major approaches:

- Inducing ovulation in women who do not ovulate spontaneously with medication
- Surgical management of disorders such as endometriosis or tubal blockage
- Assisted reproductive technology such as insemination or in vitro fertilization

The goal of infertility treatment is to obtain a healthy pregnancy with one child. Multiple births represent a sometimes unavoidable complication of treatment and are associated with significant maternal and newborn complications.

For advanced treatment, seek out a a specialist. The American Board of Obstetrics and Gynecology certifies specialists in reproductive endocrinology and infertility. In order to sit for the examination, a physician who has completed his/her training in obstetrics and gynecology requires two to three years extra training.

In summary, infertility is a common problem with complex social and medical issues. Many causes of infertility are related to lifestyle and can be modified. Medical therapy is quite successful but may be expensive.



Fact, fiction, and how to protect yourself

Most people don't realize that this virus can be spread by individuals who are unaware they have herpes

BY SEBASTIAN FARO, MD, PhD

HERPES, THE THIRD MOST COMMON FORM OF SEXUALLY TRANSMITTED DISEASE IN THE UNITED STATES, may affect up to 45 million Americans, or 22% of the population. Many infected individuals never develop symptoms, but they can still shed the virus and pass on the infection through sexual contact with a partner or to a baby delivered vaginally. Sebastian Faro, MD, PhD, of the University of Texas Health Science Center at Houston, explains what you need to know to protect yourself and others.

TWO TYPES OF HERPES. While most people think of herpes as a single disease, two types exist: herpes simplex virus, serotypes I and II (HSV I and HSV II). Usually, HSV I causes oral infections, commonly called cold sores or fever blisters, but also can cause genital infections if transmitted during oral sex. Generally, the cause of genital herpes, HSV II can also cause oral herpes. Both types are contagious even in the absence of symptoms.

SYMPTOMS OF INFECTION. After an incubation period of three to nine days, the disease typically shows up with flu-like symptoms—headache, fever, and muscle and joint pain—signaling that the HSV has entered the bloodstream. Approximately one to three days later, numerous blisters develop. These contain clear fluid and are extremely painful when touched. They last for approximately six days, then rupture either spontaneously or after local trauma, leaving an ulcer. The base of the ulcer is typically red and clean. The size of an ulcer can vary from a pinpoint or a slight slit to an obvious red lesion. The lesion can last up to 10 days or more.

People who have acquired antibodies to HSV II still can develop an initial infection without flu-like symptoms. Before the blisters develop, these individuals can experience a feeling of burning, itching, or pain at the site. They typically develop fewer blisters than are seen on someone newly infected with HSV II.

WOMEN AT GREATER RISK. Women are more likely to acquire genital herpes than men, largely because of their female anatomy.

NO SYMPTOMS? Ten percent to 50% of people infected with HSV II who don't have symptoms may still transmit the virus. Although the virus may become latent, it can recur—with or without recognized symptoms of the disease. Even if a person has no symptoms, he or she may still shed the virus and infect a partner.

HERPES AND HIV. Genital herpes can increase a person's susceptibility to other sexually transmitted diseases, including human immunodeficiency virus (HIV). This is because individuals with active HSV infection have an increase in white blood cells at the site of active infection. Other microorganisms can easily infect these white blood cells. The HSV ulcers also provide a portal of entry for microorganisms.

PREGNANCY AND HERPES. A woman without symptoms can shed the virus, which is a potentially significant problem during labor, especially if the amniotic membranes have been ruptured for a long period of time. This can result in infection of the newborn.

RECURRENT INFECTIONS. People infected with HSV II have an approximately 60% chance of the genital symptoms recurring. However, recurrent symptoms of the infection can occur anywhere on the body.

ORAL HERPES. Someone with oral herpes, either type I or II, can transmit this infection to other parts of his or her body or to another individual through kissing, touching, or oral sex.

Protect yourself and others

- The surest way to avoid transmission of genital herpes is to abstain from sexual contact or to be in a mutually monogamous relationship with a partner who has been tested and is known to be uninfected.
- Latex condoms can reduce the risk of genital herpes only when the infected area or site of potential exposure is protected. Since a condom may not cover all infected areas, even correct and consistent use of latex condoms cannot guarantee protection from genital herpes.
- Not all oral lesions (such as cold sores or canker sores) are caused by HSV infection; however, it's wise to play it safe and treat all oral lesions as being herpetic until proved otherwise.
- Persons with herpes should abstain from sexual activity with uninfected partners when lesions or other symptoms of herpes are present. It is important to know, however, that even if a person does not have symptoms he or she can still infect sex partners.
- Sex partners can seek testing to determine if they are infected with HSV. A positive HSV II blood test most likely indicates a genital herpes infection.

Source: Centers for Disease Control and Prevention

managing M

Tips from Raquel Welch to increase your energy, improve your sense of well-being, and benefit your overall health

Do you think that getting older means slowing down? Not if you take good care of yourself, says screen star Raquel Welch (born, if you can believe it, in 1940). She's never been busier—or looked better.

In this exclusive interview with Foundation for Female Health Awareness founder and director Mickey Karram, MD, Raquel talks about how she managed the menopausal transition, continues to keep her energy level high, lives life to the fullest, and enjoys the new perspective that comes with age.

gENOPAUSE

What is the one thing you do every day that helps you stay energetic and motivated?

Until I was 50, it was yoga, yoga, and more yoga. Now, I would say yoga plus my hormone therapy mini-patch. For me, hot flashes were mildly uncomfortable, but my energy, stamina, and mood were more affected. Actually, I wasn't anticipating "the change." It sort of sneaked up on me, and suddenly I thought, "What's going on? I don't get this." I was doing everything right—exercising, watching my diet—I couldn't figure out why I was going off-track.

Were lack of energy and stamina and mood fluctuations your main symptoms?

Yes, but I also had bleeding problems at the perimenopausal stage. My gynecologist recommended endometrial ablation rather than a hysterectomy. This procedure stopped the bleeding and kept the uterus intact. My doctor advised that a hysterectomy often results in premature aging.

How is your energy level now?

It's pretty good, but when I work those 16-hour days, like when I'm filming, I've have to increase my hormone therapy dosage (under supervision, mind you).

Thanks to my yoga practice, I've become really in touch with what's happening with my body. Once you're familiar with the subtle signals your body is sending, you are much better equipped to identify your health needs. You can sense what your body needs or is lacking and can share that insight with your doctor.

In practical terms, how do you benefit from being in touch with how your body feels?

You need to monitor yourself on a day-to-day basis. The buck stops with you and how you take care of yourself. When you walk into a doctor's office, you need to tell him or her specifically and very meticulously how you feel. If you can't educate the doctor about this in a very aware way, you are not participating well enough in your own health. It's a cooperative effort.

"I am more accepting of myself, my own limitations"

What do you do for fitness besides yoga?
Before doing yoga, I was never any good at weight training or cardiovascular training, but yoga made those things accessible to me. Now I do weight training and cardio on a regular basis. When I am "in training" for an appearance or filming, I do an hour of cardio a day. It's the best way to burn the extra calories. If I get really pressed I do a half hour a day as a minimum.

Given your busy schedule, what do you do for stress relief?
Yoga and its emphasis on meditation is a wonderful way to relieve stress and clear the mind of toxic thoughts, anger, resentment, insecurities, and worries.

So, really, yoga played an important role in getting the best out of your life.
Absolutely. Joan Borysenko, PhD, has written and lectured about the importance of meditation techniques. You really can't have great health if you don't develop strategies for relaxing, de-stressing, and developing an awareness of your connection to the world around you. We live in a very, very driven society. So many people put their personal relationships, their family, and their free time on the back burner. Eventually they can't sustain their good health and emotional well-being.

Does getting older have some features that you welcome? Can you list a few?
I am more accepting of myself, my own limitations, and, therefore, I am more accepting of others. This is a big, big plus. When I was younger I tended to judge myself harshly. Now, I think I make better choices and my priorities are more carefully considered.

What are your thoughts on plastic surgery or procedures

to help keep a youthful appearance, as we get older?
I think the emphasis on surgery to keep a youthful appearance has been drastically overstated, to the point of being used as a panacea, or Band-aid, to fix all kinds of problems in a woman's life. It is good that so many options are available to combat the symptoms of aging; but surgery doesn't replace eating right, exercising, and having a good attitude about yourself and your life.

Do you feel too much pressure is placed on women to look younger/thinner than should be?
It's more than "pressure"—it's more like thumb screws! What we see in the popular media is almost completely devoid of role models for adult women as opposed to teenagers or those in their 20s and 30s. This is especially frustrating for older women. We feel there's a conspiracy to make us feel like we don't fit in or have a role to play in life anymore. Don't buy into the propaganda. It's not worth it. And it's far from true.

> "I came up against a brick wall and I started to go to a nutritionist."

Some of the people that look fabulous in photographs are absolutely anorexic in person: Photographs actually add 10, 15 or even 20 pounds to your actual weight! When I look at early pictures of myself in my 20s, I was super, super thin. That is just not who I am anymore. I am certainly not that size now. Besides, when somebody is costumed, made-up, coifed and has that perfect lighting, it's not "real." It is just crazy to judge ourselves by that standard.

What are your thoughts on food and diet? Do you follow a diet regime? What advice would you give to women?
I was almost 40 when I came to the realization I couldn't eat the way I had when I was younger, and it was like coming up against a brick wall. I was forced to consult a nutritionist. For decades now, I have followed an Atkins-type, low-carb diet. This was way before Atkins came along.

I always think that when you start a diet (or try again after you've had a relapse), it takes a couple of weeks for your body to get adjusted to the program. But, if you can get through the first couple of weeks, your body changes and you lose the craving for the carbs and sweets that you had before. You gain energy, don't feel sluggish, and have enough fuel to support what you want to do. You sleep well, and pretty soon you get on a good roll, and that's the best, you know, that's the best.

I think that diets should be based on what works for your metabolism and not your personal cravings, which are often simply the reoccurring echo of former bad habits. Nobody's perfect, so when I play hooky from my diet, I don't feel as well, and then there's the "zipper problem." So, pretty soon, I'm back on the wagon again.

What is your secret for such radiant, healthy skin?
I copied my mother and started using moisturizer when I was in high school, and to this day I always use a moisturizer with UV protectant under my make-up and at night. I have my own skin care line, Raquel—Timeless Beauty. But

MEET RAQUEL

Undoubtedly one of the most glamorous actresses of the 1960s and 1970s, Raquel was born on September 5, 1940. Growing up in La Jolla, Calif., she was a star cheerleader, straight-A student, and vice president of her high school senior class. She also took dance classes, performed in school drama club productions, and won numerous beauty contests.

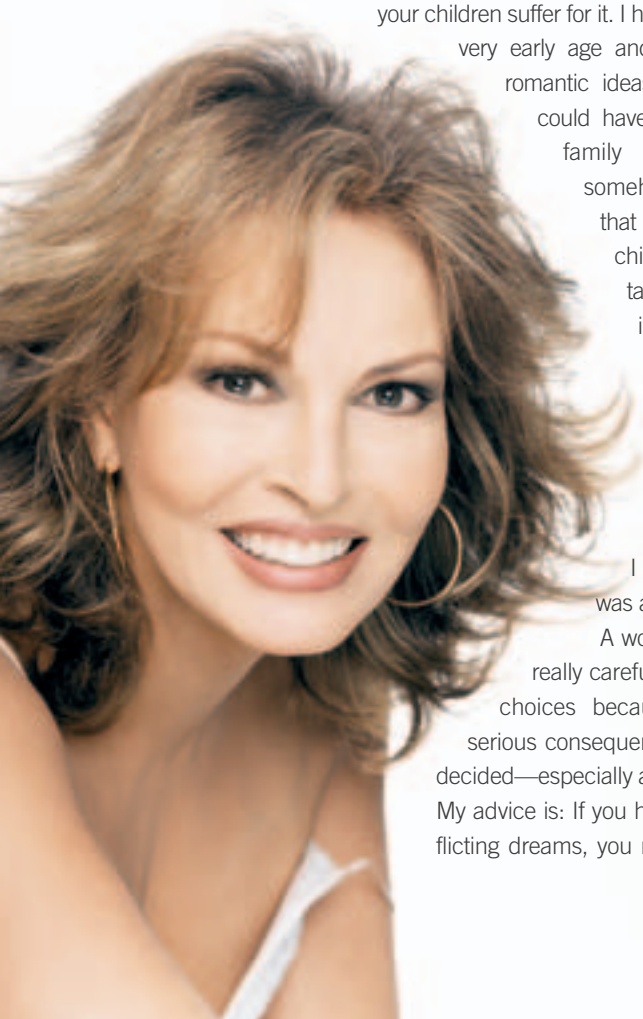
A year after starting college, she married her high school sweetheart, James Welch. By the early 60s, she was a divorced mother of two, eventually moving to Hollywood—and the rest is history. Her career spans early box-office hits, including "Fantastic Voyage," "1,000,000 Years BC" (1966), and "The Three Musketeers" (for which she won a Golden Globe Award), to the 2000 hit, "Legally Blonde" and the current PBS series "American Family."

She also has written the best-selling book, *Raquel Welch: Total Beauty & Fitness Program*, and produced a series of yoga videos. She developed a line of skin-care products—Raquel Welch Timeless Beauty Skincare—and has an internationally successful line of wig products, the Raquel Welch Wig Collection.

regardless of what skin-care products you use, it's important to remember that the skin is a breathing organism, that it really does absorb nutrients and medication through your pores. You can feed your skin, and by the same token, you can't eat badly and expect to have good skin. You can't be a couch potato and have good circulation, which also affects your skin. When I don't do my yoga, I can see little lines coming in. When I am on my routine, they diminish.

What advice would you give to a woman on how to successfully balance a career and a family?

That is a tough question. If you know at a young age that you really want to have a career, whether it is medicine, entertainment, politics, or whatever, I would concentrate on that and not get married and have children at the same time. From experience I've found that if you want to have children and a meaningful relationship with them, it demands a lot of quality time. A career requires a lot of quality time, too, so there's a choice to make. It is not going to work if you think you can have it all. It is going to be a terrible strain; something is going to suffer and the worst thing is if your children suffer for it. I had children at a very early age and had a lot of romantic ideas about how I could have a career and family and manage somehow. I believe that it did affect my children to a certain degree, and it affected my first marriage very much. If I had to make a judgment call now, at this point in my life, I would say it was a mistake.



A woman has to be really careful about her life choices because there are serious consequences to what is decided—especially at age 16 or 17. My advice is: If you have those conflicting dreams, you need to decide which direction to follow and when. You may be able to enjoy both—just not necessarily at the same time.

Is there anything else you feel strongly about regarding women's health that we didn't touch on and that you would like to?

I just want to reiterate the point I made earlier, that I think hormone therapy is a really great boon to womankind. When we look at the whole picture of hormone replacement therapy, we need to remember all the fantastic gains that have been made for the quality and longevity of our lives. For instance, my mother lived until age 92 and looked great and was active quite late in life. She was on hormone therapy.

It is, of course, up to each woman to decide how she wants to individualize and customize her hormone therapy, with the help of a qualified physician. It's not usually a "one size fits all" solution.

It's also important to remember that every new health scare is publicized as if it were a political poll. These reports are geared to prove a point and don't necessarily tell the whole story, so they shouldn't be taken as gospel until all the facts are known.

That is exactly what happened with the Women's Health Initiative. The way the studies were reported in the media was very inaccurate and caused a lot of unnecessary fear among women taking hormone therapy.

Yes, after all the publicity, every woman I met talked about it. When I said I was still taking hormone therapy, they'd say something like, "Oh, you are not on that are you?" But what about the benefits, like the positive impact hormone therapy has on osteoporosis and heart disease? Granted, there are cases in which hormone therapy is contraindicated but that is not a sweeping judgment of the therapy.

Yes, and there was a statistically significantly decreased incidence of colorectal cancer, but that wasn't reported.

Also, it's good for the skin.

I'm glad you mentioned that.

Still, I do think it's important to note that aging is an individualized process. Some people age differently than others do and will look older sooner; but I also think, as we've discussed, that there is a lot that each of us can do to stay healthy and active and mentally upbeat. If you can do that, you'll certainly feel and look younger for longer.

THE NAKED TRUTH ABOUT

Extreme Makeover's **Garth Fisher, MD, gives you tips on how to pick a plastic surgeon**

IN THIS INTERVIEW WITH MICKEY KARRAM, MD, FOUNDER AND DIRECTOR OF THE FOUNDATION FOR FEMALE HEALTH AWARENESS

How should a woman begin the process of choosing a plastic surgeon?

Schedule at least several consultations with plastic surgeons. When you meet with them, look closely and very critically at their "before and after" pictures. A surgeon needs patience and artistic skill in the operating room. Through the photographs, you can see a surgeon's style and whether or not the results look natural. The surgeon's personal taste is a factor. For instance, sometimes, in my view, plastic surgeons make the eyebrows arch too much, but that might be their sense of what looks good.

Get referrals from friends who are very happy with their results and feel that their plastic surgeons really took care of them.

Make sure that a physician is board-certified by the American Board of Plastic Surgery. (Some groups, such as the American Board of Cosmetic Surgery are not recognized by the American Board of Medical Specialties, so it's important to ask if a physician is board-certified and to identify the certifying organization.)

Ask surgeons for patient referrals to find out what other patients have experienced with doctors that you are considering.

There are facial plastic surgeons who have completed residencies in ear, nose and throat and thus just do facial plastic surgery unlike conventional plastic surgeons who

plastic surgery

perform face and body surgery. Do you think that the consumer needs to understand that difference?
The training program that a board-certified plastic surgeon has completed is ideal, but appropriately trained facial plastic surgeons are also qualified to do cosmetic surgery in their field. A physician trained in ear, nose and throat, however, should not do breast augmentation or other procedures not in their specialty.

In your opinion, how much of plastic surgery is art and how much is a healing process?
I don't think that artistry is reflected by just closing an incision. The surgeon must always adhere to basic principles of wound care: keeping the incision tension free, maintaining the patient's health, advising the patient to not smoke and to avoid sun exposure. I believe there is a side that requires an artistic sense—where to put the incision, how hard to pull, and what vectors to use for facial surgery and the rejuvenation procedures. Some surgeons just put implants in, and we've all seen the breast implants that look like headlights. There are ways to create very natural looking breasts. A lot of it is the personal taste of the doctor. Who knows whether a given result was due to bad technique or if it was something that pleased the doctor. I believe a tremendous amount of artistic sense is necessary for a natural result.

It seems to me that more plastic surgery is being done these days. Are there data to support that?
What I'm hearing since Extreme Makeover started is that plastic surgery procedures are up 30%.

What questions should a patient ask during her initial consultation with a plastic surgeon?

- Is the physician board-certified (and by what board)?
- What percentage of his or her practice is represented by the procedure you want?
- What are the non-surgical and surgical alternatives?
- What are the common complications? (If a surgeon tells you that he never has complications, you should get up and leave. Every surgeon has complications.)
- How are complications managed financially?
- How are most patients referred? Does the physician provide financial incentives for referrals? Avoid surgeons who pressure you or provide financial incentives or referrals.

It's important to develop a trusting relationship. You should feel that the physician is honest and not evasive with his answers. Don't be afraid to shop around until you find the right surgeon for you.

Hysterectomy

BY BARBARA LEVY, MD

While sometimes necessary, new less invasive options may meet your needs

BY AGE 65, MORE THAN ONE IN THREE WOMEN WILL HAVE HAD A HYSTERECTOMY. This article by Barbara A. Levy, MD, medical director of the Women's Health Center, Franciscan Health System, Federal Way, Washington, will help you make informed choices about the procedure and new alternatives.

Very few hysterectomies are absolutely necessary to save a woman's life, such as to treat cancer of the uterus, the cervix, or the fallopian tubes and ovaries or as an emergency procedure to treat uncontrollable bleeding or infection. Most are done to improve the quality of life.

Most hysterectomies are performed because of excessive bleeding, painful periods, pelvic pain, noncancerous growths on the uterus (called fibroid tumors) or ovaries (called cysts). Sometimes the muscles and ligaments that support the uterus become too weak to support the uterus, which may literally fall down outside the vagina.

Abnormal bleeding and hysterectomy

Abnormal bleeding may stem from either hormone imbalances or structural problems. Hormone fluctuations, which are very common both in teenagers just starting their periods and in women approaching menopause, are often treated with oral contraceptives. Women who can't take hormones or feel terrible when using the medication may choose to have the uterus removed to solve the bleeding.

It may be useful to discuss other treatments with your physician.

Endometrial ablation: Less invasive, shorter recovery time, less expensive

Endometrial ablation is often effective when medication fails. This surgical procedure features a quicker recovery than does hysterectomy. It also offers women a chance to keep the reproductive organs intact. The downside is that it might not work, or it might solve the problem only temporarily. As many as half of women who have an endometrial ablation need another pelvic operation within five to 10 years.

Hysteroscopy instead of hysterectomy for fibroid tumors

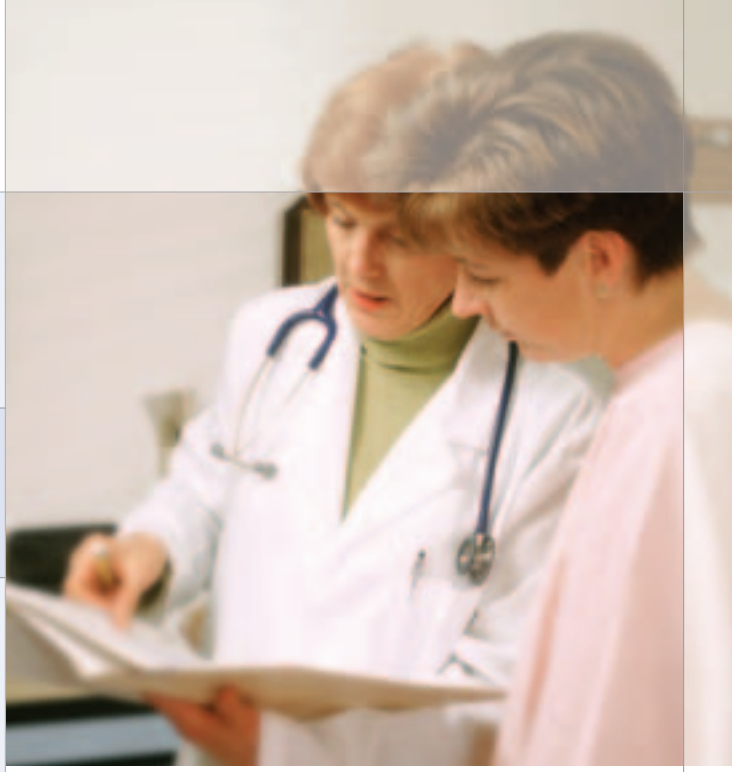
Fibroid tumors of the uterus probably account for at least 200,000 hysterectomies each year. Small fibroids (or uterine polyps as well) growing inside the uterus cause very heavy bleeding. They tend to grow as women age and may cause heavy bleeding or pelvic pressure. Some fibroid tumors can be removed by hysteroscopy. In this procedure, the scope is directed through the opening in the cervix and up into the uterus. Small tumors then are shaved off. Recovery is rapid, and women can get pregnant after the procedure. Women tend to grow additional fibroids over time so another operation might be needed.

Myomectomy: Major surgery

For women with many or very large fibroids, a myomectomy (*myoma* is the medical word for a fibroid tumor; *-ectomy* means removal) can be performed. This is major surgery and demands surgical skill, but it provides another choice for a woman who has symptoms from fibroids and wants to keep her uterus.

Options for relief

Hysterectomy:	Removal of the uterus and cervix
Recovery time:	Approximately 6 weeks for return to full activity
Side effects:	Loss of periods, possible earlier menopause
Subtotal or supracervical hysterectomy:	Removal of the muscular upper part of the uterus; the cervix is left in place
Recovery time:	Approximately six weeks
Side effects:	5% to 20% of women have cyclic bleeding or spotting
Salpingo-oophorectomy:	Removal of the ovaries and tubes. Also called a bilateral salpingo-oophrectomy, or "BSO," if both ovaries and both tubes are removed
Recovery time:	Approximately six weeks
Side effects:	Rapid system-wide decline in levels of all ovarian hormones—estrogen as well as testosterone; often called "surgical menopause"
Endometrial ablation:	This procedure involves thinning the endometrium, the lining of the uterus that sheds with each period. It is often performed to reduce bleeding in lieu of hysterectomy
Recovery time:	One week or less
Side effects:	Cyclic pain with periods, possible failure of the procedure
Myomectomy:	Removal of fibroid tumors (called myomas). This procedure requires skilled surgical technique
Recovery time:	Approximately six weeks if performed through a large incision; one to three weeks if performed through an operating telescope
Side effects:	Hemorrhage with need for blood transfusion, formation of scarring (adhesions) after surgery which could cause pain or difficulty achieving pregnancy
Hysteroscopy:	Small fibroids (or uterine polyps as well) are visualized with a tiny telescope, called a hysteroscope (hyster means uterus; scope means to look at) and then shaved off
Recovery time:	One week or less
Side effects:	Absorption of too much fluid used to visualize the uterine cavity, bleeding, failure to control symptoms
Uterine artery embolization:	Particles are introduced into the arteries that supply the uterus to block off the blood supply and shrink fibroids
Recovery time:	One to three weeks
Side effects:	Pain as the fibroid tissue dies; infection; should not be performed in women desiring pregnancy



Uterine artery embolization: High tech

In this "high-tech" procedure, also called uterine fibroid embolization, a small tube is placed through the big artery (femoral artery) in the groin and threaded into the arteries that supply the uterus. The physician then squirts small particles into the arteries to block the blood flow to the uterus. Because the fibroid tissue dies without the oxygen supplied by the blood, the growths shrink and the symptoms usually go away. This procedure appeals to women with fibroids who are not interested in either surgery or future pregnancy. Performed in a hospital, the procedure requires a physician with technical skill and experience.

Hysterectomy: What's involved?

If a hysterectomy seems like the best option, some decisions remain: How will the surgery be done? Through the vagina? Through a cut in the belly? Using an operating telescope with several small cuts in the belly? Is there a reason to remove the fallopian tubes and ovaries as well? What about keeping the cervix?

Vaginal versus abdominal approach?

Under most circumstances, having the surgery through the vagina is safest and easiest to recover from, and has the least cosmetic impact. An operating telescope is sometimes needed (to be able to see everything in the belly) if hysterectomy is being done for pain symptoms or for growths on the ovary.

Making a cut in the belly wall (abdominal hysterectomy) is almost always done to treat cancer and when fibroid tumors are so large that they cannot be removed any other way.

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What about the cervix?

Some people think there is an advantage to leaving the cervix in place at the time of hysterectomy. The theory is that we keep the structures that provide support for the bladder, vagina, and cervix intact and avoid "falling of the parts" later on. Others believe that nerves traveling next to the cervix can be hurt if the cervix is removed at hysterectomy.

These nerves may contribute to sexual sensation and orgasm. The truth is that studies have shown absolutely no difference in sexual function or in pelvic support between women who had the cervix removed and women who did not. Sometimes there was bleeding from the cervix after hysterectomy if the cervix was left in place.

What's the bottom line? This is a personal choice and something to discuss with your doctor, but you can expect excellent results and continuing normal (for you) sexual function after hysterectomy whether or not your cervix is removed.

What about the ovaries?

The only reason to remove normal ovaries is to reduce the risk of ovarian cancer. Surprisingly, even complete removal of both tubes and ovaries does not eliminate the possibility of getting this devastating cancer. If there is a strong family history of ovarian or breast cancer, or if you personally have had breast cancer and you understand that you will very likely need to take medication at least for a while to help you with the sudden menopausal symptoms, you may decide to have the ovaries removed. Rarely, women may suffer from migraine headaches or premenstrual symptoms so severe that they will choose to have their natural source of hormones removed.

As women, we fear ovarian cancer because it is so hard to find at an early stage and it is so deadly. Again, we should base our choices on facts. The truth? Only one woman out of 140 who have had a hysterectomy with the ovaries left intact will go on to develop ovarian cancer sometime during the rest of her life. That is less than 1%!

The downside of ovary removal is not only loss of our natural estrogen but also loss of other hormones that contribute to our sense of well-being and even our sex drive. My basic philosophy is—if it isn't broken don't fix it. For women who have an average risk of ovarian cancer, the benefits of keeping our natural hormones usually outweigh the risk of cancer.

When considering the options

A woman should ask herself:

Am I ready to lose my ability to have children?

Do I have the time to recover from major surgery?

Do I have the help available to cover the household and child rearing tasks while I recover?

Do I feel confident in my surgeon's experience and ability?

Do I feel that my surgeon has offered me all the possible treatments available and given me all the information I need to make this decision?

A women should ask her physician:

What will happen if I DON'T have surgery?

What other treatment options are there? Why do you recommend hysterectomy over these other choices?

How many hysterectomies do you perform in a month/year?

What is your complication rate? How many women need transfusions? How many women are readmitted to the hospital? How many women develop infections?

How many hysterectomies have you performed vaginally? Laparoscopically? Abdominally?

How long does your typical patient spend in the hospital?

How long before your typical patient can return to normal activities?

What strategies do you use to prevent and treat pain, nausea, infection, or other complications?

Making an informed choice

How will you feel after a hysterectomy? Overwhelmingly, women who make an informed choice to have the uterus removed, women who have considered all the options I've discussed and have picked hysterectomy as their choice, do extremely well. After a short period of recovery, life without bleeding or the problems related to monthly menstrual cycles can be better than ever.

Urinary incontinence

The epidemic no one wants to talk about

BY MICKEY KARRAM, MD

There's a lot you can do to rid yourself of this common problem

MANY WOMEN WILL HAVE TO DEAL WITH URINARY INCONTINENCE at some point in their lives—estimates in the United States range from 20 to 30 million. In this article, Mickey Karram, MD, director of urogynecology at Good Samaritan Hospital in Cincinnati, Ohio, describes the symptoms of incontinence, the cause, and its treatment.

Approximately 90% of women who experience incontinence have one of two (or a combination of the two) conditions.

- The first is called stress incontinence. It occurs with coughing, straining, or basically any rise in intraabdominal pressure.
- The second is overactive bladder, the "when I gotta go, I gotta go" type. Leakage occurs because a woman can't make it to the bathroom in time.

These problems are separate and distinct. When treatment is ineffective, it may be that the appropriate condition is not being treated. Adding to the complexity of diagnosis, patients often cannot distinguish symptoms of the two conditions. As a result, your health care provider should make an independent evaluation prior to initiating therapy. This should always include testing to rule out bladder infection or cystitis.

A simpler test may reveal stress incontinence: Your physician may ask you to cough very aggressively in the standing position while your bladder is full. If leakage of urine occurs with that cough, stress incontinence is likely. If leakage does not occur, then your problem is likely related to overactive bladder.

Anatomy and incontinence

Anatomy underscores the difference between these conditions: In stress incontinence, the urethra (the tube that connects the bladder to the outside) loses its ability to maintain a watertight seal and the patient begins to leak, usually provoked by a cough or a strain or some other mechanism that causes a rise in intra-abdominal pressure.

Normally, a woman perceives bladder fullness and voluntarily causes her bladder to contract and empty when convenient. Overactive bladder is associated with urgency, frequency, and possibly bladder spasms. For reasons not fully understood, women tend to lose the ability to control their bladder muscle; the bladder contracts—and may even empty—at inappropriate times.

Use these simple strategies to improve bladder control

Pelvic floor exercises. Pelvic floor exercises or Kegel exercises strengthen the pelvic floor muscles. When you feel like you are going to have a bout of urinary leakage, simply contracting your muscles will significantly reduce or prevent the leakage. It is important to understand, however, that these muscles must be appropriately contracted and many women who feel that they are performing Kegel exercises are, in reality, contracting other muscles that are in the vicinity of the pelvic floor vaginal muscles. To make sure that you are contracting the appropriate muscles, place two fingers in the vagina and apply downward pressure toward the

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The truth about sexual dysfunction

RACHEL PAULS, MD

HOW DO YOU KNOW IF YOU SUFFER FROM SEXUAL DYSFUNCTION? Sex is everywhere—on our televisions and billboards, in our newspapers and movies. Wherever we turn there are images of people desiring or having sex. With this increased exposure to all things sexual comes its flipside—sexual dysfunction.

Television shows like *Sex and the City* and explicit ads for drugs like Viagra, Levitra, Cialis and Avlimil, leave men and women today wondering about themselves. Being bombarded with information like "over half of women have sexual dysfunction" is confusing and frustrating. Who decides that there is a problem? What can people do if they think they have one? What treatments exist for sexual dysfunction?

Rachel Pauls, MD, a urogynecologist with the Center for Female Sexual Health, Tristate Urogynecology and Reconstructive Surgery, Cincinnati, Ohio, conducted an interview with two physicians who specialize in sexual health to answer some of these questions.

Laura Berman, PhD, is a sex therapist and Director of the Berman Center, a mind/body clinic for women's sexual health in Chicago.

How common is sexual dysfunction in women?

DR. BERMAN: Based on available studies most estimates range from 40% to 50% of women. The largest study in the United State, done in 1992, found that among women aged 18 to 59, 43% had some type of sexual dysfunction. This estimate was limited by not including women older 59, which may have led to higher rates.

What are the common complaints for women with sexual dysfunction?

DR. BERMAN: Female sexual dysfunction is subclassified into disorders of desire, arousal (lubrication, tingling in the genitals, swelling), orgasm, and pain with intercourse that result in distress for the patient experiencing the symptoms. Disorders of sexual desire are most common, followed by disorders of arousal. Women with disorders of desire may complain of not being in the mood, not wanting to be sexually active with their partner, or noting a decrease in their sexual desire from previous times. Women with arousal complaints may describe diminished lubrication, engorgement, or sensation in their genitals despite adequate stimulation. Orgasmic problems may include difficulty or inability achieving orgasm during sexual encounters. Finally, pain disorders include any pain with sexual intercourse or self-stimulation on the vulva or inside the vagina that interferes with sexual activity.

What are some of the common reasons for these complaints?

DR. BERMAN: Sexual function is a complex issue, since it always occurs within the context of a woman's life. It is an interplay of the relationship between the woman and her partner, her experiences and expectations, how she feels about the relationship, and how she feels about herself. Relationship problems, a history of trauma or abuse, or low self-image may contribute to sexual dysfunction. However, even women in satisfying relationships may have sexual dysfunction. This may be related to other causes such as surgery, pregnancy and childbirth, medications, or concurrent medical diseases, hormonal imbalances, or lifestyle factors such as drugs or alcohol. Some of these other factors may be treated by medications or medical intervention.

How do you suggest women deal with these complaints?

DR. BERMAN: If a woman feels she has a dysfunction that is distressing to her, she needs to seek help by contacting her physician. If her regular physician or gynecologist is unsure of how to treat these issues or doesn't address her concerns, she should be persistent about a referral to a specialist. Often, gynecologists who specialize in the pelvic floor, known as urogynecologists or female urologists, are more experienced in treating these problems. She may also require referral to a therapist for individual or couples therapy.

Treatment may involve hormonal therapy with estrogen or androgens, vaginal moisturizers, lubricants, or topical therapies. Other possibilities include

clitoral suction therapy, which may enhance lubrication, orgasm, and sensation.

What are some of the future therapies expected for women?

DR. BERMAN: There has been a lot of research interest in this area. A testosterone patch for women is planned for release early in 2005. It has been found to improve libido and sexual activity in surgically menopausal women with low desire and is currently being tested in other patient populations. Other trials are continuing and promise exciting advances in this field.

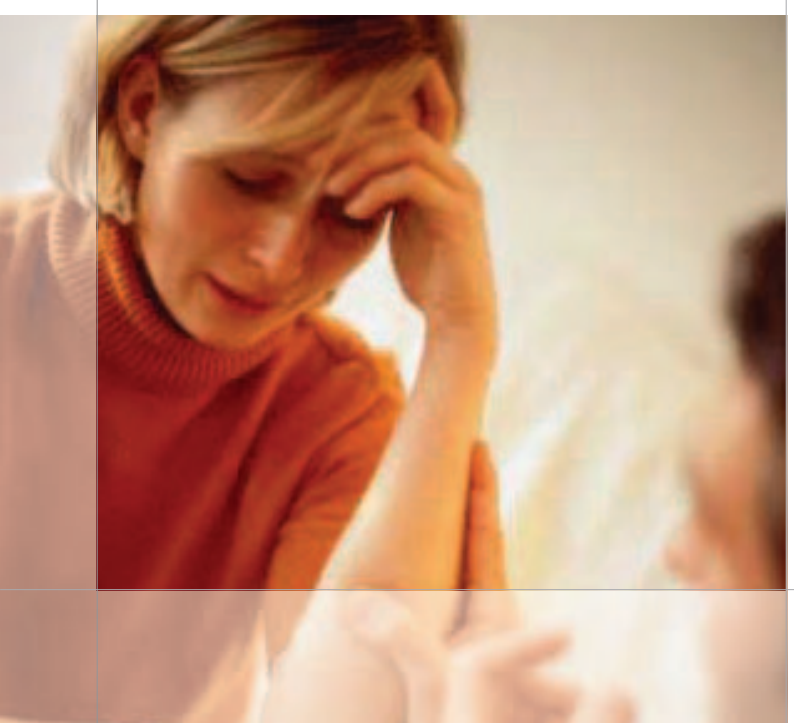
What are some ways for a woman to deal with sexual dysfunction in her partner?

DR. BERMAN: Just as women may have problems with sexual function, so may their partners. This can be difficult and stressful for a relationship. Women should encourage their partners to seek medical advice for erectile dysfunction and other sexual problems. It is also important to realize that a satisfying sexual relationship does not necessarily have to include intercourse. Kissing, fondling, mutual masturbation, and oral stimulation may be just as pleasurable as coitus and often allow a couple to reconnect on an intimate level.

Irwin Goldstein, MD, is a urologist at Boston University who treats male and female sexual dysfunction.

How common is sexual dysfunction in men?

DR. GOLDSTEIN: About half of men aged 40 to 70 have sexual dysfunction.



What are the common complaints for men with sexual dysfunction?

DR. GOLDSTEIN: Most commonly men have either erectile dysfunction (ED) or premature ejaculation.

What are the common reasons for these complaints?

DR. GOLDSTEIN: For ED, the most common causes are vascular disease, diabetes, radical prostatectomy, bicycle riding, and medications such as selective serotonin reuptake inhibitors used to treat depression. For premature ejaculation, it is often difficult to identify a single cause.

How do you suggest men deal with these complaints?

DR. GOLDSTEIN: Men should start with an evaluation by a psychologist and a physician trained in sexual medicine. The next step is often to correct modifiable causes such as changing medications and correcting the hormonal milieu.

First-line therapies include: sex therapy, oral therapies (Viagra, Levitra, Cialis), or vacuum therapy devices.

Second-line therapies include: intracavernosal injections (injections of medication directly into the erectile tissues) or MUSE (a pellet that is placed into the urethra).

Third-line therapies if the above fail include: surgical treatments, such as penile prostheses, or penile revascularization.

What are some of the future therapies expected for men?

DR. GOLDSTEIN: Some newer oral therapies are being developed such as PDE5 inhibitors and central vasodilator therapies, which are designed to increase blood flow and improve erectile dysfunction.

What are some ways for a man to deal with sexual dysfunction in his partner?

DR. GOLDSTEIN: The best way to deal with this is to have an open discussion with the partner and be involved in her care. Encourage her to seek medical attention, as many therapies are available that can help. She should seek help from a psychologist and a physician who specializes in sexual medicine.

A final note from Dr. Pauls: Sexual dysfunction can be devastating for patients and their partners. As more research continues in this area, medical information about these conditions is growing. Women and men should be aware that often these conditions have a physiologic cause and that there are treatments available. Accordingly, it is important to address these problems with your physician to ensure that appropriate attention is provided.

Feel your body relax when you allow yourself to breath fully.

Life keeps you on your toes, so treat them to a relaxing stretch!

Twisting gives you a different perspective and keeps the spine supple.

ENJOY THE

If you feel that the demands of your life are controlling you, yoga can help you to be present in each moment—and get back into control

BY GINNY WALTERS

Feel that you're moving at such a fast pace that all you can do is react to what's happening around you? At day's end, you probably don't even remember most of the events that just took place. Case in point: How many times have you lost your keys? You might think,"If I had only paid attention where I set them." But that loss of attention tells you something more: that you take actions of which you are not even aware. Where you put your keys may not be very important, but are there other, perhaps more significant, events that you experience without being present? What about the meeting at which you missed important information? Or the appointment that you forgot? In this article, registered and certified yoga instructor Ginny Walters shows you how to enjoy the moment.

▶ PHOTOS BY JERRY CHALK

MOMENT

Steady yourself through yoga and you will be prepared to perceive events, rather than just react to them.

Many times, we seem to be roped into mindless action, so we just move from one task to another without enjoying or even knowing what we want from our lives. If life moves in slow motion, we can enjoy and feel all that is happening. It's unlikely that our lives will slow down. What can we do to slow the pace and feel "the present of the present" every moment? Can we learn to perceive events before they happen so that we don't simply react? This is what yoga can begin to offer you.

You've probably heard a lot about the practice of yoga. Until you take a class and feel (yes, feel) for yourself, you can't judge how you will react. It could be a new experience that lightens your perception of the busy, heavy jobs you face every day. It could give you a vision of where you are right now. Hold on now, it might not be where you thought you were. Yoga can help you take the blinders off and see life in all its glory.

The following exercises seem straightforward but, as you read on, you'll find that there's a lot more here than you might think.

1. **Breathe.**
2. **Stand on two feet.**
3. **Stand on each foot one at a time.**
4. **Kneel on the floor without shoes on, with toes pointed out. Sit on your heels.**
5. **Kneel on the floor without shoes, curl your toes under, and sit on your heels.**
6. **Twist to each side while looking in each direction.**
7. **Lie on your back and stretch with your arms overhead.**
8. **With bent knees and feet flat, lift your hips off the floor.**
9. **Lie flat and "just BE."**
10. **Take a little time for yourself, and say no to anything that won't be helpful for your family now or in the long run.**

> "Yoga can help you take the blinders off and see life in all its glory"

I propose a few yoga exercises you can do each day to help you start on the journey of the discovery of you. These poses are going to seem easy for some and hard for others. If by chance you can do them all without a problem, I'll give you a pose that will probably be the hardest for you—the being still pose, also called the corpse pose. Can you really relax and lie still for 10 minutes without falling asleep? Can you feel yourself slowly sinking and dissolving and leaving behind this body that is you?

So give each posture a try. My suggestion is to practice for a week as a test. Take this journey without a map and see where you end up. Possibly you will find a dead end. Some folks do end there. But, more probable, you will learn a little about yourself. You will begin again to take control and pay attention.

Breathe. To breathe means that you feel the act of air moving through your lungs and the subtle movements of the body that happen as you breathe. Your breath can tell a lot about you. Notice how you hold your breath when you are angry or trying very hard to accomplish a task. When you are most nervous do you notice that your breath becomes ragged? All this can change. First be aware what smooth, easy breathing feels like. Then notice throughout your day how you breathe. Change it when you find you are not breathing fully. Notice how your belly moves out with each inhalation and in with each exhalation. With practice, this form of correct breathing can be attained.

Stand tall. As you wait in a line—any time, anywhere—stand tall and feel your weight balanced on both feet. Lean forward to feel your toes pressing stronger into the ground. Lean back and become a heel digger. Now widen your feet and feel it all. Lift like you are made of springs where the skin and muscles and bones move upward. Have your shoulders lifted too? Drop the ever-present hunched back and lift your heart to the sky overhead. Feel taller? What does this feel like?

Balance easily. Standing tall on two feet prepares you to stand on one foot. Place your weight on one column of leg and lift the heel of the other foot off the ground. If this seems easy, than take it another step: Lift your foot and let your inhalation lift the knee; grab your knee in

Learning to stand tall will lighten the busy, heavy feeling of your everyday jobs.

Experience the feeling of slowly sinking and dissolving as you become still and deeply relaxed.

Use yoga—anywhere, anytime—to be present in the moment.

front of your body. Practice with your hips steady. Use your breath as a guide to how you're doing. If the breath becomes ragged or you find you are holding it, you are trying too hard. Remember to practice balancing on each foot. It is amazing how each side of our body is different.

10 minutes of calm. All of this takes time. You need more time. Where can you grab the 10 minutes to check into yourself? These are problems that can be solved. Find the time and you will be rewarded. Sit quietly and practice calming the mind. With all the clutter in your mind, you may find this difficult, as your attention keeps shifting. Do not allow the mind to dictate how you will react to what you or others are doing. What is it like to live in your skin today?

Stretch out. Sit down on your heels and notice the stretch in the front of your feet. Keep your ankles strong and point your toes straight back. Place a block under your knees if you have problems. Place a rolled towel under the tops of your feet if you can't flatten them to the floor. Use all the help you need to slowly begin to feel your feet, your ankles, and your knees. Feel the length of your spine by slowly twisting to one side, and breath as you move to the other side. Your eyes will show your intention so be sure to look each way as the shoulders open to each side. Try sitting with your toes curled under your feet with the heels acting like a seat. Ah, your toes will love the attention and your Achilles will be stretched.

Try diagonal moves. Lie back and notice the length of your body on the floor. Lift your arms overhead and reach each arm and the opposite leg away from your center. Can you feel the diagonal? It crosses through your center. This is where your fire glows from activity. This is where your heat generates energy that can be lifted to all parts of the body.

Bend your back. Try a gentle back bend: Lie back, with your knees bent into the air and your heels near each outside hip; lift your curled tailbone and slowly peel each vertebra off the floor. Bring it toward the ceiling. Feel the back of your neck stretch, and allow your chin to move closer to your chest as you squeeze your shoulder blades down and toward one another. Lengthen each arm toward your heels, and clasp your hands. If this movement is too vigorous or intense, make it simple. Gently lift your hips onto a three-inch block or bolster. Rest your sacrum on the top. Relax. Feel as if you have nowhere to go. You can learn to let go even if for a moment.

Be ultra still. The corpse pose is much more than just laying flat. I have seen wonderful gymnast-like yogis look beautiful in their poses and then not be able to be still for one minute. If you are driven through the practice of yoga by the mind, it is awfully hard to shut it out in the end. Instead, as you breathe and move you try to become a witness. Bring your senses into action inside of you and constantly check in with them. Let the noise and the activities stay outside. You can be like a sand castle. The shape of your body is a beautiful mermaid. As the ocean washes over you, it leaves you intact. It flows through you, and still you are almost the same as before.

You learn timelessness in this way. Being present now and now and now is hard to learn. Can you imagine a life where you are not jumping the gun with reactions or missing what is happening because you were busy dreaming of your possible future? I am advocating that you help your dreams come to fruition by checking in with what your gut feels is important. In your heart, you know you are on the right path because you feel your actions are taking you where you hope you should be.

How has yoga helped me? Since participating in this life-changing practice I laugh and I cry more. It feels so much better than being tied up in knots. So I am practicing slowing down. I feel it on the mat. I know it is possible.

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Frequently asked questions regarding bladder control problems in women

Is incontinence or involuntary loss of urine a sign of a more severe or life-threatening problem?
No. This is a common misperception. Urinary incontinence is a quality-of-life condition that, if left untreated, most likely will become more severe over time. However, it will never lead to a life-threatening problem.

Why do women develop incontinence?
The majority of overactive bladder cases are classified as idiopathic, which means that the true cause is not known. We do know that women who have neurologic problems such as those with multiple sclerosis or who have developed strokes can develop bladder spasms. A correlation has been seen between vaginal delivery and ultimate development of stress incontinence. Possibly the trauma associated with vaginal birth may predispose a woman to bladder control problems later in life.

Is incontinence a normal part of the aging process?
Absolutely not. Many therapies can improve and in many cases cure a bladder leakage problem.

What type of doctor or health care provider should I seek out to evaluate and manage my bladder control problem?
Initially, you should mention your problem to your primary care provider or the physician that you see on a regular basis. Urogynecologists (gynecologists who have received extra training in female urology) are subspecialists in this area. Many urologists also have undergone special training in female bladder control problems, and they will often refer to themselves as a female urologist. These physicians will be most knowledgeable about all of the appropriate evaluations and management options.

How successful is surgery for the correction of incontinence?
About 85% of the time, surgery significantly improves or cures the problem. However, that surgery is only appropriate for patients who have stress incontinence. If a patient with overactive bladder undergoes surgery for stress incontinence, her problem will significantly worsen. Many patients who perceive that their surgery did not work very well may have not been appropriate candidates for the procedure.

What are new developments in the treatment of incontinence?
We now have very effective surgery that can be performed on an outpatient basis under local anesthesia in less than 20 minutes. Many new medications and devices are available, as well as cutting edge technology in the form of nerve modulation to the bladder muscle itself. To keep up to date on new treatments, visit the Web site for the National Association for Continence (www.nafc.org) or call 1-800-BLADDER. The American Urogynecology Society (www.augs.com) can help you identify a health care provider in your area, as well as give you information. The American Urologic Association sponsors a Web site, www.drylife.org, another source of information.

rectum on the posterior vaginal wall. If you contract the appropriate muscles, you should feel the muscles contract with your vaginal fingers. Once you have mastered this, then you will be able to perform these exercises on a regular basis at various times throughout the day. To get the best outcome, you should contract the muscle at least 20 times, three times a day. While you may not see any significant improvement for a few weeks, the goal again is to appropriately contract your muscles at the time that you are most likely to leak urine, during a cough, during exercise, or when you are experiencing severe urgency and feel you need to rush to the bathroom. In this setting, it is important to stop and contract the appropriate muscles so that you not get into a race with your bladder that you will probably lose.

Educate yourself. Keep a voiding diary, a record of the amount of fluid you take in (it is a myth that you need to take in large amounts of water to maintain a healthy bladder) and the amount of urine you put out over a three-day period. Keep track of how many bouts of leakage you have and what you are doing during those bouts of leakage. In many studies, simply being more in touch with the problem has been shown to significantly improve the condition of bladder control.

Timed voiding. Your bladder should be perceived as a poorly disciplined child in situations where bladder control becomes a problem. The tendency would be to void more frequently in the hope of not letting your bladder get full enough to have a problem with bladder leakage. In reality this is the worst thing that you can do for this condition. Instead, voiding or toileting on a regular basis can significantly improve bladder control problems. Begin with a comfortable time interval, perhaps once an hour. For one week, go to the bathroom at hourly intervals during waking hours, even if you do not feel the urge. Then increase the time interval each week at 15-minute intervals.

Consume the right amount of fluid. When you are well hydrated, your urine will be pale yellow. Many people believe you need to consume eight 8-ounce glasses of water each day. You don't.

Urinary problems can occur without leaking. Some women experience a frequent or constant feeling of needing to urinate. They feel like they are always in the bathroom. A variety of causes can trigger this feeling—your doctor is likely to offer several different treatments.

Just any doctors?

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Women's HEALTH

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