the People's Doctor
A MEDICAL NEWSLETTER FOR CONSUMERS
by Robert S. Mendelsohn, MD
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IN THIS ISSUE:

Menstrual Problems: Part II

Dr. Robert Mendelsohn

This Newsletter completes my discussion of menstrual problems whose medical treatment is as deeply steeped in myths as are the taboos which once surrounded the subject. In addition, I bring to your attention Harvard Medical School's confession that their medical curriculum has not been producing the right kind of doctors. Since many regard Harvard as America's Number One Medical School, you can imagine the educational status of all the others!

Q Although my youngest child is two years old, I still have milk coming from my breasts, and I've only had one menstrual period. The doctors have taken x-rays of my pituitary gland as well as other x-rays. Although they were looking for a tumor, they found nothing. I was on the birth control pill for three years before my four-year-old was born, but I've taken no medication since then.

I feel fine except that I have no period, still have milk, and have a large stomach. Both children were delivered by Caesarean section. I developed toxemia during my first pregnancy and lost a lot of blood during delivery. My doctor says to get another set of x-rays and to stop worrying. But I just can't stop thinking something must be wrong.--L.T.

No menstrual periods two years after childbirth

A Either you have left out some vital information in your excellent history, or your doctor has a lot of explaining to do.

Your failure to menstruate can be explained easily by your continued lactation since women who breastfeed properly often do not menstruate for long periods of time. (Following the birth of her first child, my own daughter did not menstruate again until 21 months after delivery.)

Your body may also be trying to compensate for the blood loss you suffered during childbirth. Your large abdomen (not uncommon after Caesarean sections) would lead me to recommend a thoughtful examination of your healing processes, including the possibility of an incisional hernia.

The above are commonsense approaches to your situation. Unfortunately, medical students long have been taught that when they hear hoofbeats outside the window, they should think not of horses, but of zebras. You must be very careful that your doctor has not fallen into the "zebra trap" by searching for rare disorders of the pituitary gland, especially since such investigations may expose you to potentially dangerous irradiation.

I suggest you carry this Newsletter into your doctor's office. He may have a perfectly rational explanation for his behavior, in which case I will be happy to print his response. However, if he wishes to counter my long-distance opinion that you are a healthy, normal woman, the burden of proof is on him.

I am writing to ask your help in saving my uterus. I am a 35-year-old mother of three children who were all breastfed. My youngest child is now seven years old.

Four months ago, I started my menstrual period one week early, and I menstruated for two weeks. My M.D. husband, who is a family practitioner, did a uterine biopsy in his office, and the test showed no evidence of malignancy. He suggested I take Provera for three months, 10 days before my period is due to start, 10 mg per day for seven days. I did this for two months, and then I stopped because I don't like to take medicine. During my most recent menstrual cycle, I started spotting at mid-cycle, then bleeding, and then bleeding profusely and passing clots. I am in excellent health otherwise, and I'm not ecstatic about having a hysterectomy. I have not taken oral contraceptives since the children were born, and I use a diaphragm for birth control.

Could I be deficient in some vitamin? Should I have a D & C and hope that will control the problem? I have started back on Provera, and the bleeding has slowed down considerably. I'd like to avoid a hysterectomy if I possibly can.

I have been a leader in La Leche League for six years, and your contributions to our organization through the years are greatly appreciated by all of us.--Texas Reader

Provera after one missed menstrual period

As a doctor's wife, you must be particularly careful because you fall into a special high-risk category: Fifty per cent of doctors' wives have had hysterectomies, apparently the highest rate in the country.

Now, let's take a commonsense view of your situation. You had one unusual menstrual period, hardly a noteworthy event in the lives of most women. For that, your well-intentioned M.D.-husband performed a biopsy and gave you one of the strongest female hormones in the medical arsenal. Both of these measures can lead to ensuing menstrual problems of their own.

You have a good health history, malignancy has been ruled out, and you are justifiably suspicious about the benefits of hysterectomy. Therefore, I recommend that you quickly back away from medical treatment and instead start talking to women you know who are at least your age and who have lived through an irregular period or periods without D & C's, hormones, hysterectomies, and other forms of massive medical intervention.

Many physician-husbands of La Leche League members point with pride to the knowledge about breastfeeding they have gained from their wives. I predict that the knowledge you gain from your discussions with wise women about menstrual irregularities will provide an equally eye-opening education for both yourself and your doctor-husband.

Q I am a 31-year-old wife and mother who has stopped taking birth control pills after six years of continuous use. Prior to my only pregnancy (and prior to being on the Pill), my menstrual periods were always very heavy, often causing me to stay in bed for a day or two. My energy level also was very low. While I was on the Pill, my menstrual flow was not as heavy, but cramps and lack of energy often made me spend a day in bed. I am not by nature a lazy person--aside from housework, I bowl, play racquetball, etc.

Last month, I went off the Pill. My gynecologist told me not to expect a menstrual period for six weeks. Twenty-two days after that visit, I began menstruating more heavily than ever before. My energy level has been sapped to an all-time low, and I have been in bed for several days. My gynecologist is on vacation, so I have no alternative but to ask you these questions. What is happening? Is a heavy menstrual flow normal after the Pill is discontinued? Will use of the Pill alter future menstrual periods? I am ashamed to say I never thought to ask what to expect after I stopped taking the Pill. The booklet that comes with Ovral says only that there is as yet no evidence that side effects tend to develop or become worse with long-term use, whatever that means.

Can you tell me and the many others who now take the Pill what we should expect afterwards? My fear of the continuous heavy menstrual bleeding may be unfounded, but so far this is unlike anything I have ever experienced before. Can you answer my questions and alleviate my fears?--P.M.

How the Pill affects menstruation

A Abnormal bleeding and other effects, including infertility, are not uncommon after the Pill is discontinued. This seems only logical when one considers that Wyeth's Ovral, like other pills in the same class, works by suppressing pituitary hormones by virtue of the estrogenic and progestational hormonal activity of its ingredients. In other words, the artificial hormones in the Pill suppress the natural hormones in the body, thus leading to inhibition of ovulation and all the other effects of this kind of hormonal intervention. Thus, the entire spectrum of breakthrough bleeding, spotting, and failure to menstruate at all can occur during use of the Pill, and failure to ovulate or menstruate may occur after discontinuation.

Furthermore, changes in components that affect blood-clotting ability can cause many other forms of abnormal bleeding and clotting, including cerebral hemorrhage and cerebral thrombosis. The full description of Ovral in the Physicians' Desk Reference covers 14 columns, and careful reading of this small type makes this chemical truly a bitter Pill to swallow.

Your letter addresses itself only to the narrow issue of menstrual bleeding, but it seems to me that we must avoid tunnel vision in considering the Pill.

British studies have shown soaring death rates for women who used the Pill. These studies justify the statement made by Herbert Ratner, M.D., editor of "Child and Family" (Box 508, Oak Park, Illinois 60603), who characterized the Pill as "chemical warfare upon the women of this country."

Years ago, both physicians and patients could claim that there was no good evidence that the Pill was dangerous. However, the plethora of evidence filling scientific journals as well as the lay press over the past several years makes me wonder how a physician with any degree of literacy still can write a prescription for the Pill. And I wonder how any literate patient can have the prescription filled.

Q I'd like to comment on the letter from a woman who had experienced a heavy menstrual flow both before and after using birth control pills. I had a similar experience. My gynecologist said that the flow was a side effect of the Pill. After about eight years, I went off the Pill and decided to take kelp tablets and vitamin E. I had good results with this supplement, and I have been continuing with it for more than a year. A friend of mine, who had been troubled with highly irregular and heavy menstrual periods that were accompanied by severe cramps, tried kelp tablets, dolomite, and vitamins C and E at my suggestion; she now has a normal menstrual cycle with reduced pain. Both of us feel a lot more peppy.--Mrs. V.R.

A Thank you for sharing your experiences with my readers. It seems to me that when women of childbearing age exhibit practically any symptoms, the first question a doctor must ask is, "Are you now, or have you ever been, on the Pill?"

Q My problem concerns my future wife. She's very emotional and gets upset easily. She gets extremely painful headaches, and her doctor prescribed Dilantin, which I know is for epileptics. I understand she is not epileptic, and I don't see how these pills help her. She says they're supposed to lessen the frequency of her headaches, but they don't seem to relieve the pain when she gets a headache.

Another problem she has is with her menstrual period--she often gets it more than once a month or sometimes even after just one week. She says her doctor prescribed the birth control pill to control the frequency of menstruation, but the Pill doesn't seem to have helped. Is there something else she can do, since she doesn't feel well when she menstruates so often? Do you think she should see another doctor? She would listen to what you say, and I'm really interested in learning more about these things.

I work for the printer who prints up your monthly Newsletter, and I've picked up a lot of valuable information from reading them.--J.S.

A I'm flattered that you think that if I told you to tell your future wife to see another doctor, she would listen. But would that solve your problem? Your fiancee gets headaches, takes drugs, trusts her doctor implicitly, has menstrual irregularities, and takes the birth control pill. Such behavior patterns are important indications of one's personality and thinking. You, on the other hand, admit to knowing very little "about these things," and your writing to me indicates a basic questioning attitude.

I'm sending you some of my Newsletters you may not have seen on the subjects of headaches, oral contraceptives, and anticonvulsants to help start your search for information. But of far greater importance is communication between you and your wife-to-be on these issues. If you believe as I do that consensus on basic values is a necessary component of a successful marriage, I recommend as a first step that you read my Newsletters together with your fiancee and then have some long discussions.

Anaprox for menstrual cramps

Did you know that menstrual cramps have become a disease? According to Syntex Laboratories, the cramping pain associated with menstruation now is defined as an "age-old syndrome." In case you are not familiar with that Greek word, the dictionary definition of "syndrome" is "the aggregate of symptoms associated with any morbid process and constituting together the picture of the disease."

Doctors have tried to define menstrual cramps as a disease for many years, using another Greek word, "dysmenorrhea," the dictionary definition of which is "difficult and painful menstruation." I am used to doctors employing this kind of "creative diagnosis," since anything which can be classified as a disease is then subject to treatment by physicians. But the entry of drug companies into the field of creative diagnosis is a comparatively recent phenomenon.

Syntex Laboratories now is promoting Anaprox, advertised as a new drug to relieve "mild to moderate pain and for the treatment of primary dysmenorrhea." The vehicle for the promotional blitz is a female British doctor named Miriam Stoppard whom Syntex' press release describes as "physician, business executive, author, journalist, television reporter and commentator." Although only 43 years old, Stoppard is "retired from active business life as Managing Director of Syntex Pharmaceuticals Ltd." (surprise!) of Maidenhead (!), England.

Those of you who are long-term readers of mine will remember the column I wrote four years ago about Syntex Laboratories, which then was being severely censured for its failure to report tumors and animal deaths from experiments with a certain drug--the popular antiarthritic Naprosyn. In 1976, as a result of an investigation which disclosed scandalous laboratory procedures involving damage to animals by Naprosyn, the FDA tried to remove this drug from the market.

The scene now shifts to Anaprox, a name which may sound different than Naprosyn. But when the generic names are compared, Naprosyn turns out to be naproxen, and Anaprox turns out to be naproxen sodium. A chemical manipulation consisting of the addition of this ingredient of common table salt to naproxen apparently was sufficient to lull the FDA into approving Anaprox as a new drug. Yet the indications for the new Anaprox include rheumatoid arthritis and osteoarthritis (in addi- to the new "primary dysmenorrhea"), the exact conditions for which the old Naprosyn was prescribed.

Placing the prescribing information for these two supposedly different drugs side-by-side, one is struck by their remarkable similarity. Word for word, the contraindications, warnings, precautions, adverse reactions, and overdosage are identical. Furthermore, both list "menstrual disorders" under adverse reactions!

The adverse effects for both drugs include gastrointestinal bleeding, sometimes heavy and occasionally fatal. Central nervous system symptoms which occur in one out of 12 patients originally studied include headache, drowsiness, dizziness, lightheadedness, inability to concentrate, and depression. Skin reactions (itching, rash, sweating, easy bruising, and bleeding) occurred in one in 20 patients as did ringing in the ears, visual disturbances and hearing disturbances. It is possible that patients with questionable cardiac function may be at greater risk when taking Anaprox.

My guess is that Syntex really has hit the jackpot this time. Naproxen, a drug in search of a disease, finally has found one which can afflict half the human race. And the ideal promoter has been found--a woman, a doctor, and someone with a British accent--all combined in the same person. "Unstoppable Stoppard" (as the Sunday Times of London has referred to her) criticizes her fellow physicians for not taking menstrual cramps seriously enough. But she and Syntex can change all that. "Armed with

hard scientific information," she claims, "women now can argue their case from a position of strength." And Syntex has put into her mouth one of the most clever advertising slogans I have ever seen: "The new challenge is encouraging the dysmenorrheic patient to discuss her menstrual pain freely with her physician." Stoppard tries to shepherd women into doctors' offices by encouraging them to fully express their complaints about menstrual period discomfort so that they will be properly identified as "dysmenorrheic patients" available for treatment with "a reliable and effective therapeutic agent."

In my opinion, the real challenge is for the doctor and his patient to resist Dr. Stoppard's formidable advertising and promotional campaign. The best strategy for defense is for every doctor to share with every female patient the true history of Syntex Laboratories and the full information about the risks of Naproxyn and its Siamese twin, Anaprox. A rose by any other name....

I'm a 46-year-old woman who is in excellent health, physically and mentally, as are my husband and our children (ages 17, 18, 23, and 24). My monthly menstrual periods were always exactly on time each month, and I was able to become pregnant as soon as I stopped using birth control. For more than a year, my periods have become infrequent, now occurring about once every three months and lasting from four to five days.

I have no hot flashes, no mental problems (real or imagined), no dragging body. I'm up and about at 6 a.m., handle all housework in our six-bedroom home, and do all my own cooking and baking--bread included. I volunteer once a week at the local hospital. I weigh 128 pounds, three pounds more than I did on our wedding day more than 25 years ago.

Is it unusual that I have no problems at this stage of my life? I read so much about women having difficulties that I wonder whether I am premature in thinking that the problems of menopause have passed me by. There must be many women out there in the same boat, but I never read about them. Couldn't something be said about the "silent minority" --or are we REALLY a minority?--Faithful Reader

We doctors focus so much on the abnormal that we sometimes forget what is normal--if we know at all. And, not satisfied with treating real diseases that present real symptoms, we screen entire asymptomatic populations for signs of disease; we put healthy women at risk by assuring them that contraceptive pills are perfectly safe; we prescribe potent drugs like Ritalin for children who a few years ago might have been categorized as "restless" but are now defined as "hyperactive," and we interfere so much in the natural process of childbirth that few would even consider it a natural process anymore. The mass media has participated in this process by focusing strongly on the pathological in its advertisements, its dramas, and its emphasis on "medical breakthroughs."

In the December 11, 1975 issue of the New England Journal of Medicine, Dr. Lewis Thomas took on what he called "An Unhealthy Obsession" by pointing out: "The new consensus is that we are badly designed, intrinsically fallible, vulnerable to a host of hostile influences inside and around us and only precariously alive. We live in danger of falling apart at any moment, and are therefore always in need of surveillance and propping up."

Your letter represents a refreshing reference point for all of us. Continue to enjoy your life and your good health.

Medical News

Treating newborn jaundice

In the past decade or so, jaundiced babies have become a major interest in pediatrics. Doctors often give parents of newborn babies the impression that the diagnosis and management of jaundice in the newborn is an exact science with quantitatively established values of bilirubin (bile pigment) in the blood, and the capacity to skillfully and definitely distinguish the normal from the abnormal. But what is the real truth about newborn jaundice that doctors share with each other, but not with the general public?

Writing in Pediatrics in Review (April, 1982), M. Jeffrey Maisels, M.D., Professor of Pediatrics and Obstetrics and Gynecology, and chief of the Division of Newborn Medicine at the Milton S. Hershey Medical Center of Pennsylvania State University, Hershey, states: "Approximately 50 per cent of all normal newborn infants and a considerably higher percentage of premature infants appear jaundiced during the first week of life."

Rh-negative mothers may be given an injection, Rhogam, after delivery in order to prevent subsequent babies from developing the dangerous kind of jaundice which develops due to Rh sensitization. In case any mother reading this has been under the impression that these shots offer 100 per cent protection, Dr. Maisels clearly states, "In spite of the remarkable efficacy of Rh Immune globulin, it nevertheless fails to prevent immunization [Rh sensitization] in 10 per cent to 15 per cent of women at risk."

Doctors are fond of attributing jaundice in newborns to breastfeeding, warning mothers that if they do not immediately discontinue nursing, at least temporarily, their babies can develop brain damage. Yet Dr. Maisels states that "...no cases of overt bilirubin encephalopathy [brain damage] related to breastmilk jaundice have been reported to date."

Regarding therapy, Dr. Maisels cautions: "When carefully reviewed, the data from numerous studies of bilirubin toxicity are so confusing that they permit almost no rational conclusions regarding a therapeutic approach to these infants." And just in case you were sold a bill of goods on the scientific studies, Dr. Maisels correctly points out: "Numerous guidelines have been published over the years for management of jaundiced infants, but none has been tested experimentally...There are no properly designed studies...nor even observational data...that permit scientific recommendations to be made regarding the treatment of such infants at serum bilirubin levels below 20 mg." The good doctor wisely comes to the conclusion, "It is painful, but necessary to admit that we do not know."

In case any mother reading this has been told about the absolute efficacy and safety of fluorescent light phototherapy in treatment of newborn jaundice (hyperbilirubinemia), Dr. Maisels warns: "Unfortunately, such lights produce undesirable color changes in the babies as well as discomfort and vertigo in the nursery staff." While these disadvantages are short-term in nature, Dr. Maisels cautions about long-term dangers: "...phototherapy has many biologic effects, and long-term followup studies of such infants are still needed."

Because animal experiments have shown damage to the retina of the eye from phototherapy, the infant's eyes must be covered with patches during this light treatment. Although this sounds simple, Dr. Maisels correctly states, "These patches can become displaced and obstruct the nares [nasal openings] causing apnea [failure to breathe] and even asphyxia [unconsciousness from suffocation]. Thus, constant supervision is necessary to avoid this potential hazard." In other words, as long as your baby is under those lights, you had better make sure that someone is watching him all the time.

Finally, in some forms of jaundice, Dr. Maisels writes that phototherapy may produce a dark, gray-brown discoloration of the skin, serum, and urine, referred to as the "bronze baby" syndrome.

Will Harvard Medical School heal itself?

On its 200th anniversary, Harvard Medical School has admitted that something is wrong with it. Announcing it intends to abandon the curriculum which has evolved since the school was founded in 1782, Harvard now intends to produce "compassionate healers" who show care and concern for patients' well-being and who exhibit willingness to assume responsibility for professional behavior. The paradox is that they plan to have "students...teach themselves, especially by using computers" and at the same time make sure that students and teachers work closer together. The Harvard Medical School dean now admits that medical students are "crammed full of facts with little regard for what information a doctor really needs," and that medical students are kept too busy.

As a longtime critic of medical education, my first reaction on reading about this "educational breakthrough" was to stand up and cheer at the news that America's Number One Medical School confesses it has been doing things wrong. But on more sober reflection, I realized they still don't know how to do it right. Therefore, I lay down this challenge to Harvard Medical School: Will you produce students who will be honest with their patients? Will they be taught to give each patient for whom a powerful drug is prescribed the printed prescribing information on his drug? Will students in obstetrics learn to tell patients the risks of Caesarean sections? Will they learn from midwives how to do home births? Will students in pediatrics learn to tell mothers the risks of infant formulas and the dangers of immunizations? Will medical students on the surgical service learn to tell women the early and late complications of hysterectomy? Will they learn on their psychiatry service to share with patients the side effects of tranquilizing drugs, electroshock treatment, and lithium? Will students learning general medicine be taught to tell patients they need not come for a routine annual exam? Will students learn as much emergency medicine as paramedics already know? Will they learn at least as much pharmacology as the drug detail men? Will they have a chance to learn nutrition from a source other than the food industry-funded Harvard Nutrition Department? Will students have an opportunity to learn about chiropractic from chiropractors, acupuncture from acupuncturists, and breastfeeding from mothers who have successfully breastfed? Will all students learn physical medicine and rehabilitation as well as gerontology and geriatrics? Will students who work all night get the next day off so they will be awake the next time they face a patient?

If this kind of doctor emerges from the new Harvard Medical School, then I, together with millions of other Americans, will let out a sustained cheer. If not, then the highly-touted change in curriculum will turn out to be just another triumph of style over substance.

"MalePractice: How Doctors Manipulate Women," Dr. Mendelsohn's latest book, is now available in paperback from Contemporary Books ($6.95).

"Confessions of a Medical Heretic" is available from WarnerBooks ($3.25).

Dr. Mendelsohn now writes a regular column for Let's Live Magazine as well as a monthly column for RN Magazine.

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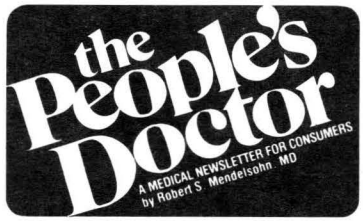

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Another View

by Marian Tompson
Executive Director,
Alternative Birth Crisis Coalition

Ten years ago, very few of us had heard of PMS (premenstrual syndrome) or knew much about it. Yet recently on the Phil Donahue show there was heated discussion as to whether or not PMS, like insanity, could legally be considered a mitigating circumstance which might make it impossible for a woman to act responsibly. Adding fuel to the conflict was some women's understandable concern that, by admitting the extent to which they suffered from this problem, they would be playing into the hands of sexists quick to exploit this evidence of women's inability to cope because of their "raging hormones."

Although, in the past, a woman menstruated fewer times than today because she was pregnant more often and breastfed between pregnancies, PMS has been with us a long, long time. Until recently, it wasn't taken very seriously because (a) most physicians, being male, had not experienced it; (b) it was not life-threatening, and (c) its occurrence was accepted as an inevitable part of a woman's reproductive cycle.

However, in 1969, Dr. Katharine Dalton wrote "The Menstrual Cycle" (Penguin Books) in which she reflected on her work with women who suffered from menstrual difficulties. Dr. Dalton used the term "premenstrual syndrome" to describe symptoms ranging from premenstrual tension and migraine headaches, bloating and breast tenderness to extreme emotional disturbances and depression. There seemed to be no single cause for these symptoms or any universally agreed-upon treatment. However, that is changing. On the Donahue show for example, a representative of PMS Action Inc. (PO Box 9326, Madison, Wisconsin 53715), pointed out that the "aggressive outbursts" some women experience during the premenstrual cycle are often symptoms of transient hypoglycemia which can be controlled by proper diet.

Other recent books also shed light on this topic, one of the best being "Menstruation & Menopause" by Paula Weideger (Alfred Knopf, 1976). Weideger's book presents not only clinical details of the reproductive cycle and old myths and taboos but also includes the pithy comments of many women who responded to a menstrual questionnaire.

A sort of "pop" digest of menstrual facts and lore can be found in "The Curse, A Cultural History of Menstruation" by Janice Delaney, Mary Jane Lupton, and Emily Toth (Dutton & Co., 1976). Then there's "The Wise Wound: Menstruation as a Powerful and Positive Resource in the Life of Women" by Penelope Shuttle and her husband, Peter Redgrove. The authors begin with the premise that childbirth and menstruation are two of the most basic experiences in human life. Just as the management of childbirth changes life experiences, so can a positive experience of her menstrual cycle enhance the growth and powers of the individual woman. Menstruation is presented as a profound, untapped resource of feminine energy and creativity.

Maybe it's because my own experience of menstruation has been a positive one that this last premise greatly appeals to me. I just can't believe that women have been cursed by having to menstruate any more than we have been cursed by having to bear children. We know how rewarding childbirth can be; menstruation accepted and properly understood might well be another blessing in disguise. The very fact that we now are questioning women's culpability for crimes committed during their premenstrual cycle shows us how much we still have to learn.