

# Health Horizons

A FOCUS ON WOMEN'S HEALTH ISSUES



FROM THE OFFICE OF DR. STEVEN R. GOLDSTEIN

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## A Word From The Doctor

There is so much happening in the world of women's health. Hormone replacement therapy is still a big issue and still so very confusing (see the last issue of Health Horizons). This issue concentrates on emerging topics... 1) The Surgeons General's Report on osteoporosis and the state of bone health. 2) The not yet approved testosterone patch for women with sexual function issues. 3) An exciting new non-surgical, non-medicinal approach to women with urinary leakage (which may improve sexual function and pelvic pain as well) and finally, 4) My own private lesson on the menstrual cycle for those who either didn't pay attention in health class or just plain forgot.

*Dr. Goldstein is a Professor of Obstetrics and Gynecology at New York University Medical Center. He has written 5 medical textbooks, numerous chapters, research articles, and hundreds of National and International Presentations to other doctors.*

*This newsletter published periodically underscores his conviction that education of the patient is just as important in this day in age as it is a physician. His first book "Could it be perimenopause" describes a unique phase up to a decade before your first hot flash on fluctuating levels of unopposed estrogen (not the absence of estrogen seen in menopause) can cause some subtle and not so subtle bleeding abnormalities and subtle and not so subtle sociopsych symptoms (sleep disturbances, mood swings, free floating anxiety, inability to concentrate, memory lapses). His other book "The Estrogen Alternative What Every Woman needs to know about hormone replacement therapy and SERMs the new estrogen substitutes" was a manifestation of his unique position as perhaps the world's foremost authority on what this category of drugs (SERMs) do to the reproductive system.*

## UPDATE ON BONE HEALTH

In October the Surgeon General released a report of more than 400 pages on osteoporosis and bone health in America. It is one of those "good news – bad news" stories. The bad news is 10 million women have osteoporosis and 34 million have a thing called "osteopenia" (low bone mass, not yet osteoporosis). And while the risk of suffering a fracture is greater obviously if you have osteoporosis, more women in this country will fracture who only have osteopenia. The rate of fracture is less but because so many more women have it, the number of fractures is greater! The greatest risk factors are increased age, poor health and being "frail". Family history, thyroid disease, using and having used steroids, and weighing less than 127 lbs are among other risk factors. Left untreated, by age 80, 1 in 2 women will have osteoporosis. 15% of women will fracture a hip in their lifetime, and of those who fracture their hip, 20% will die

within one year! Another 20% will end up in a nursing home. Spinal fractures produce loss of height and can cause hump back. Finally, there are more fragility fractures per year in women than all of the heart attacks, strokes, breast cancer, and gynecologic cancers combined. Sound pretty bleak? The good news is this is a preventable process. No matter what your age (or even our daughters) adequate calcium and vitamin D (1200 mg and 400 international units per day respectively) and what I call FAMS (flexibility, agility, mobility, and strength) are essential! Also beginning at menopause we can measure bone mass with a DEXA scan. It is less x-ray exposure than at the dentist. And for those who still lose bone in spite of exercise, vitamin D and calcium there now non-hormonal medications like the bisphosphonates (Actonel, Fasomax) and the SERMs (Evista).

## PROPER DIAGNOSIS OF URINARY INCONTINENCE

Loss of urine is a very common problem in women. A recent survey found that 29% of women actually have some leakage of urine although very few offer it as a complaint. In fact, many women are extremely embarrassed by it and it has caused diminished quality of life for far too many women. Many believe it is simply a fact of life that must be endured as they age. Many believe it only occurs in women after menopause. Neither of these could be further from the truth. Loss of urine, other as the result of coughing, sneezing, laughing, or exercise, may be related to anatomic problems but the causes can be quite varied. Many years ago, the only approach to treatment was surgical and quite extensive surgery at that. Today the therapeutic approach totally depends on the exact nature of the problem - Is the urethra too mobile? Is the bladder unstable? Is the sphincter of the urethra defective? Or is there some neurological component? Proper diagnosis is essential before assigning appropriate therapy. There is currently medication for unstable bladder; drugs to treat genuine stress incontinence are in phase III trials. Less invasive surgeries that may soon be no more involved than a colonoscopy done under conscious sedation, have been developed and are being perfected. Special exercises, bladder retraining, and voiding strategies now exist. HOWEVER, IT ALL STARTS WITH PROPER DIAGNOSIS! Our office is now performing multichannel urodynamic testing to make the correct diagnosis. This is a painless 10-minute procedure performed by a special nurse. The patient starts with a full bladder and voids into a special commode that measures vol-

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## Proper Diagnosis of Urinary Incontinence

ume and velocity of urine flow. Then a tiny catheter is inserted in the bladder. It is half the size of a traditional catheter used during surgery or after childbearing, and is painless. It can measure the pressure in the bladder and urethra. The bladder is then filled and the pressures measured. The patient is then asked to cough and bear down at various points during bladder filling. Urethral pressures are measured as well. Finally, the patient voids again. The urodynamics test is covered by all insurances including Medicare. If you have urinary issues, please bring them to Dr. Goldstein's attention. You do not have to merely "live with it".

## Not All Blood Is Your "Period"

I sometimes tease and say how that I spent much of my day teaching "Menstrual Physiology". Still, it is said that 20% of all visits to the gynecologist are for abnormal uterine bleeding. To most patients any blood that comes out of their vagina is their "period". To me a menses is a cycle that is preceded by ovulation. One certain fact is that a menses takes place 14 days after ovulation, so that in a classic 28 day cycle women are ovulating on day 14 (by the way, day one is the first day of bleeding). As women get older, into their late 30's and 40's, ovulation often occurs earlier, say day 10-12 resulting in a menses on day 24 - 26 (remember we said 14 days later). If you do not ovulate you will not make progesterone. You will still make estrogen. If these estrogen levels stay very constant you may not bleed at all, but if the estrogen levels fluctuate this can destabilize the endometrium (uterine lining) and cause it to slough (bleed). This is often called anovulatory bleeding and results from unopposed estrogen. The hallmark of ovulatory cycles are their regularity. The hallmark of anovulatory cycles (those without ovulation) are their

irregularity. So, the women whose last 6 bleeding intervals is 27, 26, 44, 13, 17 and 28 days has probably ovulated 3 times and has had 3 anovulatory cycles. Unless we had done some tests we cannot tell if the 44 day cycle was without ovulation or did she simply ovulate late (day 30 and then get a late menses 14 days later:) Anovulatory cycles are very common in adolescence as well as perimenopausal women. Do us both a favor ... keep a good menstrual calendar. It goes a long way in helping me to help you!

## Pelvic Floor Physical Therapy

Incontinence is a huge issue for mature women, especially those who have had children. Classically it is manifested by losing even small amounts of urine with increases in abdominal pressure (coughing, sneezing, laughing, running,, etc.). In the past, the only treatment was surgical. The large majority of my patients who do occasionally leak urine will not, and should not, consider surgery. I agree. It is not severe enough to warrant the risks. Within the coming year there will be a medication for this condition (also known as stress urinary incontinence or SUI). This medication is called Duloxitene. But now there is another alternative. It is pelvic floor physical therapy. The muscles of the pelvic floor are muscles just like those in your arms, legs, or abdominals. In the past Kegel exercises were designed to strengthen them. However proper Kegel exercises are extremely difficult to do and do correctly. Now we have obtained equipment (and my Nurse Ivanka has been trained) that can enable patients to markedly improve the muscle tone of the pelvic floor. Studies show that pelvic floor muscle training results in a dramatic increase in continence (staying dry regardless of activity) and some suggestion of better sexual function and less pelvic pain, in those patients in whom that is an issue. Call us and make a time to come in and try this non-surgical, non-medicinal alternative. It is totally covered by insurance (including Medicare). Help strengthen the muscles of your pelvis!

## Female Sexual Function

In the future you will see a media blitz about female sexual function that would rival the launch of Viagra and bring female sexual function into the limelight in a manner not seen since Masters & Johnson. A new testosterone patch for women has just been reviewed by the FDA. The FDA wants to see longer term safety data before approving it. Initially it will be indicated for women who have had their ovaries removed surgically and are suffering distress about their sexual function. The medical term is HSDD (Hypoactive Sexual Desire Disorder). Testing in women without previous surgery and those not on HRT is ongoing. This is not a female Viagra. Remember that Viagra is not a drug for libido, it is for men with erectile dysfunction. Dr. Goldstein has been asked to serve on the Female Sexual Function board of Proctor & Gamble. He has told many of you that he is not comfortable with testosterone formulations that are made by compounding pharmacies and not pharmaceutical and thus not adequately quality controlled. But stay tuned... there will be more to come on this pharmaceutical grade natural testosterone patch.

### Women between the ages of 55-70- A new research study may be of interest to you:

While you may be concerned about starting hormone replacement therapy (HRT), you may also be concerned about memory loss and changes in mood. In collaboration with Dr. Leslie Prichep at the Brain Research Laboratories here at NYU School of Medicine, we are evaluating the effectiveness of Raloxifene (a SERM, Specific Estrogen Reuptake Modulator) for these quality of life changes. Raloxifene is an FDA approved drug used for osteoporosis and has been prescribed to postmenopausal women since 1997, without report of the side effects of concern with other HRTs. In fact, in healthy postmenopausal women, Raloxifene therapy has been demonstrated to prevent bone loss<sup>1</sup>, decreases serum cholesterol levels<sup>2</sup> and act as an estrogen antagonist in the breast and uterus<sup>3</sup>.

[1 Delmas, et al., New Engl J Med, 1997, 337:1641-1647; 2 Walsh, et al., JAMA, 1998, 279:1445-1451; 3 Khovidhunkit & Shoback, Ann Inter Med, 1999, 130: 431-439.]

If you are interested in participating or would like more information about this study, please ask call Dr. Prichep at 212-263-6288.

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If you would like to see a specific health issue addressed, please contact us at:**

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