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SPRING / SUMMER 2011

From The American Congress of Obstetricians and Gynecologists

EVERYTHING YOU NEED TO KNOW ABOUT **MIDLIFE HEALTH**

Grappling with *grief*

Real Women Speak Up About "The Change"

Secret Sex Lives of Americans

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SPRING / SUMMER 2011
Vol 15 • No 1
ACOG
THE AMERICAN CONGRESS OF OBSTETRICIANS AND GYNECOLOGISTS

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Change is Good

If you are a regular reader of *pause*®, you probably noticed something different about this issue. I'm pleased to say that we've made some big changes. We hope you agree that, in this case, change is good. We listened to you and have redesigned *pause*® to be more readable and more online friendly. Articles are shorter, layouts are fresher, and overall, the magazine has a new and improved look and feel.

One thing that hasn't changed is our commitment to bringing you relevant, up-to-date, comprehensive information. You can be sure you're getting the same reliable and helpful advice from the experts you can trust.

Stay tuned to **http://pause.acog.org**—our website is also being updated to better serve you.

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Chair, Medical Advisory Board

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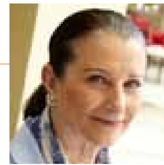
The American Congress of Obstetricians and Gynecologists (ACOG)—the nation's leading group of physicians providing health care for women. As a private, voluntary, nonprofit membership organization, ACOG:

- Serves as a strong advocate for quality health care for women;
- Maintains the highest standards of clinical practice and continuing education of its members, who include nearly 90 percent of the nation's board-certified ob-gyns—more than 40,000 physicians;
- Promotes patient education;
- Increases awareness among its members and the public of the changing issues facing women's health care.

Making our way *through* menopause

Real women speak up about "The Change"

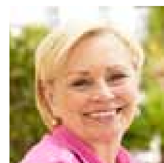
By **Meryl Davids Landau**

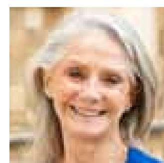

Joan, 69

Alba, 59

Judith, 44

Vonna, 76


Christine, 61


Barbara, 65

Maureen, 64

Michele, 49

he sun was shining on a beautiful South Florida beach as eight midlife women gathered to talk intimately about a topic that had once lurked in the shadows: their experience of menopause. The women, from their late 40s to mid-70s, span the spectrum around this hormonal upheaval, and each still deals with some part of its legacy.

Once the intros were made, these previous strangers started gabbing, and barely took a breath—thrilled to commiserate with fellow sufferers or discover a hot new tip. They described their flashes and their crashes, hormone therapy, worries about aging, and why some feel better (and sexier!) than ever.

You'll no doubt hear echoes of your own menopause journey in these excerpts from their fascinating discussion.

(Their stories represent their own personal experiences and may not reflect the recommendations or official positions of The American Congress of Obstetricians and Gynecologists (ACOG).)

Signs of Menopause

Maureen, 64: I was a high school teacher in my 40s, and one day I stood up in the classroom and there was this huge pool of blood. Thank goodness I had black pants on! That menstrual period subsequently continued for 30 days.

Joan, 69: I had something similar. I was walking on the beach with my husband and all of a sudden I'm gushing. I was only 38, and thought, "What the heck is going on?" My doctor later confirmed that it was my last menses. The sad part was I had still been romancing the idea of having children.

Michele, 49: I haven't actually skipped any periods yet, but in the last year and a half they've become much less regular—anywhere from two to six weeks, and really light to extremely heavy.

Christine, 61: I went through surgical menopause after a hysterectomy. My period stopped, but I immediately began crying and sweating all the time. It was the worst experience of my life.

Getting *good* information

Vonna: In my day, women didn't talk about menopause. So you either dealt with it yourself or you found a good doctor. Luckily, my doctors all steered me in good directions.

Barbara: Women not only talk about it now, they have the Internet. I can Google and find so much information.

Vonna: That's been a big innovation.

Christine: Finding that woman doctor made the difference for me—being able to talk to another woman who understands my body.

Barbara: I'm laughing, because I had a female doctor and she was not helpful and not empathic at all.

Maureen: I think we need to feel comfortable interviewing any doctor and saying, "That person doesn't work for me, but this one has the same philosophy and goals as I do and will be great."

Judith: I had to do a lot of research to get information for myself. As a journalist, I was fortunate to interview people who knew something about my situation. And then I found a doctor who integrates traditional and holistic medicine, and he has helped tremendously.

Joan: I listen most to myself, to my body. I trust the doctors to a certain degree, but it's most important to read your body and hear what it is telling you.

Flashing and Sweating

Michele: Night sweats are my main symptom. Last night I had a really big one. I had to mop myself up and change my pajama top.

Judith, 44: I sweat a lot during the day, which is a real problem for me since I work in television. I lost a big gig where I was host of a show, and I wonder if part of the reason was that I was sweating so much.

Christine: My son jokes that he can't go into a room that isn't as cold as a meat locker because I keep the house at 60 degrees.

Joan: I have to laugh because my brother recently complained that it was so cold on the plane he was in. I was a flight attendant for years, and I knew it was because those gals were going through "The Change," and keeping the cabin cool helps!

Can't Stay Asleep

Maureen: For me, the hot flashes are minimal compared to the sleep deprivation, especially when I was teaching and needed to be up at 5:30 AM. Sixteen years after menopause, my sleep problems continue, so I take medication. A lot of people are averse to it, but I need those pills to function. I'm not going to apologize anymore for taking them.

Christine: I attend an annual reunion with 13 of my college sorority sisters. We talked about sleep during our last gathering: seven of us take medication.

Vonna, 76: Have you tried natural products? I get something with melatonin at the vitamin shop. It helps me sleep through the night and doesn't create a habit. I also drink herbal tea before bed.

Maureen: People often give me suggestions: sleep in a darkened room, eliminate my TV from the room, try natural things. Of course I have tried all of those—and more! Melatonin gave me psychotic nightmares. The only thing that works for me is drugs.

Barbara, 65: But you see in the ads on TV that it can be habit forming.

Maureen: (*Joking*) It's only a problem if you can't get it.

Cures (some unexpected!) for Vaginal Dryness

Joan: I had a problem with dryness, but once my hormones got regulated with hormone therapy, the moisture came back.

Barbara: I have the best cure for dryness: a new sex partner! This is after 10 years of being with impotent men. In my late 60s, life begins again!

Alba, 59: To my surprise, when I reached a certain age I became hot to younger men. Why is it that they love sex with mature women?

Christine: They like the security of a woman who knows where she's at, what she's doing.

Alba: I have no idea what I'm doing! I just want to eat, sleep, and watch TV. And I'm not wearing a thong! Dating younger men takes a lot of energy. But it definitely solves the dryness problem.

Christine: My doctor recently added testosterone, the male hormone, to my estrogen therapy. All of a sudden, I've got this huge sex drive. One day when my husband and I were cuddling and kissing on the couch in the living room, our son, who still lives at home, suddenly came around the corner, and he said, "You know, you've got a bedroom!"

Judith: This is so good to hear because I felt profoundly unwomanly after I went into menopause when I was only 38—and I also lost part of my breast to cancer. As someone who is single, I appreciate that you still feel like very vibrant women.

Mood Issues

Alba: I suffered most from mood problems. I felt inadequate, angry, and so depressed I could barely get out of bed. I got to the point where I actually considered suicide. All that craziness ended my marriage. I went on antidepressants, anti-anxiety drugs, and sleeping pills, which helped. But what really got me through it was changing my diet, learning to release stress, and exercising more, along with my faith.

Barbara: In my late 40s, I had remarried after being a young widow, and I was going through a terrible time in my marriage. Only in retrospect did I realize that the emotional upheavals related to menopause explain a lot about what was going on.
Michele: I have nothing like that, but sometimes I feel out of sorts. Things that normally don't bother me suddenly do. I'll get annoyed and wonder, "What's wrong with me?" Then I realize it's my shifting hormones.

(ACOG notes that while many women in midlife report mood swings or depression, it is not clear whether these are due to changing hormone levels or to the natural effects of aging on the brain.)

Other Midlife Health Concerns

Maureen: I have osteopenia, and I don't want osteoporosis, so my doctor put me on a bone medication. When I talk to my friends about it, half are happy they're on one, but the other half worry about side effects like tissue deadening in the jawbone. That frightens me. I need help making the decision of whether to stay on this medication; I feel like I should stop taking it.
Christine: I'm with you. I was diagnosed with osteoporosis. My doctor gave me an injection about four weeks before we went on our first big cruise to Europe. On that cruise, I got this deep ache in my

The *wonders*—and worries—of hormone therapy

Joan: I was on hormone replacement for 10 years when the big scare came out (the 2002 publication of the Women's Health Initiative results, which found an increased risk of heart attack, stroke, and breast cancer for women taking estrogen and progestin). My doctor called and told me to stop. Fortunately, after I went off the hormones my symptoms were mostly gone.

Maureen: I was on the estrogen patch for years. My doctor wasn't worried, but all that controversy frightened me. I weaned myself. I still get hot flashes, but they're bearable. *(ACOG recommends consulting with your doctor before making any changes to your medications.)*

Christine: A few years ago, I found a new, female gynecologist who started me on compounded bioidentical hormone creams. *(It is ACOG's position that women should use FDA-approved hormones, and that there is no scientific evidence supporting the safety or efficacy of compounded bioidentical hormones.)* Even more important, she tested my thyroid—she was the first doctor to do that—and put me on thyroid medication. I started losing weight, stopped crying for no reason, and got more energy. I am a completely different person.

right hip and thigh. When I got home, I read that deep pain can be a side effect. I never took another dose, although I know I need to do something.
Vonna: I'm at the osteopenia stage. I take calcium and vitamin D supplements to help with that.
Maureen: I tend not to take calcium because it makes me constipated.
Vonna: My main concern is my arteries. My father died very young of a stroke, and I have high blood pressure. I've been on blood pressure medication since I was 30.
Barbara: Nobody talks about this one, but about eight years ago I developed urinary incontinence. I would pray my neighbors wouldn't get on the elevator with me, because by the time the elevator got to the eighth floor where I lived I was often drenched. My doctor finally recommended surgery. I figured as long as I'm lying down I'm going to do a few things I've always wanted. So, I got a tummy tuck, too!

Worry About Aging

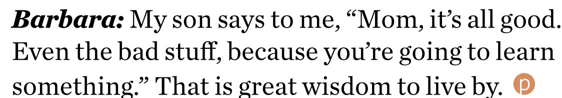
Christine: When my mother passed away unexpectedly, my father, who was 85 and had dementia, came to live with us. It was hard to watch this disease. I would feed him breakfast and then run to the grocery store, and when I'd get home he'd be on the phone with my sister complaining that I hadn't given him breakfast! Dementia is something I definitely worry about for myself.
Maureen: It's hard, because many of us going through menopause are also caregivers. You have all these balls you're juggling, and every now and again one of them drops.
Christine: I think my parents didn't plan well; my mother was in denial about my father's condition. I don't want to do that to my children. But, at the same time, long-term health insurance is so expensive.
Michele: My mom has rheumatoid arthritis. I don't have children, so I drive her everywhere and do everything for her. My husband and I are always saying we have to keep ourselves healthy because when we get older, we won't have kids to help us out.
Christine: Even if you have children, you don't want to be a burden on them.
Michele: True. But I worry about not being able to be independent, to be able to drive and do my own thing.

Lifestyle Matters

Alba: Exercise is very important to me. But whereas 10 years ago I went to the gym to get a certain body type, now I exercise to make my bones strong, and to get that endorphin high to steady my emotions.
Joan: My New Year's resolution was to get a trainer, in honor of my turning 70 this year. I've gone regularly since December. I also just started yoga.
Maureen: I love yoga! Having that kind of centering, focusing, and flexibility helped me survive twin teenage boys.
Barbara: I do the treadmill and upper body weights. But my best exercise now is sex! Plus, I'm not doing midnight eating anymore, because I'm too busy.
Michele: Too funny! For my health, I stopped eating meat when I was 19. I haven't missed it. And I switched to soy milk from cow's milk.
Judith: I try to eat organic food as much as possible.
Joan: I guess I'm the bad girl. I have my big steak and baked potato. I eat what I like.
Michele: Well, even though I don't drink milk, if there's a cheesecake, I'll eat it.
Alba: I think we worry too much about what we eat: the white bread, the high-fat foods. The worrying is what's making us sickest.

Staying Calm

Maureen: It's very important for me to get out in nature, to not be closed in all the time.
Barbara: I de-stress by being with friends. I'll call them up and say, "Let's meet for lunch." I very much need that social interaction.
Alba: I've learned to choose my battles. I ask myself, "Can I change that?" If I can't, why stress about it?
Barbara: My son says to me, "Mom, it's all good. Even the bad stuff, because you're going to learn something." That is great wisdom to live by.



The Smart Woman's Guide *to Hormone Therapy*

By Stacey Colino

When it comes to treating various health ailments, sometimes the pendulum swings one way...then the other...then back again.

For years, hormone therapy (HT)—either estrogen alone or combined with progestin—was seen as the panacea for pesky menopausal symptoms and possibly as a shield against diseases that often strike menopausal women. The tide turned when the initial findings of the Women's Health Initiative (WHI), linking combined HT with a slightly increased risk of heart attacks, strokes, and breast cancer, were released in 2002. The results and the media frenzy that followed sent many menopausal women to their doctors in a panic over whether they should quit HT right away.

In recent years, questions have been raised as to how HT affects women depending on their age and where they are in the menopausal transition. For example, further analysis of the WHI found that women between the ages of 50 and 59 who took estrogen alone (conjugated equine estrogens) or estrogen plus progestin actually had a 30 percent reduced risk of dying whereas women between 70 and 79 who took HT had a 14 percent increased risk of dying, although the results for women in their 70s weren't statistically significant. It appears that "hormones may be less risky and perhaps even good for you if you start taking them early in menopause, but harmful if started many years after menopause," says Nanette F. Santoro, MD, professor and E. Stewart Taylor chair of obstetrics and gynecology at the University of Colorado at Denver.

According to experts, these shifts in perspective are in part due to how the research was conducted and whom it was conducted on. A little background: "There were many observational studies from the 1980s, such as the Nurses' Health Study, that showed that women who took estrogen had

less heart disease," says Isaac Schiff, MD, chief of the Vincent Obstetrics and Gynecology Service at Massachusetts General Hospital and the Joe Meigs Professor of Gynecology at Harvard Medical School in Boston. "In the 1990s, the WHI was conducted using randomized trials—the gold standard for research—in which women were given hormones or a placebo, to see what, if any, effect hormones had on heart disease and other conditions. When the WHI results came out in 2002, we were shocked to learn that combined HT did not prevent heart disease. In fact, it increased nonfatal heart attacks, strokes, and venous thromboembolic disease in the first few years of use, so the study was stopped. As it turned out, most of the heart events occurred in older women (the average age of women in the WHI trial was 63) so there was a trend for age.

"In 2004, the WHI research in women using estrogen alone came out," Schiff continues. "Women using estrogen were more likely than women not using hormones to have a stroke or blood clots but did not have an increased risk of heart attack. Now, we're trying to reconcile the observational studies, in which healthy women took hormones in their early 50s, with the randomized trials which studied older women, some of whom already had some heart disease."

Despite the "earlier is better" theory, more evidence is needed before HT can be used for cardiovascular protection in anyone. HT is recommended only for the treatment of moderate to severe hot flashes and vaginal dryness. Still, for many women, the findings about short-term use of HT being less risky in younger women than previously thought should come as a bit of relief in and of itself. After all, it is estimated that two-thirds of postmenopausal women will have vasomotor symptoms such as hot flashes, and up to 20 percent of those women are likely to find those symptoms virtually intolerable.

"Most women come into the office for hot flashes but have a whole laundry list of symptoms," says Douglas H. Kirkpatrick, MD, past president of The American Congress of Obstetricians and Gynecologists (ACOG), an ob-gyn in private practice in Denver, and an assistant clinical professor at the University of Colorado Health Sciences Center. "And the reality is: Hormones are still the most effective treatment for hot flashes, vaginal dryness, and other menopausal symptoms."

Weighing the Benefits and the Risks

Nearly every medication known to man- and womankind carries some benefits and some risks—and that's true of HT. Deciding whether the benefits outweigh the risks, or vice versa, is a highly individual decision, but if menopausal symptoms are making you miserable, this much is clear: HT can improve your quality of life.

"A substantial proportion of women are going to have symptoms when they reach menopause, and some of them are going to have them severe enough that they will want therapy," says Herbert B. Peterson, MD, professor and chair of the department of maternal and child health and professor in the department of obstetrics and gynecology at the University of North Carolina at Chapel Hill. "For women with moderate to severe symptoms, HT clearly improves quality of life."

WHI Updates

Just this past April 2011, the latest WHI study looking at women who have had hysterectomies found an overall lower risk of breast cancer and heart disease in women who started taking estrogen-only therapy beginning in their 50s. But among older women in their 70s who had their uteruses removed, the use of estrogen alone was associated with increased health risks. The results are reassuring for millions of middle-aged women who've had a hysterectomy and take estrogen to relieve hot flashes and other menopausal symptoms.

In October 2010, after a follow-up of 11 years, yet another study of WHI participants reported a slight elevation of the risk of breast cancer and slightly higher risk of dying from breast cancer among those women taking combined HT compared with non-users. "This is a very powerful study and I will share the results with my patients, but I don't think it makes the case for removing hormones from the market," says Schiff.

When it comes to long-term health risks, the picture is slightly more complicated. At this point, the risk of developing cardiovascular disease seems to depend largely on a woman's age, her overall health risks, and which hormones are used. As far as matters of the heart go, "hormone therapy might be protective in younger women but harmful when started in older women," says Schiff. "One of the newer theories is that it has to do with the development of plaques and atherosclerosis in older women: Estrogen can lead to plaque rupture and heart events. Younger women don't have that plaque, and estrogen can prevent plaque formation."

While both combined HT and estrogen-only HT raise the risk of stroke, pulmonary embolism, and deep vein thrombosis, they both decrease the risk of developing osteoporosis, and combined HT also lowers the risk of colon cancer. The WHI study found that the risk of breast cancer was slightly elevated with the use of combined HT, but there was no increased risk found with estrogen-only HT. "There's also some suggestion that earlier initiation of hormone therapy—around the time of menopause (defined as one year after a woman's last period)—may be associated with some reduced risk for Alzheimer's," Peterson notes.

Despite these promising findings, right now, major health organizations, including ACOG, do not recommend HT for the prevention of cardiovascular or most other chronic diseases. For many chronic diseases, "there are alternative strategies—such as exercise, nutrition, and medications to prevent heart disease or osteoporosis—which may be why medical organizations are not revisiting the issue of hormone therapy and disease prevention," says Peterson.

The Details

Combined hormone and estrogen-alone treatments are forms of drug therapy that are given to compensate for the lower levels of estrogen that are produced by your ovaries after menopause. If you still have an intact uterus—meaning, you haven't had a hysterectomy—you should be given a progesterone-like agent (synthetic forms are called progestins) to help lower your risk of uterine cancer; taking estrogen alone increases the risk of uterine cancer. Sometimes male hormones called androgens (such as testosterone) may be prescribed off-label for women who have experienced a serious downturn in sexual desire, although research is still being done to assess the safety and effectiveness of going this route.

As far as HT goes, numerous formulations are available. Estrogen comes in the form of pills, patches, and gels, as well as vaginal creams, tablets, and a flexible vaginal

WHAT ABOUT OVER-THE-COUNTER ALTERNATIVES?

Although there's no shortage of soy-based products and other herbal remedies available on drugstore shelves for the treatment of menopausal symptoms these days, there is a shortage of scientific proof that any of them do much good.

Most studies have not shown them to be effective for hot flashes. Another drawback is that over-the-counter (OTC) herbal products, including soy, black cohosh, red clover, and progesterone creams derived from Mexican yams, are not strictly regulated by the US Food and Drug Administration (FDA), so potency may vary from product to product, or even from batch to batch of the same product.

Still, some women who use these products swear by them. If you decide to use soy or other alternative therapies, be sure to tell your doctor. Some could cause interactions with other medications you are using.

Remember: Just because alternative therapies are referred to as "natural" remedies doesn't mean they're without risks or side effects. You should use them with the same care you would when using any OTC or prescription medication.

What about bioidentical hormones? These substances, sometimes called "natural" hormones, are chemically similar or identical to hormones your body makes and are often custom-made by specialized pharmacies. Despite claims made by these pharmacies that bioidentical hormones are safer than the ones manufactured by pharmaceutical companies, and just as effective, there is no scientific evidence to support the claims. In fact, these drugs have not undergone rigorous scientific scrutiny for safety or efficacy, and you should assume they have the same risks as hormones approved by the FDA. To learn more, read the FDA's consumer article "Bioidenticals: Sorting Myths from Facts" at http://www.fda.gov/ForConsumers/ConsumerUpdates/ucm049311.htm.

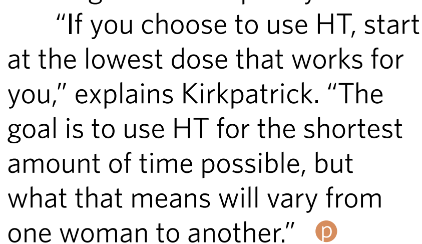
ring for women who have vaginal dryness without other menopausal symptoms. Most forms of estrogen therapy come in a variety of strengths or dosages. For women who need to take progestin, too, there are progestin-only and combined estrogen-progestin pills and patches, a progesterone gel to be used vaginally, and an intrauterine device that includes progestin.

About 10 percent of women who take HT experience side effects such as breast tenderness, fluid retention, and cramping, while those who take combined HT (progestin and estrogen) may also have occasional bleeding similar to a period. Often, changing the form of HT or the dosage can reduce or eliminate such side effects. Talk to your doctor at least once a year to evaluate how you are doing.

The Final Analysis

Ultimately, deciding whether to use HT is a highly personal decision, one that depends on the severity of a woman's menopausal symptoms and her individual health risks. It's important to weigh the benefits of HT versus the risks so that you can make the best possible decision, for both the short term and the long run. If you're thinking about trying HT as treatment for menopausal symptoms, schedule a visit to your doctor so you can have a physical exam. Your doctor will also evaluate your personal and family history of cardiovascular disease, blood clots, and breast cancer so that you can make a truly informed decision about how the potential risks and benefits of using HT stack up for you.

"If you choose to use HT, start at the lowest dose that works for you," explains Kirkpatrick. "The goal is to use HT for the shortest amount of time possible, but what that means will vary from one woman to another."



CHECKLIST *Four Key Questions to Consider*

Deciding whether to take HT isn't something you should treat lightly. Some careful reflection and a full assessment of your health status and your symptoms are in order so that you can decide what's right for you. Ask yourself:

01

What benefits are you looking for? Think about the symptoms that are bothering you most—whether it's hot flashes, insomnia, or mood changes, for example—then consider whether you can obtain relief from other, nonhormonal treatments or whether HT is likely to make the biggest difference.

02

What are your specific risks of taking these hormones? To engage in a comprehensive risk-benefit discussion with your doctor, come to your appointment armed with your personal and family medical history, especially when it comes to heart disease, breast cancer, and deep vein thrombosis. Also, "have an idea of your breast density," Santoro advises, "because if you have very dense breasts, your doctor might be reluctant to prescribe HT." Some women with dense breasts have a higher risk of breast cancer.

03

How much relief are you looking for? "If you're willing to tolerate partial relief from hot flashes or vaginal dryness, you may be able to take a lower dose of estrogen," Santoro says. "You really want to try to get this right as quickly as possible."

04

What route of administration would be best for you? If you decide to take HT, consider whether your symptoms are localized (as in vaginal dryness) or systemic (as in hot flashes), as well as how good you are at remembering to take pills (which may determine whether you're a candidate for pills or the patch).

Forget About HT If...

There are some women who definitely should not use HT because of their overall health status or their risk factors for various diseases. It's just considered too risky for them. These include women who:

- Have undiagnosed abnormal vaginal bleeding
- Have a known or suspected estrogen-dependent cancer (except in appropriately selected patients)
- Have active deep vein thrombosis, pulmonary embolism, or a history of these conditions
- Have active or recent arterial thromboembolic disease (stroke, heart attack)
- Have liver dysfunction or liver disease
- Are or may be pregnant
- Have hypersensitivity to estrogen therapy preparations

Hysterectomy:

What You Need to Know Before You Need One

By Cathy Cassata

There is no doubt that the word "hysterectomy" stirs up feelings of fear and loss. Hysterectomy is the second most frequently performed major surgical procedure among reproductive-age women. Nearly all of us know someone who has had one. Just a few decades ago, hysterectomy was about the only option to treat fibroids, heavy bleeding, chronic pelvic pain, and pelvic support problems.

Today, physicians can provide an array of treatments that are not only less invasive than the traditional hysterectomy, but are allowing many women to avoid the procedure altogether. If you are facing a hysterectomy, understanding what the procedure is all about and what your alternatives are may help ease your concerns. So, read on...

What is a Hysterectomy?

Hysterectomy is the surgical removal of all or part of the uterus. "Each year more than 600,000 hysterectomies are performed in the US, and the type of hysterectomy varies depending on a woman's diagnosis," says Charles E. Miller, MD, from The Advanced Gynecologic Surgery Institute in Naperville, IL, and clinical associate professor in the department of obstetrics and gynecology at the University of Chicago. Here's what Miller means by type:

- **Supracervical** (also called **partial** or **subtotal**)**:** The uterus is removed, but the cervix is left in place.
- **Total:** The entire uterus and the cervix are removed.
- **Radical:** The entire uterus, cervix, upper part of the vagina, and support structures around the uterus are removed (performed if certain types of cancer are present).

Take note that a hysterectomy does *not* include removal of the ovaries and fallopian tubes. When these organs are removed at the same time as the uterus it is called a salpingo-oophorectomy.

Why You Might Need One

The reasons for hysterectomy differ by age. "The largest group of patients who have a hysterectomy are women in their later reproductive years," says Miller. For these women, ages 33–54 years, the primary diagnosis is uterine fibroids, while the most common diagnosis for women over 55 is either uterine prolapse or cancer. Other reasons include endometriosis (though not common in menopausal women), pelvic pain, abnormal bleeding, and preventive measures for cancers.

"I always tell patients that your hysterectomy is not your mother's hysterectomy."

Not Your Mother's Hysterectomy

Today's surgical options range from invasive to less invasive. "Approximately two-thirds of hysterectomies are done by open abdominal surgery, about 12 percent are done laparoscopically, and the remainder are done vaginally," says Arnold P. Advincula, MD, professor at the University of Central Florida, School of Medicine at Celebration Health Hospital in Celebration, FL. "I always tell patients that 'your hysterectomy is not your mother's hysterectomy.' The traditional abdominal surgery is not the only option."

Here is a breakdown of the various ways your hysterectomy may be done.

- **Abdominal Hysterectomy:** This is considered the "traditional" hysterectomy whereby the surgeon makes an incision in the lower abdomen to remove the uterus. Recovery is longer than with vaginal or laparoscopic surgery.
  Hospital Stay: 2–4 days
  Recuperation: Approximately 6 weeks
- **Vaginal Hysterectomy:** The uterus is removed through the vagina, which avoids scarring on the abdomen. Compared with abdominal hysterectomy, vaginal hysterectomy has a shorter hospital stay and a faster return to normal activity.
  Hospital Stay: 1–4 days, or outpatient with no hospital stay
  Recuperation: Approximately 2–6 weeks
- **Laparoscopic Supracervical Hysterectomy:** The uterus is removed through the abdomen with a laparoscope, but the cervix is left in place. Recovery is quickest with this procedure.
  Hospital Stay: 1 day, or outpatient with no hospital stay
  Recuperation: Approximately 2–4 weeks
- **Total Laparoscopic Hysterectomy:** With the aid of a laparoscope, the uterus is removed in small pieces, along with the cervix, through tiny incisions in the abdomen. Compared with abdominal hysterectomy, it has a shorter hospital stay, less blood loss, fewer wound infections, and a faster return to normal activity. However, laparoscopic hysterectomy has a longer operating time and a higher rate of lower urinary tract injuries compared with abdominal hysterectomy.
  Hospital Stay: 1 day, or outpatient with no hospital stay
  Recuperation: Approximately 3–4 weeks
- **Robot-Assisted Laparoscopic Hysterectomy:** A robotic device is used to remove the uterus through the vagina. The surgeon sits at a console a few feet away and controls the robotic arms that are conducting the surgery. Recovery is similar to total laparoscopic hysterectomy and vaginal hysterectomy. Robot-assisted surgery is relatively new, so you may need to do research to find a physician who has expertise in this procedure.
  Hospital Stay: 1 day
  Recuperation: Approximately 3–4 weeks
- **Laparoscopically-Assisted Vaginal Hysterectomy:** In order to remove the uterus through the vagina, a laparoscope is put into the abdomen through a small incision to allow the surgeon to see the pelvic organs on a screen. A portion of the hysterectomy is performed with the aid of a laparoscope and the remainder is completed vaginally. Recovery is similar to vaginal hysterectomy and total laparoscopic hysterectomy.
  Hospital Stay: 1–2 days
  Recuperation: Approximately 3–4 weeks

"Many women don't want a hysterectomy at all, but if they are given the choice, most would prefer the least invasive option," says Cheryl B. Iglesia, MD, director of the section of female pelvic medicine and reconstructive surgery at Washington Hospital Center and associate professor at Georgetown University School of Medicine in Washington, DC. "Although it may be disappointing for a woman wanting a less invasive surgery, sometimes an abdominal hysterectomy is the safest approach," she notes.

Some situations only allow for a laparoscopic or abdominal approach, rather than vaginal, such as an extremely large uterus or scar tissue buildup from previous surgeries, prior infection, or endometriosis. Miller adds, "It's important for women to keep in mind that one of the reasons why

vaginal hysterectomy is the least complicated is because it can only be performed on simpler cases."

Risks and What to Expect Afterward

The risk of problems related to hysterectomy is among the lowest for any major surgery. As with any surgery, though, there are potential complications including blood clots, infection, bleeding during or after surgery, bowel blockage, injury to the urinary tract or nearby organs, anesthesia-related problems, or death.

No matter the type of hysterectomy or the procedure used, you will need time to recover and heal afterward. Lifting heavy objects is a no-no until your doctor gives you the go-ahead. And, you will be advised not to have sex or use tampons for approximately six weeks. You'll be able to slowly resume your normal activities as the weeks progress and you feel better.

After hysterectomy, even though your periods will stop and you're no longer able to get pregnant, your ovaries will continue to produce hormones. A hysterectomy in itself may lead to ovarian failure earlier than normal. If the ovaries are removed before menopause, you will go through menopause immediately, rather than over the course of a few years.

Women may also experience both physical and emotional effects of hysterectomy. "Some women might feel depressed after the loss of their uterus, while others are relieved their symptoms are gone," says Iglesia.

> *"Many women don't want a hysterectomy at all, but if they are given the choice, most would prefer the least invasive option."*

Some women report a difference in sexual response after hysterectomy. Because the uterus has been removed, uterine contractions that you may have felt during orgasm will no longer occur. However, many other women feel more sexual pleasure after hysterectomy because they no longer have to worry about getting pregnant or because their pain and discomfort or heavy bleeding has stopped. If the ovaries are left in place, a woman's sexual activity is usually not impaired, but if they are removed, a decreased sex drive and vaginal dryness may be a problem. These concerns can usually be reversed with hormone therapy. Over-the-counter remedies such as vaginal creams and lubricants, and low-dose estrogen creams, tablets, and rings that are absorbed locally, can restore moisture to the vagina.

Despite the possible complications, Miller says studies show that more than 80 percent of women are satisfied after their hysterectomy. "Women who have a good support system generally do the best since there is a psychological component that impacts overall patient satisfaction."

Know All of Your Alternatives

Increasing numbers of women today are able to avoid a hysterectomy because they are candidates for a variety of uterus-sparing alternatives. For instance, a myomectomy, which surgically removes fibroids but spares the uterus, may be an option. In many cases, myomectomy can be performed as a minimally invasive outpatient procedure with laparoscopy or hysteroscopy through the vagina. Hysteroscopy has a 1–2 day recuperation and laparoscopy has a 1–2 week recovery time. If your fibroids are removed through an abdominal incision,

you'll likely stay in the hospital for 3–4 days and need 4–6 weeks to recover. The major downside to myomectomy is the risk of recurrence which can be as high as 25 percent, says Miller. Women who become pregnant after a myomectomy may need to deliver by cesarean because of the risk of the uterus rupturing at the location of the earlier surgery.

> *"Make sure you understand the diagnosis and why you need the surgery."*

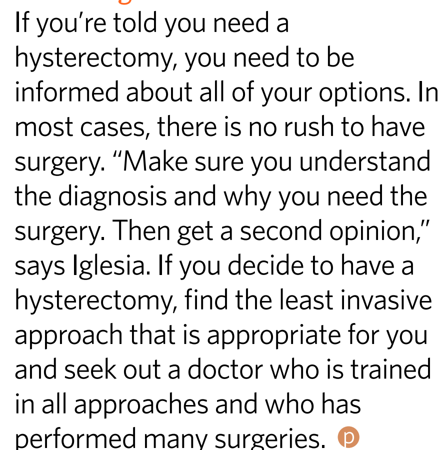
Uterine fibroid embolization (UFE) is another alternative to treat fibroids. UFE cuts off blood flow to fibroids and shrinks them by injecting tiny particles of plastic into blood vessels supplying the fibroids. This procedure, performed by an interventional radiologist, can be very painful and often requires a short hospital stay, Miller says. Other risks include infection, tissue breakdown of the fibroid, and early menopause (especially for women in their 40s). It is generally not recommended if you want to become pregnant in the future. Recurrence of fibroids can be as high as 33 percent.

If you suffer from uterine prolapse, Kegel exercises may restore some muscle tone to help hold the uterus in place. A pessary device inserted into the vagina can help support the uterus.

If abnormal uterine bleeding is an issue for you, treatment depends on the cause of the problem. Hormonal or drug therapy may help. The FDA recently approved the Mirena® intrauterine device (IUD)—a contraceptive which secretes low-dose progesterone—to treat abnormal uterine bleeding. Potential side effects include weight gain, acne, ovarian cysts, and irregular vaginal bleeding. A dilation and curettage (D&C) with hysteroscopy procedure to scrape uterine tissue may control bleeding, but only on a short-term basis.

Endometrial ablation—which destroys the endometrial lining of the uterus with heat, microwaves, freezing, or other methods—may be an option if you no longer wish to bear children but want to keep your uterus. This may not be an option for women who have very large uteruses and works best in women with heavy periods. The potential risks of endometrial ablation include persistent bleeding and injury to organs near the uterus, such as the bladder. In appropriate candidates, 80 to 90 percent of women will see a marked reduction in bleeding afterward, and up to 40 percent will stop having a period altogether, says Miller.

A more recent development is MRI-guided focused ultrasound therapy that uses high-intensity ultrasound waves to shrink fibroids, but more research is needed on long-term outcomes. This procedure should not be used in women interested in having children in the future, according to Miller. A newer experimental procedure is radio frequency ablation which uses low-energy heat to target and shrink fibroids. Much more research is needed on this, too, to determine both its short- and long-term risks and its effectiveness.



Making a Decision

If you're told you need a hysterectomy, you need to be informed about all of your options. In most cases, there is no rush to have surgery. "Make sure you understand the diagnosis and why you need the surgery. Then get a second opinion," says Iglesia. If you decide to have a hysterectomy, find the least invasive approach that is appropriate for you and seek out a doctor who is trained in all approaches and who has performed many surgeries.

Tests You Need Now

The Life-Saving Test Women are Skipping

Colorectal cancer (often referred to as colon cancer) is the third leading cause of cancer death among women in the US, after lung and breast cancers. An estimated 70,480 women were diagnosed with colon cancer in 2010 and 24,790 died from the disease. This is far too many women dying from a cancer that is extremely preventable and treatable.

While the value of early detection for some cancers has been widely debated, the benefits are undeniable for colon cancer—screening for colon cancer saves lives! If you're turning 50, it's time to get screened. Routine screening helps detect precancerous polyps so that they can be removed before they can turn into cancer. Likewise, if the cancer has already developed, it can be detected at its earliest stages through regular screening—when it is 90 percent treatable.

Because the risk of developing colon cancer increases with age, all women age 50 and older should be screened for this disease. Approximately nine out of 10 people with colon cancer are older than 50, yet estimates suggest that about 37 percent of women in this age group skip the recommended screening. Screening should begin earlier for African Americans and those with risk factors, including a personal or family history of colon polyps or colon cancer; a personal history of inflammatory bowel disease, such as chronic ulcerative colitis or Crohn's disease; or a family history of colorectal cancer syndromes.

Colon Cancer Screening Tests

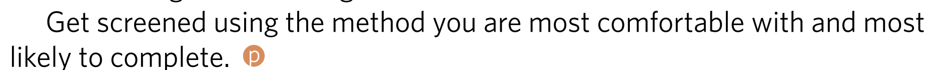
While colonoscopy is the gold standard when it comes to colon cancer screening, it's not your only option. Your doctor can discuss the advantages and limitations of the other screening methods and help you decide which type of screening test (or combination of tests) is best for you and how frequently you'll need to be screened.

- **Colonoscopy** is the preferred method for colon cancer screening. A lighted instrument called a colonoscope is used to examine the entire colon and rectum. Patients are sedated for the procedure, which generally lasts 20 to 30 minutes. Polyps can be removed during the exam. Colonoscopy should be repeated every 10 years.
- **Flexible sigmoidoscopy** examines the lower colon using a lighted flexible tube. Polyps can sometimes be removed during flexible sigmoidoscopy. Sedation may or may not be necessary. Women who choose this procedure should have it every five years.
- **Double contrast barium enema.** Patients are given an enema using contrast dye. X-rays of the colon and rectum are then taken. Women should have this exam once every five years.
- **Guaiac fecal occult blood test** or **fecal immunochemical test.** Patients collect stool samples at home for several days. Samples are sent to a lab to be checked for hidden blood. These tests must be performed annually.

You can also ask your doctor about newer, less-invasive screening tests such as **CT colonography** (a 3-D imaging exam) and **stool DNA testing** (detects cancer-related gene changes).

Follow-up will include a diagnostic colonoscopy if any test comes back abnormal. Regular screening saves lives.

Get screened using the method you are most comfortable with and most likely to complete.



Did You Know?

COLON CANCER OFTEN HAS NO SYMPTOMS

1 IN 20 WOMEN WILL DEVELOP COLON CANCER

Colon cancer is diagnosed in more women than all types of gynecologic cancer combined

Only 39% of colon cancers are detected in the early stages

Uterine Rebellions

By Stacey Colino

For years, my period was like clockwork: I could pinpoint practically to the day when it would arrive, what the bleeding would be like, and when it would end. Then, last spring, the pattern shifted: My periods were still predictable, but around mid-cycle I started experiencing spotting and cramping.

Initially, I shrugged this off as a side effect of being in my mid-40s, a topsy-turvy time, hormonally speaking. But after this happened three months in a row and I began getting more intense mid-cycle cramps, I headed to my ob-gyn where I quickly discovered my mistake: This abnormal bleeding was unlikely to be hormonally driven, she told me, because I was still getting regular periods. Something else was going on. So I embarked on a diagnostic odyssey—complete with hormone tests, an endometrial biopsy, an ultrasound, and a sonohysterogram—to find out what was causing my abnormal uterine bleeding.

It turns out, abnormal uterine bleeding (AUB) is one of the most common reasons women see their doctors, accounting for approximately 20 percent of visits to gynecologists, according to the North American Menopause Society. Some women at midlife may correctly assume that unusual bleeding patterns may just come with the territory of perimenopause and forgo seeing their ob-gyn, like I did initially. In some cases, that may be true, but abnormal uterine bleeding can also be a sign of a potentially worrisome condition, which is why it's always smart to get it checked out.

"Oftentimes, a woman's worst fear is that abnormal bleeding is a sign of cancer, but abnormal bleeding is most often due to benign causes," says May Hsieh Blanchard, MD, an assistant professor of obstetrics, gynecology, and reproductive sciences and chief of the division of general obstetrics and gynecology at the University of Maryland School of Medicine in Baltimore. "However, it does need to be evaluated to rule out cancer

or other problems that require further evaluation and treatment."

A wide array of conditions, ranging from stress to hormonal abnormalities to abnormal growths, can cause this kind of AUB. "In the years preceding the ultimate cessation of your menstrual cycle, which is the definition of menopause, there can be a change in the regularity of your periods," notes Sharon B. Mass, MD, an ob-gyn at Morristown Memorial Hospital in NJ. "You may skip periods or have variations in the intervals between periods—that's normal. Or you can have regular periods but also have bleeding in between the periods—that should be considered abnormal. The same is true if the actual blood flow during the period is excessive or if the interval between periods is more frequent than every 21 days. Those are all red flags." (Your doctor may use different words to describe these bleeding patterns; see *What's In a Name?* on page 26.)

"Oftentimes, a woman's worst fear is that abnormal bleeding is a sign of cancer, but abnormal bleeding is most often due to benign causes."

The cause of those bleeding patterns can include hormonal abnormalities, such as thyroid disease, diabetes, elevated levels of the hormone prolactin (which stimulates breast development and milk production in women), or a response to starting or going off hormonal contraceptives. It can be due to structural abnormalities, such as cervical polyps, endometrial polyps, fibroids, adenomyosis (a condition in which the lining of the uterus grows into the muscular walls of the uterus), endometrial hyperplasia (excessive growth of the lining of the uterus), or endometrial cancer.

"Abnormal bleeding is very common in the 40s," says Howard T. Sharp, MD, vice chair of the department of obstetrics and gynecology at the University of Utah School of Medicine in Salt Lake City. "The longer the uterus is in place and the longer you've been exposed to estrogen, the more likely these (uterine) growths are to develop." If the cause isn't diagnosed properly, some of these conditions can worsen or lead to more serious health problems. Meanwhile, excessive bleeding itself can lead to anemia, severe fatigue, and major disruptions to a woman's life and work.

Getting to the Bottom of the Problem

To figure out what may be causing the unusual bleeding, your ob-gyn will start with a physical exam, perhaps along with blood tests to check your blood count and measure key hormone levels. (You also may get a pregnancy test, just to be sure.) After that, "the first step is to rule out cancer or endometrial hyperplasia," says Sharp.

Your doctor will need to look at the endometrium and may recommend a hysteroscopy (a thin telescope-like device used to diagnose the problem) or an ultrasound, which uses sound waves to create a picture of the pelvic organs including unusual growths that may be on them. Or, you may be advised to have a sonohysterogram, a saline infusion ultrasound, in which a saline solution is used to inflate the uterus to give a clearer picture of unusual growths or tissue that may be in the uterus. "Polyps usually look like a grape hanging on a stalk, whereas fibroids are often half stuck in the wall of the uterus," Sharp says, "but sometimes it's hard to tell the difference until we remove it." Your ob-gyn may perform an endometrial biopsy (a sample of tissue is taken from the lining of the uterus) in the office instead of these procedures or in addition to them.

If a premenopausal woman's endometrial tissue is normal but she's not ovulating, a low dose birth control pill or a once-a-month progesterone supplement may solve the abnormal bleeding problem. Or, if the problem is hormonal, the Mirena® IUD, which contains a small amount of progesterone, will thin out the lining of the uterus and may reduce heavy bleeding. (This is considered an off-label use.) A newer option: An oral medication called tranexamic acid can reduce heavy menstrual bleeding significantly if it's taken for five days during a woman's period. "If a woman is menopausal and her biopsy was normal and there are no polyps or fibroids present, often she can be watched and monitored," Blanchard says.

Sometimes surgery is needed to remove growths that cause abnormal bleeding. More often than not, it's advised that polyps be removed if they're causing symptoms. The reason: "Before menopause, polyps can continue to grow so the bleeding could increase," Mass says. "And they're not going to go away after menopause the way fibroids can once hormonal stimulation is withdrawn with the loss of estrogen."

What's In a Name?

Your ob-gyn may use a technical name to describe the type of abnormal or dysfunctional uterine bleeding pattern you have. Here's the low-down on what the different terms mean:

- **Amenorrhea:** The absence of a menstrual period for six months or longer.
- **Dysmenorrhea:** Painful periods, including intense menstrual cramps.
- **Hypermenorrhea:** Abnormally heavy periods or prolonged periods.
- **Menorrhagia:** Prolonged (as in more than seven days) or abnormally heavy periods at regular intervals.
- **Menometrorrhagia:** Prolonged or excessive uterine bleeding that occurs irregularly and more frequently than normal.
- **Metrorrhagia:** Uterine bleeding at irregular, more frequent than normal intervals, especially between expected periods.
- **Oligomenorrhea:** Infrequent periods, typically more than 35 days apart, often with only four to nine in a year.

Keep in mind that a dilation and curettage (D&C), a procedure in which the opening of the cervix is enlarged and tissue is gently scraped or suctioned from the lining of the uterus for diagnostic purposes, may not cure the problem for good. "A D&C will only scrape out the lining that's there right now; it's not changing anything that's going to happen in the next cycle or at a later date," Mass says. In some cases, polyps can be removed right in the doctor's office with forceps via hysteroscopy, in which your doctor places a thin telescope-like device into the uterus to see inside. A 2009 study from Leiden University Medical Center in the Netherlands found that hysteroscopic polyp removal in premenopausal women with AUB reduced monthly blood loss significantly after six months, earning the procedure a high satisfaction rating from the women.

Oral contraceptives and the progestin-releasing IUD can help reduce heavy, painful periods, whereas gonadotropin-releasing hormone (GnRH) agonists can be used for several months (sometimes as a precursor to surgery) to stop the menstrual cycle and shrink fibroids. On the surgical front, myolysis (in which an electric current or laser is used to destroy the fibroids), myomectomy (in which just the fibroids are surgically removed), or uterine artery embolization (in which small particles of foam are injected into key arteries to cut off the fibroid's blood supply, causing it to shrink) can allow a woman to keep her uterus without the debilitating symptoms caused by fibroids.

Meanwhile, endometrial ablation, which uses electricity, a laser beam, heat, or freezing to destroy the lining of the uterus, may be used to control heavy bleeding—but only if a woman is sure she doesn't want to have another child; in some women, endometrial ablation stops menstrual bleeding permanently. In general, endometrial ablation has a success rate of 90 percent, Mass notes. "Of the 90 percent that are successful," she adds, "about half of the patients experience a reduction in the amount of bleeding and half experience amenorrhea (the cessation of periods)." If other treatments fail, hysterectomy may be an option but this is major surgery with a significant recovery time. (See *Hysterectomy: What You Need to Know Before You Need One*, page 18.) In a study of premenopausal women with dysfunctional uterine bleeding, researchers at the Johns Hopkins Bloomberg School of Public Health in Baltimore found that endometrial ablation and hysterectomy were both effective at relieving pain, fatigue, and other symptoms 24 months later, though hysterectomy treated the bleeding more effectively.

If a woman has endometrial hyperplasia, often a precursor to endometrial cancer, her condition may be treated hormonally (with progesterone to prevent a build-up of the uterine lining) or surgically (often with a hysterectomy), depending on the classification of her hyperplasia, Mass explains. And if full-blown endometrial cancer is responsible for the AUB, a hysterectomy is in order.

The culprit in my case: Uterine polyps, which (thankfully) turned out to be benign. After having surgery to remove the polyps, along with endometrial ablation (to stem the flow of the increasingly heavy periods I was getting), my AUB disappeared. So did my periods, which turned out to be the hidden blessing in this gynecological adventure.

News Flash

- *Smoking and Breast Cancer*
- *More than a Cup a Day Keeps Stroke Away*

GREATER CHANCE OF BREAST CANCER THAN NON-SMOKERS

25%

LOWER RISK OF STROKE DRINKING MORE THAN A CUP A DAY

Smoking and Breast Cancer

Lighting up may actually up your risk for breast cancer, according to a new *Archives of Internal Medicine* study. While the association between smoking and other cancers, namely lung cancer, has long been known, the relationship to breast cancer hasn't been as clear. This study found that any history of smoking increased a woman's chance of breast cancer by six percent; the risk was higher for heavy smokers.

Tobacco's effect on a woman's breast health differs depending on her age. Young women who lit up before they had children had an 18 percent greater risk of breast cancer. Long-term heavy smokers (25 cigarettes a day for 35 or more years) who began smoking before age 18 had a 25 percent greater chance of the disease than nonsmokers. The study, however, did find that smoking after menopause slightly lowered the risk of breast cancer, most likely because tobacco works against the hormone estrogen which fuels breast tumors. But smoking's link to other serious health problems, such as heart attack and stroke, negates this protection. It's important that menopausal women who smoked when younger get regular mammograms.

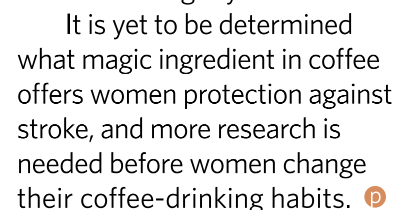
Smoking is bad for your health and breasts, too—no ifs, ands, or butts.

More than a Cup a Day Keeps Stroke Away

A major study in *Stroke: Journal of the American Heart Association* has found that drinking coffee may protect against stroke in women. According to the decade-long Swedish study of nearly 35,000 women ages 49–83, women who drank more than a cup of coffee a day had about a 25 percent lower risk of stroke compared with those who drank less. It was not determined whether the women were drinking regular or decaffeinated coffee but the researchers say consumption of decaf in Sweden is very low.

Stroke is the No. 3 killer of women in the US. Over the years, health experts worried that coffee raised blood pressure and increased heart rate, but it doesn't appear to be as bad as previously thought. Evidence has been growing that actually shows some health benefits of coffee, including helping prevent cognitive decline and possibly reducing the risk of liver cancer and diabetes.

Similar findings from the 2009 Nurses' Health Study done in the US also found a reduced risk of stroke among women coffee drinkers. This study concluded that women who drank four or more cups of coffee a day had a 20 percent lower risk of stroke compared with women who had less than one cup per month. Women who drank decaf had a slightly lower risk.



It is yet to be determined what magic ingredient in coffee offers women protection against stroke, and more research is needed before women change their coffee-drinking habits.

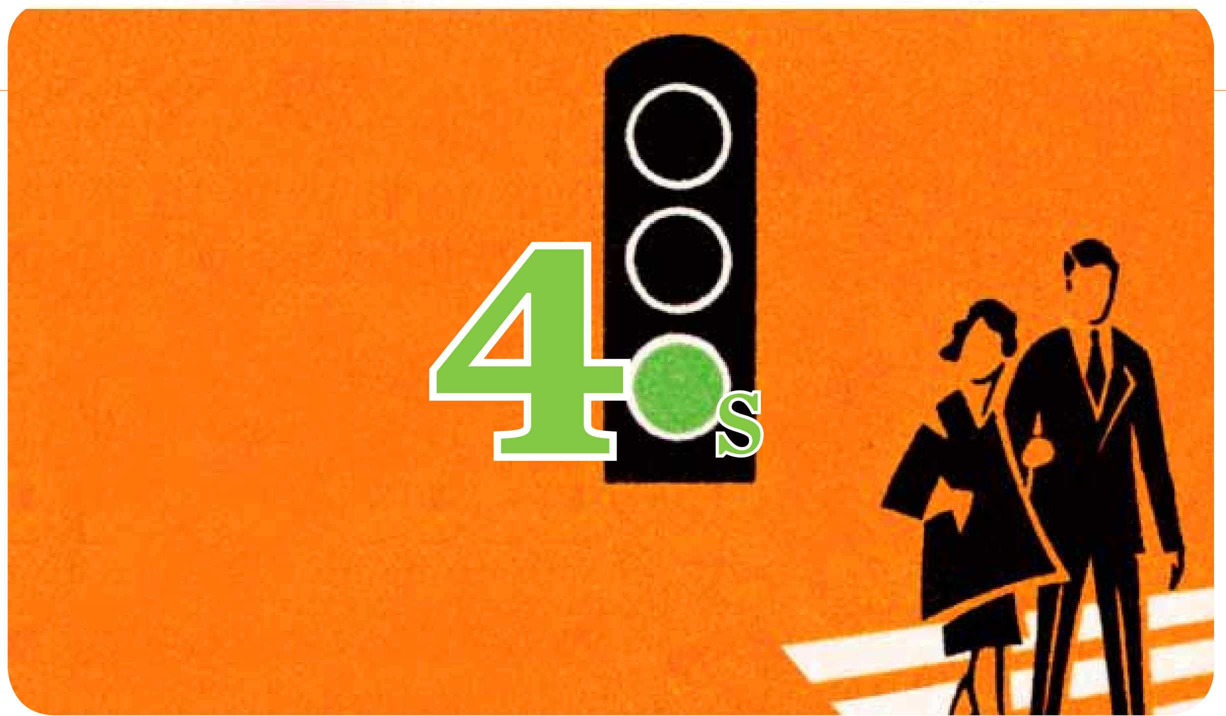
78.2 YEARS Americans are living longer—life expectancy in the US is at an all-time high.

The Vaginal Dialog

What happens "down there" when you're in your 40s, 50s, 60s, and beyond

By **Lisa Collier Cool**

We're living in an age of "designer vaginas," "vaginal rejuvenation," and even "G-spot amplification." These controversial procedures are either intended to improve the appearance of a woman's genitalia by reshaping or trimming the labia (outer lips surrounding the vagina) and in some cases the hood of the skin over the clitoris, or to heighten sexual pleasure by tightening the vagina to increase friction. While the number of women who undergo these operations is still small, demand is on the rise, despite scant data about the safety and effectiveness of cosmetic vaginal surgery. Driving the trend, critics



charge, is marketing hype that exploits women's insecurities, causing some to go under the knife needlessly to fix supposed flaws.

Fueling the anxiety that many women feel about whether their vagina is healthy and attractive is lack of understanding about what's normal. A survey by the Association of Reproductive Health Professionals found that 57 percent of women don't think their vagina is the right size. While many of the women had performed a breast self-exam, one in four of those polled hadn't looked at her vagina in the past year and only half had ever done a self-exam. The survey also found that only 18 percent of women described their private parts as beautiful or sexy.

"The whole concept of 'vaginal rejuvenation' makes women worry that they don't look pretty 'down there,'" says Jeanne A. Conry, MD, PhD, assistant physician in chief for Kaiser Permanente's Sacramento-Roseville region in CA. "Patients often ask if their vagina is too wide, too loose, or has lost muscle tone. Others wonder if they need cosmetic surgery because a partner has told them their labia are too big. A lot of women don't realize that there's considerable variation in the size and shape of normal, healthy vaginas."

Like the rest of your body, the vagina changes with age. What do you need to know—and do—to maintain sexual confidence throughout your life? Here's a guide to what happens below the belt when you're in your 40s, 50s, 60s, and beyond—with the answers to your most embarrassing questions.

If You're in Your 40s

VAGINAL CHANGES: During the early 40s, your vagina is bathed in estrogen, keeping the tissue moist, plump, and elastic. Folds and furrows allow the walls to stretch like a rubber band during lovemaking or childbirth. "This is the one area of your body where it's good to have wrinkles," says Mark S. DeFrancesco, MD, MBA, medical director of Physicians for Women's Health, LLC, in Waterbury, CT, and assistant professor of obstetrics and gynecology at the University of Connecticut Health Center. As hormone levels gradually wane over this decade of life, you may start to notice occasional vaginal dryness, which can be one of the first signs that menopause is approaching.

SEXUAL CHANGES: If dryness, which affects about 20 percent of women in their 40s, is making sex uncomfortable, try an over-the-counter (OTC) vaginal lubricant. Doctors advise only using water-based lubricants because they don't damage condoms or diaphragms and wash off more easily after sex than oil-based products do. Water-based lubricants are usually labeled "for use with condoms and diaphragms." Not only do vaginal lubricants ease intercourse, but some products contain ingredients designed to increase pleasure, such as creating a warming sensation. Regular sexual activity (either with a partner or solo) at least once a week actually improves vaginal health by boosting blood flow to the genitals and helps maintain elasticity.

Women who have given birth vaginally, particularly to large babies, may notice widening of the vaginal opening or weakness of the pelvic floor, the hammock of muscles that holds pelvic organs in place. An effective way to tone the muscles is Kegel exercises, which can also enhance sexual response and for some women intensify orgasms. Kegels are also helpful for treating or preventing stress incontinence (leaking urine during physical activities such as exercise, coughing, sneezing, or laughing).

Here's how to perform Kegel exercises: First, identify the right muscles. Pretend you're sitting on a marble and trying to pull it up into your vagina. Try not to tighten your buttocks or abdomen. Once you've located the muscles, squeeze them for 10 seconds and then relax. Conry advises 10 repetitions of the pelvic squeeze, three to four times a day. "It's like firming flabby arms—you need to do Kegel exercises for a few months before you get noticeable results." The squeezes can be performed sitting, standing, or lying down and take just a few minutes a day.

WHEN TO SEE YOUR OB-GYN: A once-a-year pelvic exam to check for medical problems, such as fibroids or vaginal disorders, is a must. However, you may not need an annual Pap test. For women ages 30 to 64, after three normal results in a row, cervical cancer screening can often be reduced to once every three years, except for women with certain health conditions. Ask your gynecologist what screening schedule is appropriate for you.

If You're in Your 50s or 60s

VAGINAL CHANGES: After menopause, your labia and vaginal lining become thinner. The folds and creases in the vaginal walls that are typical for younger women gradually disappear, reducing elasticity. Your vagina may also shrink slightly. The culprit is loss of estrogen, which may also diminish lubrication during sex. The pH of your vagina rises, changing the healthy acidic environment—one of the body's defenses against germs—to one that's alkaline. As a result, postmenopausal women are more susceptible to yeast and other vaginal infections, conditions that can spark itching, irritation, abnormal discharge, sexual discomfort, and burning during urination. Consult your gynecologist if you have any of these warning signs or other below-the-belt symptoms.

SEXUAL CHANGES: How does menopause affect the libido? Your sexual interest may go up, down, or stay the same. About 40 percent of postmenopausal women develop vaginal dryness, the leading cause of painful intercourse. If you're one of them, don't grit your teeth and try to tough it out. Having sex when you're not lubricated can cause microscopic tears in thinning vaginal walls, setting the stage for infections. And when sex hurts, you're likely to do it less often, adds DeFrancesco. "This creates a double whammy, since infrequent relations cause the vagina to become less flexible, which makes sex even more painful."

Talk to your doctor about solutions, which include using OTC vaginal lubricants (such as Astroglide® or Silk-E®) during sex to ease penetration and reduce friction and vaginal moisturizers such as Replens®, which are applied two or three times a week to maintain or improve lubrication. Moisturizers reduce vaginal pH, which may help combat infections. Avoid douching, using products that contain fragrance, and washing your genitals with excessive amounts of soap, all of which can magnify dryness or irritation, cautions Conry.

If these steps aren't enough, adds DeFrancesco, "your doctor may prescribe vaginal estrogen therapy, which not only improves lubrication, but actually has a rejuvenating effect by raising the thickness and elasticity of the vaginal tissues, cushioning sex." Because the medication—in the form of a cream, tablet, or ring—is inserted into the vagina, very little of the hormone is absorbed into the bloodstream, adds DeFrancesco. "The dose is much lower than that used in hormone therapy (HT) for menopausal symptoms.

HOW DOES A HYSTERECTOMY AFFECT SEXUALITY?

About 600,000 American women a year undergo hysterectomies. If your doctor has advised this common surgical procedure to treat a medical condition, you may be wondering—or worrying—that you'll lose desire or find lovemaking less satisfying. Many studies have looked at sexual response after the procedure, with reassuring findings, reports Mark S. DeFrancesco, MD, MBA. "There's general agreement that the presence or absence of the uterus and cervix doesn't affect the quality of orgasms, so sex can be just as good. One-third of women have no change in libido after hysterectomy, one-third report a drop in desire, and one-third an increase. For some women, not having to worry about birth control and getting relief from painful symptoms that may have led to the hysterectomy help them to relax and enjoy sex more."

Over a few months, you'll gradually notice a substantial improvement in tissue quality."

To keep pelvic floor muscles strong after menopause, include a daily Kegel workout in your fitness routine, consisting of one set of 10 pelvic squeezes, performed four times a day. If that doesn't provide enough toning below-the-belt, talk to your doctor about vaginal weights (weighted tampon-like cones used to strengthen the pelvic floor during Kegel exercises). Basically dumbbells for the vagina of increasing weight, these OTC devices boost the effectiveness of Kegel exercises, which make sex more pleasurable and also combat or help prevent urinary incontinence, a problem that's more common after menopause. Last, but definitely not least, the best way to maintain vaginal health at every age is regular sexual stimulation. And it's also the most fun!

WHEN TO SEE YOUR OB-GYN: For women up to age 65, and many women older than 65, The American Congress of Obstetricians and Gynecologists advises annual pelvic exams. If you've had three or more normal Pap tests in a row, your doctor may advise reducing screening to every two to three years. After 65, Pap tests may not be necessary if you've had three or more normal results in a row, no abnormal results in 10 years, no history of cervical cancer, and no exposure to DES in utero. Discuss the pros and cons of discontinuing screening with your doctor.

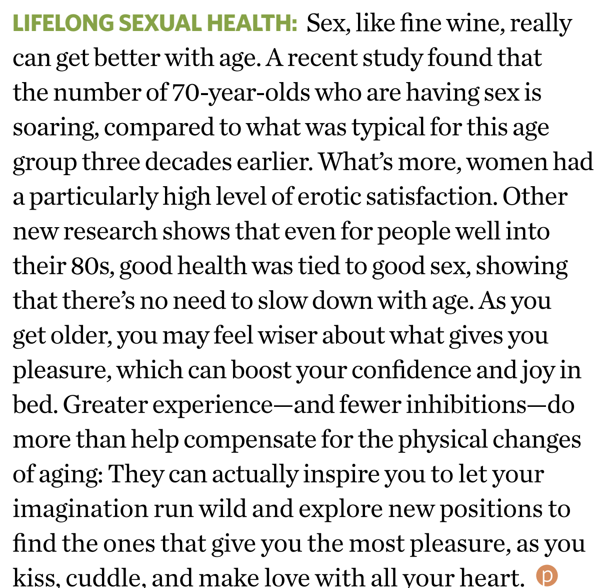
If You're in Your 70s or Beyond:

VAGINAL CHANGES: As you age, lack of estrogen can cause vaginal tissue to become increasingly thin and inflamed, a condition known as vaginal atrophy, says DeFrancesco. "If nothing is done to treat it, you're likely to develop significant tightening of the vagina due to loss of elasticity and experience symptoms like itching, irritation, and dryness." Older women also have a higher rate of vaginal infections, such as bacterial vaginosis (BV), which can cause a "fishy" odor or discharge. Consult your ob-gyn if you have these or other vaginal symptoms. And if you smoke, here are two more reasons to kick the habit: It decreases blood flow to the vagina, contributing to atrophy, and also raises the risk for BV.

SEXUAL CHANGES: Not all postmenopausal women develop vaginal atrophy, which is most likely to strike women who have sex infrequently (less than once a week). Atrophy can shrink the vagina's mucous membranes, leading to narrowing of the vaginal opening, making penetration painful or even impossible. One solution is using vaginal dilators, available in various sizes and widths, to gradually increase the elasticity of the vagina, says DeFrancesco. Treatment typically involves a few minutes of daily use, with a vaginal lubricant. However, you should consult your gynecologist before trying dilators to make sure this is an appropriate therapy since painful sex can have a variety of causes, emphasizes DeFrancesco. "Your doctor needs to do a pelvic exam and check for other conditions."

Aging can also weaken your pelvic floor, sometimes causing bladder leakage during climax (or from other stressful activities, such as sneezing or lifting your grandkids). Kegel exercises, performed in one set of 10 pelvic squeezes, four times a day, help control incontinence—and also strengthen your "love muscles," which can boost sexual pleasure. Ask your doctor if you need weighted vaginal cones (tampon-like weights that boost the effectiveness of Kegels). If arthritis is making sex uncomfortable, loosen up and get in the mood by making a warm shower and sexy massage part of your foreplay.

WHEN TO SEE YOUR OB-GYN: Once a year, however, you may not need Pap tests if you've had three or more normal results in row, no abnormal results in 10 years, and no history of cervical cancer. It may be reasonable to stop having routine pelvic exams if you would choose not to be treated for disorders that might be found, due to advanced age or ill health. Such a decision should be discussed with your doctor.

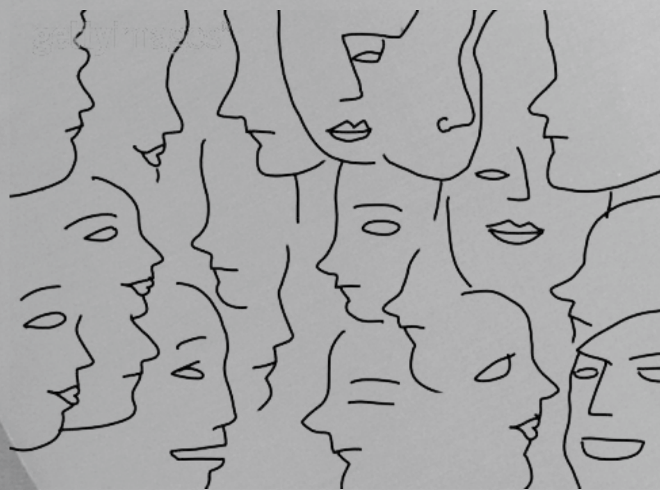


LIFELONG SEXUAL HEALTH: Sex, like fine wine, really can get better with age. A recent study found that the number of 70-year-olds who are having sex is soaring, compared to what was typical for this age group three decades earlier. What's more, women had a particularly high level of erotic satisfaction. Other new research shows that even for people well into their 80s, good health was tied to good sex, showing that there's no need to slow down with age. As you get older, you may feel wiser about what gives you pleasure, which can boost your confidence and joy in bed. Greater experience—and fewer inhibitions—do more than help compensate for the physical changes of aging: They can actually inspire you to let your imagination run wild and explore new positions to find the ones that give you the most pleasure, as you kiss, cuddle, and make love with all your heart.

the Secret

Sex Lives of Americans

By **Lisa Collier Cool**



Almost all of us have wondered if our sex life measures up to the national average. Are other people having hotter sex, wilder sex, or more sex?

And what about our friends and neighbors? Is that seemingly sedate couple down the street finding more bliss between the sheets—or on the living room rug, the kitchen table, or somewhere even naughtier—than we do? Until recently, there was a dearth of scientific data about what really goes on behind America's bedroom doors. Now, the most comprehensive national sex survey in nearly 20 years, of nearly 6,000 teens and adults ages 14 to 94, offers new insights.

Conducted by researchers from Indiana University's Center for Sexual Health Promotion and the Kinsey Institute for Research in Sex, Gender and Reproduction in Indianapolis, the findings were published in a special 2010 issue of the *Journal of Sexual Medicine*, with commentary by former US Surgeon General Jocelyn Elders, MD. With 30 percent of health care costs relating to sexuality, it's crucial for doctors to understand which activities are common, so they can better educate patients about maintaining sexual health—and enjoyment—at every age, wrote Dr. Elders. "We must revolutionize our conversation from sex only as prevention of pregnancy and disease to a discussion of pleasure."

A New Sexual Smorgasbord

So, let's talk about what's giving Americans pleasure. First of all, couples are increasingly creative in bed, reports Michael Reece, PhD, MPH, director, Center for Sexual Health Promotion, and a co-author of the study. "We identified 41 combinations of sexual acts, suggesting that the American sexual repertoire has evolved and expanded. Vaginal intercourse remains the predominate activity, but it's occupying less of the sexual space than in the past, because people feel more empowered to find out what else feels good." Part of this trend, says Reece, is the wider use of sex toys. "Another of our studies found that more women, particularly those in their 40s to 60s, are incorporating vibrators into both masturbation and partnered sex."

There's also a boom in oral sex. While it's not new for women to perform it on men, the survey found that far more men are returning the favor than did in past. More than half of women ages 18 to 49 had received oral sex from a male partner in the previous year, as had more than one-third of women in their 50s and nearly one-fourth of women in their 60s. "Probably the reason for the rise is that women feel freer to tell men what they find exciting," says Reece. "A lot of women report that they're more likely to have an orgasm from oral sex than they are from vaginal intercourse."

One surprising finding was that 40 percent or more of women ages 20 to 49 have experimented with anal sex, compared to 30 percent or more of women ages 50 to 69. "These are much higher rates than we've seen in the past," notes Reece. "What we're finding is that more heterosexual couples are trying anal sex, but in most cases they're not doing it very frequently."

Unsafe Sex Common After Age 50

The poll also revealed that it's not just 20-somethings who have "friends with benefits." So do Baby Boomers, with about 14 percent of those in their 50s reporting that their most recent sexual encounter was with a casual or dating partner, 17 percent saying they hooked up with a friend, and 11 percent bedding a new acquaintance. And contrary to the popular stereotype that young people are irresponsible, the overwhelming majority of teens practice safe sex. However, 90 percent of men over 50 didn't wear a condom the last time they had sex with a date, and 70 percent didn't use one during intercourse with a stranger. Among women over 50, the majority also skipped a condom when making love, even during casual encounters. What's more, most people over 50, though sexually active, have not been checked for STDs in the past year.

What's behind these troubling statistics? "As Viagra® has entered the world, more older people are having sex, but they're less aware of the risk of sexually transmitted diseases," says Irwin Goldstein, MD, director, sexual medicine, Alvarado Hospital, in San Diego, CA. "If you go to any college campus, you'll see jars and bowls of condoms in the dorms, but men and women in their 50s, 60s, and 70s grew up in an era where condoms weren't widely used. And talking to middle-aged or older patients about safe sex still isn't a routine part of the medical discussion at many doctors' offices, so people who are widowed or divorced aren't getting the education they need on how to protect themselves when they start dating again."

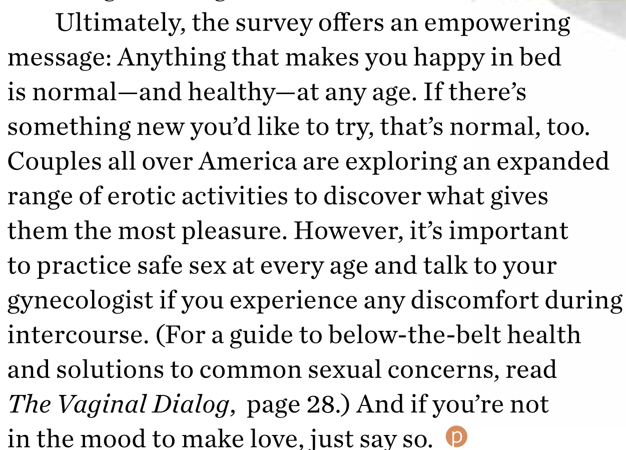
"If you go to any college campus, you'll see jars and bowls of *condoms* in the dorms, but men and women in their 50s, 60s, and 70s grew up in an era where condoms weren't widely used."

How Often Do Americans Make Love?

Predictably, the survey found that women who were married or in a committed relationship were four times more likely to be sexually active than their single sisters. For those with partners, the majority report having sexual activity a few times a month to two to three times a week. Starting at 30, the proportion of women not having any vaginal intercourse in the past year rose sharply, from about one-fourth of 30-somethings to nearly one-third of women in their 40s, one half of women in their 50s, and ultimately nearly four-fifths of those age 70 and up. More than 20 percent of women in all age groups had masturbated in the past month, and more than 40 percent had engaged in solo sex within the past year.

When it comes to measuring sexual pleasure, men and women don't seem to be using the same yardstick. Although 85 percent of men thought that their partner reached orgasm during their most recent sexual encounter, only 64 percent of women said they had actually climaxed. So are a lot of women faking it? Not necessarily, says Reece. "A lot of people think this means that women are lying, but some men don't know if their partner had an orgasm or just assume that she enjoyed it as much as they did." In other words, men don't always ask and women don't always tell. The survey also found that men are most likely to climax from vaginal intercourse, while more women are more likely to achieve erotic bliss from other stimulation, including receiving oral sex.

Ultimately, the survey offers an empowering message: Anything that makes you happy in bed is normal—and healthy—at any age. If there's something new you'd like to try, that's normal, too. Couples all over America are exploring an expanded range of erotic activities to discover what gives them the most pleasure. However, it's important to practice safe sex at every age and talk to your gynecologist if you experience any discomfort during intercourse. (For a guide to below-the-belt health and solutions to common sexual concerns, read *The Vaginal Dialog*, page 28.) And if you're not in the mood to make love, just say so.

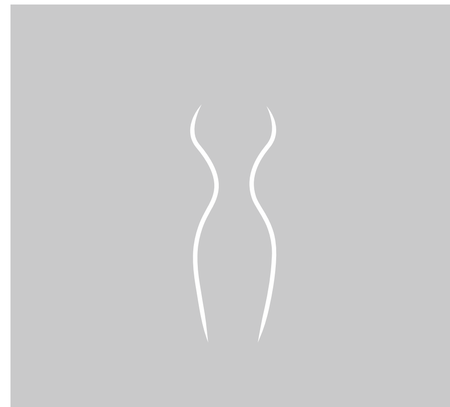


food & fitness

8 Reasons to Get Moving—Now!

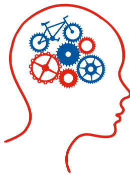
Here's why you should make exercise your top priority

By Winnie Yu



Walk. Run. Spin. Lift. We've all heard how important it is to exercise. After all, it's the key to maintaining a healthy weight, so you can look good and squeeze into those jeans, right? In reality, of course, exercise is so much more than that. It's an anti-aging remedy, a bone booster, and a sleep tonic, all rolled into one. "Everyone talks about getting Botox®, but exercise is the true fountain of youth," says Sharon Brangman, MD, president of the American Geriatrics Society. "Do something you enjoy, and it won't feel like torture. And if you have a buddy with you, you'll add a social component, so it won't be so onerous." Here are some of the big benefits you'll reap:

More Brain Power 01



A good workout can do wonders for your brain. For starters, regular exercise can improve memory and cognitive function. "Exercise turns on the genes that make a type of growth hormone for the brain, known as BDNF (brain-derived neurotrophic factor)," says David Perlmutter, MD, a neurologist in Naples, FL, and author of *Power Up Your Brain* (Hay House, 2011). "BDNF enhances the way brain cells connect to each other and the growth of new brain cells, and serves to protect existing brain cells from damage."

This benefit may also help reduce your risk for Alzheimer's. "Degeneration of the brain's memory center, the hippocampus, is a hallmark of Alzheimer's disease," Perlmutter says. "Regular aerobic exercise is associated with an annual growth of the hippocampus by an astounding two percent as opposed to the normal process of aging in which this area loses about one to two percent of its mass each year." According to the Alzheimer's Association, regular physical exercise may be a beneficial strategy to lower the risk of Alzheimer's. The association recommends a medically approved exercise program as a valuable part of any wellness plan.

Sounder Sleep 02

Recent research from Northwestern University in Chicago, IL, found that adults age 55 and older who had insomnia improved their sleep patterns by doing two 20-minute bouts of aerobic exercise four times a week, or one 30- to 40-minute workout four times a week.

"We don't know exactly why it helps us sleep better, but we have some ideas," says Phyllis Zee, MD, the lead author of the study and associate director of the Sleep Disorders Center at Northwestern. "Exercise spurs metabolism and our metabolic need for sleep. Physical fitness decreases inflammation and stress, and also lifts our mood, which can help us sleep."

Enhanced Mood

Physical activity doesn't just make us happy—it can actually alleviate depression, says Mary Jane Johnson, PhD, a spokesperson for the American Council on Exercise. Researchers at Duke University in Durham, NC, have found that exercise had the same positive effects on depression as sertraline (Zoloft®). Though the exact mechanism isn't clear, exercise does increase levels of serotonin, a neurotransmitter that enhances mood as well as tryptophan, a precursor to serotonin, Johnson says.

Try exercising with others or outdoors for an extra boost, she adds. Repetitive workouts such as spinning, swimming, or dancing are particularly effective for triggering the release of serotonin, says Pamela Peeke, MD, assistant clinical professor of medicine at the University of Maryland, School of Medicine, in Baltimore, and author of *Fit to Live* (Rodale Books, 2007).

Heart Protection

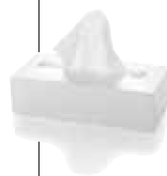
Physical activity is the foundation of preventing heart disease, says Nieca Goldberg, MD, a cardiologist at New York University and author of *Dr. Nieca Goldberg's Complete Guide to Women's Health* (Ballantine Books, 2009). "A regular, moderately-paced walking program done every day at 3.8 miles per hour can lower your heart disease risk by 35 to 50 percent," she says.

Exercise lowers blood pressure by making your blood vessels more flexible. "Relaxed blood vessels not only lower blood pressure but are also resistant to plaque build up," Goldberg says. In addition, exercise raises HDL cholesterol, the good kind that improves the transport of bad cholesterol (LDL) out of the blood. Moreover, physical activity lowers blood sugar levels, which helps you lose weight and prevent type 2 diabetes.

Less Belly Fat

Too much fat in the midsection means you'll have excess visceral fat, the kind that increases inflammation and ups your risk for cancer, diabetes, and heart disease. Exercise—both cardio and strength training—helps shrink belly fat, says Mary Jane Minkin, MD, a clinical professor of obstetrics and gynecology at Yale University in New Haven, CT, and co-author of *A Woman's Guide to Perimenopause and Menopause* (Yale University Press, 2005). "I started a weight training regimen six months ago, and along with improved muscle mass, my fasting blood sugar has dropped 10 points," Minkin says. High levels of fasting blood sugar mean you're at greater risk for developing diabetes.

Increased Immunity



Regular exercise is also the best defense against the common cold. A study in the *British Journal of Sports Medicine* found that people who exercised aerobically for 20 minutes or more at a time—five or more days a week for 12 weeks—had 43 percent fewer sick days due to the common cold compared with people who did no aerobic exercise.

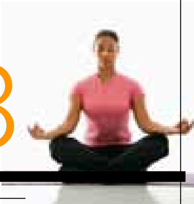
"No pill or supplement comes close to the cold-prevention power of aerobic activity, but time and effort are requisite," says David C. Nieman, DrPH, lead author of the study and director of the Human Performance Lab at Appalachian State University in Kannapolis, NC.

Neiman says exercise can shorten the length of a cold as well. "Of all lifestyle factors, aerobic exercise done five or more days per week was the most powerful in lowering the number of days with an upper respiratory infection and symptom severity," he says.

Stronger Bones 07

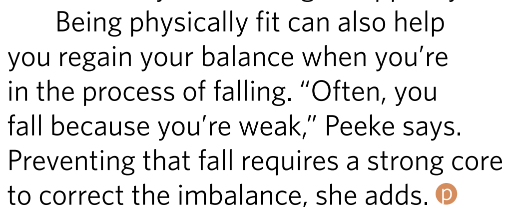
Bone is living tissue that is constantly in a state of turnover. As you age, the breakdown of bone accelerates while bone formation slows, which puts you at risk for osteoporosis. Exercise is essential to increasing the integrity of bone, particularly with weight-bearing exercises such as walking, dancing, hiking, elliptical machines, aerobics, and stair climbing.

Weight-bearing exercises use your own body for resistance, which forces your bones to work harder. "When you exercise, the bony matrix is stimulated to turn over at a more rapid rate, so the osteoblasts that make bone are stimulated to do even more and faster, while the osteoclasts that break down bone have to work harder," Peeke says. Resistance training using free weights, elastic bands, and weight machines is also important for strengthening bone, according to the National Osteoporosis Foundation.



Better Balance 08

Every year, one in three women over the age of 65 suffers a fall, according to the Centers for Disease Control and Prevention. One of the key ways to prevent a fall is to exercise regularly, Brangman says. Exercise strengthens muscles, which helps you become more balanced and steady on your feet. "Muscles support our body structure which enables us to maintain our posture and ability to walk and move around," Brangman says. "If you don't exercise, you'll lose muscle mass over time—they'll get so soft that they can no longer support you."



Being physically fit can also help you regain your balance when you're in the process of falling. "Often, you fall because you're weak," Peeke says. Preventing that fall requires a strong core to correct the imbalance, she adds.

Getting Started

If it's been a while since you exercised, the hardest part can be making the decision to start. Begin by getting educated about the exercise programs available to you that suit your age, fitness level, goals, and limitations, says Mary Jayne Johnson, PhD, exercise physiologist and a spokesperson for the American Council on Exercise.

Start slowly. You might even want to do short 10-minute bouts of exercise at first instead of a lengthy workout. "The goal is to accumulate a certain amount of exercise during the day," Johnson says. "You want to make a conscious effort to move more."

If you have physical conditions such as osteoporosis, heart disease, or diabetes, talk to your health care provider about limitations. Then, zero in on an activity you think you'll enjoy. Walking is often a good start because it's easy to do and accessible. "The best exercise is the one that not only is safe and appropriate for your health and fitness level, but the one that you enjoy and can and will do," Johnson says.

food & fitness

Vitamins & Minerals

Help or Hype?

By Phyllis McIntosh

Wouldn't it be great to pop a daily pill that would lower our risk of major afflictions like cancer and heart disease? Back in the 80s and 90s, hopes were high that supplements of specific vitamins and minerals might prove to be magic elixirs. But some 20 major studies later, promise has turned to disappointment for nutrients such as vitamin C and E and the mineral selenium. One of the key issues is that people who take supplements often practice healthy lifestyles, so it's difficult to determine whether any benefits come from the pill or from the behavior.

The jury is still out on the health benefits of some supplements, including vitamin D and a daily multivitamin, so there may yet be good news. In the meantime, say the experts, taking a daily supplement won't hurt and may provide nutritional insurance for some people, especially those with a diagnosed deficiency. Just be sure to choose wisely and don't expect a daily pill to take the place of what's known to reduce risk of disease, such as stopping smoking, exercising regularly, and eating a healthy diet.

Disappointing Results

The early hope that vitamins might play a key role in preventing chronic diseases was based on laboratory research and observational studies, says J. Michael Gaziano, MD, a cardiologist and epidemiologist in Boston and professor of medicine at Harvard Medical School, who has been involved in much of the definitive research. "One main theory for antioxidants like vitamin C, E, beta-carotene, selenium, and zinc was that oxidation is important in a lot of chronic diseases," he explains. "As we age, various components in our body sort of begin to rust, and the idea was that certain vitamins might slow down that oxidation process."

"There's a lot of very interesting research that strongly suggests vitamin D may play a role in prevention of cardiovascular disease and cancer..."

But large randomized studies, in which thousands of participants were given a single vitamin, a combination of several, or a placebo, and followed for eight to 10 years, have found little benefit. Vitamin C and E supplements, for example, did not reduce risk of heart attack, stroke, or cancer in men over 50; vitamin E had no significant effect on preventing cardiovascular disease or cancer in women over 45; and neither folic acid, other B vitamins, nor vitamin D with calcium reduced risk of breast cancer among women in several studies.

A cautionary note: The US Preventive Services Task Force found that heavy smokers who take beta-carotene supplements actually have a high incidence of lung cancer and overall death rates. For this reason, it recommends against the use of beta-carotene supplements, either alone or in combination, for the prevention of cancer or heart disease.

Some Reason for Hope

While supplements so far have had little proven effect on cancer and heart disease, "eye disease is the one area where antioxidant vitamins have had some suggestion of success," Gaziano reports. Studies have shown that people given various combinations of B vitamins, E, C, beta-carotene, selenium, and zinc for two years or more had lower incidence or slower progression of macular degeneration, a leading cause of vision loss in older Americans.

The news also is encouraging about vitamin D, which is the subject of ongoing research. Already known to help the body absorb calcium and prevent osteoporosis, it may, according to recent studies, protect against chronic diseases and mental decline. An analysis of 18 studies of vitamin D found that people who take D supplements have lower rates of death from all causes. Furthermore, the study concluded, 53 percent of American women and 41 percent of men do not get enough vitamin D. Ironically, one of the best sources, sun exposure, itself raises the risk of skin cancer.

It may take a while to sort all of this out. "There's a lot of very interesting research that strongly suggests vitamin D may play a role in prevention of cardiovascular disease and cancer, and it may need to be given at levels considerably higher than we're getting in the diet and potentially even more than we're getting in an average vitamin supplement," Gaziano sums up. "A large trial being done by one of the groups I work with is looking directly at that question, but the jury is still out. We're at the same place now with vitamin D that we were with vitamin E in the 90s and with beta-carotene in the 80s."

Gaziano and his team also are in the midst of a study to determine if a daily multivitamin has disease-fighting properties; results are not expected until 2012. "What's different about this trial is that the other randomized studies have looked at a single agent or a combination of just a few vitamins," Gaziano says. "There's never been a long-term trial of a commonly used multivitamin like Centrum® Silver®."

What Should You Take?

While research continues, taking a daily multivitamin can still be a wise choice, especially for people on the go who may not eat the most healthful diet. "Also, many people over age 50 don't absorb vitamin B12 well from food, so the multivitamin can help avoid low levels," notes Walter Willett, MD, professor of medicine at the Harvard School of Public Health. Premenopausal women are often deficient in iron, he adds, so a supplement makes sense. After menopause, daily calcium plus vitamin D is essential for preventing osteoporosis. In light of the recent research on vitamin D, Willett also favors supplements that contain 1,000 international units (IU) of vitamin D, twice the current recommended daily value for people over 50.

More Tips

- **Ignore marketing gimmicks.** Whether vitamin C is derived from organic rose hips or mass-produced in the laboratory, your body won't know the difference. There is no evidence that nonvitamin ingredients such as echinacea and bioflavonoids are essential to health. Nor is there hard evidence to support claims that specialized multivitamins "promote" breast or prostate health, for example, or provide extra energy. (The energy boost usually comes from added caffeine.) The difference in formulations aimed at certain age groups are relatively minor. "Senior" supplements include no iron, because postmenopausal women usually do not require extra iron.
- **Store brands are as good as name brands.** In fact, they may be made by the same companies. But multivitamins do have a shelf life, so check the expiration date before you buy them.
- **Don't expect miracles.** Never rely on supplements as substitutes for eating right, taking prescribed medications, or making healthy lifestyle choices, Gaziano stresses. "Taking a multivitamin with the idea that it's going to prevent cancer or heart disease," he says, "is certainly premature."
- **More is not necessarily better.** In most cases, not enough is known about the effects of large doses of a particular vitamin or mineral, says Gaziano. To be safe, stick fairly close to the recommended daily allowance.

"Never rely on supplements as substitutes for eating right..."

The Vitamin D Debate

In the quest for a magic elixir to stave off chronic diseases, many promising candidates—vitamin E, folic acid, beta-carotene, selenium—have fallen by the wayside when large studies proved them ineffective. Most recently, hope rested with vitamin D, which some studies suggested might help prevent such killers as cancer and heart disease.

But a committee of the Institute of Medicine (IOM), a branch of the prestigious National Academy of Sciences, has put the brakes on the vitamin D bandwagon. The 14-member committee, convened by the federal government to look at both vitamin D and calcium, combed through nearly 1,000 studies and heard testimony from a bevy of experts. Their investigation concluded that both nutrients are indeed important for bone health. However, at this point there is no solid evidence that vitamin D plays a role in preventing conditions such as cancer, cardiovascular disease, diabetes, autoimmune disorders, and cognitive decline.

The findings were unexpected even among the committee itself. "It was surprising that the evidence was so inconsistent and so inconclusive and that few large scale randomized trials had been designed to look at chronic disease outcomes," says committee member JoAnn E. Manson, MD, professor of medicine and women's health at Harvard Medical School.

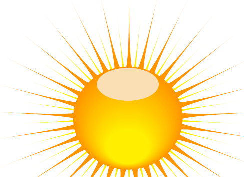
The committee concluded the prevalence of vitamin D deficiency has been overestimated as tests for blood levels have become more widely used. Measurements that laboratories use to determine if someone is deficient are not standardized and not based on sound scientific studies, which means that the same person could be declared deficient, or not, depending on which lab reads the test.

Moreover, the committee said, most Americans don't need as much vitamin D as they think and are already getting enough without high-dose supplements. A daily intake of 600 international units (IU) a day is sufficient to promote bone health in more than 97 percent of the population, even people who get minimal sun exposure. Seniors 71 and older should get 800 IU a day. The committee cautioned that for those who do take supplements, more is not better. At levels above 4,000 IU a day, the risk for harm to the kidneys and other

97%

of the population need 600 IU a day to promote bone health

SENIORS OVER 71 NEED 800 IU



Get your daily supplement through ordinary sun exposure

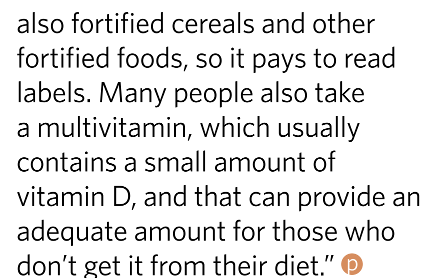
Salmon is a good source for vitamin D

organs begins to increase.

The committee acknowledged that the verdict on vitamin D is still out until rigorous clinical trials test its role in overall health and disease prevention. One study that may provide some answers is the Vitamin D and Omega-3 Trial (VITAL), slated to get underway in 2012. Funded by the National Institutes of Health and conducted by Harvard Medical School and the Brigham and Women's Hospital in Boston, the study will follow 20,000 men and women for five years to determine whether taking daily supplements of 2,000 IU of vitamin D or fish oil reduces the risk of developing cancer, heart disease, and stroke in people with no prior history of these illnesses. It is the first large scale randomized trial—in which some participants get a supplement and others a placebo—that will look specifically at vitamin D's role in cancer and heart disease, says Manson, who is directing the study.

"If the trial shows benefits, it's very likely the Institute of Medicine will convene another committee in the future to reassess whether the recommendations should be changed and the recommended daily allowance increased," she says.

So, what to do in the meantime? "Many people are able to get the recommended 600 IU of vitamin D a day through food and ordinary sun exposure," Manson says. "Foods high in vitamin D include milk, other fortified dairy products, and fatty fish, such as salmon and mackerel. There are also fortified cereals and other fortified foods, so it pays to read labels. Many people also take a multivitamin, which usually contains a small amount of vitamin D, and that can provide an adequate amount for those who don't get it from their diet."



How You Can Help The VITAL study that will look at the impact of vitamin D on chronic disease is recruiting participants throughout 2011. Researchers are looking for women 65 or older with no history of heart attack, stroke, or cancer. If you or someone you know is interested, send your name and mailing address to **vitalstudy@rics.bwh.harvard.edu** or call 1-800-388-3963. Read more about the study at **www.vitalstudy.org**.

Stuck in a Rut?

Dig yourself out with an enticing hobby

By Cathy Cassata

If each day seems like the last, try mixing things up with a new challenge. "Hobbies that show results give us the sense of accomplishing or producing something," says Ann Dunnewold, PhD, psychologist in Dallas, TX. "Many activities of life show no concrete outcome—work products are services, not tangible items, and parenting is definitely vague with delayed visible results," she adds. Finding a gratifying hobby might provide the spark you need. "Few women make time for themselves, and scheduling time for hobbies can be a way to say, 'I matter,'" says Dunnewold. "No one will make time for you, but you!"

Still need convincing? Take it from these women who put their hobbies first.

Wild Ride

Paulette Romtvedt, 52
Baker City, OR

Paulette Romtvedt jumped on her first Harley Davidson motorcycle at 42 years old. "I was on my 20th wedding anniversary trip in Maui, and my son had told us that we should ride Harleys. So we took his advice and immediately fell in love," she says. So much so that Romtvedt bought a Harley. "I rode it for years until I crashed it on a road trip in Idaho."

The accident didn't keep Romtvedt from her passion. A month later she was back on the road with her new motorcycle, a 650 Dual Sport. "I bought myself these fabulous white leather pants, gathered the courage to go for a ride, and all I kept thinking was, 'Yes, I still want this. I'm free!'"

A pre-school teacher for Head Start, which serves disadvantaged preschool children, Romtvedt says motorcycling re-energizes her for work. "My husband and I both have summers off so we do most of our riding then, but we try to bike once a month," she says. Motorcycling helps Romtvedt connect with her husband in ways she never imagined. "We've gone on some really romantic bike dates to camp sites, concerts, and beautiful places of nature," she says.

Nothing tops the sense of empowerment Romtvedt feels from motorcycling. "People don't expect to see a woman, especially of my age, when I get off that bike," she says. "After conquering something like riding to the top of Hells Canyon, I'm completely refreshed and ready to take on all that middle age throws at me."

Barbara Gallagher, 69
North Topsail Beach, NC

Find Your Thrill

Whether you know what hobby you'd like to try or don't have a clue, the following are good places to start. Most offer a variety of classes geared toward different age groups.

- Recreation centers
- Senior centers
- Community centers
- Colleges
- Church groups
- Craft and sewing stores
- Dance studios

Crafty Touch

At five years old, Barbara Gallagher started helping her mom cross-stitch kitchen towels. "We'd make them for every day of the week with different pictures of chores for that day, like Monday had a picture of washing clothes, Tuesday had an iron on it, and so on. It's funny when you think of how things have changed."

Gallagher's taste in hobbies has stayed the same. After graduating from nursing school in 1962, she worked in a hospital. "One of my long-term patients who was recovering from multiple surgeries crocheted to pass time," says Gallagher. "I admired the colors and patterns, and she offered to teach me, so after work I'd stop in to learn. I've been crocheting ever since."

After retiring two years ago, Gallagher put cross-stitching and crocheting into high gear. "When you're working, so much of your time is focused on that, so when you finally stop working, it's wonderful to have time just for you," she says. "If I get a project done, great. If I don't, it's okay. I like that I can put something down and go back to it later. The sense of accomplishment when I finish is even greater because it's at my own pace and on my own terms."

The best part of Gallagher's pastime is sharing her outcomes with others. "I have eight children and 10 grandchildren, so I take pride in giving them personal gifts I make especially for them," she says. "While my hobbies are about relaxation and time for me, it's rewarding that others can benefit too."

Family Ties

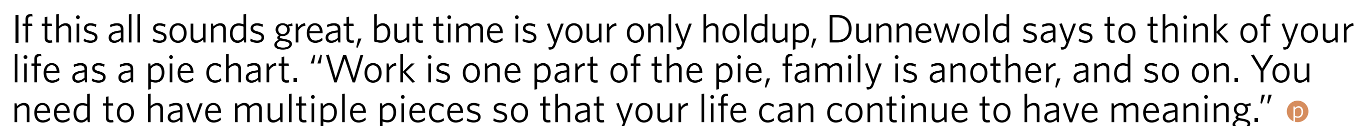
Donna Akers, 70
Cedar Rapids, IA

Old family photos kept calling out to Donna Akers. "I wanted to find out something about these people. I had heard terrific stories that were passed down through the family, but I wanted to understand more about their circumstances and what kind of lives they led," she says.

So three years ago, Akers started digging into her genealogy by subscribing to an online website. "I was fascinated and would stay up all night looking for specific people I had heard about and anyone whom I was related to," she says.

Akers uncovered information about her family and in-laws, but one story hit close to her heart. "My husband's great uncle had told me years ago about my husband's great grandmother who walked 45 miles from Missouri to Chillicothe, IA, the day she was freed from slavery," she says. "I researched, verified the story, and am so inspired by this amazing and determined woman's life. I even came across a picture of the one-bedroom house she lived in after she was freed."

Akers says there's always more family history to discover. "It's a hobby that I can do any time of the day, and it's something different and exciting to keep my mind engaged," she says. "Not only do I feel connected to generations of my past, but sharing what I learn helps create a new connection with my children and grandchildren."

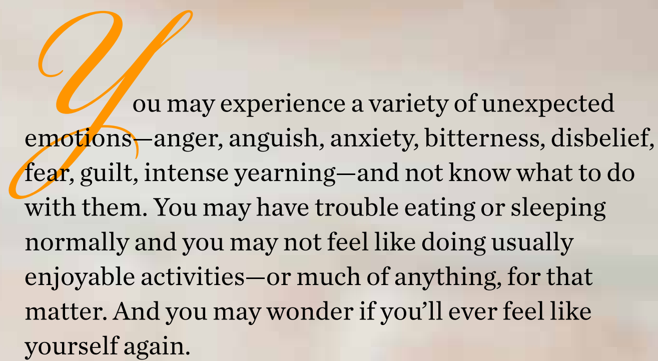


If this all sounds great, but time is your only holdup, Dunnewold says to think of your life as a pie chart. "Work is one part of the pie, family is another, and so on. You need to have multiple pieces so that your life can continue to have meaning."

GRAPPLING with grief

When you experience the loss of a loved one, the pain and sadness can be intense and overwhelming. Without that person in your life, your world may feel turned upside down.

By **Stacey Colino**



You may experience a variety of unexpected emotions—anger, anguish, anxiety, bitterness, disbelief, fear, guilt, intense yearning—and not know what to do with them. You may have trouble eating or sleeping normally and you may not feel like doing usually enjoyable activities—or much of anything, for that matter. And you may wonder if you'll ever feel like yourself again.

Rest assured: These are all normal reactions to grief and loss. "There's a pretty wide band of tolerance within any given culture in terms of how we grieve," says Robert A. Neimeyer, PhD, a professor of psychology at the University of Memphis and author of *Grief and Bereavement in Contemporary Society* (Routledge, May 2011). "But there are many different grieving styles. It's a highly individualized process."

In 1969, psychiatrist Elisabeth Kubler-Ross outlined what came to be known as the five stages of grief—denial, anger, bargaining, depression, and acceptance—a predictable series of stages that would eventually result in recovery and healing. Now, there's growing recognition among experts that people do not need to go through each stage to come out of the grieving process. "Grief doesn't end at any particular point—it ebbs and flows," says Joseph Nowinski, PhD, a clinical psychologist in Tolland, CT, and co-author of *Saying Goodbye: How Families Can Find Renewal Through Loss* (Berkley Hardcover, 2011).

There also isn't necessarily a typical response to the death of a loved one with a typical timetable for recovery. "Grieving has many phases and characteristics, but they're not the same for each person or each death," says Ann Rosen Spector, PhD, a clinical psychologist in private practice in Philadelphia and an adjunct faculty member in the department of psychology at Rutgers University. To some extent, the intensity of the grieving experience depends on your personality, your state of mind when the death occurs, and your relationship with the person who died. Naturally, the closer you are to that person, the more intense your grief is likely to be. The truth is, grief is often more like a roller coaster with sudden ups and downs and twists and turns than a predictable, linear process.

If anyone can attest to this, it's Sam Jernigan, whose husband died of cancer in June 2007. After his death, life became a daily struggle, one that was often aggravated by people's insensitive remarks about how long the grieving process should last or questions about whether she had started to date again. "Grief is something of an unpredictable and violent monster: One minute, I could swear I was 'getting better,' but then the beast would strike with no notice and I'd suddenly dissolve into tears at the supermarket or on a plane, really inappropriate places," says Jernigan, now 54, a consultant who lives in Grass Valley, CA.

For the first year and a half after her husband died, Jernigan also felt as though her brain wasn't fully functional; it took all of her mental energy just to get through the days and be able to fulfill the most basic aspects of her professional obligations. "In time, the grief monster has become tamer and life has begun to look more normal—on the outside, at least," says Jernigan. "But in my own mind and heart, the experience and deep trauma of losing my Beloved have been the closest thing to going totally mad. The whole perception of time becomes warped—how could this person be here and now gone? He quite honestly was my better half so there's a psychic amputation that feels like my very being has been split in two. It's like trying to get along with half a body."

The Trajectory of Grief

The depth and intensity of a person's grief may depend somewhat on whether the death was expected (after a serious illness, for example) or quite sudden (a result of a tragic accident). "If the source of the death was violent—due to a suicide, homicide, or fatal accident—denial and anger may be higher," Neimeyer notes. On the other hand, "with a death that is the result of a chronic or terminal illness, there's the advantage of having time to say things you hadn't said before and address problems in the relationship," Spector says. With a prolonged illness, however, there also may be mixed emotions following the death: A sense of relief, on the one hand, if the burden of caregiving has been lifted (which can bring feelings of guilt with it) but also a loss of purpose because you're relinquishing that role.

According to Neimeyer, research suggests that 30 to 50 percent of the aggrieved respond with remarkable resilience, bouncing back with an incredible ability to function, just like before their loss, within six months. "Another 20 to 25 percent respond with a profound sense of mourning that's still quite visible at six months, but over time they begin to experience an alleviation of distress and emerge, regain their ability to function, and become re-engaged with life," he explains.

But sometimes grief doesn't go away. If it doesn't and your grief interferes with your everyday life, consider seeing a mental-health professional. For about 10 percent of bereaved people, grief can turn into depression or evolve into "complicated grief" (aka, prolonged grief disorder), a syndrome in which someone gets almost "stuck" in the throes of disabling grief. People who've experienced major depression, generalized anxiety disorder, or panic attacks in the past or who are extremely dependent on the deceased are at risk for complicated grief. They may experience persistent feelings of intense yearning or a preoccupation with the person who died. They may feel a loss of purpose or goals in their lives. "This can drag on for years," Neimeyer says. "For people with complicated grief, life doesn't return to any sort of baseline."

Healthy Coping

While grieving, it's crucial to take good care of yourself—by consuming healthy meals, exercising, and getting enough sleep—so that the stress of your circumstances doesn't drain your energy and your emotional strength. In addition, it helps to:

- **Tune into your feelings.** "It's normal to have all kinds of emotions—sadness, anxiety, resentment, anger, guilt about feeling angry," Nowinski says. Give yourself permission to feel whatever you're feeling—without judgment—for as long as you feel that way.
- **Turn to—not away from—others.** Whether you seek support from family members, friends, or community groups, getting social and practical fortification is essential. "The key is to understand your own needs as clearly as possible, spell out what would-be supporters can do to help, and allow them to meet your needs imperfectly," Neimeyer says. Jernigan found tremendous comfort in a support group for young widows and widowers. "I've made lasting friendships through this group," she says. "They're the only people I find I can really share with heart-to-heart."
- **Distinguish between your reality and your loved one's.** "Acknowledge that the person who died is not you and you have a right to go on and laugh again and enjoy your life," Spector says. "Some people feel guilty about doing that."

How to *help* a Grieving Friend

When a friend has lost someone she loved, it can be hard to know what to say or do to help. "Very often, people are inclined to say, 'I'm really sorry. Please let me know if there's anything I can do,'" says Nowinski. "But people are often reticent to take you up on such an offer so you need to go beyond that." Here's how:

- **Offer practical assistance.** You might go grocery shopping for your friend, deliver home-cooked meals, or watch her kids so she can have a break or take a walk.
- **Extend invitations.** Ask the friend to join you in a pleasantly distracting activity such as playing tennis, dining out at your favorite restaurant, or going to a museum. It'll help take her mind off her circumstances, even briefly, and remind her there is still enjoyment to be had in the world.
- **Be a good listener.** One of the best ways to support your friend emotionally is to meet for a cup of tea and simply listen as she talks about how she's feeling.
- **Walk down memory lane together.** Share stories about how her loved one made an impression on you or small things he or she did that made a difference in your life. That often means a lot to someone who's grieving, Neimeyer says.

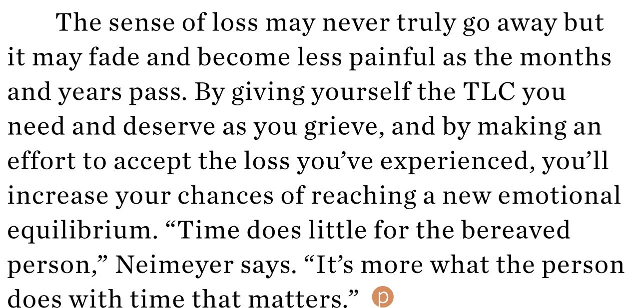
Pets Count

When someone you love dies, people understand how sad, stunned, or off-kilter you might feel and they often rally around to lend support. Unfortunately, the same can't always be said if the one who dies is your beloved dog or cat. People won't automatically understand why you feel so blue or weepy or exhausted (from sleeping poorly) after your pet dies. But the truth is, "many people have very strong relationships with their pets, so the loss is similar to losing a person they love," Spector says.

Complicating matters, our society doesn't have rituals or ceremonies that bring the community together to support you when you lose a pet, Spector points out. That's why it's up to you to find ways to grieve the loss of your pet in a way that feels right. To that end, it helps to:

- **Acknowledge how real your loss is**, perhaps by writing about what your pet meant to you or how you feel without him in a journal;
- **Reach out to those who can lend a sympathetic ear** and talk about how you really feel;
- **Hold a memorial service and write a eulogy** to acknowledge your loss and your pet's place in your life;
- **Create a scrapbook or collage** with photos and other mementos of your pet;
- **Consider adopting another pet**—there is no rush to do so, but there are lots of furry friends out there who need a good home.

- **Volunteer for a meaningful cause.** If you devote your time and energy to a charity your loved one supported or do something symbolic to honor him or her, you'll be taking steps to help yourself heal. After Nancy Gruskin's husband Stuart was tragically hit by a delivery cyclist going the wrong way down a one-way street in Manhattan and died of massive brain injuries in May 2009, people started speaking up publicly about this New York City problem. Five months after her husband's death, Gruskin created The Gruskin Foundation whose mission is to promote a more responsible bike culture and stricter bicycle safety laws. "Working on the foundation has been a way to make sure that Stuart's death was not in vain," explains Gruskin, now 50, and the mother of 14-year-old twins in New Jersey. "It has given me a sense of purpose and helped me make sense of his tragic death and cope with it."
- **Re-organize your environment.** Whether you rearrange a room or clean out your desk or a closet, "it feels good to have control over something," says Roberta Temes, PhD, a psychotherapist specializing in bereavement and hypnosis in Scotch Plains, NJ, and author of *Solace: Finding Your Way Through Grief and Learning to Live Again* (AMACOM, 2009). This is especially important as you learn to adjust to circumstances that are beyond your control.
- **Find new ways to embrace your loved one.** "Grieving is a process not of letting go but holding onto a loved one in a different way," Neimeyer notes. To honor and retain your connection with the person who died, you might exchange stories with others who knew and appreciated him or her or consciously remind yourself of wise or amusing things he or she used to say. "We lose the person's voice physically in our lives, but we can internalize their voices," Neimeyer says.



The sense of loss may never truly go away but it may fade and become less painful as the months and years pass. By giving yourself the TLC you need and deserve as you grieve, and by making an effort to accept the loss you've experienced, you'll increase your chances of reaching a new emotional equilibrium. "Time does little for the bereaved person," Neimeyer says. "It's more what the person does with time that matters."

Varicose Pains

By Stacy Brooks

Who says the signs of aging are mostly evident from the neck up? An estimated 31 percent of women will develop varicose and spider veins, a telling sign of age that can affect any vein in your lower body, most commonly those in the legs and feet. They are much more likely to develop as we get older and are notorious for popping up around times of hormonal changes, such as those that occur during menopause.

Varicose veins are easy to spot—dark purple or blue veins that are rope-like, twisted, and bulging. Spider veins are smaller, closer to the skin's surface, and are red or blue in color. They are often found on the legs or the face and may resemble a spider's web or a road map.

Varicose and spider veins can make women feel self-conscious about their legs, and some will go to great lengths to cover up. "I guess I hadn't looked at the back of my legs in a while. I was in a dressing room and when I turned to see the back, I was shocked at how many (varicose veins) I had behind my knees and how they were starting to pop out. Then I decided to wear capris for the rest of the summer," says Maura Shaunessey (*not her real name*), a teacher in Alexandria, VA. "It's embarrassing because I feel like they really age you and are not pretty. I try to stay tan in the summer to lessen the appearance of them and I would not wear dresses or skirts above my knees unless I had a tan. Winter is fine with pants."

A Cosmetic Concern and Much More

According to Nelson Lee Novick, MD, clinical professor of dermatology at Mount Sinai School of Medicine in New York, most people with spider or mild varicose veins do not have any symptoms at all aside from the visible changes in the veins themselves. But while the appearance of the legs often top the list of complaints among sufferers, varicose and spider veins can also cause discomfort and may be a sign of more serious circulatory problems.

"At least 50 percent of people with big and small veins complain of pain or dull aching or heaviness. Most often, people do not even realize that their legs hurt until they are treated and they feel better," says Mitchel P. Goldman, MD, voluntary clinical professor of dermatology at the University of California San Diego. Other symptoms can include burning, throbbing, and muscle cramping in the lower legs; itching around the veins; pain that gets worse after sitting or standing for extended periods; and ulcers around the ankles. Some people develop phlebitis—an inflammation within one of the veins—which must be treated to prevent complications, such as blood clots.

Varicose veins develop when the circulatory system is not working correctly. With normal circulation, the blood picks up oxygen from the heart and is pumped out through the arteries to fuel all the cells in your body. After the oxygen is delivered, the blood filters into the veins to be pumped back to the heart. The veins in your legs—with the help of your leg muscles and small valves within the veins that open to let blood go up to the heart and close to prevent it from flowing

“It is important to find a doctor who is an expert in these treatments. Anyone can inject veins, but it takes an expert to do it painlessly.”

backward—have to work doubly hard against gravity to squeeze the blood back up toward the heart.

As we age, the vein walls lose some of their elasticity causing them to stretch. The valves in the veins weaken, allowing some of the heartbound blood within to flow backward. Pooled blood can lead to additional stretching of the vein walls. Couple those factors with the pressure that standing and walking exerts on the veins along with poor muscle tone in the legs, and the stage is set for varicose veins to appear. Women are especially susceptible because female hormones relax vein walls.

Why Me?

A number of factors can put you at higher risk of vein problems. Your family tree can be a good predictor. Maura’s sister, Kathleen Vinnicci (*not her real name*), a restaurant manager in Washington, DC, remembers, “I always feared varicose veins growing up from looking at my mom and dad’s legs and asking about it. They would tell me ‘It’s hereditary, and you’ll soon have them too.’ Scary!”

Changes in circulation related to pregnancy and the extra pressure that it exerts on the lower body may speed varicose development. Pregnancy can also weaken the valves in the veins. So, even though the veins often improve after delivery, women who had varicose veins during pregnancy have a higher chance of seeing them return in the future.

Jobs that require you to sit or stand for long periods of time also contribute because being in the same position for too long interferes with blood flow. And what of the oft-told old wives’ tale that crossing your legs can lead to varicose veins? Well, that’s true, too. “Crossing the legs cuts off blood flow back to the heart,” Goldman notes.

What’s a Girl to Do?

If varicose veins are plaguing you, you can take action to prevent, slow the progression of, or eradicate them.

“If you stand all day, you need to wear medical support stockings. All my nurses, and even I, wear them every day,” Goldman says. You’ll need a prescription to get them, but happily, today’s stockings are actually attractive and come in a variety of colors. Exercise can help strengthen leg muscles, and if you’re overweight, losing weight will reduce pressure on the lower body and may improve the appearance of varicose veins. Elevation of the legs above the chest (when lying on your back) permits drainage of blood toward the heart and is another good method for dealing with an existing problem. But these techniques will not repair or reverse the damage.

If you want to get rid of varicose and spider veins for good, there are several options that can often be performed in your dermatologist’s office and require little to no down time.

Many times, simple injections with a solution that scars and closes the vein (sclerotherapy) are all that is necessary. These injections cause veins to collapse and become scar tissue that is reabsorbed into the body in time. “It is important to find a doctor who is an expert in these treatments. Anyone can inject veins, but it takes an expert to do it painlessly,” Goldman cautions.

Laser therapy uses intense pulsed light to destroy visible veins, which fade and slowly disappear—no needles or incisions needed. Laser treatments may take several treatments to achieve the desired result and are generally more effective in women with lighter skin tones. There is a risk of discoloration for women with darker skin.

Closure is a technique that uses radio-frequency energy delivered through a heated catheter or a small tube to shut the vein. One small incision above the knee is all that’s needed, and you can immediately resume normal activity afterward.

Ambulatory phlebectomy removes surface veins with a series of tiny punctures along the path of an enlarged vein. This procedure is performed under local anesthesia and does not leave scars.

“Spider veins are quite easy to treat. The gold standard is sclerotherapy,” Novick says. For those worried about destroying veins that you need, he adds, “these tiny veins actually serve no purpose, so they may be eliminated for cosmetic purposes.”

If you’re ready to improve or eliminate your varicose or spider veins, talk to a board-certified dermatologist. You’ll be on your way to working shorts and skirts back into your wardrobe in no time.

Ask the Doctor

Do you have a question you've been meaning to ask your doctor? Email it to us at pause@acog.org.

Q: Will my fibroids go away after menopause?

A: Fibroids typically shrink after menopause, but they don't disappear altogether.

Uterine fibroids are benign growths that grow on the inside of the uterus, on its outer surface, or within the muscle wall of the uterus and occur in about 20-25 percent of all women. Fibroids can range from small, pea-sized growths to large, round ones that may be more than 5 to 6 inches wide. Fibroids are most common in women ages 30–40 and occur more often in black women than in white women.

The cause of fibroids is unknown, but estrogen is thought to play a role in causing them to grow. In women nearing menopause, often no treatment is necessary if the fibroids are not causing bleeding or pain. The low levels of estrogen in hormone therapy are unlikely to make fibroids grow.

Many times fibroids cause no symptoms. When they do, symptoms can include changes in your period, pain or pressure in the abdomen or lower back, pain during sex, difficulty urinating or frequent urination, constipation, rectal pain or difficult bowel movements, and abdominal cramps. If you have any of these symptoms, make an appointment with your doctor.

Q: My last mammogram showed calcifications. Could taking calcium supplements have caused them?

A: Calcium in your diet does not cause calcifications in the breast, and breast calcification cannot be prevented through any specific measures. Breast calcifications (calcium deposits) are seen on mammograms performed in most women and are especially prevalent after menopause. On a mammogram, calcifications can appear as large white dots or dashes (macrocalcifications) or fine, white specks, similar to grains of salt (microcalcifications).

Macrocalcifications are almost always noncancerous and require no further testing or follow-up. They are often associated with old tissue injuries or aging of the breast arteries.

Microcalcifications are usually noncancerous, but certain patterns, such as tight clusters with irregular shapes, may sometimes be a sign of cancer. If calcifications are suspicious, your health care provider may ask you to have further testing, including additional mammograms with magnification views, or a breast biopsy.

Q: I never had a UTI before menopause, so why do I get them frequently now?

A: As you reach menopause, the level of estrogen in your body decreases as your ovaries make less of it. This can cause changes in the tissues around the urethra—the short, narrow tube that carries urine from your bladder out of your body—causing it to become dry, inflamed, or irritated. This can make you more prone to a urinary tract infection (UTI).

To help prevent UTIs, try:

- Emptying your bladder as soon as you feel the urge, or about every two to three hours
- Emptying your bladder before and after sex
- Wearing underwear with a cotton crotch
- Wiping from front to back after a bowel movement
- Washing the skin (using a gentle soap) around the anus and the genital area after using the bathroom
- Avoiding the use of douches, powder, and deodorant sprays
- Drinking unsweetened cranberry juice and taking cranberry pills which may decrease the risk of getting a UTI

Some women with recurrent UTIs may need to take preventive antibiotics. If you have symptoms of a UTI, see your doctor right away. With prompt, proper treatment, these infections can be treated with success.