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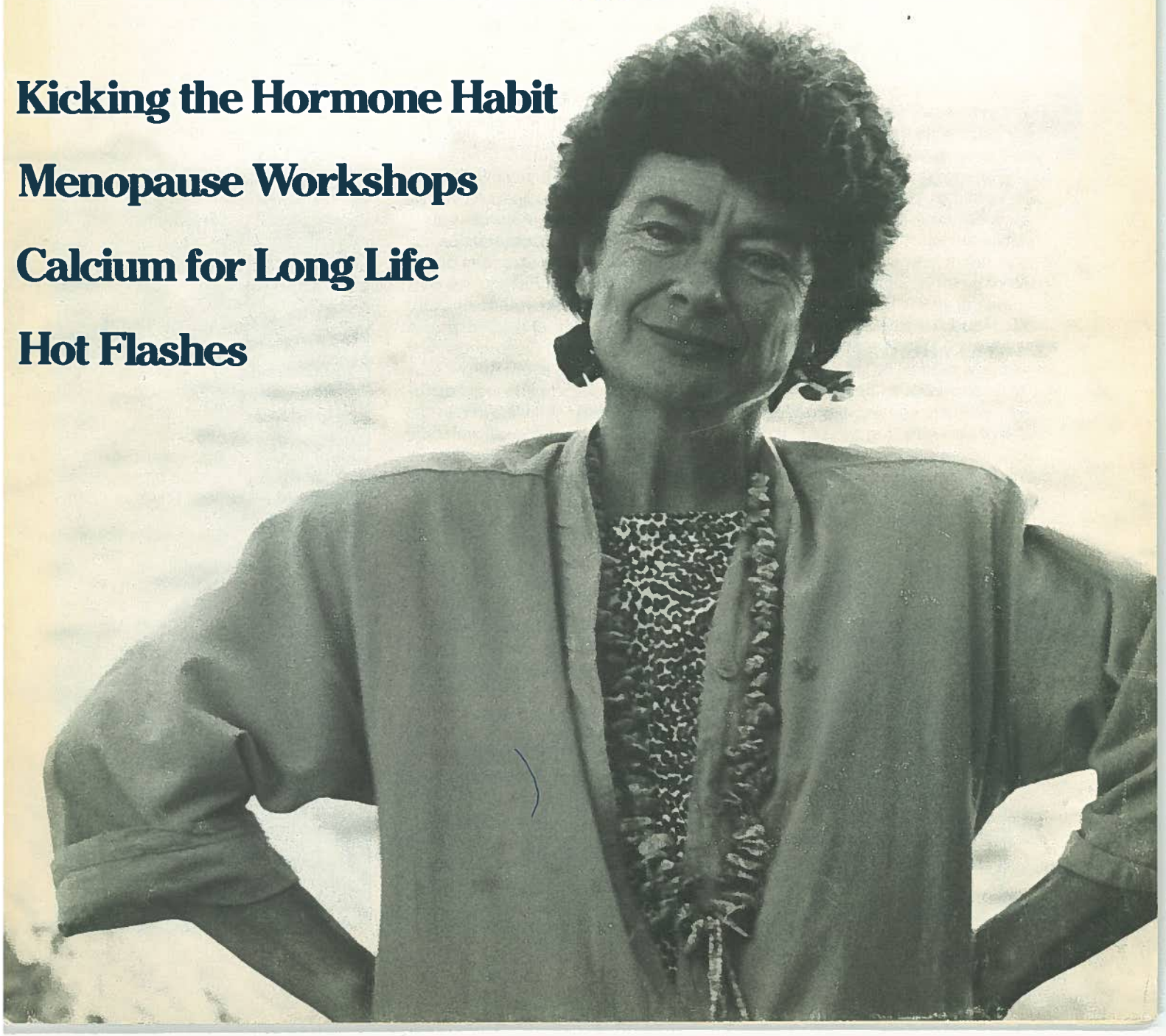
Healthsharing

Special MENOPAUSE Issue

A CANADIAN WOMEN'S HEALTH QUARTERLY

The Great Hormone Debate



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ALWAYS IN HEALTHSHARING

Pat Foote-Jones

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Healthsharing

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COLLECTIVE NOTES

COMPLIMENTS OF HEALTHSHARING

Hot with Pride

It is with pleasure that we have turned over the writing of Collective Notes *to our guest editor, Anne Rochon Ford. Anne is presently Resource Coordinator of Women's Health Care Programs at Women's College Hospital in Toronto. She is a former member of Women Healthsharing, and a co-founder of both the Toronto Women's Health Network and DES Action Toronto. This issue benefits from Anne's knowledge of menopause issues, developed in part from her research about images of women in medical advertising and a long-standing interest in hormone use in women.*

The Women Healthsharing Collective

When I was a member of Women Healthsharing (1982-1984) I shared the "collective guilt" for the fact that in almost five years of publishing, we had never printed an article on menopause. A women's health magazine that had never published an article on menopause. Absurd.

This was, perhaps, partially due to the fact that it was not an immediate reality for any of us — our oldest member at the time was under 40. Then again, neither were mitral valve prolapse, genital mutilation or any number of other topics we had featured over the years.

When Diana Majury asked me over lunch last spring whether I could help in providing names of some potential writers on the subject, I suggested that a special issue devoted to the menopause might be in order, given our years of neglect. Before the lunch was over I had agreed to edit the issue, not totally sure of what I had gotten myself into. I agreed to do it for one very simple reason: women need to hear the other side.

Since leaving Women Healthsharing in 1984, I have had the pleasure of meeting and getting to know some of the wonderful women who have contributed to this issue. One thing that all these women share is concern for the way in which this seemingly natural process, this normal change which all women go through, has become medicated. It is because they share that concern that they were the women I chose to approach about contributing to this issue.

Menopause is becoming a popular topic, osteoporosis even more so. Mainstream magazines and newspapers now frequently publish articles telling us of the importance of calcium and estrogen in preventing osteoporosis. We are reassured of the "safety" of taking estrogen, now that it is being given in conjunction with progesterone to minimize previously reported risks (i.e. cancer). One advertisement for Kraft cheese slices tells us that eating the stuff for the rest of our lives will help prevent this deadly disease.

At a conference on menopause which I recently attended, participants learned of certain Canadian doctors who now like to give estrogen to women who have not yet reached the menopause *as a prophylactic measure*. Some women are being told by their doctors that a fracture resulting from osteoporosis could have worse long-term repercussions than the cancer which could develop from taking estrogen to prevent it.

Women, understandably, are confused by this barrage of frightening information. Some have doctors who will listen to their concerns and not be so quick to pull out the prescription pad. Others are not so lucky. Most sources of information that women turn to propose a medical solution. This issue of *Healthsharing* does not.

With an overview of the current literature on hormone replacement therapy, Janine O'Leary Cobb tells us that we must learn not to think of the onset of menopause as cause for a trip to the doctor. Sidney Thomson offers one of the better solutions for women needing other women to talk to about this subject: menopause workshops. Ann Voda, who has been studying women's experiences of hot flashes, reports on the physiology of the hot flash and some useful information on how to get through them without hormones. Phyllis Jensen takes a refreshing look at the importance of calcium in *every* woman's diet. If you've ever stood baffled in front of the calcium section of your health food or drug store wondering how to decipher all the names and combinations (let alone which brand to buy!), this article will ease your task.

At that same conference where I learned of the Canadian doctors giving estrogen prophylactically, I also witnessed a minor revolution. All participants at the conference were given fans with their conference kits and later were told that these were to fan yourself if you were experiencing a hot flash. Over the lunch hour, Ann Voda stood up at her table and began fanning herself as her face turned a bright shade of red. A spontaneous round of applause broke out around the room. The few men in our presence (mostly doctors) looked somewhat stunned and visibly uncomfortable. We applauded even louder. We were applauding for Ann but we were applauding for all women who have concluded their decades of menstruating, in some cases have borne children, and can now move on to a new phase of their lives as women.

We must not be ashamed. We must, as Susan Sontag wrote of women aging, learn to tell the truth.

Anne Rochon Ford

LETTERS

Healthsharing reserves the option to print letters edited for length, unless they are marked 'not for publication.'

We encourage readers to write. Your debate is just as vital as the original articles and columns published in the magazine. Please take the time to share your opinions with other readers.

Match & Share Housing

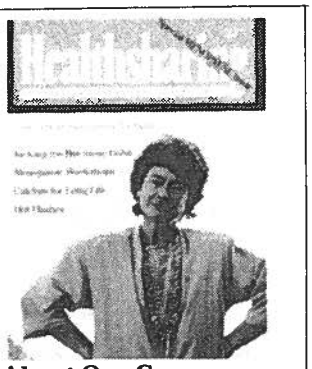
The fall 1986 edition of *Healthsharing* did a great disservice to its readers.

In Debra Pilon's article *There Was an Old Woman* . . . (an inappropriate title for the discussion that followed) an Ottawa-Carleton organization called Match and Share was mentioned, as were others. The writer did not do justice to the organization, its purpose and accomplishments. Instead, she went on at great length to report what one person said, and credits that person with "expert status." Ms. Doyle's comments about her aunt are hardly proof of the success or failure of anything!

There are advantages and disadvantages to many kinds of living arrangements. To highlight the disadvantages of Homesharing with total disregard to the many benefits to both home providers and home seekers does not give a full picture of the program. More to the point would have been an examination of the role of Match and Share in offering a viable option to a life in an impersonal institution — a solution that, in our day, is all to often the choice of our "throw-away" society.

The article might have further explored the *real life* story of the two ladies pictured, and told of the happy sharing situation that they have experienced for the past two years.

Sharon Peebles
Suzanne Hale
Match & Share/Homesharing
Ottawa



About Our Cover Photograph . . .

Libby Oughton, photographed by Cheri Westmoreland, appears on our cover. Libby is the 49 year old owner of Ragweed, a women's press in Charlottetown. Her own menopause has "been a long, curious, sometimes terrifying, sometimes satisfying experience" and she "can't imagine wanting to be any other age."

Every woman's health

When I saw Teena Marie Johns' review of *Every Woman's Health: The Complete Guide to the Body and Mind* (Spring, 1986), I was anticipating that she would be as enthusiastic about the book as I am. But alas, Johns deemed the book too general and mainstream.

About five years ago I discovered an earlier edition of this book and it helped me to know a great deal about how my body works. I believe that most women know much less about their bodies than they should (or would like to), and a basic guide such as this is ideal for them.

It is not meant to be the last word on any area of health, but rather it provides an overview. Yes, this is a very traditional approach to health but I think it would be very unlikely that a book written by physicians would take any other approach.

I supplement such books with periodicals such as *Healthsharing* and feminist health books. One shouldn't dismiss this volume out of hand. It has a lot to offer anyone who wants general information in a straightforward, understandable format.

Cathy Smith
Toronto, Ont.

PID: everyone's business

I was delighted to see your magazine take the forefront in an issue that I feel the American women's movement has long ignored. For years, especially since the "sexual revolution," many women have suffered needlessly from pelvic inflammatory disease because many doctors laboured under unfair, highly prejudiced views of both these diseases and the women who suffered from them. Not only did they refuse to test the male partner, but in many cases became so embroiled in trying to assess the morals that they totally forgot to treat the disease. Many of them had the attitude that "nice women don't get disease" and therefore, if a woman did not get well, it was her own fault.

Even more unfortuately, many women also believe that anyone who contracts a disease through sex is somehow morally bankrupt. Most people who are ill, are ill regardless of their beliefs and/or morals. Let us please stop these archaic, judgemental approaches to disease and start demanding proper treatments for these diseases, which are:

1. Avoid any type of surgery at all until infection is absolutely cleared.
2. Test *both* partners.
3. Treat *both* appropriately.
4. Follow up and repeat treatment of both parties as required.
5. Most importantly, listen to the patient!

There is an epidemic of chlamydia right now. Every year from three to 10 million cases occur in the United States, 20 per cent of those will result in infertility; many more will result in permanent debilitating pain. PID is everyone's business; and if women continue to be sexually active, they run the risk of contracting the infections that cause it.

Gina de Miranda
Bedford, Texas

Absurd quackery

On sitting down to write to you and explain why I am not renewing my subscription to *Healthsharing*, I went through my back issues and reread the letter from Dr. A. Schoichet of Mission, B.C. (Winter, 1984), on the same subject. I agree with what she said.

Not long ago, I met with a woman gastro-enterologist. We confessed to each other that during the years we had spent in the medical milieu, we had been made to feel so isolated from other women, and from the sisterhood we craved, that we somehow felt we had landed on Mars. We knew that we were just ordinary feminists, but even the mildest feminism, when you work in a mainly male environment, is tough.

Then when I go home and pick up a women's magazine, I get to read the same old doctor bashing that I've been reading for 20 years. This time I have

somehow landed on Jupiter.

Furthermore, *Healthsharing* seems unable to discriminate between useful alternative medicine and absurd quackery. This does not help women.

I wrote to the editor of the *Canadian Medical Association Journal* and enclosed some *Healthsharing* articles, pointing out that a sexist, classist, and racist medical system will inevitably produce reaction, sometimes irrational, and that if the male dominated system doesn't clean up its act, women will fall prey to more and more irrational therapists.

When I see a sympathetic review of what it's like being a feminist health worker struggling with an unsympathetic system, I'll resubscribe.

Kirsten Emmott
Vancouver, B.C.

Fluoride in drugs

I read Cathy Smith's *My Story, Our Story* (summer, 1986) with interest and concern. I have worked on environmental factors in health for a number of years. This has included study of toxic chemicals as related to hyperactivity, learning disability, women's problems, etc.

A number of chemicals are neurotoxic, as you may know, and can therefore contribute to depression, all too often considered only from the emotional and psychological point of view.

Fluoride is one of these chemicals and Toronto, like many cities and towns, is fluoridated I believe. According to American Medical Association figures, people in such areas ingest 5 mg/day. This does not include flouride from toothpaste, rinses, *cigarettes*, drugs, air pollution, etc. "Intakes of more than 6 mg of fluorine per day results in fluorosis. Symptoms are weight loss, brittleness of bones, anemia, weakness, general ill health . . . " (This quote is from the 11th Edition of *The Handbook of Poisoning* by Robert H. Dreisbach, MD, PhD, published in 1983.)

Haldol contains fluoride. Dalmane, Stelazine and a number of other drugs contain fluoride. It was originally thought that the fluorine-carbon bond in these drugs was stable and fluoride would not be released separately. "It is now apparent that few, if any, organo-fluorine compounds are biologically stable," says the National Research Council of Canada on page 71 of its *Environmental Fluoride*, written by Dyson Rose and John Marier.

I am deeply concerned about this possibility of treating a problem with a fluoride-containing drug when fluoride may be a factor in it.

Alice Steele
New Hampshire

International Healthsharing

I am a 24-year-old woman living in Poland. This year I finished my German study. Now I am learning English. My interests are: self-realization, spiritual development, new age, yoga and natural healing methods. For one year I have practiced polarity therapy.

In Poland there are very few people interested in such subjects. We have no opportunity to get magazines or publications on these themes. We have to get the knowledge ourselves.

I have received your address from the *Alternative Press Centre*. I think your magazine would be interesting and important for me and my friends. It would help us to come into touch with the people who are progressing the same way.

Teresa Bres
Torun, Poland

Genetic screening

I truly enjoy reading your magazine. I love the Canadian content, the updates and the analysis.

In the summer 1986 issue, *New screening method for genetic defects*, Susan Elliott describes CVS and states that "if it proves to be safe and accurate, it may become an attractive alternative for the early detection of genetic abnormalities." She also directs "interested women" to their nearest participating genetics department. We thought we learned with DES. Yet I am one of the few women I know to have refused ultrasound. We don't know the long-term effects, and we won't know until it's too late. I am no strong advocate of amniocentesis as the alternative; I would simply like to see more caution in reporting this new method. (By the way, more and more of us are interested in learning about current research around ultrasound and pregnancy — more in depth than what was presented in your issue of reproductive technology.)

Regarding Susan Elliott's article on iron overdose, many of us use Floradix, a natural iron supplement. Is there reason to be concerned about poisoning with this vitamin?

Thanks, and continued good luck.

Lisa Weintraub
Montreal, Que.

Response

Thanks for sharing your comments. Iron overdose is always possible regardless of the source — I would suggest checking the label for mg of iron per tablet or per teaspoon. The recommended daily dose is 18 mg for women, 10 mg for men and 6-10 mg for children, whether from supplements or from iron-rich foods such as organ meats, green leafy vegetables and whole grains.

S. Elliott

UPDATE

Abortion challenges

OTTAWA — One of Canada's most controversial topics — abortion — is back in the law courts. The Supreme Court of Canada opened hearings in Ottawa on October 6 to hear the appeal of doctors Henry Morgentaler, Robert Scott and Leslie Smolling after their jury acquittal of November 1984 was overturned by the Ontario Court of Appeals. The doctors were all charged with procurring illegal abortions after performing abortions in freestanding abortion clinics in Toronto.

The outcome of this case, which is not expected until the spring of 1987, will have far reaching effects extending beyond the question of accessibility to abortions. The doctors' lawyer, Morris Manning, is arguing the case based on a primary principle of feminism: control of reproduction as a fundamental woman's right essential to her autonomy.

Under the present federal law, a therapeutic abortion committee of three doctors decides a woman's reproductive fate. Criteria vary from hospital to hospital and many communities have no committees at all, leaving large parts of the country without access to abortion services. During the summer Newfoundland joined PEI as the two provinces with no standing committees on therapeutic abortion.
This case may provide an indication of how fundamental women's rights will be dealt with under the Charter of Rights and by the Supreme Court of Canada. Manning is also presenting several civil libertarian arguments which would also affect Canadian law broadly, not just abortion laws. He is arguing that the courts should not be able to overturn jury acquitals. Further, the defense asserts that lawyers must be able to argue that a law is unworkable.

No matter what the Supreme Court decision is, the struggle for accessible non-coersive abortions is far from over. In Quebec, where community health clinics have been providing abortions for years, the Liberal government is imposing funding cut backs such that centres are being forced to curtail or even suspend abortion services.

Despite this, there are still bright spots on the horizon. It is rumoured that more women's groups across the country are seeking ways to start local abortion clinics. Concretely, Concerned Citizens for Choice on Abortion is raising funds to open a clinic in Vancouver. For more information or to send donations, contact Concerned Citizens at P.O. Box 24617, Station C, Vancouver, B.C. V5T 4E1 or phone them at (604) 876-9920.

FRUMIE DIAMOND

Nurses work affected by computers

DARTMOUTH, N.S. — The National Federation of Nurses' Unions has just released the preliminary results of a three part study, INFOSTAT I, which is investigating the effects of computer technology on the nursing profession and resulting patient care. The urgency of this research, the first of its kind, cannot be underestimated: it is predicted that computers will be introduced into every acute care facility within the next five years.

Nurses, the largest group of health care professionals responsible for direct patient care, have had minimal input to date in developing patient information systems, yet they are accountable for the information contained in these systems.

The preliminary results indicate three crucial areas of concern: the way in which nurses are prepared to use the computer; how nurses are involved in decision making in regards to use of computers; the context in which the computer is used (for example, its physical location, its ease of use and the kind of information it provides). Most computer systems do not now provide any nursing information.

The final results of INFOSTAT I will explore the above areas in depth to enable nurses to negotiate with hospital administrators to ensure improved patient care and working environment for nurses as a result of computerization.

For additional information contact Kay Desborough, Infostat I, 2 Susan Place, Dartmouth, N.S. B3A 4M3, or phone (902) 469-5464.

FRUMIE DIAMOND

Regional reporters

Women Healthsharing needs additional regional reporters to write items for *Updates*. Suitable are short articles about local events and ongoing women's health projects, new services or legislation affecting women's health, and lobbying or strategy campaigns.
This is an ongoing commitment. Please contact us if you are interested. Tell us your involvement in women's health issues (if possible, send a resume) and let us know if you've ever written (if possible, send a sample). Be sure to include your current address and your telephone number(s). Send your letter to: Connie Clement, Women Healthsharing, 101 Niagara St.,Suite 200A, Toronto, Ont. M5J 1C3.

Regional reporters... where are you?

Controversial pregnancy drug still sold

This year approximately 10,000 prescriptions of a highly controversial anti-nausea drug were sold in Canada. The drug, used by pregnant women experiencing morning sickness, is best known by the brand name Bendectin. Bendectin was voluntarily withdrawn from the market in 1983. According to a segment on *The Journal* on October 20th, the problem didn't go away then. Duschenay Labs, a generic pharmaceutical manufacturer in Montreal, has been quietly selling Diclectin, their own version of the same drug, for 15 years.

Diclectin is a combination of an anti-histamine and Vitamin B6. The case against this combination drug is controversial and anecdotal: lab studies have linked it to animal defects, but epidemiological studies have failed to find hard evidence of teratogenicity in humans. Even so, approximately 1,500 liability cases against Merrell Dow , the manufacturer of the brand-name product, have been filed by U.S. families which link use of the drug with a birth defect. According to Gillian Findlay, a reporter at *The Journal*, a Washington, D.C. couple were just awarded $1.6 milion, in the second largest settlement.

CONNIE CLEMENT

Investigate the rest

LONDON, U.K. — In July, 1986 another major round in the battle for quality childbirth was won in England. Dr. Wendy Savage, a practicing obstetrician and professor charged with incompetence, was absolved of any wrong doing. The case against Savage presumed that she should have performed caesarian sections sooner than she did in 5 cases chosen from her caseload of 800 births during the past year and a half.

The British media covered the case as one of women vs. men and one of natural vs. high technology birth. Overall, Savage's perinatal mortality rate is 6.3 per thousand. For other obstetricians working at her hospital the average rate is 8.4. The section of the hospital of which Savage is in charge has a C-section rate of 10.9 (very close to England's national average); the section headed by the Chief of Obstetrics has a 17.2 rate. Unfortunately, only Savage was on trial. Her supporters wore badges during the hearings reading 'Wendy is Best, Investigate the Rest.'

Not only did Savage get off, attention *has* turned to the rest. The government's chair of the Commons Social Services Committee has asked the Prime Minister to ensure.that the accusing physicians are investigated. In a supportive editorial *The Guardian* called for increased accountability of the National Health Service. The trial, the paper stated, "revealed just how little control the public has over the health service upon which it relies. It was blindingly obvious from the start that Mrs. Savage was popular locally and that women and GPs wanted her to stay on."

This case parallels cases in Canada which have attempted to use hospital sanctions, inquests and court cases to hinder practitioners of non-interventionist birth approaches. "It's a victory for all of us," said Savage, "The right of a woman to choose what kind of care she has is at the heart of the battle."

EILEEN SIMMONS

Government asks few about birth control

OTTAWA — The government held closed door meetings in six Canadian cities during September, ostensibly to find out public opinion about fertility control methods and needs for information. The meetings were called, at least in part, to deflect the Canadian Coalition on Depo Provera's call for public hearings about Depo (medroxyprogesterone acetate).

Many feminist health organizations took the limited opportunity provided to address the all-doctor panel about Depo Provera. In each city at least one or two speakers spoke on behalf of approving contraceptive use status for Depo Provera. Others spoke about various aspects of family planning — need for improved funding, sex education, etc.

Across the country the panel's mandate and task changed: at the first meeting attenders were told the panel would simply channel comments to the deputy minister; by the end of the meetings, it was admitted to the press (which was barred from the meetings) that the panel would make recommendations.

The only concrete task the government has indicated in relation to the meetings is the writing and distribution of a new birth control pamphlet. Speakers across Canada spoke strongly against large investments of money going into writing yet another birth control pamphlet, when several adequate pamphlets are already in use.

Feminist health groups active in the coalition in Vancouver, Calgary, Winnipeg, Toronto, Montreal and Halifax each have some of the briefs presented to the panels. The Canadian Coalition on Depo Provera is collecting copies of the briefs presented to the panels.

CONNIE CLEMENT

Sweet talk

Many women use artificial sweetners to reduce their calorie intake in order to maintain weight or to promote weight loss. Results of a new study suggest they may not work. A survey of close to 80,000 older women (50-69 years) found that women who used artificial sweeteners were more likely to gain weight than non-users, regardless of initial weight. The study, which was part of a larger survey conducted by the American Cancer Society concludes that "the data do not support the hypothesis that long-term artificial sweetener use helps weight loss or prevents weight gain."

SUSAN ELLIOTT

Caffeine — how much is too much?

We are all aware that caffeine is contained in coffee, tea and some soft drinks — but what about other sources such as prescription and over the counter drugs? Many of these contain as much caffeine as is found in a cup of coffee. What is considered excessive caffeine intake for a given individual is difficult to estimate, but 500-600 mg. daily has been associated with a level of tolerance that results in withdrawal symptoms when caffeine is stopped suddenly. Excessive caffeine can cause an anxiety disorder characterized by irritability, tremulousness, muscle twitching, insomnia, sensory disturbances, irregular and speeding heart beats, flushing and stomach upset.

How Much Caffeine Is There . . .

In one cup of coffee? (5 oz.)	**Range/mg.**	**Average**
Brewed, drip method	60-180	115
Brewed, percolator	40-170	80
Instant	30-120	65
Decaffeinated, brewed	2-5	3
Decaffeinated, instant	1-5	2
In one cup of tea? (5 oz.)	**Range/mg.**	**Average**
U.S. brands, brewed	20-90	40
Imported brands, brewed	25-110	60
Instant	25-50	30
Iced (12 oz.)	67-76	70
In chocolate and cocoa?	**Range/mg.**	**Average**
Cocoa (5 oz.)	2-20	4
Chocolate milk (5 oz.)	2-7	5
Dark, semi-sweet chocolate (1 oz.)	5-35	20
In a soft drink?	**per 12 oz.**	
Cocoa-Cola	45	
Dr. Pepper	40	
Mountain Dew	53	
Pepsi	41	
Diet Pepsi	38	
Tab	47	
In these prescription drugs?	**per tablet or capsule**	
Cafergot	100 mg.	
Darvon	32 mg.	
Fiorinol	40 mg.	
In these over the counter medications?	**per tablet or capsule**	
Anacin	32 mg.	
Excedrin	65 mg.	
Dristan decongestant	30 mg.	
Triaminicin	30 mg.	
Midol	32 mg.	
No Doz	100 mg.	

data from *American Journal of Nursing.*

SUSAN ELLIOTT

Rural outreach for status

REGINA — In an effort to increase Saskatchewan rural women's access to resources and information on health and status of women issues, Regina Healthsharing, Inc. is sponsoring *Saskatchewan Women's Outreach for Status.* A series of winter workshops will be held throughout rural parts of the province. The workshops, using research and materials developed during the past one and a half years, will address patient assertiveness, women's relationship to the medical system, the utilization of alternative health practices and self-responsibility.

Status of women issues are often fragmented, isolated and separated out from a larger whole. This fragmentation contributes to the 'dis-ease' of women's low status. In these workshops, therefore, women will examine the interrelationship between women's health and status of women issues such as violence, social relations, poverty, educational needs, economic self-sufficiency, isolation, cultural identification.

Shannon Buchan and Carol Gordon have been working as coordinators on this project since April, 1985. They bring to their work and working process a feminist and holistic approach which centres around nurturing and supporting self-esteem, self-reliability, self-respect and the recognition and value of skills, perceptions and heritage acquired during our lives as women.

For further information about the project, contact Regina Healthsharing, Inc., P.O. Box 734, Regina, Sask. S4P 3A8 (306) 352-1540.

CAROL GORDON

Infant deaths higher

WHITEHORSE — Sudden Infant Death Syndrome (SIDS) is more common in the north. In the Yukon there have been 23 SIDS deaths out of 1,777 births since 1983, a rate of 8-10 per 1,000 births. The Canadian average is less than 2 deaths per thousand.

A number of factors have been associated with SIDS. For example, half of SIDS babies have upper respiratory tract infections, but not severe enough to cause death. According to Dr. Sydney Segal, chair of the Scientific Advisory Committee of Canada for the Study of Infant Deaths, known factors cannot be interpreted as causes of SIDS.

Evidence explaining the increased SIDS rates in the north is also inconclusive, according to an article by Irene Marusko in the September, 1986 *Optimist.* One factor may be the climate: winter is the season during which most upper respiratory tract infections occur. Although Canadian figures are not available, in Alaska three times as many Native children as non-Native children died from SIDS.

The latest research about causes of SIDS point to the possibility of a congenital defect of the nerve endings in children who die from SIDS or abnormal organs (e.g. a scar on the brain stem). It will be several years before enough evidence is accumulated to substantiate these theories. Segal feels that if proven true either of these theories might help parents blame themselves less when an unexpected SIDS death occurs.

ANDREA EISEN

International DES gathering

Carol Allen

Members of the DES Cancer Network attending the DES Action Conference, Sept. 1986: (l. to r) Harriet Simand, Joyce Bichler, Margaret Lee Braun, Vicki Dandridge, Linda Hastings, Susan Helmrich, Mary Sullivan, Carol Allen

BOLTON, ONT. — On September 26-28, DES Action/Toronto hosted the first international DES conference. The conference set a precedent as the first DES conference to reach beyond North America: joining the women from across the U.S. and Canada were representatives from the Netherlands and Chile.

The international perspective was new for many attenders. Amparo Claro, from the Isis International office in Santiago, told attenders that in Chile, where multiple drug use during pregnancy is not uncommon and records are often incomplete, identifying whether or not someone is DES exposed is extremely difficult. Ellen t'Hoen, of DES Action/The Netherlands, which is undertaking an international study into current use of DES, informed conference paticipants that DES is considered an essential drug in Brazil; it is still sold for use in pregnancy in many developing countries and is sold over-the-counter without prescription in some countries.

DES Action/Canada announced that new groups are forming (most recently in Calgary) and that they have developed new outreach materials in Quebec. In the U.S. research is suffering because of federal cutbacks. A lot of attention is being put to various court cases, including a suit on behalf of a third generation daughter born with cerebral palsy.

The conference included medical updates and workshops intended for local DES Action groups to improve necessary skills (e.g. fundraising, working with volunteers, counselling). Several workshops were emotionally laden — a comparison of the use of in vitro fertilization and the use of DES, gynecological self-examination, pregnancy issues.

The conference ended with participants deciding to move to increasing ties with feminist health organizations and, without draining energy from critical DES issues, to develop more joint actions on issues of concern.

CHRISTINE GAUCHER

Bottle-caries syndrome

Dentists at Montreal Children's Hospital are alarmed at the increasing number of babies as young as 9 months old with tooth decay. More than 400 youngsters are treated with fillings, reconstructions and cleaning each year. The culprits are sugar-coated pacifiers, sticky snacks and, as the name suggests, bottles of milk or juice, particularly when given to lull babies to sleep. Because the back of the upper teeth where the liquid pools is the first area to be affected, the problem often goes unnoticed until damage is extensive. Even though they will eventually be replaced, healthy baby teeth are crucial as they act as guides for the placement of permanent teeth. To prevent early caries, bottles used other than at mealtimes should be filled with water. Children who are drinking bottles of juice or milk should be held rather than allowed to lie down to avoid pooling of the liquid behind their teeth. Wipe infants's teeth daily with a piece of moistened gauze without toothpaste, and when the child is eating solid foods be aware of the fact that sticky snacks like raisins although nutritious, adhere to the surface of the tooth and can be detrimental. Most importantly, the dentists recommend that parents thoroughly check their children's teeth every other week and take a child to the dentist around her second birthday.

Fatness and menarche

Two recent studies of over 17,000 young women have confirmed that fatness is related to the time of the menarche. Women who began menstruating at an early age were found to be slightly shorter, about 4 kg. heavier and about 30% fatter than women who matured later. Environmental and cultural influences were explored, but they did not alter the results, according to a report in the June, 1986, issue of the *American Journal of Clinical Nutrition*.

SUSAN ELLIOTT

Sidney Thomson

Sharing the Menopause Experience

"If menopause is to become an integrated part of life rather than the separate crisis it now is, women must define and share their own experiences."

Paula Weideger
Menstruation and Menopause

When I first realized that the pattern of my menstrual periods was changing (sometime in my late 40s), I began looking for information to help me understand what was happening to my body. I quickly found out that, in the mid-1970s, there was very little easily available material and almost nothing of a positive or non-technical nature. I had become quite frustrated and discouraged when, in 1977, I discovered some books written by women for women, obviously a fall-out of the great strides forward made by the women's movement and the increasing popularity of self-help groups.

I felt so inspired by what I read (notably Rosetta Reitz's *Menopause: A Positive Approach*) that I decided there and then to give up my business job, with the goal of doing more research and eventually organizing menopause workshops. Soon after taking the plunge of retiring from office work, I accepted an offer from the board of education in North York, Ontario to organize a six-session menopause workshop for their continuing education department. I had to start swimming faster and sooner than I had expected.

That was five years ago. Since then I've been involved in many workshops, seminars, rap groups, documentary films and TV shows on menopause. Obviously I've learned a great deal in that time. Most importantly, I've learned that, although there is a wide range of normal symptoms, feelings and perceptions around going through "the change," each woman's experience of the process is unique to her.

There are, however, enormous benefits to be gained by sharing experiences with each other: new information, support and reassurance, validation of our symptoms and feelings, increased awareness of resources, and choices in coping with stress. The primary aim of the workshops I facilitate is to provide a place and an atmosphere where this sharing can take place.

The women who attend range in age from 40 to 60, and in economic and educational background. As the workshops have to accommodate different administrative guidelines (according to the sponsor), they vary in length from one six-hour day to ten two-hour weekly meetings, the most usual format being two or three sessions of three hours each. The number of participants ranges from six to 20. Most are in the paid work force, are or have been in heterosexual marriages, and have raised children. Older lesbians I have talked to have also often been through long heterosexual marriages. Not surprisingly, they feel that their symptoms are not affected by their lesbianism, but that perhaps they receive more emotional support from their partners than women in heterosexual relationships. Single women are in the minority in the workshops I lead. They are less likely to express concerns around personal relationships. Their concerns tend to be work-related and they worry about their ability or suitability to continue as post-menopausal women. One woman feared she might lose her job as an executive if a wrinkle or grey hair were allowed to show! This is a good example of the effect on women of the double standard of aging. As Susan Sontag says "Men are 'allowed' to age, without penalty, in several ways that women are not."

At the beginning of each workshop I introduce myself: name, age, number of years post-menopausal, why I think workshops are important, my background in homemaking, childrearing, teaching and business administration. I tell participants how I'm feeling at the moment, what I like to do in my spare time and anything else I can think of to break the ice. There's one thing I always emphasize: "I have had *no* medical training and am *not* qualified to given any medical advice." I go on to say that I'm not an expert on anybody's menopause except my own, that we are all our own experts and I hope we'll all participate in learning.

Then we get down to finding out what our particular concerns are, usually by means of questionnaires and group introductions. As we start talking about ourselves and our fears, we also talk about the myths and stereotypes of women in menopause which have been handed down both orally and in literature through many generations. Upon hearing that medical literature at the turn of the century considered menopause to be a terminal illness and that this attitude has persisted right up to the present, many

women realise that fears are not unfounded. Authors of *The Curse* state that: "Victorian medicine men knew in their hearts that, during the menopause, a woman could expect to have mental problems." Women usually greet this statement with hoots of laughter; even the horror stories we have heard are not as obviously misguided as this!

But women have been fed a great deal of misinformation about menopause and need to check out 'myths' with each other. One woman who had been given no information at all about menopause, felt a tremendous responsibility to learn as much as she could about it so that she could "speak freely to my five sisters and help them to understand." Another wanted to "... know that I'm not alone, to know if what I am going through is normal," and, "... to share with other women the sadness and emptiness that I am feeling." We can see from such statements the harm which results from the taboo against talking about menopause.

In the workshops, our discussions generally begin with some factual information which is aimed at demystifying what happens physiologically as women grow older. I like to start off by stressing that, as part of the reproductive process, menopause belongs uniquely to women and *each* woman's experience of it is unique to her. It is important to stress this fact, as it is only by destroying the myth of the monolithic nature of women's experiences, whether childbirth or menopause, that we can validate who we are and expand our knowledge of what is 'normal.'

A brief look at what happens physically during the transition from pre- to post-menopausal (i.e. the climacteric) includes a discussion on the gradual decline in the bodies' production of female hormones, the length of time this may take, the early changes in emotions or period patterns which may ensue, the usual menstrual changes which may occur prior to becoming post-menopausal. It is welcome news to many women that their bodies continue to produce androgens throughout life (some of which are converted into estrogen in fat cells). These hormones help to maintain energy, muscular strength, sex drive and feelings of well-being.

Fortunately, the majority of women do not have troublesome symptoms, and, like Eliza Farnham, a suffragist writing in 1860, may experience menopause as a time of "secret joy, spiritual growth and super-exaltation." For some, however, the stresses are considerable and the symptoms distressing and bewildering.

One woman reported hot flashes and night sweats so severe that she had to change her bedsheets every hour during the nights. Another had tingling in her hands and feet, palpitations and cold sweats, while other women have mentioned uncomfortable days and disrupted sleep from bloating, indigestion and joint and muscle pain. Every time someone reports any discomfort, there is at least one other woman in the group who is having a similar experience. The same holds true for feelings of anxiety, nervousness and depression which are also widely reported as part of menopause in statements such as: "I get depressed and have bad mood swings, like I used to have before my periods;" "I feel confused and irritable a lot of the time about things which never used to bother me." Women blame themselves for being difficult to live with. One workshop participant with a large family to care for spent many hours each day in front of a mirror practising smiling!

So far researchers have not been able to pinpoint the causes of distress in menopause. Could this be because almost no research has been done using women who don't seek medical help? Until very recently, no researchers have bothered to turn for information to the only real experts: the women who are going through and have gone through menopause. Some doctors and researchers claim severe menopausal discomfort is the result of genetic predisposition, more rapid than usual estrogen decline (especially in the case of premature surgical menopause), too high levels of hormones released by the pituitary gland in an effort to revive aging ovaries or low stress tolerance. I would add to these a lack of positive information, the disrespect our society shows to older women, and low self-images internalized early in life and reinforced by the limited options available to women.

There comes a point in every workshop when someone lifts the lid of

Katharine Mann-Buchanan

Sidney Thomson leading a workshop

Pandora's box by enquiring diffidently, "Will taking estrogen help?" and out pop all the questions, conflicting stories (often several times removed) and gut feelings about Hormone Replacement Therapy (HRT). We all scoff at ludicrous claims that estrogen is an "elixir of youth." Participants are insulted by comments, made by doctor-writers such as Robert Wilson and David Reuben in the 1960s, about post-menopausal women who choose not to remain young and feminine forever.

But many participants have also heard about women with severe symptoms who were helped over the transitional period by taking HRT or that HRT is often prescribed to prevent osteoporosis. At the same time women are concerned about the potentially dangerous side-effects linked to HRT. We have a lively discussion about what we know of the risks, benefits and contraindications of hormone treatment. Some women find the self-rating scale in the book *Menopause, Naturally* useful in helping to determine a personal risk profile.

Communicating with health practitioners is an important issue for nearly all women. "My doctor gave me some pills but didn't explain what they were for and I'm afraid to take them," tells a woman whom one couldn't imagine being afraid of anything; another woman, obviously very competent in her business life, remarks that she has recently had a hysterectomy but isn't sure what parts of her were removed! "How will I know when I'm in the menopause?" she asks the group. These questions lead to a discussion of what choices we have in finding the kind of medical/therapeutic help we want. We talk about our right to shop around, as well as when and how to ask for a second opinion. We encourage each other to take responsibility for our own health by becoming informed, asking questions, participating in medical decisions and complaining when we are not satisfied.

Armed with information and support, it becomes easier to question what other people think we need and to decide for ourselves what makes us feel better and more in control of our lives. "I know now what I'm going to do the next time I go to the doctor," said a woman who had never spoken in the group before. "I'm going to take a friend along for support and I'm going to make sure that the doctor listens to what I say and that I understand what he has said before I leave. I'm also going to tell him what my experience of menopause is like. Thank you." And she sat down smiling but with tears in her eyes.

Workshops which address women's real but often unspoken health needs are a direct result of the excellent work done in the past and still continuing by the women's health movement — collectives, networks, health education projects, self-help groups, etc. Thanks to these groups, women can now obtain information and support on most aspects of life cycles and health problems. Thanks to them also, many more individual doctors are increasingly sensitive in their treatment of women. Medical *training*, however, is still deficient in addressing women's concerns, while continuing to reflect and reinforce society's traditionally disparaging attitude to older women.

On the whole, women want to learn how to manage their own way through the menopausal process. There is growing interest in the benefits of making changes in dietary and exercise patterns, factors that have proved to be important for good health and increased energy in later life. A participant who, in answering the questionnaire I provided, stated that she was attending the workshop because she felt desperate about her lack of energy and frequent depressions, was told by other participants that they had been helped by vitamin and mineral supplements. She was referred to books they had read and therapists they had consulted. Some women find non-hormonal jellies or vitamin oils effective for vaginal dryness, especially when accompanied by Kegel's pelvic floor exercises. [Kegel exercises can also help with problems of incontinence and increase sexual pleasure. See *The New Our Bodies, Ourselves* or contact a local pre-natal teacher.]

Explaining ways of dealing with the seemingly ubiquitous hot flash is one of the most frequent activities in any workshop. A few women with extremely severe and disruptive flashes have been helped by a short-term use of HRT, while others have found relief in non-hormonal drugs. We are all delighted to hear comments such as: "I deal with my hot flashes with ice cubes or a cold gel pack on my cheeks or the back of my neck;" "I wear layers of clothing made of natural fibres which I can take off and put on easily;" "If people notice, I just say 'hot flash' with a grin and carry on." A tall, graceful woman made us all laugh by announcing that the best remedy is to stand at an open window in the nude, especially in winter. She's been known to run out and play in the snow in the same outfit (after dark, of course!).

We also discuss factors that can bring on a hot flash — stress, hot drinks and overheated rooms are

some examples. Some women report that after attending a group they are able to use the energy they get from hot flashes in constructive (or humorous) ways. In Rosetta Reitz's gutsy book there is a wealth of home remedies to try. They won't work for everybody, but there is a great deal to be gained in experimenting; a sense of fun and sharing can be beneficial to all of us.

Another lively group session is the one devoted to other stresses and changes in personal life which may coincide with menopause. At this time we air feelings about teenagers leaving (or worse, returning) home, parents becoming more dependent just when we were getting our first taste of freedom, mates/lovers going through their own mid-life crisis and friends becoming ill or widowed. Women who have stayed at home to raise children are sometimes finding out that the skills acquired as wives and mothers don't have much value in the marketplace. Women who have always worked outside the home often have anxieties related to aging or financial insecurity. Single women, lesbians, women of colour and recent immigrants often experience double or triple oppression on top of everything else.

Finally, as part of coping, we talk about different ways of getting information and support — from family, friends, women's groups, workshops. We share strategies to reduce stresses in our lives — relaxation techniques from classes, tapes or books, keeping fit through enjoyable physical activity. We reaffirm our right to accept needs and to remember to take time for ourselves, and to choose a supportive health practitioner, whether chiropractor, naturopath, massage therapist, psychotherapist or traditional doctor.

It's a short and natural step to start talking about the positive side of our new status. There are many expressions of relief at being free from fear of becoming pregnant, from monthly periods, and mood swings, from having to perform in traditional roles of wife and mother. Then we get to the benefits of being older, even without society's approval! "I feel freer to take risks and I don't care as much about what other people think," and "I feel excited about having more time and energy to try new things and find out what I'm really like. I've heard that some women experience post-menopausal zest — I'm really looking forward to that."

One woman was concerned that her husband was beginning to wind down just when she was ready to go. Unfortunately this is sometimes the case, as has been noted in Susan Sontag's writings about our society's double standard of aging. All too often older women are "disqualified as sexually attractive persons," sometimes when they "are feeling more sexually responsive than ever before in their lives." Overall, the prevailing feelings at the end of the workshops are ones of hope and enthusiasm.

For me there is a certain sadness when each workshop draws to a close. I will not see this particular group of women in exactly this way again. I have been the recipient of invaluable information about menopause which is ignored and discarded by a society which does not encourage us to celebrate our passage through mid-life with joy and hope, and which does not recognize as one of its most valuable assets the wisedom and experience of the post-menopausal woman. As facilitator, I get a tremendous satisfaction from the warmth and trust which we have shared as a group. I feel touched and often overwhelmed when women thank me for listening to them. (I think, "My god, has no one ever listened before?".)

My greatest satisfaction lies in having been part of an experience where women learn that we need not be helpless victims of "raging hormones," that we can be more in control of what happens to us by taking more responsibility for our own health and that life after menopause can be as richly rewarding (if not more so) as any other part of our lives.

Sidney Thomson leads menopause workshops in the Toronto area. She is currently building on a teaching background by taking a masters in education at the Ontario Institute for Studies in Education.

This article is based on an essay prepared for Jerri Wine at the Ontario Institute for Studies in Education.

Ann Voda

Cool News for Hot Flashers

"It is the worst heat. I think I am going to smother. It's a horrible feeling. I feel hot, like a glowing furnace. But the heat is a different kind of heat than you get from running or mowing the lawn, it is very much internal and suffocating. When I have hot flashes I break out in perspiration — on my feet, legs, in fact everywhere — to the point where sweat runs down my back and down the front. I always carry tissues, towels, handkerchiefs to wipe myself under my eyes, my forehead, anywhere I can wipe. Most of the time I look like I belong down south in the winter instead of in the north country. In below zero weather I can walk around with my coat open when I have a hot flash but when it is over I'm terribly cold because the sweat starts, and then I'm wet and shivering all over. When people see me this way they think I'm sick, and I'm not. I asked my doctor when the flashes would stop and he said that eventually they go away. When I asked when, he said he didn't know."

The above anecdote dramatically describes a hot flash, the most common bodily change associated with the menopause. It identifies the question most frequently asked by flashing menopausal women: **How long will they last?** Unfortunately for women, researchers do not yet know the answer to this question. The good news, however, based on work done with colleagues in my laboratory, is that even though women can expect to experience hot flashes for 10 or more years, the frequency and the intensity of the experience decreases over time. Our research also strongly suggests that most women can expect to experience hot flashes through the menopause. The experience will vary from woman to woman and across time in the same woman.

No one knows what causes hot flashes. Indeed, the first scientific investigation of this most common mid-life experience did not occur until 1975 when G. Molnar, a physiologist in the United States, undertook the research in order to find relief for the severe discomfort his wife was experiencing. Prior to Molnar's research, the hot flash was either treated as simply another indication of female emotionalism, or as a disease to be treated with drugs and replacement therapy. Since Molnar's initial study, other research has been stimulated and attitudes about the hot flash have changed. My own work on the hot flash over the past eight years suggests that most women can and do deal with the hot flash as a normal part of life without resorting to automatic and regular estrogen use. Unfortunately, many care providers are *not* aware of the research that has been done, and women continue to be treated as if hot flash were a symptom of a disease rather than a normal bodily change associated with the menopausal transition. The resources from which care providers obtain their information are either from outdated or inaccurate textbooks, or from drug company ads or representatives. The latter has an economic motive for describing menopausal women as diseased.

Some of the other most common questions women ask about the hot flash are: **What is a hot flash?** Technically, a hot flash is defined as "vasomotor instability." This is a fancy term for describing blood vessels that appear to dilate (open) and then constrict, to first dissipate and then conserve heat. The point to keep in mind is that this physiological activity appears to go on ignoring normal temperature control. Research suggests that prior to a hot flash, peripheral blood vessels constrict increasing internal body temperature, which is followed by vasodilation, an opening of blood vessels in order to cool down. Because body temperature has increased, another mechanism — sweating — is initiated in order to further cool the body by evaporation. The heat dissipation phase is the hot flash, and the cooling phase, enhanced by the sweat, is often described as a cold sweat.

Consistent with the anecdote at the beginning of the article, a variety of sensations are associated with hot flashes, as well as varying intensities which may range from mild to severe. It is important for women to know that the hot flash is real; it is associated

with an increase in body heat (from less than 0.5 to more than three degrees centigrade) that radiates from within the body or from some part of the surface of the skin. It may affect only a portion of the body, or it may spread uniformly over the whole body. It may last less than 30 seconds or more than 12 minutes. Also, the flash may or may not be accompanied by a flush which is a change in skin colour, often on the head, neck and chest, which can range from pink to bright red.

How prevalent is the hot flash? Results of our research suggests that more than 88 per cent of menopausal women will experience the hot flash. It appears to be as universal as the menopause itself. The high prevalence of the hot flash found by our research strongly suggests that it is a normal part of the menopause transition. An event that prevalent cannot be abnormal or a symptom of disease.

We must tune-in to our bodies, learn the pattern and frequency of our hot flashes, and be firm in our belief that it is not a symptom of a dreaded disease. I have already mentioned that the duration of the hot flash from start to finish is unknown. I have had 30-year-old women, as well as 80-year-old women, report hot flashes. For 25 subjects I followed over a three-year period, the average duration of the hot flash experience was between eight and nine years. These results contradict what is found in the texts and journals which care providers use in order to prescribe estrogen replacement therapy (ERT).

In textbooks the duration of the hot flash is reported as two to three years. Based on this erroneous information, some care providers encourage women to take ERT to "ride out the

menopause and the hot flashes," and when the two years have passed, they take women off of the hormone thinking that the menopause will be over.

Research from my laboratory and others suggests that ERT merely prolongs the transition and as soon as estrogen is withdrawn, the woman must then go through the menopause. This means she experiences the sensations and changes associated with the transition at an older age. And, going through the "change" at a later age may have important health implications for women.

Thus, women, care providers and researchers must be aware that the exact parameters of the hot flash and the menopausal transition are unknown, and that analysis of hot flash frequency data across a three-year period for 25 women I studied shows that hot flash frequency does decrease over time. This finding emerged from analysis of self-report cards over a two-week period for three years in which a decrease from 1802 to 1127 hot flashes was recorded. When these same women were measured in the laboratory over a three-year period (a four-hour measurement once each year), a decrease from 73 to 39 hot flashes was recorded.

We found also that as frequency decreased, so did hot flash intensity. The "climax" of the hot flash, that is high frequency associated with moderate to severe intensity of long duration, appears to cluster around the time of the last menstrual period. About a year after the menopause, women can expect their bodies will begin to settle into a new biological rhythm consistent with decreased levels of circulating estrogen, but they will still flash. Care providers must also be aware that if ERT is used and then withdrawn, that menopausal sensations and changes reappear.

Obviously, the most important thing all women can do as they face their menopausal years and the spectre of hot flashes, is to learn as much as possible about the research that has been done and what the experiences of other women have been. The hot flash is not a disease nor is it a sign of emotional instability. It is a normal and natural part of menopause. It may even begin while you are still menstruating. Worrying about it will not help because stress can be a trigger for a hot flash.

My research with women suggests that their feelings of control over their bodies increases as they have more information about their bodies and about what they can expect. Women can control certain aspects of diet, dress, and environment in order to find relief from hot flash discomfort. The first thing to do is to begin to keep a record of the hot flash, its origin, spread, frequency, perceived intensity, trigger, etc. Most women I have worked with have been helped by this self-knowledge.

Dawna Gallagher

As a researcher and a woman who experiences hot flash warmth, I believe that the hot flash is telling us something very important about our bodies. I don't yet know precisely what the message is, but I'm not giving up. Nor should you. Until we have more data, relief will continue to be self-generated. So buy fans, keep records, dress in the layered look, and write or call me if you have questions.

Ann Voda is a graduate in physiological nursing from the University of Utah College of Nursing.

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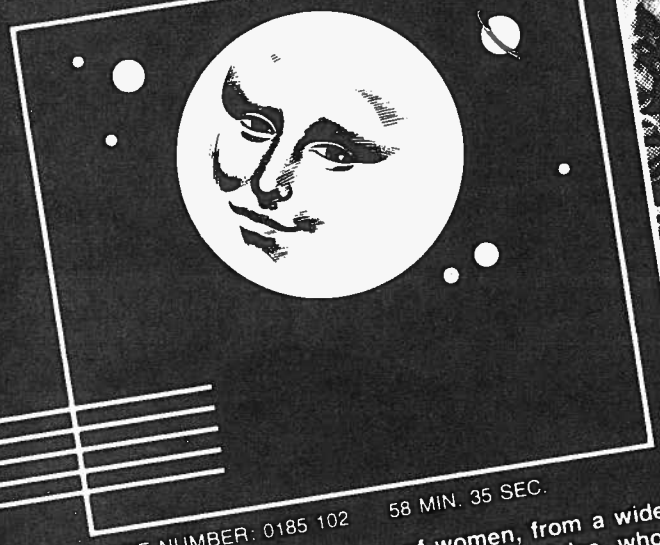

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The Great Hormone Debate

Mary Firth

Because menopause has been labelled a disease, women believe they must be treated by physicians with ... estrogens in order to be "cured."

Kathleen MacPherson

The treatment of menopausal complaints today is highly polarized. Orthodox medicine endorses and actively promotes the use of hormone replacement therapy. Growing numbers of informed and concerned women view artificial hormones as potentially carcinogenic. Left hanging are nearly three million Canadian women between the ages of 40 and 59. The decision about whether to seek or to accept hormone therapy remains *the* crucial issue for most menopausal women.

The story starts in 1923 with the discovery that the ovaries produce two hormones, estrogen and progesterone. Fifteen years later, the first clinical trials of synthetic estrogen were undertaken. Just before the midpoint of the century, the first cautionary voices were raised (and ignored): might there be a link between synthetic estrogen and endometrial cancer (cancer of the lining of the uterus)? Prescriptions for estrogen replacement therapy (ERT) were conservative but steady. The medical literature of the 1940s and 50s reveals a growing interest in the intricacies of female physiology at menopause and an increasing, and unwarranted, expectation that the onset of menopause should signal a visit to the doctor.

The reliance on estrogens by physicians and menopausal women was enormously boosted with the publication, in 1965, of a book called *Feminine Forever* by Robert Wilson, M.D. Spurred on by the extravagant promises made by Wilson, women *demanded* estrogen from their doctors. Many doctors were already confidently employing one form of estrogen, diethylstilbestrol (DES), to minimize the risk of spontaneous miscarriages or to suppress the breastmilk of new mothers. Other forms of estrogen were in oral contraceptives which had recently been hailed as a major breakthrough in reproductive technology. Long-term effects were not part of the optimistic mind-set of the age.

It is ironic that middle-aged women, who disparaged their own children's profligate use of untested drugs, could have been so easily seduced into using yet another chemical with unknown long-term consequences. And it is shameful that physicians, who prided themselves on scientific detachment, should have not only *accepted* their patients' neurotic need to appear forever young, but encouraged it. The attraction of estrogen during the decade of 1965-1975 was *not* its ability to alleviate hot flashes or to lubricate dry vaginas, but to prevent wrinkles, to maintain a youthful silhouette, to keep hair luxuriant and shiny. In their search for the prescription to perpetual youth, women visited their doctors in droves. It was in this way that women unwittingly handed over to doctors, more often than not male, the right to "manage" menopause for them — thus "medicalizing" menopause.

Then the balloon burst. Studies were published in the late 1970s demonstrating that estrogen users were much more likely to develop endometrial cancer. The risk was calculated to be from six to 14 times that of non-users, depending on the strength of the dose and the number of years that estrogen was taken. More recent studies show that the increased risk remains for at least ten years after estrogen is discontinued.

When sales plummeted in 1980, new hormone formulations were sought in an effort to eliminate the negative effects on the endometrium. The most promising was estrogen-plus-progestogen (synthetic progesterone). The progestogen tablets are taken separately, the estrogen started on day one and the progestogen added later, then both withdrawn for a few days at the end of the cycle. This mimics the cycling of natural hormones and causes a "withdrawal bleed" (similar to a menstrual period). By washing out the endometrial cells stimulated by estrogen it is hoped that the cancer risk is reduced. The current recommendation is for a *minimum* of 13 days of progestogen per cycle, to offset the effects of the estrogen. Generally the term hormone replacement therapy (HRT) is used to distinguish this type of treatment from estrogen only treatments.

Given the expressed concern of the late 1970s to protect women from cancer, one might expect to find only women who have had their uterus removed continuing to receive ERT, with all women in natural menopause on HRT (the estrogen/progestogen

regime). Not so. The prescriptions for *both* ERT and HRT have been increasing dramatically since 1981. Why?

Progestogen may produce side effects such as swollen, tender breasts, abdominal bloating, headaches and depression. However, according to some doctors, the most undesirable side effect of any menopausal treatment is withdrawal bleeding; it is widely assumed that women hate menstruating and will object to artificially prologed periods. To enlist patient cooperation therefore, ERT rather than HRT is often prescribed, with the assurance that it will only be needed "for a year or two" until the hot flashes disappear.

But ERT and HRT are *not* stopgap palliatives that cure hot flashes caused by low levels of estrogen. Hot flashes are experienced concurrent with a sudden *drop* in estrogen. Adding more estrogen to the system merely postpones the period of adjustment. Some women may discontinue estrogen after a year or two with no problem; others find, to their horror, that they suffer such agonizing withdrawal they are forced to continue estrogen for the rest of their lives. It is hard to know how severe the hot flashes would have been had these women not taken estrogen in the first place.

Many doctors neglect to inform patients of the substantially increased risk of endometrial cancer associated with ERT. Because this cancer is 90 per cent curable if caught in time, and because estrogen users are more likely to be booked for regular Pap smears, physicians may decide that the benefits of ERT outweigh the risks. Also some gynecologists tend to regard hysterectomy — the probable eventual solution for consistently abnormal Paps — as a fairly routine procedure. Women's wisdom recognizes that a hysterectomy is anything *but* routine (particularly as one grows older). According to HERS (Hysterectomy Educational Resources and Services) depression follows in over 50 per cent of the cases; energy levels may be low for a full 12 months; full orgasmic potential is lost and sex drive may *never* return. If women understood that the choice could be between a potential hysterectomy and putting up with hot flashes, they might choose the latter.

Some restrictions about the use of ERT are medically recognized. If you have ever had any form of cancer or if there is a strong history of cancer in your family, ERT is not likely to be prescribed. Hypertension (high blood pressure) and some forms of coronary heart disease might contraindicate its use. Women at risk for blood clots (thromboembolisms), phlebitis, gallbladder attacks or liver disease are generally discouraged from taking ERT. Migraine-sufferers and diabetics are rarely given it. And women with uterine fibroids or too much fat on their bones (20 per cent or more over 'ideal weight') are also discouraged.

Mary Firth

"I keep wondering if our bodies require these hormones?"

These guidelines as to who should get ERT and who should not are part of the reason why many regard ERT with deep suspicion. For instance, obese women or women with uterine fibroids or chronic fibrocystic breast disease are not given ERT because additional estrogens might lead to proliferation of the wrong kinds of cells in the breast or in the uterus. Obese women are at increased risk for both breast and endometrial cancer simply because their fatty tissue may already produce more estrogen than their bodies can clear out efficiently. But recent studies indicate that the ovaries of many women perk along producing quite startling amounts of estrogen after menopause, but at a very uneven rate. (Perhaps this is a clue to the very elderly women who still experience hot flashes.) It is difficult to know just how much estrogen is produced by one individual over a period of time. What if ERT overburdens the system? What effects might this have? We don't know.

It is also important to consider the effects of other kinds of estrogens. Many women who are menopausal today were prescribed very early oral contraceptives, pills which were much stronger than those currently in use. Some middle-aged women took DES when they were younger. It has been known for some time that daughters and sons of DES mothers are prone to abnormalities of the reproductive system and must be watched carefully for cancer. More recent studies suggest that DES mothers are at higher-than-normal risk for breast cancer. Preliminary studies also suggest that exposure to DES may lead to increased vulnerability to other disorders and, if animal studies are an indication, the damage may even extend to the third generation. The sad history of DES leads many women to think about the possible combined effects of these hormones. Will these various estrogens, all administered for different reasons at different times, have a cumulative effect?

Every woman with breasts has the potential to develop breast cancer and the risk increases dramatically after age 45. The same is true for every woman with an intact uterus. When doctors speak of "slight risks" in connection with hormone administration, we must recognize that such risks are additive, that aging puts one at risk even without ERT. Pathologists have told us that the majority of women already harbour quiescent tumours of such small sizes that they are only detected after death. No one knows what accelerates the development of a tumour in one woman and not in another, but estrogen is respected as a potential catalyst — not necessarily cancer-causing itself, but powerful in its effects.

Currently, ERT is being heavily promoted for benefits other than the relief of hot flashes or vaginal dryness. Estrogen administered during the perimenopause (when periods are irregular or scant but the woman is still ovulating) halts the drastic loss of bone mass for some years, perhaps for a lifetime. Many prescriptions for ERT are written solely on the basis of osteoporosis-prevention despite the fact that estrogen may not offer the protection directly, but rather influence other hormones to reduce calcium excretion from bone mass.

Osteoporosis is said to affect from 25 :o 40 per cent of aging white women n North America. A general profile of :he osteoporosis-prone woman is avail- ıble but this is a rough guide at best, ınd cannot target specific high-risk ıomen. Most doctors distrust a wom- ın's ability to sustain the kind of exer- :ise and diet required to stave off os- eoporosis, and many believe that *all* ıomen should receive ERT for life, or ıntil accurate screening programs are n place, whichever comes first.

Recently, compelling (but not yet inal) evidence has suggested that ERT eads to positive and beneficial :hanges in blood chemistry which nay act to reduce the risks of heart lisease and stroke. Since some forms)f progestogen cancel out this benefit,)hysicians may prefer ERT to the use)f the HRT combination. ERT has a)eneficial effect on skin collagen con- ent, maintaining the skin's thickness ınd firmness and restoring the lining)f the vagina which tends to get thin- ıer and drier at menopause. Because)f this, it may be prescribed to permit)ain-free intercourse and to reduce the isk of vaginal or urinary inflamma- ion or infection. Doctors may not hink to mention alternative and non- ıormonal preparations such as water)ased lubricants or natural yogurt vhich may be equally effective.

Although there is no solid evidence hat ERT alleviates such common nenopausal symptoms as depression, nxiety, panic attacks or memory ıpses, given the other benefits of ERT, : may be surprising that so many ıomen are reluctant to adopt it. The nedical literature abounds with glow- ıg reports of new and ingenious ways ı which to manipulate female hormo- al states: studies have been done sing clomiphene citrate (the fertility drug) to relieve hot flashes. Continuous administration of estrogen/progestin has been attempted, with the addition of testosterone to boost energy levels and sex drive. They have even given ERT to women recovering from surgery for endometrial cancer.

Pharmaceutical companies tell us that conjugated estrogens (i.e., made from the urine of pregnant horses) are *natural* and should not be tarred with the same brush as synthetic estrogens. Vaginal creams are prescribed to women fearful of side effects from the pill or from injections (although creams are absorbed systemically and are not confined to the site of application). You don't have to remember to take a pill. Injections are used when "patient non-compliance" (forgetting to take it) is anticipated. Implants inserted under the skin of the thigh or abdomen and patches worn unobtrusively under the clothes are the newest ways of making sure that the estrogen gets into you. Everything possible is done to make ERT both readily available and worry-free.

But patient non-compliance is more than simply forgetting to take a pill or use a cream. Forgetting is often a reflection of a deep-seated uneasiness with the whole process. Too many menopausal women who are reluctant to take aspirin for a headache find themselves popping powerful pills. This uneasiness is expressed in the kinds of questions doctors hear: "Will I have side effects?" "Should I take an injection?" "Why do I get so angry with my husband and children?" "How come my friend's doctor told her not to take ERT?" "Why do I have a brown pill and she has a yellow one?" These questions skim the surface of deeper concerns more difficult to put into words.

Experience tells us that anything that works as quickly and effectively as ERT has another side to it. After all, we have lived through the introduction of miracle drugs like sulfa and penicillin. We respect their ability to heal but we know they render the long-term user more vulnerable. We also know of people for whom the side effects are worse than the cure.

Many women are more comfortable with treatments which work from the inside out, like the gradual, positive benefits of regular exercise. Many feel less safe about the powerful and sud-

HEALTH WANTED

Mother-Daughter Incest

I am a psychotherapist and writer preparing a book on mother-daughter incest. I am seeking factual, first-person accounts of the experiences of survivors for inclusion in my book. Absolute confidentiality/anonymity will be maintained as requested. Send manuscripts and requests for further information to: Teresa DeCrescenzo, 8235 Santa Monica Blvd., No. 214, West Hollywood, CA. 90046.

Assault & Dreams

I am researching how the experience of sexual assault is reflected in women's dreams. If you have been sexually assaulted and can recall dreams you associate with that experience, please contact me. I am an experienced individual counselor. Confidentiality is ensured and material will only be used with your written permission. Please contact: Carrie Doehring, P.O. Box 224, Rockwood, Ont. N0B 2K0 (519) 856-9094 (collect).

In Vitro Fertilization

Do you have experience with IVF treatments? I am seeking individuals to answer a survey about IVF treatments as part of my university research. Confidentiality is assured. Please contact: Barbara Nesto, 36 Bedford Terrace #7, Northampton, MA 01060.

Hysterectomies

I would like to hear from women who have had hysterectomies. I have developed a questionnaire (in consultation with medical practitioners) to collect information about the effects of this surgery. To receive a questionnaire, please write: Robin Goodfellow, 16-796 Wolseley Ave., Winnipeg, Manitoba, R3G 1C6.

den changes caused by drugs. These reservations about ERT are difficult to articulate and virtually impossible to broach in a doctor/patient conversation. Such concerns lie outside the medical arena.

Menopause *can* be difficult. A small minority of naturally-menopausal women, perhaps 15 per cent at the most, *must* have medical help to continue to function. Added to these are women who undergo complete hysterectomies, losing both ovaries and uterus. They are plunged into a precipitous surgically-induced menopause and sometimes experience the whole range of menopausal symptoms at once. Even when ovarian tissue is left, the trauma of a hysterectomy may hasten the onset of severe menopausal distress. The women deserve help; for some the long-terms risks of ERT or HRT may pale in comparison to immediate benefits. This right to choose must be respected.

Let us concede that menopause can be a time of stress, both physiological and psychological. It also seems likely that the physiological stress triggers the psychological effects. This stress, when added to a system already under attack during life changes such as children leaving home and elderly parents who need help, may result in an intolerable situation. Menopause may be the last straw, but it is *not* a disease.

What if our cultural and medical standards didn't define menopause as a disease? What if it was viewed as a natural and normal transition period marking the end of the reproductive years? What if the more severe effects were minimized by a change in diet and more exercise? What if we recognized women in other cultures who have never heard of hot flashes, and who rarely see rounded backs or hear of broken hips? What if menopause were to be regarded as self-limiting, variable from person to person and eminently treatable using methods passed along from mother to daughter? Wouldn't the high-tech bombardment of chemicals like ERT and HRT seem like over-kill?

We already know a fair amount about environmental factors which influence the experience of menopause: caffeine and alcohol often trigger hot flashes; caffeine is also implicated in fibrocystic breast disease; smoking can double the amount of calcium excreted and sharply increase the risks of both osteoporosis and heart disease; a diet high in refined sugar may increase the risk of vaginal infection; too much salt may invite high blood pressure; cutting down on fat intake may help to protect against breast cancer; regular orgasm will help the vagina stay moist and healthy; moderate weight gain will help to alleviate hot flashes; and a weekly routine of three hours of brisk walking can strengthen bone and minimize the risk of depression. Informed preparation for menopause will enable most women (not all) to recognize and withstand the stresses of menopause without the need for supplementary ERT. The satisfaction of being in control is even more gratifying when one is being buffeted by unpredictable hormones.

"I am glad to have confirmed my own judgement that getting through the menopause without any drugs is the only route to go."

No one wants to regress to the times when menopause was a secret, a shameful affliction to be hidden from all but the closest intimates. On the contrary, hot flashes are easier to tolerate if they are generally accepted: the folded fan is at the ready and embarrassment is gone. Women need to be able to talk — to each other and to their families — about the discomforts and travails of menopause without being pressured into visiting a doctor. This society has learned to tolerate the altered behaviours of young girls at puberty without invoking disease mentalities and putting them on powerful drugs. Menopause is merely puberty in reverse. Why can't it be given the same respect?

Janine O'Leary Cobb is founder and editor of A Friend Indeed, *a newsletter for women in the prime of life. She lives in Montréal.*

MY STORY, OUR STORY

Kicking the Hormone Habit

Mary Madsen

I had ovarian cancer when I was 33 years old. As a consequence of the surgical treatment, both of my ovaries and my uterus were removed. I was told that I was not post-menopausal; I had become what the medical profession so delicately refers to as a 'young castrate'!

Approximately one year later I went to my doctor with complaints of being *very* tired and having very low energy — I couldn't get out of bed in the morning. We discussed my medical history and she said she thought I was suffering from menopause and a consequent lack of hormones. I expressed concern about going on hormones after having had cancer; I seemed to recall vaguely that hormones were linked with causing cancer. She wrote to the Cancer Clinic in Vancouver and showed me their response which assured her that I could indeed receive estrogen replacement therapy (ERT).

I started taking estrogen in the form of Premarin, which she assured me was a natural source estrogen, 0.625 mg once a day for three weeks, followed by one week off. I continued this program for several years and my regular six-month cancer check-ups remained clear.

I continued, however, to have niggling doubts about being on estrogen and discussed these concerns during a check-up visit at the Cancer Clinic. The doctor with whom I spoke confirmed that indeed there were links between taking estrogen supplements and cancer of the endometrium (the lining of the uterus). But the risks were somewhat mitigated by taking progestin, the synthetic form of the hormone progesterone, in conjunction with the estrogen. Neither he nor I were clear why I should be concerned with endometrial cancer since my uterus had already been removed. Nevertheless, he suggested I take the progestin as this would most closely duplicate what previously would have occurred naturally in my body.

So I was now on hormone replacement therapy (HRT) insead of ERT. I took Premarin daily for three weeks followed by progestin each day for a week. Somehow my concerns remained. I have never been a pill-taker; in fact, I have to eat something to get one down! My mother had always cautioned against taking any form of medication (taking an aspirin was serious business in our household), and my sister was exploring women's health issues herself. While she wanted to support me in whatever decision I made, she was becoming increasingly alarmed at what she was learning. She made subtle suggestions that I might want to do some reading on my own about hormone use and would, on occasion, enclose clippings or articles with her letters to me. She mentioned a book, *Women and the Crisis in Sex Hormones*, by Barbara and Gideon Seaman. Although I did not get around to reading it until much later, I now think it should be mandatory reading for all women and young girls. I did once try to stop taking the hormones but I was very nervous about doing this. I felt dependent on them. I was sure the original symptoms would reappear, and after a few days without estrogen it seemed as if they had, so I quickly reverted to taking my little red pill every night! I felt uncomfortable taking them but afraid to stop.

Finally I called the Vancouver Women's Health Collective and found out they were putting on a workshop on menopause, at which HRT would be discussed. I couldn't wait for that evening to come. Some of the things I was beginning to read made me less trusting of the medical profession. Among other things, the DES story was making the news at this time.

At the workshop, Beth and Annette allowed each of us (about seven or eight women attended) time to say why we had come and to express our concerns. They listened to us, recommended books and resources (Rosetta Reitz' book *Menopause: A Positive Approach* became a real favorite of mine), supported us in our ideas, and encouraged us to share our experiences. At the workshop, I met Marian, whose concerns were similar to mine; she had had a hysterectomy and had been immediately started on HRT. She thought she would like to stop taking

Terri Roberton

HEALTH WANTED

Cardiomyopathy
I have an illness known as dilated cardiomyopathy and would like to find someone else who has it or who has had it and recovered. Please contact Debbie Sherrard, 12 Victoria St., St. Johns, Nfld. A1C 3V3.

Cancer Survivors
If you or your lover has had cancer, please help with research for my book on love and sex after cancer. To receive a questionnaire, write: Jacquelyn Johnson, Box 92, Powassan, Ont. P0H 1Z0. Confidentiality is assured.

Sexual Imagery
I am interested in hearing from anyone who has information about photographic images about sexuality (heterosexual and lesbian) made by women for women. My research is both contemporary and historical. Please write: WSIP c/o The Toronto Photographers Workshop, 80 Spadina Ave., Rm. 310, Toronto, Ont. M5J 2J3.

hormones but felt afraid to do so on her own. Both our doctors were adamant we should stay on this treatment and we had been nervous to go against their authority and expertise.

The workshop leaders suggested we might want to use a buddy system and by the end of the evening Marian and I had adopted the following plan:

Keep in contact with each other by phone and call each other *whenever* we needed to — to share new information, to share our feelings, to share our fears, to share anything.

Go to our doctors to ask for tests to determine our present estrogen levels (this, neither of our doctors had done for us prior to or after prescribing estrogen for our 'deficiency').

Seek out any advice on alternate sources of estrogen in the body (my readings have since confirmed that there are indeed other sources, such as the adrenal glands and also extra-glandular sources).

Maintain good health habits — lots of sleep, exercise and good nutrition.

Slowly, *very* slowly reduce the amount of estrogen that we were taking.

Our reasoning behind this plan was twofold: to attempt to be as scientific as possible by comparing our estrogen readings throughout (we wanted to see if in fact the levels would drop and whether we could stimulate new sources by doing such things as eating raw adrenal tissue); and to attempt to duplicate the very slow natural decline of estrogen our bodies would have gone through, had we not undergone surgical menopause.

However, for me the most wonderful part of the plan was that Marian was always there. When I was sure that my skin was wrinkling rapidly (thanks to a friend who told me my skin tone was much 'better' when I was taking estrogen!), she could talk me back into sanity. When she was nervous that she wasn't going to sleep well, I told her to try running. (She took up running in her nightgown and gumboots in the morning to collect eggs from her hens!) We slowly, ever so slowly, weaned ourselves of the hormone habit and discovered to our great relief that we didn't go crazy, didn't become listless zombies — in fact didn't experience any symptoms at all (hot or cold flashes). We may have been lucky in this as I've since read that HRT can make symptoms *worse* for some women when they stop it. Maybe the laughter and support we gave to each other and the great care we were giving ourselves did the trick. At least I think so!

It took us about a year to really be off the hormones and since that time many things have happened. We've become good friends. We've attended a conference on women's health issues sponsored by the Vancouver Health Collective and shared with other women. We've participated with a lot of other women in a wonderful National Film Board film on menopause directed by Haida Paul and Laura Alper. We've put on our *own* workshop on menopause for about 15 women. (I think it was Beth and Annette's original hope that women would leave their workshop and go back and hold workshops on their own, encouraging women to talk to other women, to share their experiences and support one another.)

For myself, I became so fascinated by the whole subject of women and aging in our society that I am doing graduate work in this area. I did finally

get around to reading medical journals, hard work due to the barriers of medical language and conservatism. What I've read has certainly confirmed for me my choice in discontinuing HRT. I read that there is a "residual effect of estrogen use on the risk of endometrial cancer long after such use has ceased" and that "in post-menopausal women, withdrawal of estrogen therapy is followed by a phase of rapid bone loss which largely negated the benefits to bone of estrogen therapy." Also, "since the advent of estrogen replacement therapy, there has been widespread speculation about the effect of this practice on risk of breast cancer. Overall, (for those on ERT) the observed number of breast cancers is 30 per cent greater than expected." Studies show that "the risk of endometrial cancer was 4.5 times greater among women exposed to estrogen therapy" and that "the giving of estrogens to healthy women is controversial." Interestingly, all thse quotes come from the same journal (*New England Journal of Medicine*) from 1975 to 1982.

I now question the removal of my healthy ovary and I question ever beginning to take ERT or HRT. My original symptoms could have been as much the result of emotional stress of a failing relationship as the cessation of estrogen production. Most discussions about taking hormones attempt to present an objective view, weighing the so-called pros and cons. I make no pretense of objectivity. I am against taking synthetic hormones. The known risks are already far too great and I believe there are probably other risks that we have yet to discover and for which we will pay the costs. There are alternatives that are not life-threatening.

The overall process that I have tried to describe here has been, finally, a positive and exciting one for me. I've learned to do my own research and to form my own conclusions. I've learned to seek out and share with other women information and advice. And I've learned a form of personal empowerment by taking back the responsibility for my body and my health.

Mary Madsen is completing a masters of education at Simon Fraser University in Burnaby, B.C.

Phyllis Jensen

Calcium for Long Life

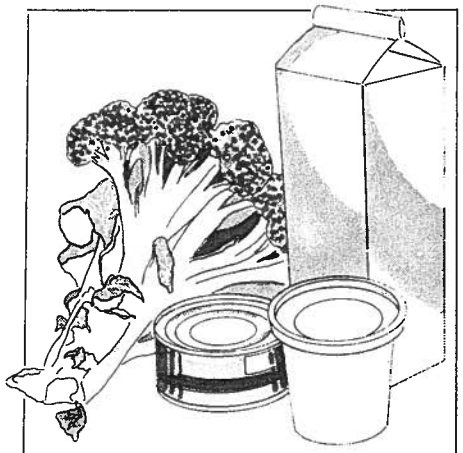
The truth is that low levels of estrogen do contribute to osteoporosis and estrogen replacement can help prevent bone loss after menopause, but estrogen replacement has its own risks and osteoporosis is preventable. So says Dr. Louis Aviolo, Director of the Division of Bone and Mineral Metabolism at Washington University in St. Louis. "Since women began breaking bones shortly after menopause it was assumed that osteoporosis was brought on exclusively by low levels of estrogen. In about 1950 the myth of post-menopausal osteoporosis became popular."

Bones get their strength from crystals of calcium embedded in protein fibres called collagen. The human skeleton reaches its peak density at about 35 years. The process of slow decline into old age is not inevitable. With proper diet, exercise and room for personal growth you can have very strong bones and live happily to a ripe old age.

Women are more likely to develop osteoporosis than men because their bones are generally smaller and lighter. Women tend to consume both less calories and less calcium than men and have an even greater need for calcium throughout the reproductive cycle.

Bone loss can begin in the early 20s and worsen with prolonged calcium deficiency. One solution to preventing osteoporosis is to get more calcium throughout the life cycle.

Dowager's Hump, so called because it is more common in women, occurs when, because of osteoporosis, the vertebrae lose their strength, collapse upon each other and are pulled by the surrounding muscles into a high back hump. Broken hips have often been thought to be caused by a fall. Now some authorities believe, conversely, that a spontaneous collapse of the hip due to osteoporosis causes the fall. An ill-fitting denture, the result of shrinkage of the jaw may be a symptom of the same problem. Getting enough calcium is one preventative approach to all these unfortunate conditions.



L. Emily Elliott

For many women, exercise and lifelong consumption of adequate calcium will enhance strong bones, healthy teeth and a feeling of well-being.

Preventing osteoporosis is not the only reason to make sure that you get enough calcium. This important mineral, the most abundant in our bodies, is essential for all muscular action and nervous system transmissions. It plays a strong role in keeping the heart healthy and the disposition happy.

Almost 99 per cent of our calcium is found in our teeth and bones. When it is not available in the bloodstream from a dietary source, parathryroid hormone is released to dissolve it from these bony masses. Since the teeth are more visible than the bones, they are the best indicator of the bone strength. Teeth that are pitted, eroded and even periodontal disease (gingivitis or inflammation and bleeding of the gums) can be signs of a calcium deficiency.

Cornell researchers led by Lennort Krook and Leo Lutwat, gave five women and five men with advanced periodontal disease 500 mg of calcium twice a day for six months. "All patients had gingivitis and bleeding at the start. After treatment, inflammation was improved in all cases and absent in three."

Causes of Calcium Deficiency

Some women who have a calcium-rich diet (adequate milk, yoghurt and cheese) can be calcium deficient if there are problems with assimilation, absorption and replacement in the bones. If you eat enough calcium and your digestion is excellent you should not have a calcium deficiency, but some older people experience a reduction in gastric functioning and need

additional hydrochloric acid to dissolve calcium from food sources. Taking vitamin C with a calcium-rich meal will help to increase the acidity of the gastric juices and assist in calcium assimilation.

Alcohol and caffeine inhibit calcium assimilation. And, since sodium ions are processed by the kidney at the same time as calcium, a high salt diet can cause calcium to be lost. Excessive fat, which combines with calcium to form an insoluble compound, and a lack of vitamin D, which escorts the mineral from the intestine into the bloodstream, may also affect the amount of calcium available from the diet.

Chocolate, spinach, sorrel, swiss chard and rhubarb all contain oxalic acid which some authorities believe combines with calcium to form an insoluble compound. It may be preferrable to avoid these foods when you take your highest calcium meal of the day.

While grains supply small amounts of calcium, a substance in bran (phytic acid) can tie up calcium and prevent absorption. Too rapid passage of food through the digestive system because of spastic bowel syndrome, diarrhea, too much fibre or over reliance on mineral oil laxatives may also interfere with calcium absorption in some people.

Calcium and Magnesium

Calcium works in concert with magnesium and, unless there is enough magnesium in your diet to aid in the utilization of calcium, it won't matter how much milk you drink; you may still be calcium deficient. Although it is controversial, the ration of 2:1 calcium to magnesium has long been generally accepted.

It is magnesium and not calcium that forms the hard tooth enamel that prevents tooth decay. Without magnesium, calcium will only produce soft tooth enamel.

Magnesium, one of the components of chlorophyll, is found alongside calcium in green leafy vegetables. The best sources of magnesium are whole grains, seafood, soya beans, figs, corn, apples and oil-rich nuts, especially almonds.

The Role of Estrogen in Bone Calcium Levels

Estrogen is important in the transfer of calcium back into the bones after it has been borrowed for other uses. That is why osteoporosis can speed up after the menopause when the ovaries stop producing estrogen. But the ovaries are not the only place where estrogen is made; the adrenals also produce it. It is not a hormone exclusive to women, just more dominant in women.

Dr. Verna Hunt, a Toronto naturopath and chiropractor says, "After the menopause, the adrenals should produce sufficient estrogen to promote proper calcium utilization; but often they do not because many of us suffer from adrenal exhaustion. It is the modern woman forced into three simultaneous roles — mother, wife and worker — who doesn't get enough rest, recreation, time for personal growth and relaxed meals who has difficulty producing adrenal hormones including estrogen. The signs of menopause that we all recognize: mid-cycle spotting, vaginal dryness and hot flashes are all signs of adrenal exhaustion and not the exclusive property of the menopause experience. In fact the only sign one should have of menopause is the cessation of the menstrual period. All the rest, all the accepted myths of menopause, will not happen if a woman is in good health and makes certain her adrenals are functioning properly."

Without sufficient estrogen to assist in its deposit in the bony masses, calcium may be stored in the soft tissues producing muscle tightness or spasm, often in the calves, or it may be deposited in the joints producing symptoms of arthritis. That is why women who have had their ovaries removed before menopause, dramatically reducing their estrogen levels, are more likely to get osteoporosis and to have it happen earlier than a woman who experiences a natural menopause.

Suggested Daily Calcium Requirements

Infants (0 to 6 mo.)	360 mg
Children (boys & girls)	800 mg
Girls (11 to 18 yrs.)	1200 mg
Adults (men)	800 mg
(women)	800-1000 mg
Pregnant	1500 mg
Lactating	1500 mg
Menopause	1500 mg

"Nutritional Allowance Chart," *Nutrition Almanac*, (ed.) John Kirschman, McGraw-Hill, 1978.

How to Identify a Calcium Deficiency

If you have any question about the adequacy of calcium in your diet keep a food journal for a week or two. Mark down everything you eat. Then, using the available calcium tables, calculate your average daily intake. You may be surprised by the result!. Dr. Avioli found that half the women tested took in less than 500 mg a day. Because calcium is essential, he says, "I cannot overemphasize the importance of young women cultivating the habit of supplementing their daily calcium intake with at least one 500 mg tablet of calcium." Don't however overlook the first and simplest remedy: improve your diet! Make it as rich in calcium and other essential nutrients as you possibly can.

In *Diet and Nutrition*, Dr. Rudolph Ballantyne explains that calcium is important in all muscular actions and nervous system responses. "If a muscle doesn't have enough calcium ions, the fibres are motionless and do not slide together and mesh, so the muscle cannot contract, or once it has contracted it will not relax. The result is a rather painful situation we call a cramp."

Menstrual cramps may be a sign of a low level of calcium. They may indicate a long-term deficiency or simply a temporary lack since calcium needs are higher in the premenstrual phase. That is why lower leg and toe cramps while resting are more common just before the menstrual period.

If menstrual cramps are a result of low levels of calcium they can be alleviated by taking calcium tablets alternated with magnesium, allowing a 20-minute interval. The calcium will assist the uterus to contract and the magnesium will help the muscle relax.

During a few years before menstruation, a young girl's need for calcium increases. Without adequate calcium she may become irritable, nervous, a nail-biter, suffer from insomnia, have increased tooth decay or generally be "impossible" to live with. One solution may be more calcium in her diet.

Because of calcium's role in all muscle action, a deficiency may be the cause of heart problems, including palpitations and low pulse rate. Cynthia Morris, an epidemiologist in the Division of Nephrology at the Oregon Health Sciences University in Portland, reports that too little calcium in the diet, rather than too much salt, may be the cause of some types of high blood pressure.

Joint pains, impaired growth in children ("growing pains" may be calcium linked, but may also indicate a more serious disorder), slow blood clotting, a tendency to hemorrhage, as well as excessive irritability and nervousness, may be related to low calcium levels. In te[illegible] women to quit smoking, I find that adequate levels of calcium can reduce the nervousness that may signal the need for a cigarette.

In his article in the *Journal of the American Medical Association*, Dr. William Crosby notes that vegetarians tend to have stronger bones than meat eaters. It was found that the high phosphorus content of meat, fast foods and processed foods works against the retention of calcium in the bones. Weight-bearing exercise also plays a part in making the bones stronger because, without the effects of gravity experienced through exercise, the bones begin to lose calcium. That is why those who are bedridden are more vulnerable. (American astronauts in space lost an average of 200 mg calcium per day, despite a rigorous exercise program, because of weightlessness.)

Daily Requirements of Calcium

Calcium needs vary throughout the life cycle. We recognise its importance

Dairy Sources of Calcium

Milk and milk products are a rich source of calcium. One cup of milk contains about one third of an adult's daily requirement. There is some evidence that pasteurization makes calcium slightly more difficult to absorb, but yoghurt, a fermented form of milk, is easier to digest. Some types of yoghurt have added milk protein which doubles calcium content. Hard cheeses like cheddar are high in calcium, but also in saturated fat — the bad kind that clogs up arteries.

Whole milk	1 cup	291 mg
Low fat milk	1 cup	297 mg
Buttermilk	1 cup	285 mg
Yoghurt (whole milk)	1 cup	274 mg
Sherbet	1 cup	103 mg
Ice Cream	1 cup	176 mg
Brie	1 oz	110 mg
Camembert	1 oz	211 mg
Cheddar Cheese	1 oz	815 mg
Cottage Cheese	1 cup	126 mg
Mozzerella	1 oz	147 mg
Processed Cheese Spread	1 oz	158 mg
Ricotta (whole milk)	1 cup	509 mg

Non-Dairy Sources of Calcium

If you are lactose intolerant (lack the enzyme needed to digest milk), you may experience intestinal gas, bloating, stomach cramps, diarrhea or constipation when you consume milk products. Some lactose intolerant people find that Lact-Aid, an enzyme which can be added to milk about 12 hours before using, will predigest the lactose; but it doesn't work for everyone.

Those who are allergic to milk, have a milk sensitivity, are vegans (don't include any animal products in their diet) or simply don't like milk *can* get enough calcium without taking supplements.

Fish

Oysters or a small tin of mackerel, salmon or sardines complete with the bones have about the same amount of calcium as a cup of milk. (Some fish also provide those essential oils which are making headlines for keeping arteries free form cholesterol.)

Mackerel	1 cup	388 mg
Oysters	1 cup	226 mg
Salmon (pink)	1 cup	431 mg
Salmon (sockeye)	1 cup	570 mg
Sardines	1 oz	124 mg

Nutrition Almanac

Vegetables

Cooked vegetable leaves are a good source of calcium and much lower in calories than other foods. They are also high in iron and vitamin C, and they contain the important twin mineral, magnesium, plus many B vitamins. The rule is: the greener the leaf, the higher the amount of essential nutrients. But watch spinach. It's got oxalic acid, so eat it occasionally and preferably raw. Increase calcium by adding a garnish of chopped chives or parsley.

Dr. Rudolph Ballantyne advises that "probably the richest non-dairy soruce is lamb's quarters, usually regarded as a weed in Europe and America. In northern India it is the most universally popular leafy green vegetable eaten and prepared in a variety of delicious ways."

Cooked		
Broccoli	1 cup	136 mg
Collard greens	1 cup	220 mg
Kale	1 cup	206 mg
Lamb's quarters*	1 cup	400 mg
Mustard greens	1 cup	284 mg
Turnip greens	1 cup	267 mg
Raw, Chopped		
Chives	1 Tbsp	106 mg
Parsley	1 cup	122 mg

**Diet & Nutrition*, Himalayan International Institute, 1982.

Beans

Some beans are moderate sources of calcium with soya beans heading the list. Tofu, a soya bean curd is a staple of the oriental diet which does not include dairy products for adults. One block of tofu (provided it has been curdled with calcium sulfate) contains a calcium equivalent to that contained in a glass of milk.

Tofu is rich in protein, low in saturated fats and balanced in calcium and phosphorous. Calorie counters will be happy to hear that versatile tofu is considered an ideal diet food.

If tofu is new to you, the *Book of Tofu* by Shurtleff and Aoyagi has hundreds of recipes from main courses to cheesecake desserts. You might also explore another staple of the Japanese diet, miso, fermented soya bean paste, used for soups and sauces. Miso is a fairly good source of calcium and an excellent pick-me-up to replace coffee.

Chickpeas (dry)	1 cup	300 mg
Pinto beans	1 cup	257 mg
Soya beans (cooked)	1 cup	131 mg
Tofu (calcium sulfate curdled)	3.5 oz.	308 mg
Miso	100 mg	467 mg
Soya bean De-fatted flour	1 cup	366 mg

Nutrition Almanac

in childhood, but adolescent girls have increased need for calcium as they enter puberty and as the menstrual cycle regulates. Pregnant and breast-feeding women should also increase their calcium. With age may come a reduced ability to assimilate calcium and again a high calcium diet is required.

Calcium Supplements

While many people insist on getting all essential nutrients from food sources, some nutritionists argue that this is not reliable due to modern methods of agriculture, nutrient-poor soil, extensive food processing and delayed time to market. "Soil painstakingly tilled by hand varies significantly from that of the plains where it is cultivated under modern conditions, plowed on a large scale and fertilized artificially," says Dr. Ballantyne.

Some health experts like Dr. Avioli advise women to supplement their daily diet with a tablet of calcium. If you decide to "play it safe" and use calcium supplements, there is a confusing array of products to choose from. Since it is impossible to make a powder, capsule or tablet that contains only calcium, your decision must involve an assessment of the substance the mineral is combined with: carbonate, lactate, or phosphorous.

While multi-vitamin tablets do contain some calcium, Patricia Hausman in *The Calcium Bible* argues against relying on them. "We need calcium in amounts that are too bulky to fit in a pill along with other vitamins and minerals. Taking two or three of some calcium-containing multi-vitamins and mineral supplements would give you a healthy dose, but also might give you more of the other vitamins and minerals than is advisable." The only way to decide which supplement to take is to read the labels.

Not everyone needs to or should supplement dietary intake of calcium. The National Institute of Health (U.S.) recommends that no one take more than 1,500 mg of calcium daily and that anyone with a personal or family history of kidney stones consult a doctor prior to supplementing calcium. Several other conditions can require increased need or medical supervision of calcium intake.

Calcium Phosphate

Bone meal is a source of calcium from ground bones of cattle; it should not be confused with bone ash fertilizer. There is some controversy about this animal source of calcium because chemically it is calcium phosphate and the average diet is high in phosphorous which interferes with calcium absorption.

Dr. Ballantyne in *Diet and Nutrition* says that "while bone meal may seem biologically more acceptable than other sources, bones tend to concentrate not only useful minerals, but are a site where toxic metals are deposited." Bone meal may be contaminated with lead and strontium 90.

Calcium Lactate

Calcium lactate is made from milk and so is not an appropriate supplement for the lactose intolerant. It is easily absorbed, but the amount of calcium is low in relation to the lactate and many tablets may be required for an adequate dose of calcium. Some authorities recommend it for insomnia.

Calcium Carbonate

Oyster Shell, or calcium carbonate, like bone meal is from an animal source and contains phosphorous and trace minerals. It is not as easily assimilated as other sources, and with older women it needs hydrochloric acid assistance. Calcium carbonate has a reputation for producing nausea and constipation in some people. Taking it with meals may reduce these symptoms.

Dolomite

Dolomite is from rock cliffs named after a European mountain range, the Dolomites. This mineral combination related to limestone, chalk and marble is made up of the residue of sea creatures who lived about 30 million years ago. Chemically dolomite is calcium carbonate and magnesium in a ratio of 2:1. It has been a popular source of calcium supplementation for many years but recently there is some evidence of lead contamination.

Dolomite is not easily absorbed without hydrochloric acid so it is not the best choice for the elderly. However, chelation or combining the min-

Seaweed

Seaweed, an integral part of the acclaimed Japanese and macrobiotic diets, has not been a typical part of the Canadian diet except in some maritime communities where seaweed is harvested. Seaweed, a good source of calcium, is very versatile and can be added to soups, salads, eaten as an appetizer or as a side dish.

Nori, the black sheets of seaweekd used to wrap sushi, can be creatively used with other grains and chopped vegetables to make fingerfood or bag lunch treats.

Hijiki and wakame are the best sources of calcium, while kelp, an important source of iodine and essential minerals, can be used as a salt substitute.

Dulse	100 mg	567 mg
Hijiki	100 gms	1400 mg
Kelp	1 Tbsp	156 mg
Kombu	100 gms	800 mg
Nori	100 gms	260 mg
Wakame	100 gms	1300 mg

Nuts

Some nuts are high in calcium while sesame seeds and sunflower seeds are moderate sources. Nuts and seed butters can be used in cooking, on biscuits, sandwiches, drizzled on vegetables or be the base oil in salad dressings.

Almonds (raw)	1 cup	332 mg
Brazil	1 cup	260 mg
Hazelnuts	1 cup	282 mg
Peanuts	1 cup	104 mg
Sesame seeds**	1 Tbsp	67 mg
Sunflower seeds	1 cup	174 mg

**Martha Wagner, "Tasty High Calcium Cooking" in *Medical Self Care*, May/June 1986.

Other Sources

Blackstrap molasses should not be ignored. Blackstrap is many times richer than the light variety. If you are baking, adding soya flour to the recipe will increase the calcium. Good tasting yeasts, like Torula can replace cheese sprinkled on vegetables, salads or pasta.

Blackstrap molasses	1 Tbsp	137 mg
Light molasses	1 Tbsp	33 mg
Torula yeast	1 oz	120 mg

Nutrition Almanac

eral with a protein may make it easier to absorb.

Herbal Sources

Calcium in a capsule form from herbal sources is easy to absorb, however, there is no identification on the package of the amount of the mineral in each capsule. Applied kinesiology can be used to determine the daily requirement.

Antacids

Over-the-counter antacids have become a popular source of calcium supplementation, but the tablets contain only small amounts of calcium, and so a large number of tablets may have to be chewed. Since stomach acid is needed to assimilate calcium and the tablets are alkaline, which tends to neutralize stomach acid, there is some debate about its absorption. Some people experience an "acid rebound effect" so that after a while the tablets actually stimulate stomach acid secretion rather than countering it.

If you are using antacids read labels carefully and avoid those with aluminum which has been implicated in Alzheimer's disease.

Calcium and Prescription Drugs

There are a number of prescription drugs that can interact adversely with calcium. These include: Cholestyramine (a cholesterol-lowering drug); heparin (a blood thinner and anti-clotting drug); furosemide (a diuretic or 'water pill'); anticonvulsants; thryoid medication; corticosteroids; tetracycline (an antibiotic); and isoniazid (for tuberculosis).

Calcium is necessary for all nervous system transmissions and muscle responses. As well it is the source of healthy teeth and strong bones. Weight-bearing exercise is also imperative to the maintenance of strong bones and walking is probably the simplest, most inexpensive and most easily scheduled exercise for most of us.

If you dislike drinking milk, start making your own yoghurt and enriching it with powdered milk to increase the calcium content. You might treat yourself to a Japanese cooking course and learn about the magic of miso, shushi and seaweeds. They are quite delicious but, like many foods, are an acquired taste, so give them a chance. Whichever way you approach increasing your calcium intake you will be rewarded by feeling more calm, you will probably be able to keep your own teeth all your life and you may never break a hip.

Further Reading

Rudolph Ballantyne, *Diet and Nutrition*, The Himalyan International Institute, 1982.
Patricia Hausman, *The Calcium Bible*, Warner Books, 1985.
Recommended Nutrient Intakes for Canadians, Health and Welfare Canada, 1985.
Also see *Resources* in this issue.

Phyllis Marie Jensen is the Principal Researcher on the Metro Toronto Justice Advisory Committee on Spousal Abuse. She is a nurse and runs SMOKEFREE, a program teaching women to quit smoking.

REVIEWS

Overcoming the Menopause Naturally

Caroline Shreeve, Arrow Books, London, U.K., 1986, $10.95, paper, 127 pp.

Menopause Naturally

Sadja Greenwood, Volcano Press, San Francisco, 1984, $14.95, paper, 202 pp.

Reviewed by Susan Kaiser

When I set out to review these books this summer, I ran into an unexpected problem — I didn't want to read them on the subway, in public. Openly reading books about sex hadn't bothered me in the past, probably because many of us worked hard, individually with our own attitudes and together in groups, to challenge attitudes that keep a dome of silence over the details and emotions of sex, sexuality and reproduction. To be able to give a gift of a copy of *Our Bodies, Ourselves* to a younger sister, where it would be passed around with other gifts for public display may seem commonplace for some people, but it took years of attitude changes, on the part of givers and receivers.

The mythology of menopause is logically the next area of women's health to be the focus of attention. As millions of baby boom women approach menopause, the demand for accurate, direct information will increase. And so will our comfort as we talk about and read about menopause.

Manufacturers are already responding to the growing older markets. Calcium supplements are advertised as vital to prevent osteoporosis. (Another isntance of a "pill for every ill?") The dairy industry has just developed a milk-based soft drink. When it hits the market in a year or two, will we be urged to drink it because it's so good for us?

Our experiences with the best of the women's health and sexuality handbooks has yet to be widely applied to menopause and all its biological and social expectations.

Two recent books which approach this need are notable because they present biological information in the context of women's real life situations. Both of them use first person stories which show how greatly our unconscious or unexamined experiences of aging and menopause influence our day-to-day activities.

Sadja Greenwood, in *Menopause Naturally: Preparing for the Second Half of Life* has created a model resource book. Her writing is relaxed. She provides a lot of help understanding the biological and medical information, much of which is produced in lists, charts or illustrations. Greenwood and her publishers, Volcano Press of San Francisco, have also dealt with the problem of outdated information in an unusual way. Readers are offered a yearly update by the author on menopause, hormone use and the lifestyle issues covered in the book. Although this is an American book, only a few references to U.S. drug laws intrude. Greenwood's recommendations for responding to medical and social "prescriptions" for menopause symptoms fall into the "don't take anything until you've weighed the risks and benefits yourself" school of thought; they are generic, rather than specific to the United States.

So, what does she say about estrogen? Estrogen Replacement Therapy (ERT) has gained a foothold as the big health issue for women at menopause (see O'Leary Cobb in this issue). The questions arise quickly: Who needs the pills for menopause? Is this an illness or a natural process?

Greenwood and Caroline Shreeve, author of *Overcoming the Menopause Naturally*, share a similar analysis of the development of ERT. For them, the key response to menopause shouldn't be hormone therapy, but getting your life in order: reducing stress, eating well, getting regular exercise, and building a life around activities you want to do. Not exactly a catchy theme, but certainly sensible. And not new to menopause health issues. As with PMS and pregnancy, the message is treat your body well to reduce the amount and severity of symptoms which our culture wants to treat as illnesses.

Greenwood supplies readers with a personal rating scale to aid in clarifying the pros and cons of ERT. Shreeve is much more convinced that ERT is not necessary — her book's subtitle is *How to Cope Without Artificial Hormones*. While she discusses the pros and cons of hormones, far more of her time is spent on prevention through natural diet, exercise, vitamin supplements and reducing stress.

Shreeve's book is marred by her often directive, "just do this and you'll feel much better" style. And although she spends a lot of pages describing the benefits of vitamin supplements to treat symptoms of menopause such as headaches and hot flashes, she never discusses how to notice physical changes, except those for the better.

Both authors emphasize the long term benefits of taking care of your body. This means that no matter what your age, reading about menopause and the prevention of problems is a good idea. Greenwood's *Menopause Naturally* is the best bet for a practical overview of menopause. For any woman concerned about the pros and cons of ERT, both are useful.

Sue Kaiser is a community worker in Toronto.

Terri Roberton

Silent Pioneers

Directed by Lucy Winter, Produced by OTM Productions, N.Y., Distributed in Canada by Development Education Centre Films (229 College St., Toronto, M5T 1R4, 416-597-0524), 16mm and video formats, 43 minutes.

Reviewed by Alice Grange

Finally a film has been produced about the lives of lesbians and male homosexuals of a "certain age." *Silent Pioneers* presents the lives of eight men and women between the ages of 50 and 90. Some, like Merle Markland, an 83-year-old great grandmother, led long heterosexual lives before coming out. Others, like Gene Harwood and Bruhs Mero, have been in an enduring and endearing relationship for 54 years and proudly brag of their continuing love for each other.

This documentary touches on their interactions with younger people, families, friends and lovers and speaks fleetingly of a time in the not so distant past when the existence and reality of homosexuals was unacknowledged by, if not unapparent to, mainstream society. It successfully responds to the myth that gays and lesbians are incapable of sustaining long term relationships and briefly addresses assumptions about aging homosexuals.

The film was originally produced as a 26 minute version for a general television audience. Because of this the film combats prevalent stereotypes. The classic image of homosexual men as limp wristed, promiscuous bar cruisers is humourously caricatured by Harwood, as he is observed laughingly by Mero.

Clips of such characters as a former Catholic monk turned cowboy were interspersed with 'on the street' interviews with similar age heterosexuals to contribute to the humourous nature of *Silent Pioneers*. This was particularly seen in the contrast between one heterosexual woman who disapproves of lesbian desires as 'unhealthy' and another who quipped "there are more women than men, so what's a woman to do?"

My major criticism of the film is that its upbeat nature, bordering on the comical at times and the ironic at others, does not help the film live up to its title *Silent Pioneers*. Except for high profile individuals such as Barbara Deming, most in the film had been closeted until recent years. Yet the film only hints at the hardships for these men and women living *silent* lives. The film does not portray the emotions of dealing with essentially secretive lives in which one's loves and desires are excluded from the knowledge of one's friends and family. The film only touches the edge of understanding what it meant to Markland to feel safe enough to come out after the death of her lover of 58 years, just six years prior to the filming of *Silent Pioneers*.

In addition, *Silent Pioneers* seemed choppy and of decidedly short duration. The version I saw at DEC was 42 minutes long (a 30-minute version exists), which left one with the desire to see more. Apparently the unused footage is available for research purposes through the Lesbian Herstory Archives. It's regrettable more isn't available for the general public.

Nevertheless the film's positive emphasis spoke eloquently of the joys, vitality, pride and lust for life of a select group of aging individuals. It's a pity that we couldn't all have been privy to the unedited conversations between the filmmakers and these eight *Silent Pioneers*.

Alice Grange is a member of Women Healthsharing. She recently moved back to Toronto from British Columbia and Colorado.

Pat Giniger

The late Barbara Deming is one of the women profiled in *Silent Pioneers*.

The Best Time of My Life

National Film Board of Canada, Studio D, Directed by Patricia Watson, 1986, 16mm and video formats, 59 minutes.

Is It Hot in Here?

National Film Board of Canada, Pacific Studio, Directed by Haida Paul and Laura Alper, 1986, 16mm and video formats, 36 minutes.

Reviewed by June Rogers

Menopause seems to be the hot media topic today in women's magazines and TV talk shows. Not surprisingly the National Film Board of Canada has jumped on the bandwagon producing two films, "Is It Hot in Here" by the Pacific Studio in Vancouver, and "The Best Time of My Life: Portraits of Women in Mid-Life" by the Studio D group in Toronto.

"Is It Hot in Here?" starts off slowly with a woman in her 40s describing her art work, interspersing her commentary with thoughts about menopause. We are then introduced to a group of middle-aged women discussing their sexuality, myths about menopause, and feelings about no longer being able to reproduce and how that negatively affects their value in society. One woman notices, with some regret, that men don't pay attention to her anymore.

Although this film concentrates on women's feelings about menopause, it also gives concrete explanations about the physiological changes, signs and symptoms.

Menopause can occur over the course of 10 to 15 years. Sidney Thomson, a facilitator of women's workshops on menopause, explains that this is because the ovaries begin to produce less estrogen when women reach their late 30s and that by the early 40s, most women will start to experience a change in their periods. (See article, this issue.) Besides hot flashes, women may find that their voices get lower, that they begin to experience headaches, vaginal infections due to a lack of natural lubrication, and severe bouts of sweating. One woman soaked her pillow three times a night for several months. Another woman, however, had very few problems during the cessation of her

TIPS

Another coffee drawback

Caffeine consumption can double calcium loss through urination. A researcher at Washington State University advises that for every two cups of coffee, you should drink an extra one-third cup of milk or eat an extra half ounce of cheddar cheese.

Microwave warnings

Be careful heating baby foods in microwaves. Don't heat food in baby food jars, as droplets of water in the food can create pockets of hot steam. Instead, transfer food to a small bowl. Also, it is not advised to heat baby bottles with plastic disposable linings in a microwave. Instead, transfer formula or expressed milk to a glass jar.

Pill protection

Remove the cotton from the bottle of pills once you have opened it, advises *Health Views*, a publication of the Washington University Medical Centre in St. Louis. The cotton is just to protect the pills during shipping. If kept in, it can absorb moisture and affect strength of the pills. And don't combine different medications in the same container; they may react with one another.

Suffer from Migraine?

Certain foods are notorious for triggering migraine headaches; particularly those containing tyramine, phenylethelamine, sodium nitrite, sodium nitrate and mono-sodium glutamate (MSG).

These five additives are commonly found in alcohol, aged cheese, bananas, avocados, chicken livers, chocolate, herring, nuts, onions, yogurt, processed meats (bacon, bologna, hot dogs, pepperoni, sausages) and Chinese food. Citrus fruits and juices have also been implicated as well as tea and coffee including decaffeinated.

periods. Every woman's experience of menopause is unique. But if there is no support in the community or from friends, emotional isolation can make the symptoms seem worse.

The most informative part of the 35-minute film is the detailing of the medical interventions such as hysterectomies, mood altering drugs and estrogen replacement therapy. Up until 1975, women were given estrogen to reduce the symptoms of menopause, but that therapy was halted when studies showed that there was a link to uterine cancer. At that point, medical scientists added progesterone to the estrogen, causing a return of cyclic bleeding. Scientists are unable to determine whether the progesterone has made any difference in arresting the development of uterine cancer.

The film then explores the future and how the next generation of women will deal with menopause. A woman scientist discusses the fact that not enough is known about the subject. Calling for more research, she hopes that women will begin to see menopause as a natural process and as a result surgery and drugs may become obsolete. She also suggests that women should exercise to reduce the risk of osteoporosis — bone loss due to the lack of estrogen.

The second film, "The Best Time of My Life," focuses on menopause more as part of the transitional phase of mid-life rather than as a physiological phenomenon. The film starts off very strongly with a testimonial by journalist Fredelle Maynard, but it begins to deteriorate during a litany of similar stories by 16 women from a variety of backgrounds and income levels.

Still, the film attempts to help women see that there is a lot to live for past the childbearing years. As Maynard points out, "I found that I wasn't living for anyone else — not my parents, not my husband, not my children. I barely felt responsible for my plants." Another woman comments that she feels psychologically free from men. "Men can no longer blackmail us like they used to."

Benefits aside, many of the women in the film talk about the fact that society sees them as useless and hysterical. One woman recounts that she shook and cried constantly during the initial phase of menopause and her doctor admonished her, calling her "gutless." Recognizing that women she knew were feeling isolated at mid-life, Janine O'Leary Cobb recently started a newsletter called *A Friend Indeed* as a forum for menopausal women. The initial response was incredible: she has received more than 900 requests for the newsletter. She has also printed many harrowing stories. One writer said that while on estrogen replacement therapy she had a stroke, developed a blood clot in her eye, and suffered from gallstones. (See article, this issue.)

Still, the women talk about their new lives with enthusiasm, some returning to university, others taking on larger responsibilities at work. The film is definitely upbeat, perhaps too upbeat, glossing over the fact that some women may not feel that it is the best time of their lives. I would have preferred hearing from five women with different backgrounds in a much shorter version of the film.

There is no doubt, however, that both of these films are worth viewing — "Is It Hot in Here?" for its solid physiological information, and "The Best Time of My Life," for its ability to inject self-esteem into women who would otherwise feel useless because they are no longer able to bear children. Both are available from the NFB.

June Rogers is a freelance writer and a volunteer sexuality counsellor/educator based in Toronto.

Pat Foote-Jones

MENOPAUSE RESOURCES

Menopause: Me and You

This 47 page handbook, in an easy-to-read format, is filled with answers to commonly asked questions about menopause. Written by Ann M. Voda with Jim Tucker, it is based on workshops and research carried out by Voda.

To order, write Ann Voda, College of Nursing, University of Utah, 25 South Medical Drive, Salt Lake City, Utah 84112.

A Book About Menopause

This hot-off-the press handbook follows the format of other Montreal Health Press handbooks, the best known of which is *A Book About Birth Control*. The 52 page handbook makes use of extensive quotes and stories from women in menopause, along with interpretation of medical literature.

To order, contact the Montreal Health Press, Box 1000, Station La Cité, Montréal, P.Q. H2W 2N1, or telephone them at (514) 272-5441. Anticipated price is $2.50 single copies; bulk rates available.

Helping Ourselves

This is a practical book detailing step-by-step the how to's of setting up self-help groups. *Helping Ourselves: A Handbook for Women Starting Groups*, is based on the cumulative experiences of the Women's Counselling Referral & Education Centre in Toronto. It would be a useful tool for women starting menopause groups.

The book is published by Women's Press, and can be ordered from them at 229 College St., Suite 204, Toronto, Ont. M5T 1R4. Cost is $8.95 plus $.75 shipping.

Terri Roberton

Facing the Change of Life

This menopause resource kit, produced in 1984, is designed for use by self-help and support groups. It includes information on the physiology of menstruation and menopause, social attitudes, estrogen replacement therapy and diet and exercise.

The kit may be purchased for $35 from Planned Parenthood Newfoundland/Labrador, 203 Merrymeeting Rd., St. John's, Nfld. A1C 2W6.

A Friend Indeed

This monthly newsletter provides an information exchange, practical help and emotional support for menopausal women. It began publishing in early 1984, and is available in either English or French.

The newsletter is available to individuals at a cost of $20 per year (10 issues) from A Friend Indeed Publications, P.O. Box 9, NDG Station, Montreal, P.Q. H4A 3P4.

The Time of Our Lives

This 20-page booklet answers basic questions about menopause in an easy-to-understand format.

The booklet is available in limited quantities. For a free copy contact the Voluntary Resource Centre, 81 Prince St., Charlottetown, P.E.I. C1A 4R3.

Fitness and Aging

This 42-page booklet, *Don't Take it Easy: Fitness for the Older Canadian*, provides ideas about fitness programs suitable for women and men 65 years of age and older.

It is available free of cost from Fitness Canada, 365 Laurier Ave. W., Ottawa, Ont. K1A 0X6.

HERS

Hysterectomy Educational Resources and Services is just what its title implies. This organization is an all round resource for staying in touch with what's known about hysterectomies.

For more information contact HERS at 422 Brynmawr Ave., Bala Cynwyd, PA 19004.

Nutrition and Aging

This selected bibliography lists over 800 journal articles, pamphlets, books and teaching aids on nutritional aspects of aging.

The book is available for $8 by cheque, $8.50 if invoiced by the publisher, from Ryerson Polytechnical Institute, 50 Gould St., Toronto, Ont. M5B 1E8.

Osteoporosis Society

The Osteoporosis Society of Canada is a charitable organization, engaged in prevention, rehabilitation and public education related to osteoporosis. The society provides medical referrals for some cities and is preparing a series of videotapes on osteoporosis. There are similar local organizations forming in many parts of Canada.

For further information contact the *Osteoporosis Society of Canada*, 76 St. Clair Ave. W., Suite 601, Toronto, Ont. M4V 1N2.

The Menopause Self-Help Kit

This kit contains a 20-page self-help booklet discussing menopausal symptoms and treatments, with a special emphasis on non-drug, natural approaches. It also has articles on aging, medical politics and stress, information on breast self-examination and tips for starting a menopause support group.

The kit is available at a cost of $5.50 from the Vancouver Women's Health Collective, 888 Burrard St., Vancouver, B.C. V6Z 1X9.

Help Yourself Through Menopause

This brief pamphlet, produced by Planned Parenthood Newfoundland/ Labrador, contains practical hints for dealing with menopausal symptoms, with special attention to diet, herbal remedies, exercise and emotional support.

The pamphlet is available free from Planned Parenthood Newfoundland/ Labrador, 203 Merrymeeting Rd., St. John's, Nfld. A1C 2W6.

Broomstick

This bimonthly feminist periodical is published by, for and about women over 40. Broomstick functions as a network, printing experiences, ideas and strategies for change and clarifying social exclusion and exploitation of older women.

A year's subscription costs $20 in U.S. funds. Order from Broomstick, 3543 18th St., San Francisco, CA 94110.

Books Available from Your Local Bookseller

The following books all relate to menopause or aging. You may find them of interest. All can be ordered from your local bookstore.

Our Own Years: What Women Over 35 Should Know About Themselves. Alice Lake,.New York, NY, Random House Inc., 1979.

Stand Tall! The Informed Woman's Guide to Osteoporosis. Morris Notelovitz and Marsha Ware. Triad Publishing Co., Box 13096, Gainesville, FL 32604, 1982.

Growing Older, Getting Better: A Handbook for Women in the Second Half of Life. Reading, MA, Addison-Wesley, 1983.

Menopause: A Positive Approach. Rosetta Reitz. New York, NY, Penguin Books, 1979.

Women and the Crisis in Sex Hormones. Barbara and Gideon Seaman. New York, N.Y., Bantam Books, 1978 (paper).

How a Woman Ages, Robin Marantz Henig, Ballantine Esquire Press, NY, 1985.

Women of a Certain Age: The Mid-Life Search for Self, Lillian B. Rubin, Harper Colophon Books, NY, 1979.

Menopause: A Guide for Women and the Men Who Love Them, Winnifred Berg Cutler et al, WW Norton, NY, 1983.

Menstruation and Menopause, Paula Weideger, Dell, NY, 1977.

Menopause Naturally, Sadja Greenwood, Volcano Press, San Francisco, 1984.

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RESOURCES & EVENTS

Emergency Consultation

In June, 1986 a delegation of 55 women responded to a government freeze on funding to the Women's Program of the Secretary of State. Representatives of organizations funded by the national office of the Women's Program and others met with the Secretary of State and the Acting Director of the Women's Program. The final report on the meeting prepared by the planning committee is a valuable strategic and lobbying tool.

Copies are available in French and English. To order, write CRIAW/ICREF, 151 Slater St., Suite 408, Ottawa K1P 5H3. Please include your language preference. Free.

Battered Women's Legal Rights

A 28-page booklet, entitled *Compensation for Battered Women*, outlines legal steps to obtain compensation from government boards and how to take a batterer to court. The booklet was prepared by law students at the University of Western Ontario under the direction of Connie Backhouse.

The booklet can be ordered from the Faculty of Law, University of Western Ontario, London, Ont. N6A 3K7. Free.

Butting Out

How To Be A Happy Ex-Smoker is a detailed self-help manual produced by the Canadian Cancer Society. The 25-page booklet is divided into 4 sections: Taking Stock of Your Smoking; Strategies for Quitting; Celebrating Quit Day; and How to be a Happy Ex-Smoker. Questionnaires and charts are provided to give smokers a clear understanding of their habit.

For a copy, contact your local branch of the Canadian Cancer Society. Booklets are free.

Periods

Volcano Press has recently announced the publication of *Periodo: Libro Para Chicas Sabre La Menstruacion*. This is the Spanish translation of *Periods*, a popular and informative book on menstruation written specifically for young women.

Request at your local bookstore or write to Volcano Press, 330 Ellis St., San Francisco, CA 94102. U.S. price (without shipping) is $7.

International Conference

The 5th International Women & Health Conference will be held in San José, Costa Rica, May 23-28, 1987. The main themes of the conference will be: population policies and reproductive rights; community health; environmental health hazards; drugs; health care systems. This is the first meeting to be held in a developing country.

Individuals are encouraged to donate toward the cost of running the conference and funding travel for delegates from Canada and developing countries.

For general information about the conference or to donate towards Canadian delegates' costs, contact Connie Clement, c/o Women Healthsharing, 101 Niagara St., Suite 200A, Toronto, Ont. M5V 1C3.

To propose workshops, obtain answers to detailed queries or donate towards conference costs, contact Marta Trejos, Cefemina, Apdo 5355, San José 1000, Costa Rica [Tel. 27.15.68].

Price Change

The Fall 1985 edition of *Healthsharing* included in its *Thematic Resources* a reference to an artificial insemination booklet.

The cost of this information packet is now $5 (U.S. funds). It is available from the Lesbian Mothers National Defense Fund, P.O. Box 21567, Seattle, WA, 98111.

Allergies & Children

This excellent small book answers many questions asked by parents of the approximately three million Canadian children with allergies. Preventative measures that any family can carry out are stressed as a means of keeping allergies under control. *Allergies and Children* was developed by The Hospital for Sick Children in Toronto in 1986.

Copies can be ordered from Kids Can Press, 585 1/2 Bloor St. W., Toronto, Ont. M6G 1K5. Cost is $6.95.