Your Guide To Uterine Health

Presented by the National Women's Health Resource Center, Inc.

Gynecologic Health Information

Complete this form and keep a copy of it handy during appointments with health care professionals, when filling prescriptions or in case of an emergency.

Name _____ Phone _____ Date _____

Emergency Contact Name _____ Phone _____ Cell _____

Primary Health Insurance _____ Group # _____ ID # _____ Phone _____

Secondary Health Insurance _____ Group # _____ ID # _____ Phone _____

Family Physician _____ Phone _____ Gynecologist _____ Phone _____

Surgeon _____ Phone _____

Pharmacy _____ Address _____ Phone _____

Hospital _____ Phone _____

Physical Exam/Date(s) _____

Surgery/Date(s) _____

Chronic Medical Conditions _____

Medications Taken Regularly (prescription and over-the-counter) _____

Known Allergies (medications, food, etc.) _____

Blood Type _____ Number of Pregnancies _____

Age menstruation started _____ Average length of period (days) _____ Typical menstrual symptoms (heavy bleeding, pain, etc.) _____

Family history of gynecologic or breast cancer? ( ) Yes ( ) No

Family history of heart attack or stroke? ( ) Yes ( ) No

Uterine Health Starts with You

If any part of your body epitomizes femininity, it's the uterus. The womb. One of the strongest muscles in your body, second only to the heart. Instead of pumping blood, however, the uterus is designed to pump out a baby.

Despite its awesome nature, it is easy to take your uterus for granted. You probably don't give it a second thought, unless you are pregnant or menstruating or, perhaps, nearing menopause.

But for some women–those who suffer with debilitating menstrual cramps and heavy bleeding; women battling infertility; and anyone diagnosed with fibroids, endometriosis or another uterine disorder—the uterus cannot be ignored.

Even if you're lucky enough to have avoided uterine disorders thus far, you can increase the likelihood of keeping your uterus healthy by learning more about its intricate functions and vulnerabilities and practicing good preventive care. Contrary to what you might think, your uterus' role doesn't end at menopause.

This guide contains all you need to know about the uterus. You'll learn more about this pear-shaped organ's role in the reproductive system and ways to manage the conditions that can afflict it. You'll also find the latest information on hysterectomy, including how to avoid one.

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What is Uterine Health?

Maintaining or improving the health of your uterus is no different from maintaining or improving the health of your skin, muscles, heart or any other organ. You must educate yourself, become aware of any conditions in your family that may be inherited, understand what could go wrong and get regular checkups and health screenings to detect any problems early. Just as you would consult a health care professional if you felt lightheaded or had trouble breathing, you should consult a health care professional if your periods get heavier or irregular, or if you develop pelvic pain or another symptom that could signal a uterine disorder.

Your Family History

How much do you really know about the reproductive health of your mother, sisters, aunts and grandmothers? If the answer is "not much," then it's time to put on your detective hat.

The seeds for many health issues, both positive and negative, are stored in the DNA passed down from both sides of your family. For instance, gene analyses from families in which women suffer from fibroids have revealed a mutation that could predispose women to these abnormal uterine growths.[1]

So if your mother suffered from painful periods, fibroids or a difficult menopause, your risk for these conditions is greater than that of a friend whose mother sailed through her reproductive milestones. We say "risk" because simply having the genetic tendency for uterine problems doesn't set your fate in stone. Maintaining a healthy diet and body weight, avoiding unprotected sex, using preventive medications and other measures may possibly help you overcome genetic tendencies.

It isn't always easy to be a family health detective. Asking your grandmother or other elderly female relatives about their reproductive health, a "taboo topic" for many women of that generation, may be uncomfortable. And if you have no access to your biological family it's even more difficult to discover any family patterns for certain disorders.

So it's important to take this discovery process one step at a time. Here are some suggestions that may ease the way:

- Make a list of all living female relatives on both sides of your family. Write down anything you know about their medical history. Childhood memories may be clues. (Aunt Mary spending several days each month in bed, for example.)
- Ask relatives what they know about your mother's and grandmother's health history, if communication with these older women isn't possible.
- Decide whom you can ask directly about such issues and who might be better approached by a carefully worded letter or e-mail.
- Explain verbally or in writing that you need this information to learn what might lie ahead for you, healthwise.
- Write down everything you learn, and share that information with your health care professional.
- Check the laws in your state. In some states, doctors and hospitals will provide medical records of your deceased relatives if you make your request in writing.[2]

Uterine Health Family History Checklist

Start learning more about your uterine health family history by asking female relatives on both sides of your family these questions:

1. At what age did you begin menstruating? _____

2. Were/are your periods regular? ( ) Y ( ) N

3. Did/do you have any problems during menstruation with any of the following?

   ___ heavy bleeding ___ severe pain ___ mood swings ___ weight gain

4. Have you ever been diagnosed with uterine fibroids? ( ) Y ( ) N

5. Have you ever been diagnosed with endometriosis? ( ) Y ( ) N

6. Did you have any trouble getting pregnant? ( ) Y ( ) N

   If yes, why? _____

7. How many pregnancies have you had? _____ Live births: _____ Miscarriages: _____

8. Were your pregnancies and deliveries normal? ( ) Y ( ) N

9. Did you take DES (diethylstilbestrol, a synthetic estrogen) to prevent miscarriage while pregnant with me? ( ) Y ( ) N

10. Have you ever been diagnosed with any kind of reproductive cancer, including breast cancer? ( ) Y ( ) N Type: _____

11. Have you had a hysterectomy or any other kind of gynecologic surgery? ( ) Y ( ) N

    What for? _____

    _____

12. What was menopause like for you? _____

    _____

13. Did you experience any of the following menopausal symptoms?

    ___ hot flashes ___ mood swings At what ages did they start and end? _____

Understanding Your Reproductive System[3]

The uterus is part of a complex system of tissues and hormones that, together, make up the female reproductive system. The main parts of the system are the vagina, cervix, uterus, fallopian tubes and ovaries. A complex cascade of hormones released from your pituitary gland governs their health and functioning. And, it all begins before birth.

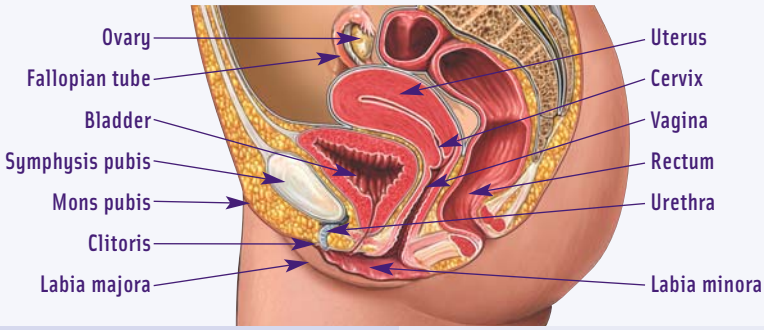
By seven weeks' gestation, your fallopian tubes, ovaries, uterus and vagina were formed. Two months before you were born, your ovaries contained as many as five million eggs. That number dropped to about one million by the time you emerged from the womb, and to about 500,000 by the time you hit puberty. During your childbearing years, however, only about 450 eggs reach maturity and can be fertilized–still plenty for the 2.5 kids and white picket fence, if these were in your plan. The rest of the eggs slowly disintegrate. So by the time you hit menopause, only about 3,000 remain.

But the eggs are just one part of your reproductive system, all designed for the express purpose of creating, carrying and birthing a baby. Start with the external genital area. (See diagram below.) Called the vulva, this includes the labia minora, the inner lips enclosing the opening to the vagina; the labia majora, the outer, hair-bearing lips surrounding the opening to the vagina; and the urethra, the opening to the bladder.

The clitoris, a small, bud-shaped organ, is located just above the urethra—you can see and feel it if you try. Traveling through the muscular tube of the vagina, you reach the uterus, opening up like a room at the end of a long corridor. The opening of the uterus, the cervix, projects into the upper end of the vagina. You could feel it by inserting a finger into your vagina. The cervix also acts as a barrier to the uterus; it can't be penetrated by a penis, tampon or finger. Only when you're in labor does it (painfully) open.

The uterus itself is a hollow, muscular organ, about the size of a pear. Its lining is called the endometrium, which changes in thickness depending on where you are in your menstrual cycle. (If you get pregnant that menstrual cycle, endometrial tissue nourishes the embryo until the placenta grows.) Except during pregnancy, the cavity of the uterus is triangular and flat, its front and rear walls touching.

The Female Reproductive System



Anatomy of the Uterus

The uterus has three layers. The outside layer is the peritoneum. This membrane secretes a blood-like fluid that partially covers the uterus. The middle layer of tissue, the myometrium, is very firm and muscular and makes up most of the uterus. The endometrium, a mucous membrane, is the innermost layer of tissue. It lines the uterine cavity and contains numerous glands, blood vessels and lymphatic spaces.[4]

On either side of the upper end of the uterus are the fallopian tubes. They're about four inches long and reach outward like fingers toward the ovaries. Tiny, hair-like projections on the ends of each tube catch the egg the ovary releases each month and funnels it along the tube down to the uterus. In addition to incubating eggs, the ovaries secrete the reproductive hormones estrogen and progesterone, which brings us to the next dimension of the reproductive system.

Honing in on Hormones

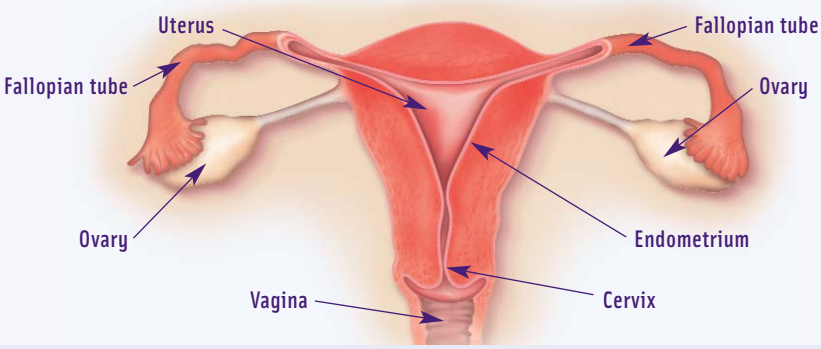
Hormones, the body's chemical messengers, determine when and how fast you grow, if you're hungry or satiated, whether you'll gain or lose weight; they even play a role in determining if you'll feel like making love tonight. They are part of a complex, related group of glands and tissues called the endocrine system.

In women, six key hormones play the leading roles in the reproductive system: gonadotropin-releasing hormone (GnRH), follicle-stimulating hormone (FSH), luteinizing hormone (LH), estrogen, progesterone and testosterone (yes, women do have a bit of the male hormone, just as men's bodies secrete some estrogen).

Directing the continual hormonal play is a cherry-sized gland in the center of the brain called the hypothalamus—the ultimate link between body and brain. When it detects too much or too little of a particular hormone, the hypothalmus sends another hormone to its nearby partner, the pituitary gland, which, in turn, secretes its own hormones that instruct various other glands to turn up or down their hormone production.

Like a sentry, the hypothalamus keeps constant watch over the levels of both estrogen and progesterone, thus creating the mechanism that is supposed to keep these hormones in balance throughout your menstrual cycle.

The Uterus



Uterine Health Across the Lifespan

As any woman can tell you, reproductive functions change as you move through life—from the often-erratic menstrual cycles of adolescence, to the regular-as-clockwork periods of early adulthood, to the amazing changes triggered by pregnancy, birth and breastfeeding; to the seemingly unpredictable cycles of perimenopause and, finally, to menopause, the end of the reproductive years.

The female reproductive system changes in other ways, as well. For instance, fibroids, which are usually benign tumors of the uterus (see page 11), are more common in women between the ages of 30 and 40. Teens, meanwhile, are more likely than 30-year-olds to suffer from menstrual cramps. That's why it's so important to keep a handle on your uterine health by getting regular medical checkups and by doing periodic "internal" checks in which you decide what's normal and what's not.

A Teen Girl Should See a Health Care Professional If[6] . . .

- She hasn't developed breasts or pubic hair by age 14.
- She hasn't started menstruating by age 16.
- She's had periods for two or three years, but they're still not regular.
- She has very heavy periods.
- She has severe or debilitating pain during menstruation.
- She decides to become sexually active and needs information about birth control options and STDs.
- She suddenly stops menstruating.

During Adolescence

Adolescence is a unique space in time for many reasons. Ideally, it lays a healthy and hopeful foundation for adulthood. For girls entering puberty, understanding what it takes to be and stay healthy gynecologically can pay lifelong health dividends.

Menstruation typically begins between ages 11 and 14. At first, menstrual cycles tend to be irregular because most girls don't ovulate on an even cycle until two to three years after menstruation starts. Some periods are light, others very heavy; your period may last seven days this month and three days next month. Cycles could last three months, 28 days, or somewhere in between. It's a good idea for girls and teens to track their cycles on a calendar to help them predict when their next period is likely to occur.[5]

Most girls have no problems with their menstrual cycles, but others endure very heavy bleeding (menorrhagia) or very painful cramps (dysmenorrhea). If you have either problem with your menstrual period, you should be medically evaluated.

Teens and STDs

Sexually active teenage girls are at increased risk for sexually transmitted diseases (STDs) because they may have multiple sexual partners and may not insist on using condoms or use condoms incorrectly with each sexual act (including oral sex). Studies show that two-thirds of those who contract an STD are 25 or younger. One study found that one in five adolescent girls had an undiagnosed STD.[7] The threat to long-term uterine health posed by STDs can't be overestimated.

Teens' STD risk is also elevated because of their physiology. Anatomically, girls have a greater risk of acquiring chlamydia, the second most common STD, because their reproductive system hasn't fully matured. The lining of the uterus is more exposed in adolescence, providing a bigger target for the bacteria that causes chlamydia. Ten to 20 percent of women diagnosed with chlamydia or gonorrhea develop pelvic inflammatory disease (PID), which can lead to chronic pelvic pain, infertility and potentially fatal ectopic pregnancy—the leading cause of pregnancy-related deaths for American women in the first trimester.[8] As women age, the lining slides back into the uterus, where it is less vulnerable to infection. Thus, it may take fewer exposures when you're young to actually catch the disease than when you're older.[9] That's one more argument for postponing sexual intercourse or, at the very least, using adequate protection against STDs.

Throughout Young Adulthood

Vigilance about your reproductive health is especially important during your 20s and early 30s. If you notice any unusual vaginal itching, discharge or odor, or if you've had an unexplained abdominal pain or fever, call your health care professional. Early treatment can often prevent the kind of infections that can lead to permanent infertility.

The best way to protect your fertility is to protect yourself against STDs by using condoms (male or female) consistently and correctly and seeing a medical professional at the first sign that anything is amiss.

If you decide to get pregnant, make an appointment with a health care professional for a complete physical before you start trying. There is much to learn and to do to make your pregnancy as healthy as possible. Don't worry if getting pregnant takes several tries. Even young, healthy couples have only a one-in-five chance of conceiving during any given menstrual cycle. In addition, a woman's fertility starts to slowly diminish as early as her late 20s and early 30s.[10]

About one-third of infertility cases stem from male-related factors, such as a low sperm count; one-third from female-related factors; and the remaining third by problems with both partners or unexplained causes.

Infertility treatments can range from losing or gaining weight under medical supervision, as well as lifestyle modifications such as limiting or curtailing an intensive exercise regimen, if you are engaged in one; to a variety of medical treatments. Conventional medical treatment options include: fertility drugs to stimulate ovulation; surgery to repair or unblock damaged fallopian tubes or to remove uterine fibroids; artificial insemination, in

Common Causes of Infertility[11]

- Blocked or damaged fallopian tubes
- Low sperm count, or abnormally shaped or dysfunctional sperm
- Ovulatory disorders—ovaries that don't release eggs normally, problems with egg quality and number or hormonal conditions that adversely affect ovulation
- Uterine or vaginal disorders, such as endometriosis or fibroids

which sperm is concentrated and injected into the uterus through the vagina; and in-vitro fertilization, in which eggs are removed, fertilized in a laboratory petri dish, allowed to grow for three to five days until they reach the several-cell stage, then implanted back into the womb.

At Middle Age

Once most women reach their late 30s their reproductive capabilities slow down. At first, the signs may be subtle. You may notice your periods coming every 35 days instead of every 28. Or one month your period might be unusually light (a relief) while the following month, it's frightfully heavy. Any mood swings or other premenstrual symptoms you've had in the past may become more pronounced. And there are nights when you could wake up so soaked in sweat you have to change the sheets. Of course, there are just as many nights you lie awake for hours, battling insomnia. At times, you might fear you're losing your mind.

Making Your Pap Test as Accurate as Possible[12]

Follow these simple steps to help ensure the accuracy of your Pap test:

- Don't schedule your Pap test during your menstrual period. Wait at least five days after your period has stopped.
- Don't douche or use tampons, spermicidal foam, cream, gel or vaginal medicine for two to three days before your Pap test.
- Refrain from intercourse for two days before your Pap test.

Symptoms of menopause can occur any time from about age 35 to 60. That's because the gradually declining levels of estrogen and progesterone that mark the eventual end of your reproductive years don't happen over a steady curve. Rather, your hormone levels rise and drop like a roller coaster. That helps explain many of the irregular periods women experience as they approach menopause and the month-to-month changes in how they feel.

What's Happening and Why

Beginning in your mid-30s, your ovaries start shrinking as the number of egg follicles diminishes. Both the ovaries and their follicles become resistant to follicle stimulating hormone (FSH) and luteinizing hormone (LH), so your pituitary gland starts producing more and more of these hormones to keep up estrogen production. That's why an elevated FSH level is one indicator of perimenopause. At the same time, the ovaries are producing less progesterone (production of this hormone will stop altogether after menopause).

Progesterone prepares the uterus for a fertilized egg and signals the uterus to shed its lining if the egg isn't fertilized. But if the ovary isn't producing enough progesterone, the lining may continue to grow until a drop in the amount of estrogen brings on your period. A very heavy period is the result because the lining has grown so thick.

That's why symptoms will change as time goes by. Some are more prevalent in your 30s and 40s; others show up after menopause. Some are quite obvious and annoying (think hot flashes); others are silent but potentially crippling (think

Gynecologic Checkups and Screening Guidelines[13]

The screening tests listed below can help identify diseases or conditions at their earliest stages. How often you should have certain screenings depends on your age and risk factors. Remember, no matter what your age, you should see your gynecologist or health care professional once a year for a general health checkup.

PAP TEST. Tests for precancerous cells or cancer of the cervix or vagina; may also detect some infections.

- **Ages 18 to 29:** 3 years after onset of sexual activity or by age 21, whichever comes first. After that, every year with regular Pap and every two years with liquid Pap test until age 30.
- **Ages 30 to 69:** If 3 Pap tests in a row are normal, test can be done every 2 to 3 years with either conventional or liquid-based Pap test. Important exceptions that may dictate that Pap tests be done once a year: infection with a cancer-causing form of human papillomavirus (HPV); infection with AIDS virus; chlamydia infection; exposure in utero to DES, a synthetic estrogen-like drug; a personal or family history of cervical cancer; an increased cancer risk because of certain conditions such as smoking; poor diet; a weakened immune system or treatment with an immune-suppressing medication.
- **Ages 70 and older:** After 3 or more normal Pap tests in a row and no abnormal test in the last 10 years, Pap tests are no longer necessary. Once a year checkups by health care professional are still advised, however. Women who have had total hysterectomies do not need a Pap test.

PELVIC EXAM. Manual exam by a health care professional of the ovaries and uterus for abnormalities.

- **Ages 18 to 64:** Once a year.
- **Ages 65 and older:** Once a year or less frequently, on the advice of your health care professional.

SEXUALLY TRANSMITTED DISEASE (STD) SCREENING.

- **Ages 18 and older:** Once a year at your routine physical even in the absence of symptoms, if you have multiple sexual partners, a partner who has multiple sexual partners or a partner with an STD. Both you and your partner should be tested before initiating a sexual relationship.

BREAST EXAMINATION. A breast exam performed by a health care professional (clinical breast exam) and breast self-exam (BSE).

- **Ages 20 to 39:** Clinical breast exam about every 3 years.
- **Ages 40 and older:** Clinical breast exam annually.
- **All women:** Report breast changes promptly; you may choose to do BSE occasionally to look and feel for breast changes, or not do them, though research shows that BSE plays a small role in detecting breast cancer.

MAMMOGRAM. Low-dose x-ray views of both breasts for abnormalities.

- **Ages 40 and older:** Annually.

THYROID TEST. A blood test of thyroid hormone levels.

- **Ages 35 and older:** Have your first thyroid test at age 35, then have one every 5 years.

BONE MINERAL DENSITY TEST. A specialized x-ray scan to detect abnormal bone loss.

- **Ages 18 to 39:** Not necessary.
- **Ages 40 to 49:** Usually not necessary if you're not at risk for bone fractures; discuss with your health care professional.
- **Ages 50 to 64:** Periodic screenings may be recommended if you are postmenopausal or at risk for bone fractures.
- **Ages 65 and older:** Periodic screenings may be recommended; discuss frequency with your health care professional.

osteoporosis). As you get closer to menopause, you may experience additional menopause-related symptoms—urinary incontinence or frequent urinary tract infections, weight gain caused by a slowing metabolism, memory loss and hair loss (or gain).[14] Some women—about 15 to 25 percent—experience no menopausal symptoms at all.[15] The average age of menopause—defined as the day after 12 months of no periods—is about 51 years. Less than one percent of women experience natural menopause before age 40.[16]

It might surprise you, however, to learn that the average age for hysterectomy is 42.[17] This may be because hysterectomy is often recommended as a treatment option for fibroids, which are most common for women in their 30s and 40s. But, this major surgery is rarely your only option. (See page 21 for more information about hysterectomy.)

Common Changes at Menopause [20]

Menopause is a unique experience for every woman. It's a natural event marking the end of fertility. You may experience a handful of physical and emotional changes at menopause–or none at all. Common changes include:

- Changes in menstrual patterns
- Hot flashes
- Sleep disturbances
- Changes in sexual function
- Urinary changes
- Psychological symptoms

Post-Menopause and Beyond

Just because your body can no longer become pregnant is no reason to put your gynecologic health on the back burner. This is the time of your life when your risk of gynecologic cancers–uterine, cervical and ovarian–increases. Nor does it mean that your uterus and ovaries have become superfluous. For some women, the uterus plays a role in their ability to have an orgasm and in urinary control.[18]

Continue to get regular gynecologic check-ups, and see your health care professional if you experience:

- Severe abdominal pain, nausea or vomiting that lasts several days
- Chest pain (call 911 immediately)
- Pain during sex
- Pain or difficulty urinating; an urge to urinate frequently; suddenly not being able to urinate; bloody urine
- Painful or bloody bowel movements
- Body temperature changes
- Persistent bloating
- Breast lumps or unusual breast changes
- Sudden changes in moods or persistent, prolonged sadness
- Vaginal bleeding or spotting after you've stopped menstruating.[19]

Uterine Conditions

Your uterus relies on a complex interplay of hormones to stay healthy. When hormone levels are off-balance, certain medical conditions can develop. Although most of these conditions are benign, they can cause troublesome symptoms, such as excessive bleeding, infertility or pain. In addition to hormonal imbalances, certain infections can damage the uterus. The causes of some other uterine conditions are still a mystery. Here's what you need to know about some of the more common conditions and diseases affecting the uterus:

Fibroids[21]

Fibroids, usually benign (non-cancerous) growths in the uterus, are rarely life-threatening. They can cause a variety of symptoms or no symptoms at all.

Fibroids are composed primarily of muscle cells that grow as a single lump or cluster of lumps within the uterine wall. They affect an estimated 77 percent of American women, most of whom don't even know they have them.

Fibroids range in size from less than one inch in diameter to the size of a grapefruit. They are responsible for more than 200,000 hysterectomies every year nationwide.

Fibroids are classified in three ways, depending on their location:

- **Submucosal.** These grow just under the uterine lining into the uterine cavity. They can cause bleeding, pain and infertility.
- **Intramural.** This most common type of fibroid grows in between the muscles of the uterine wall. These fibroids usually cause pressure-type symptoms and, less often, heavy menstruation.
- **Subserosal.** These fIbroids grow from the uterine wall to the outside of the uterus. They can push on other organs, such as the bladder, bowel or intestine, causing abdominal bloating, pressure, cramps or pain.

Some fibroids grow on "stalks" sticking out from the uterus or into the uterine cavity. Should the stalks twist, they can cause pain and nausea as the tissue degenerates or fever if they become infected.

Causes. Fibroids are most common among women between ages 30 and 40, among African-American women and women with a family history of fibroids. Being overweight raises your risk slightly, while childbirth and being athletic seem to lower your risk slightly. Some studies suggest that women who use oral contraceptives have a lower risk, too. Estrogen is known to influence fibroid growth, but the exact cause of fibroids is unknown.

Symptoms. Most fibroids produce no symptoms. If fibroids trigger symptoms—generally because of their size, number or location—they can cause longer and heavier menstrual bleeding, pelvic discomfort and pain, pressure on other organs, miscarriages and infertility. Having fibroids also increases your risk of complications during pregnancy.

Diagnosis. Your health care professional may be able to feel fibroids during a pelvic exam. One or more tests or procedures may be used to diagnose fibroids. However, it should be noted that these tests may identify fibroids that haven't triggered any symptoms and may not require treatment. (See box on page 12.)

Treatment. Fibroids need treatment only if they cause problems. Because fibroids tend to shrink after menopause, women in their late 40s and early 50s with fibroid-related symptoms may opt to wait and see if the symptoms go away.

Treatment depends on the size of your fibroids, your symptoms and whether you are planning a pregnancy. The only cure is a hysterectomy, but other less radical treatments may provide symptom relief. These treatments include:

- **Myomectomy.** This procedure removes just the fibroids, leaving the uterus intact. It's a good option for women who want to maintain their fertility, but the fibroids may eventually recur. A myomectomy can be performed through a long abdominal incision, laparoscopically (through tiny incisions in the abdomen), or hysteroscopically (through the cervix with no incision). The form of surgery depends on the size and location of your fibroids, your medical history and your surgeon's preference.
- **Uterine artery embolization.** One of the newest, non-surgical methods of treating fibroids, this procedure is still being studied. It works by cutting the blood supply to the arteries that feed the fibroids. Risks include infection or massive bleeding that may require emergency surgery.
- **Myolysis.** Another experimental procedure still under study, myolysis involves using lasers, electrical current or freezing (cryomyolysis) to destroy fibroids during a laparoscopy. No long-term studies on safety and effectiveness have been conducted on this procedure.
- **Medication.** Mifepristone (RU-486), also known as the "abortion pill," is showing promise as a treatment for fibroids. Other hormonal treatments include gonadotropin-releasing hormone (GnRH) agonists, which temporarily shrink fibroids by blocking estrogen production. Unfortunately, GnRH blocks all production of estrogen, triggering hot flashes and other menopausal symptoms. That's why these drugs are generally used only when a woman is close to or already in menopause or before surgery to shrink the tumors and decrease bleeding. This approach may reduce the risk of surgery and allow for a more cosmetic incision. Treatment with GnRH lasts just three to six months, after which the fibroids generally return.

Prevention. There is no known way to prevent fibroids.

Tests Used to Diagnose Uterine Conditions

- **Ultrasound** uses sound waves to generate a picture of the uterus.
- **Magnetic resolution imaging (MRI)** uses magnets and radio waves to create an image of the uterus.
- **Hysteroscopy** permits viewing of the uterus through a small telescope after the uterine cavity is expanded with a saline solution or a gas.
- **Hysterosalpingography (HSG)** uses radio-opaque dye and x-ray to reveal uterine abnormalities.
- **Laparoscopy** uses a camera on a fiber optic device, threaded through a small abdominal incision to view the uterus, ovaries and fallopian tubes.

Menorrhagia[22]

If you have heavy, prolonged or irregular periods, or you bleed between periods, but you aren't diagnosed with fibroids or another condition, a hormonal imbalance may be responsible. Known as menorrhagia or dysfunctional uterine bleeding, this condition is most common among women over age 45, although it can also affect adolescent girls who are beginning to menstruate.

Causes. Menorrhagia often stems from an imbalance of the hormones that control menstruation, resulting in "anovulatory bleeding," or menstruation without ovulation. Without ovulation and sufficient levels of progesterone, the uterine lining (endometrium) continues to grow, becoming thicker than usual and causing abnormally heavy bleeding. Also, without progesterone, the endometrium lacks structural support and sloughs off irregularly, causing heavy bleeding, irregular periods or both.

Anovulatory periods can occur in women who take oral contraceptives or estrogen therapy. Menorrhagia is also associated with polycystic ovary syndrome (the accumulation of many incompletely developed follicles in the ovaries).

Women who ovulate can also experience menorrhagia. In such cases, the cause is too much progesterone, and while bleeding is regular, it may be abnormally heavy. This may occur in women who take progesterone-only contraceptives.

Other causes include blood clotting problems, and problems with ovulation resulting from stress, weight changes, thyroid abnormalities and certain medications.

Symptoms. The amount and frequency of abnormal or excessive bleeding can vary and change over time. If you need to change tampons or pads every one or two hours (or use more than 10 tampons or pads per day) or have a period that lasts longer than seven days, you are probably experiencing menorrhagia. You may also experience cramping or pelvic pain, significant fatigue, anemia (low blood iron), sadness or nervousness with menorrhagia.

Diagnosis. Before being diagnosed with menorrhagia, your health care professional should rule out fibroids, polyps, cancer, damage from an intrauterine device (IUD), a tubal pregnancy and pelvic inflammatory disease (PID). (For more information on PID, see page 16.)

Treatment. The first line of treatment for menorrhagia is generally hormone therapy—typically oral contraceptives or progesterone therapy—to normalize menstrual bleeding. Some medications, such as ibuprofen, may also relieve excessive bleeding and cramps. Surgical options, in addition to hysterectomy, for treating menorrhagia include:

- **Endometrial ablation.** This minimally invasive procedure uses electricity, heat or freezing to destroy the lining of the uterus to reduce or stop heavy bleeding. Endometrial ablation is only for women who have finished having children because a subsequent pregnancy would be considered extremely high risk. Unlike a hysterectomy, ablation can be performed with local anesthesia. It is usually done in the hospital on an outpatient basis.

- **Dilation and curettage (D&C):** During a D&C, the uterine lining is scraped away. Once a mainstay in the treatment of excessive menstrual bleeding, newer options are now considered more effective. Many health care professionals no longer recommend a D&C because it's not a long-term solution—heavy bleeding is likely to return after just a few menstrual cycles.

Prevention. There is no way to prevent menorrhagia.

Endometriosis[23]

Endometriosis is one of the most common gynecologic diseases. It is also one of the most painful, often triggering heavy periods, severe cramps, chronic pelvic pain (including lower back pain), intestinal pain and even pain during or after sex. Endometriosis is also a potential cause of infertility.

Endometriosis occurs when the uterine lining or endometrium grows outside the uterus, usually on the surface of pelvic organs. In very rare cases, endometrium can grow in the lungs or on other distant organs and tissues. Unlike endometrial tissue in the uterus, which builds up and sheds monthly during menstruation, this tissue growing outside the uterus builds up but can't leave the body. Eventually, endometriosis can cause bumps, nodules and scar tissue on the affected organs.

Endometriosis can occur in any woman of childbearing age, regardless of race, age or whether she has given birth. Most women who suffer from endometriosis develop the condition shortly after they begin to menstruate. More rarely, endometriosis can occur after menopause, usually if a woman takes hormone therapy. There is no link between endometriosis and endometrial cancer.

Causes. Researchers don't know what causes endometriosis. One theory is that some of the tissue shed during menstruation flows into the pelvis, where it begins to grow. There also are suspected genetic factors since women with a family history of the disorder are 10 times more likely to have it than women without such a history. Because estrogen causes the tissue to grow, researchers suspect that endometriosis may be related to a disease of the endocrine system, the system that regulates the body's hormones. The immune system also may play a role—by failing to destroy the abnormal endometrial growth.

Symptoms. The most common symptoms of endometriosis are pain and infertility; however, most painful periods are not due to endometriosis. Endometriosis-related pain can occur all month but generally worsens during menstruation. Pain can also occur during intercourse or bowel movements. Although endometriosis is associated with infertility, the actual link still isn't clear beyond the fact that the endometrial tissue may physically block the egg and sperm from uniting.

Diagnosis. Diagnosis is generally based on your symptoms, a pelvic examination and ultrasound or other imaging tests. A laparoscopy may be recommended.

Treatment. A variety of options exists to combat endometriosis.

- **Pain medication.** These range from over-the-counter, non-steroidal anti-inflammatories such as ibuprofen, and aspirin, to prescription narcotics.

- **Hormone therapy.** There are at least four types of hormonal treatments used for mild endometriosis: birth control pills, progesterone (oral or injected), danazol (a synthetic male hormone sold under the brand name Danocrine), gonadotropin-releasing hormone (GnRH) agonists, administered by injection or nasal spray (Lupron).

  All hormonal treatments work by regulating or changing hormone levels, thus minimizing abnormal endometrial growth and reducing the menstrual flow. Once treatment is stopped, endometriosis may return.

- **Surgery.** Extensive endometriosis accompanied by pain may require surgery ranging from laparoscopy to destroy the abnormal endometrial growth, to hysterectomy. If your pain is severe, your surgeon may cut the nerves in the pelvis during a procedure called a presacral neurectomy.

Prevention. There is no known way to prevent endometriosis.

Uterine Prolapse[24]

Uterine prolapse, or "dropped womb," refers to a uterus that has fallen below its natural position in the pelvis. Composed of numerous muscles and connective tissue, the pelvic floor is attached to the pelvic bones in such a way as to support the uterus. In the most serious cases when these ligaments and muscles weaken, the uterus drops from its normal position and sometimes falls out of the vagina.

Causes. Uterine prolapse usually results when the pelvic floor is damaged during a vaginal delivery, particularly if it was a long labor or involved the use of forceps or vacuum extraction. Prolapse can also stem from an inherited weakness of the pelvic floor as well as from aging and menopause. Additionally, anything that puts significant pressure on the abdomen over a long period of time can weaken the muscles—heavy lifting, wearing a tight abdominal girdle, chronic coughing or chronic straining during bowel movements, for example. Race is also a factor, with Latinas having the highest risk for uterine prolapse.

Symptoms. Symptoms generally depend on the severity of prolapse. You may have no symptoms, or you may feel pelvic pain or pressure, a sensation of something "falling" in your vagina, or low back pain. Other symptoms might include urinary incontinence, painful bowel movements and pain during intercourse.

Diagnosis. Many women are embarrassed about seeking treatment for uterine prolapse. Still others have such mild symptoms that they may not feel the need to consult their health care professional.

To diagnose this condition, your health care professional will perform a pelvic exam and take a detailed medical history. Then, he or she will measure the position of your uterus to determine how severely it has dropped or "prolapsed."

There are several treatment options for uterine prolapse. Be sure to discuss any unusual symptoms you have with your health care professional.

Treatment. Nonsurgical options include:

- **Kegel exercises** to strengthen the pelvic muscles. To perform the exercise, squeeze your pelvic muscles as though trying to stop the flow of urine. Hold for

a few seconds, then release. Do up to 10 repetitions up to four times daily.

- **Estrogen supplements** may prevent any further weakening of the pelvic floor.
- **Pessary**, a plastic, diaphragm-like device, which fits into the vagina and helps prop up the uterus.
- **Lifestyle changes.** If you avoid lifting heavy objects, wearing a tight girdle and successfully treat your chronic cough or constipation, you can slow or halt the progression of uterine prolapse.

If your prolapse is severe enough to cause significant symptoms, surgery may be recommended to strengthen stretched ligaments or to repair and reconstruct the entire pelvic floor. Even after surgery, however, the ligaments may fail again. That's why hysterectomy is the treatment of choice and why uterine prolapse is the third most common reason for hysterectomy in women over age 55. Unfortunately, removing the uterus doesn't resolve the initial problem—a weakened pelvic floor and the potential for incontinence.

Prevention. Beginning Kegel exercises early in life can help maintain a strong pelvic floor and may help prevent uterine prolapse later in life.

Pelvic Inflammatory Disease [25]

One of the most common and serious complications of STDs among women is pelvic inflammatory disease (PID). PID is an infection of the upper genital tract that can lead to infertility, tubal pregnancy, chronic pelvic pain and other serious consequences affecting the uterus, ovaries, fallopian tubes or pelvic organs. More than one million American women and teens experience an episode of acute PID each year, and the condition is responsible for the majority of ectopic (tubal) pregnancies that occur annually in this country. PID is the most common, preventable cause of infertility in the United States.

Causes. PID is caused by bacteria that migrate from the vagina or cervix into the fallopian tubes, ovaries and uterus. Although numerous types of bacteria can cause PID, the two most common are the bacteria that cause gonorrhea and chlamydia. The more sexual partners you have, the greater your risk of PID.

In some cases, bacteria that normally live in the vagina can also cause PID. These bacteria are thought to gain access to the upper genital tract during ovulation and menstruation, particularly if menstrual blood flows backward from the uterus into the fallopian tubes. Some experts believe douching may also contribute to the disease by flushing bacteria into the uterus, ovaries and fallopian tubes. An intrauterine device (IUD) may slightly increase your PID risk. PID can develop days, weeks or months after the initial infection.

Symptoms. You may have PID but no symptoms, particularly if the original cause was chlamydia. The most common symptoms of PID are lower abdominal pain and abnormal vaginal discharge. Other symptoms include: fever, painful intercourse, irregular menstrual bleeding and pain during a pelvic exam.

Sometimes, PID can produce scar tissue in other areas of your abdomen, causing chronic pelvic pain that can last for months or even years. The more bouts with PID you

have, the more likely you are to become infertile, suffer an ectopic pregnancy, and develop chronic pelvic pain.

Diagnosis. PID is often hard to diagnose if the symptoms are mild or nonexistent. Because there is no specific laboratory test for PID, the disease is usually diagnosed using a pelvic exam and tests for gonorrhea and chlamydia. Many physicians recommend laparoscopy to diagnosis recurrent PID.

Treatment. PID can be cured with antibiotics, but the damage it can cause is irreversible. Your sexual partner(s) should also be treated to prevent reinfection.

Prevention. Abstinence or limiting your sexual partners, correctly using male or female latex condoms, and seeking medical attention for any vaginal discharge with odor or bleeding between periods (a sign of possible infection) are the main preventive measures you can take. Avoiding douching and getting tested regularly for STDs can also help. Oral contraceptives may provide some protection by creating thicker cervical mucus, making it more difficult for bacteria to reach the upper genital tract.

Intrauterine Adhesions[26]

Sometimes called Asherman's syndrome, intrauterine adhesions refer to scar tissue within the uterus. The adhesions cause lighter than normal menstrual periods or absent periods and can prevent conception or increase the risk of miscarriage.

Causes. The most common cause of intrauterine adhesions is trauma to the uterus, a pelvic or uterine infection after a D&C, or an abortion. Long-term IUD use, endometriosis and certain surgical procedures (such as removal of fibroids) may also cause adhesions.

Symptoms. Not all adhesions have consequences, but the most common are infertility or recurrent miscarriage. Adhesions may also cause periods to stop or become very light or infrequent. Asherman's syndrome may also be accompanied by pelvic pain or painful menstrual periods if the adhesions block blood from leaving the cervix.

Diagnosis. Adhesions are usually diagnosed with hysterosalpingography. (See "Tests Used to Diagnose Uterine Conditions" on page 12.)

Treatment. Adhesions are usually removed surgically.

After removal, many surgeons place a temporary plastic catheter or small balloon inside the uterus to keep the uterine walls apart and prevent more adhesions from forming. You may also start hormonal treatment with estrogens and progestins and

Preventing Adhesions

A common complication of gynecologic surgery is post-surgical pelvic adhesions—bands of scar tissue that form as part of the body's healing process and can lead to infertility, pelvic pain and bowel obstruction. Ninety percent of women who have gynecologic surgery are at risk for developing adhesions. While not all pelvic adhesions cause problems, it is important to talk to your health care professional about ways to minimize the formation of pelvic adhesions following gynecologic surgery.

take non-steroidal anti-inflammatory medications to further reduce the chance that the adhesions will form again. Seventy to 80 percent of women treated for mild to moderate adhesions achieve full-term pregnancies. However, only 20 to 40 percent of women with severe adhesions are able to carry a pregnancy to term.

Prevention. If you have a D&C or surgical abortion, inquire about prophylactic antibiotics, which may reduce the risk of adhesions forming. Most cases of Asherman's syndrome cannot be prevented, however.

Severe Menstrual Pain[27]

Menstrual pain severe enough to interfere with your normal activities is known as dysmenorrhea. Between 43 and 90 percent of women experience dysmenorrhea, making it the most common gynecologic problem among menstruating women.

Causes. Primary dysmenorrhea results from the release of prostaglandins, or hormones produced by the uterus and cervix, that cause the uterus to contract. It is not yet known what triggers the release of these hormones. The pain may also result from the stretching of the cervix as it expands to allow passage of blood clots from the uterus to the vagina.

Secondary dysmenorrhea may be the result of endometriosis, fibroids, PID, ectopic pregnancy or IUD use. Women who smoke, drink alcohol during their periods, are overweight, or who started menstruating before age 11 have an increased risk of dysmenorrhea. Stress, caffeine and a family history of severe menstrual pain may also increase your risk.

Symptoms. Abdominal pain, which may radiate to the back of your legs or lower back, is the most common symptom of dysmenorrhea. Symptoms may also include: nausea, diarrhea or vomiting, fatigue, fever, headache and lightheadedness. Pain usually develops within hours of menstruation starting and peaks as the flow becomes heaviest during the first day or two.

Diagnosis. Primary dysmenorrhea is diagnosed if severe pain occurs during menstruation. Dysmenorrhea tends to be most severe in the early teens but lessens with age. Secondary dysmenorrhea generally begins earlier in the menstrual cycle and lasts longer than normal cramps.

Treatment. The first line of treatment is usually medication, such as aspirin or ibuprofen, which inhibits prostaglandin production. These medications are most effective when started 24 to 72 hours before the onset of menstruation. Oral contraceptives that prevent ovulation can also help, as can exercising regularly and applying warm compresses to the abdomen.

In secondary dysmenorrhea, it is important to treat the underlying cause. This may involve more invasive treatments, such as endometrial ablation. (See page 13.)

Prevention. There is no prevention for primary dysmenorrhea. Avoiding STDs by either abstinence or limiting your sexual partners, using condoms correctly and consistently and seeking medical advice for any signs of infection that might be caused by STDs are steps you can take to help prevent secondary dysmenorrhea. (For more tips on STD prevention, see page 17.)

Uterine/Endometrial Cancer[28]

Uterine cancer is the most common female reproductive cancer, affecting about 40,100 women in 2003, according to the American Cancer Society. However, the disease is highly curable if caught and treated early.

About 90 percent of uterine cancers begin in the uterine lining (endometrium). Uterine sarcoma develops in the muscle of the uterus (myometrium).

Causes. Experts are unsure what causes uterine cancer, but there are several known risk factors. (See box at right.)

Symptoms. Abnormal vaginal bleeding is the most common symptom of uterine cancer. See your health care professional right away if you develop abnormal vaginal bleeding or vaginal bleeding after menopause.

Diagnosis. Uterine cancer is rarely detected during routine exams, nor is there a useful screening test for this disease. Most cases are diagnosed because women are experiencing symptoms.

Prevention. Most cases of uterine cancer cannot be prevented. However, you may be able to reduce your risks for developing this disease.

Treatment. Treatment depends on how early the cancer is diagnosed. Surgery is the most common treatment and generally involves a total abdominal hysterectomy in which the uterus, fallopian tubes and ovaries are removed. The surgeon may also remove lymph nodes in your pelvis to prevent any remaining cancer from spreading.

Uterine Cancer Risk Factors

- **Age.** Cancer of the uterus occurs mostly in women who are past menopause.
- **Hyperplasia with atypia.** A condition in which the cells lining the uterus grow too quickly.
- **Estrogen therapy.** Women who use estrogen without progesterone have an increased risk of uterine cancer.
- **Obesity.** Because the body makes some estrogen in fatty tissue, obese women are more likely to have higher levels of estrogen, which can lead to uterine cancer.
- **Tamoxifen.** Women taking the drug tamoxifen to prevent or treat breast cancer have an increased risk of uterine cancer.
- **Race.** Hawaiian, Caucasian, Japanese and African-American women have the highest risk for uterine cancer.
- **Colorectal cancer.** Women who have had an inherited form of colorectal cancer have a higher risk of developing uterine cancer than other women.
- **Estrogen exposure.** Women who have not given birth, begin menstruation before age 12 or enter menopause after age 50 are exposed to estrogen longer and thus are at higher risk for uterine cancer.

Surgery may be preceded or followed by radiation therapy. Chemotherapy is used to treat endometrial cancer only in advanced cases.

Endometrial Hyperplasia[29]

Endometrial hyperplasia is an overgrowth or thickening of the lining of the uterus. It affects about one out of 1,000 women in the United States. It is generally benign, rarely progressing to cancer. However, "hyperplasia with atypia" (precancerous changes in the cells) may result in endometrial cancer if not effectively treated.

Causes. Hyperplasia generally occurs when your body doesn't produce enough progesterone to rein in the effects of estrogen, which spurs cells of the uterine lining (endometrium) to divide. Hyperplasia is most common during adolescence and as a woman approaches menopause. Women with polycystic ovary syndrome and those on estrogen therapy (without progesterone) also have an elevated risk of endometrial hyperplasia. Obesity and late menopause (after age 55) are other known risk factors.

Symptoms. Bleeding between normal menstrual periods, heavy menstrual flow (saturating a tampon or pad once every hour), bleeding after menopause and vaginal discharge (especially after menopause) are possible signs of hyperplasia.

Important Reminder

- Having an annual physical and sharing your family health history with your health care professional is one of the best gifts you can give yourself. (See "Uterine Health Family History Checklist" on page 3.)
- Studies show that some gynecologic cancers tend to run in families but can be successfully treated when detected early.

Diagnosis. The disorder is usually diagnosed by examining a sample of the endometrium obtained during an endometrial biopsy, a D&C or a hysteroscopy.

Treatment. Hyperplasia without atypia may need no treatment since it often disappears on its own. However, treatment with progesterone to reverse the hyperplasia is often suggested.

Because hyperplasia with atypia persists in about 75 percent of cases after multiple D&Cs and progestin treatment, and up to 15 percent of women with atypia will develop endometrial cancer, hysterectomy is usually recommended. If you are planning a pregnancy, high-dose progestin may first be recommended.

Prevention. There is no known prevention for endometrial hyperplasia other than regular exposure to progesterone for at least three months.

If You Need A Hysterectomy

The bleeding, pain and inconvenience from your fibroids or endometriosis have simply become too much to bear. Or you've received the terrifying diagnosis of uterine cancer. Or, after several children, your uterus has prolapsed. To resolve your condition, your health care professional suggests it might be time for a hysterectomy.

Hold on. While there's no doubt that removing the uterus is often a necessary operation, it's also one of the most overdone surgeries in the United States. Every 10 minutes, 12 hysterectomies are performed in the United States, nine of which fail to meet guidelines for hysterectomy set by the American College of Obstetricians and Gynecologists.[30]

So before signing a consent form to have a hysterectomy, get the answers to all your questions, as well as a second opinion, if you think one is necessary. It's also important to learn about the alternatives to hysterectomy. (See page 25.)

When Hysterectomy is Recommended

Being told that you need a hysterectomy can come as a shock. That's why it's important to schedule a follow-up visit or phone call with your health care professional to discuss the issue at length. Consider bringing a friend or family member to the follow-up appointment to take notes. Some women actually tape record (with their doctor's permission) the discussion and listen to it later when they can think more clearly.

Another helpful tool is a list of questions, to ask your health care professional. (See list at right.)

There's usually no need to rush into this decision. Most hysterectomies are not emergencies, so take the time you need to explore and understand your options.[31] And remember that most health insurance plans will cover a second opinion. Even if yours doesn't, paying for a second opinion could be money well spent.

Before having the surgery, tell your health care professional everything about your medical history, even things you think aren't relevant, such as a long-ago treatment for an STD. Also share information about all medications and supplements you may be taking, including over-the-counter medications, herbal supplements and vitamins.

Questions to Ask Your Health Care Professional

- Why is a hysterectomy recommended?
- What alternative treatments are there for my condition?
- How will the surgery be performed? (vaginally, laparoscopically, abdominally?)
- What are the risks?
- Will my ovaries or any reproductive organs other than my uterus be removed?
- How long will I be hospitalized?
- How long will it take before I can return to my normal activities?
- Will I need help at home? For how long?
- How will I feel after the operation?
- Will having a hysterectomy affect my sex life? If so, for how long?
- What will be done exactly?
- Will I have a scar? How large and where?
- What kind of anesthesia will be used?
- How much will my surgery cost? (Check with your insurance provider to find out how much will be covered.)

If You Need a Hysterectomy

Choosing a Surgeon

Surgery is serious business. Find a surgeon with whom you feel comfortable and can trust. Get referrals from your health care professional, or from friends or relatives who have had a hysterectomy. The following issues also are important to consider when choosing a surgeon (or any other health care professional):[32]

- **Board certification.** Board-certified physicians have extra training after medical school to become specialists in a field of medicine such as obstetrics and gynecology (OB/GYN). You want a surgeon who is either board certified or board eligible in OB/GYN, and who is also credentialed at your hospital to perform the type of surgery you're having.
- **Communication style.** Find a surgeon who listens carefully to your concerns, answers your questions and explains things clearly and fully. Make sure you can understand the health care professional. If English is your second language, you may want to choose a surgeon who is fluent in your native language.
- **Insurance issues.** Find out in advance whether the surgeon accepts the type of health insurance you have.
- **On call.** Find out who covers for your surgeon if she or he is not available and there is an emergency.

Preparing For Surgery

If possible, schedule your hysterectomy two or three months out. This gives you time to prepare mentally. It also allows ample time to arrange time off from work and to change family schedules to accommodate your surgery and recovery.

Another great use of this time is getting your body as healthy as possible. Ask your health care professional if there is anything else you should do to prepare for the surgery. Consider donating your own blood in advance of surgery.

Types of Hysterectomy

Gone are the days when the only surgical option was the traditional "total" hysterectomy requiring a large incision across your abdomen often followed by a long recuperation period. Today, there are several basic types of hysterectomy, as well as several kinds of surgical approaches to consider.

- **Total hysterectomy.** This type of hysterectomy removes the uterus and cervix. The ovaries and fallopian tubes may or may not be removed.

Hysterectomy Surgical Options

TYPE	INCISION SITE	HOSPITAL STAY	RECOVERY TIME
Total abdominal	abdomen (4 to 6 inch incision)	3 to 6 days	6 weeks
Vaginal	vagina	1 to 3 days	4 weeks
Laparoscopic-assisted vaginal (LAVH)	vagina or navel	1 to 3 days	4 weeks
Laparoscopic supracervical (LSH)	tiny incisions in abdomen or navel (less than 1/4 inch)	1 day or less	6 days

- **Hysterectomy with bilateral salpingo-oophorectomy**. This procedure removes the ovaries and fallopian tubes along with the uterus and cervix.
- **Subtotal or partial hysterectomy.** This surgery removes the uterus above the level of the cervix, so the cervix stays in place. The fallopian tubes and ovaries may or may not be removed.
- **Radical hysterectomy.** This extensive surgery is usually only recommended to treat some cancers of the uterus or cervix. The uterus, cervix, and surrounding tissue are removed as well as the upper vagina and usually the pelvic lymph nodes.

There are different ways to perform a hysterectomy. These surgical options include:

- **Total abdominal, or open, hysterectomy.** This is the classic form of hysterectomy, in which an abdominal incision allows the surgeon to see the pelvic organs easily and provides more operating space than is permitted by a vaginal hysterectomy. It is generally used for large pelvic tumors or suspected cancer. Expect to have a longer stay in the hospital and a longer recuperation time.
- **Vaginal hysterectomy.** With this type of hysterectomy, the surgeon removes the uterus and the cervix through an incision within the vagina. This surgical option is ideal if the uterus is not enlarged or has dropped as a result of uterine prolapse. Vaginal hysterectomy can be performed in two ways: entirely through the vagina; or using a laparoscope, a small, telescope-like device inserted into the abdomen through a small incision, enabling the surgeon to visualize the pelvic region. Standard vaginal hysterectomy and abdominal hysterectomy each take between one and two hours and are performed under general anesthesia.

  A laparoscope is often used if the ovaries also need to be removed. When a laparoscope is used, the procedure is called a **laparoscopically assisted vaginal hysterectomy (LAVH)**. Though less invasive than a traditional hysterectomy, LAVH takes longer to perform than a standard hysterectomy, so you'll be under anesthesia longer. It also requires more surgical skill to perform.[33]
- **Laparoscopic supracervical hysterectomy (LSH).** This newer type of hysterectomy also uses laparoscopic techniques to remove the uterus, but leaves the cervix intact, which some studies suggest may help reduce the complications associated with total hysterectomies, such as pelvic floor prolapse and urinary incontinence. LSH is less invasive and less traumatic for your body than a total hysterectomy. LSH also requires a shorter recovery period and hospitalization.

As with any form of surgery, risks associated with hysterectomy include postoperative infections, bleeding and problems related to anesthesia. Other risks are: blood clots in the legs, bleeding that may require a transfusion, a painful or ugly scar, injury of other structures in the pelvis and even death (although that risk is exceedingly small).

After Surgery

Regardless of the kind of operation you have, a hysterectomy is still major surgery, and you're going to need some time to recover. Most women go home the third day

after an abdominal hysterectomy and the first or second day after a vaginal hysterectomy or LAVH. That doesn't mean going home to cleaning, cooking and driving kids to activities, however. It means going home to rest.

Complete recovery from an abdominal hysterectomy usually takes six to eight weeks, during which time you'll gradually feel your strength return and slowly be able to resume your normal activities. In the beginning, though, you'll need to avoid walking, laughing and anything else that challenges your abdominal muscles while they heal from the incision. Expect that going to the bathroom will be painful, and you shouldn't lift anything heavier than a magazine for the first two weeks after surgery. By the sixth week, most patients are recovered enough to resume such activities as having sex and taking a bath.

Recovery is usually much quicker from a vaginal hysterectomy, although it will still take some time. Remember, your body needs time to recover from surgery, even minor surgery.

Be sure to notify your health care professional immediately if you develop any of the following symptoms:

- Fever or chills (a possible sign of infection)
- Heavy bleeding or vaginal discharge
- Severe pain
- Redness or discharge from incisions
- Problems urinating or having a bowel movement
- Shortness of breath or chest pain

After Recovery

Once you're recovered from the surgery, you're ready to begin your life without a uterus. For some women, this will be a relief from painful or disruptive symptoms. In fact, many women consider having had a hysterectomy the best thing they ever did. They find the freedom from menstrual problems, and no longer needing to worry about pregnancy, energizing. When University of Maryland researchers interviewed 1,200 women before and after their surgery, 96 percent said the hysterectomy had completely or mostly resolved the problems or symptoms they experienced before the surgery; 94 percent said the results of the operation were better than or about what they expected; and 85 percent said their health was better than before the hysterectomy.[34] The women also reported significant improvements in libido and frequency of sexual relations, enjoyment of sex, orgasm frequency and relief from painful intercourse.[35]

Some women, however, face more challenging issues, including early menopause (if the ovaries were removed), changes in sexual desire and enjoyment, and discomfort.

If you were premenopausal (still menstruating) before the operation and have your fallopian tubes and ovaries removed, you can expect some symptoms of menopause, possibly including hot flashes and mood changes, as your body adjusts to different hormone levels.

You may feel a sense of loss after the surgery—a feeling that is entirely normal. Give it time. If you had still planned to have children, or had your uterus removed because of cancer or a severe illness, you may experience some depression. Don't hesitate to talk to your health care professional or to a mental health specialist about your feelings.[36]

Alternatives to Hysterectomy

In recent years, more alternatives to hysterectomy have been introduced. These include both medication and less invasive surgical options to treat those conditions for which hysterectomy is often recommended. Be sure to ask your health care professional about the following alternatives:

Endometrial Ablation

Considered minimally invasive surgery, **endometrial ablation** uses electrical energy, heat or cold to destroy the endometrium (the lining of the uterus), to minimize or even stop heavy bleeding. Bleeding is reduced or stopped in 70 to 80 percent of women who have received this form of treatment. The results aren't permanent, however, and the heavy bleeding may return. It is effective in those women who have no physical reasons (fibroids, for example) for their bleeding problems. This procedure may be considered an option only by women who have finished having children since a pregnancy any time after the procedure would be considered extremely high risk.

There are many methods of ablation approved by the U.S. Food and Drug Administration or in development.

Ablation can be performed under local anesthesia and it is usually done in the hospital on an outpatient basis.

Common postoperative side effects include nausea, vomiting and a vaginal discharge that can last from days to weeks. Complications are rare but may include blood loss requiring a transfusion, perforation of the uterus or unintended damage to other internal organs.[37]

Myomectomy

If you hope to become pregnant or want to keep your uterus but need to consider fibroid treatment, you may be a candidate for **myomectomy**. This surgery cuts away fibroids without removing the uterus. However, it is major surgery, with all the attendant risks. It also tends to weaken the uterine wall; children born after the procedure may need to be delivered by cesarean section.

A myomectomy can be performed through a laparotomy, in which a surgeon enters the uterus through a small incision in the abdomen; or through a laparoscopy, in which the surgeon inserts a laparoscope through the navel and other instruments through very small incisions in the abdomen. Another method involves using a fiber optic tube called a hysteroscope and other small surgical instruments inserted into the uterus to cut out only those fibroids in the endometrial canal. A downside to myomectomy is that fibroids can recur, sometimes within a year of surgery.

Uterine Fibroid Embolization

Another minimally invasive procedure for treating fibroids, **uterine fibroid embolization** blocks the arteries that carry blood to the fibroids. It's performed under local anesthesia by a specially trained radiologist, called an interventional radiologist. The radiologist threads a catheter through a vein in your groin or leg, injecting tiny particles (embolic agents) into the uterine artery to block the arteries. Clots form around the particles, which are about the size of grains of sand and are usually made from plastic (polyvinyl alcohol) or gelatin sponge.

Alternatives to Hysterectomy

Risks associated with uterine fibroid embolization include infection, ovarian failure leading to early menopause, and expulsion of the fibroid from the uterus at a later date, requiring another procedure. Recent studies suggest that a significant number of patients will eventually need surgery for their fibroids. Women who undergo embolization may be able to become pregnant and carry a fetus to term, although there are no long-term studies on this question.[20]

Remember, hysterectomy is not your only option for treating fibroids and other uterine conditions. Be sure to re-read pages 11 to 20 of this booklet for additional information on treatment options and discuss them with your health care professional.

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3. "Utah Center for Reproductive Medicine." University of Utah Health Sciences Center. http://uuhsc.utah.edu
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The National Women's Health Resource Center, Inc. (NWHRC) is a not-for-profit organization dedicated to helping women make informed decisions about their health. The NWHRC provides in-depth women's health information to consumers in a variety of ways: on the Internet at www.healthywomen.org; in the publication *National Women's Health Report* and in other comprehensive health publications and products; and through partnerships with corporations, organizations and consumer groups. For more information, contact:

National Women's Health Resource Center, 120 Albany Street, Suite 820, New Brunswick, New Jersey 08901.
Toll free 1-877-986-9472 info@healthywomen.org www.healthywomen.org

Resources

Books

- **21st Century Complete Medical Guide to Uterine Cancer**, by PM Medical Health News (Progressive Management, 2002)
- **Coping With Endometriosis**, by Robert H. Phillips, PhD and Glenda Motta (Avery Penguin Putnam, 2000)
- **Cancer Schmancer**, by Fran Drescher (Warner, 2002)
- **The Official Patient's Sourcebook on Pelvic Inflammatory Disease: A Revised and Updated Directory for the Internet Age**, by James N. Parker, MD and Phillip M. Parker, PhD, eds. (Icon Health Publications, 2002)
- **Dr. Susan Love's Menopause and Hormone Book: Making informed Choices About Menopause**, by Susan M. Love and Karen Lindsey (contributor), (Random House, 1998)
- **Taking Back the Month: A Personalized Solution for Managing PMS and Enhancing Your Health**, by Diana Taylor and Stacey Colino (Perigee, 2002)
- **A Gynecologist's Second Opinion: The Questions and Answers You Need to Take Charge of Your Health**, by William H. Parker, MD and Rachel L. Parker (Plume, revised edition, 2003)

Web Sites

- **American Academy of Family Physicians**
  www.familydoctor.org
- **Gynecologic Cancer Foundation Women's Cancer Network**
  www.wcn.org
- **Hysterectomy Recovery Support**
  www.hystersisters.com

Organizations

- **American Society for Reproductive Medicine**
  1209 Montgomery Highway
  Birmingham, AL 35216-2809
  205-978-5000
  www.asrm.org
- **Centers for Disease Control and Prevention**
  National STD Hotline: 800-227-8922
- **Endometriosis Association**
  8585 N. 76th Place
  Milwaukee, WI 53223
  800-992-3636 (toll free)
  www.endometriosisassn.org
- **Hysterectomy Educational Resources & Services (HERS) Foundation**
  422 Bryn Mawr Avenue
  Bala Cynwyd, PA 19004
  888-750-4377 (toll free)
  www.hersfoundation.com
- **National Family Planning and Reproductive Health Association**
  1627 K Street NW, 12th Floor
  Washington, DC 20006
  202-293-3114
  www.nfprha.org
- **National Uterine Fibroids Foundation**
  PO Box 9688
  Colorado Springs, CO 80932-0688
  877-553-6833 (toll free)
  www.nuff.org
- **National Women's Health Resource Center**
  120 Albany Street, Suite 820
  New Brunswick, NJ 08901
  877-986-9472 (toll free)
  www.healthywomen.org
- **RESOLVE:**
  The National Infertility Association
  1310 Broadway
  Somerville, MA 02144
  888-623-0744 (toll free)
  www.resolve.org

Menstrual Cycle Diary

Keeping a menstrual cycle diary can help you identify when you are most fertile. It can also help your health care professional diagnose, rule out or treat premenstrual syndrome and other uterine disorders. Use the key below to record details about your menstrual cycle.

Day[1]	Date	Temp[2]	Weight	Mucous[3]	Mood[4]	Symptoms[5]	Flow[6]	Stress[7]
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								
11								
12								
13								
14								
15								
16								
17								
18								
19								
20								
21								
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28								
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30								
31								

KEY:

1 First day of menstrual flow is Day 1

2 Body temperature before getting out of bed in the morning

3 Cervical mucous: wet (w), dry (d), sticky (s)

4 Mood: 1 = very sad, 10 = extremely happy

5 Ordinary cramps (c), severe pelvic pain (p), breast tenderness (bt), bloating (b)

6 Light (l), medium (m), heavy (h)

7 Stress level: 1 = very low, 10 = very high

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