

AMERICAN SOCIETY FOR REPRODUCTIVE MEDICINE

PELVIC PAIN

A Guide for Patients



PATIENT INFORMATION SERIES

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PELVIC PAIN

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A glossary of italicized words is located at the end of this booklet.

INTRODUCTION

Women commonly experience episodes of mild pelvic or abdominal discomfort at certain times during the menstrual cycle. Some women, however, have pain which is not explained by the normal physical changes that occur in the *uterus* and *ovaries*. This pain can have many causes which may involve the reproductive organs and sometimes the nearby *urinary tract*, *bowel*, or other abdominal structures. A person's reaction to pain depends not only on its cause but on how it affects their ability to function. Because there are many causes of pelvic pain, the medical assessment and potential treatments are varied. The evaluation includes a thorough history and examination, tests and procedures, and possible assessment of the pain's psychological effect. This booklet will provide information about the common causes of pelvic and abdominal pain, tests for diagnosis, and potential treatments.

CAUSES OF PELVIC PAIN

Because there are many structures which make up the pelvis and abdomen (Figure 1), there are numerous possible causes of pelvic pain. Some of the more common causes are described below.

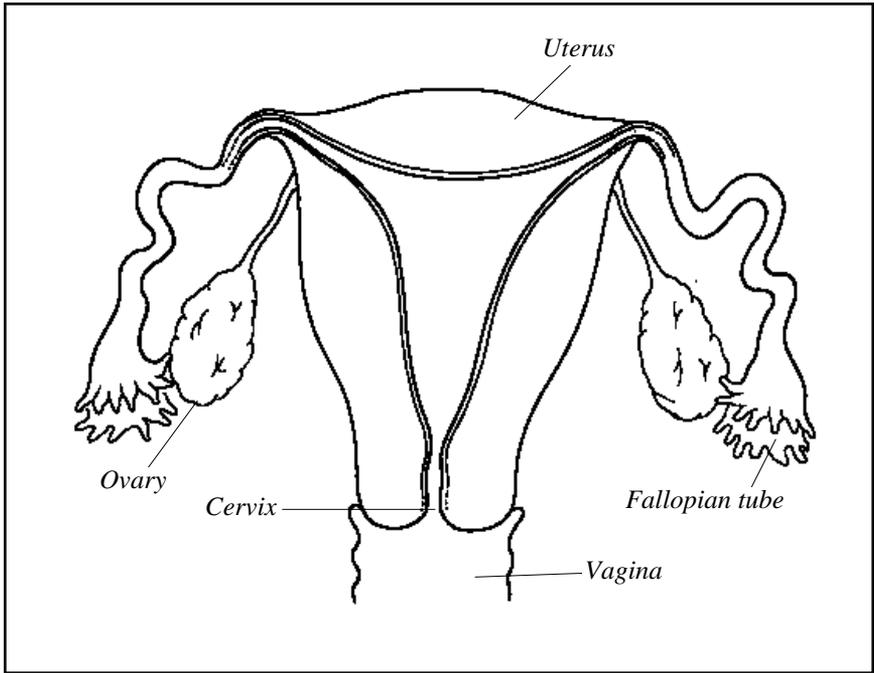


Figure 1. Female reproductive system.

The Menstrual Cycle

Women can experience pain due to the normal physical events that occur during the menstrual cycle. Pain may commonly occur during *ovulation*. This pain is called *mittelschmerz*, a German term which means “pain occurring in the middle,” a reference to the usual time of egg release at the midpoint between menstrual periods. This pain is usually described as a mild cramping, but in some women it can be quite severe. The amount of pain can vary from month to month, but the timing is predictable, usually about two weeks before every period. *Mittelschmerz* usually lasts for only one or two days. Sometimes it is more noticeable in women receiving fertility medications.

Another common time for women to experience discomfort is during menses. Menstrual cramps, referred to as *dysmenorrhea*, are often an intermittent aching sensation in the pelvis, lower abdomen, lower back, and/or upper legs. Some women experience a heaviness or fullness in addition to the cramping sensation. It is not unusual to also experience generalized muscular aching, nausea, and diarrhea.

Women who experience severe menstrual period pain from the time they first start having regular cycles may be diagnosed with *primary dysmenorrhea*, which is caused by the production of *prostaglandins*. Prostaglandins

are chemicals produced by many body tissues, including the lining of the uterus (*endometrium*). When the endometrium is shed during menstruation, prostaglandins are released from the lining and cause contraction, or tightening, of the uterine muscles. These contractions cause discomfort such as cramping or pain. Prostaglandins can also affect other body tissues and are responsible for the mild nausea and loose bowel movements which some women experience during the menstrual period.

The amount of pain and other symptoms that a woman experiences during her menstrual cycle is quite variable. The pain is not always the same each cycle and can change from month to month, decrease with age or after childbirth, or remain unchanged. If menstrual pain becomes progressively more severe, it may be a sign of a problem other than the normal release of prostaglandins. Pain that worsens over time and is due to other conditions is called *secondary dysmenorrhea*, to distinguish it from pain associated with normal events during the menstrual period, or primary dysmenorrhea. Secondary dysmenorrhea is caused most commonly by *endometriosis*. Other causes may include *adenomyosis*, *fibroids*, uterine *polyps*, intrauterine device (IUD) placement, bowel disease, pelvic infection, or pelvic adhesions (scar tissue). Treatment is directed toward the cause of the pain.

It is important to know that mittelschmerz and/or dysmenorrhea experienced during the menstrual cycle is not necessarily a sign of a health problem. Often the pain during the normal menstrual cycle is mild and requires no treatment. For some women, however, pain medication called non-steroidal anti-inflammatory drugs (NSAIDs) can help control the pain by limiting the production of prostaglandins. These medications will be discussed later in this booklet under the section on treatment.

Uterine Problems

Several conditions of the uterus can lead to pelvic and abdominal pain. Fibroids, or *uterine leiomyoma*, are a common *benign* overgrowth of the uterine muscle tissue that can cause pelvic pressure or pain (Figure 2). The location and size of uterine fibroids determines the symptoms. Although small fibroids may not cause any symptoms, large fibroids can place pressure on adjacent structures such as the bladder or bowel. Uterine fibroids that lie next to or inside the uterine cavity can commonly cause heavy menstrual bleeding and may increase menstrual pain or dysmenorrhea. Rarely, the tissue within the fibroids degenerates and causes sudden, severe pain. For more information on this subject, refer to the ASRM patient information booklet titled *Uterine Fibroids*.

Adenomyosis is a condition where the glandular lining of the uterus is found within the muscle of the uterus. This condition may cause painful menstruation and heavier menstrual bleeding. Adenomyosis is difficult to diagnose and may only be confirmed if the uterus is removed and examined.

However, imaging studies such as *hysteroscopy*, *ultrasound*, *computerized tomography (CT scans)*, and *magnetic resonance imaging (MRI)* may sometimes be useful to diagnose adenomyosis.

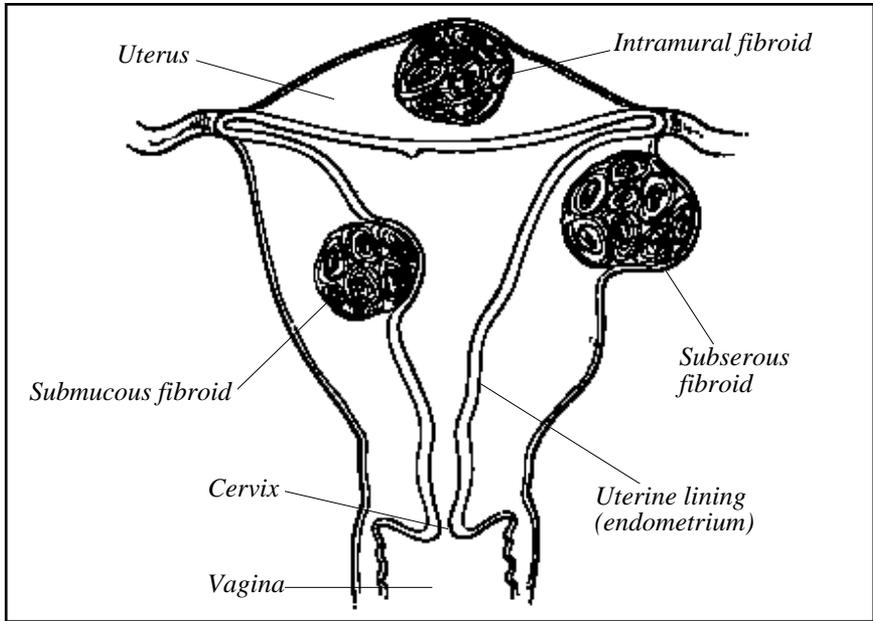


Figure 2. Uterine causes of pelvic pain. Subserous fibroids are located just beneath the outer wall of the uterus. Intramural fibroids are found in the muscular layers of the uterine wall, and submucous fibroids are located under the uterine lining and may protrude into the uterine cavity.

Ovarian/Tubal Problems

Infections in the *fallopian tubes* usually cause a sudden onset of pain and fever. Women who have had prior infections of the fallopian tubes or ovaries may have pain symptoms that persist long after the infection has been treated. Pelvic infections, sometimes called *pelvic inflammatory disease (PID)*, are typically caused by sexually transmitted diseases. After the infection is treated, scar tissue (*adhesions*) around the tubes and ovaries can stretch between the pelvic organs, bowel, and bladder and cause discomfort in the abdomen or pelvis. Blockage of the tube by scar tissue leads to fluid collection within the tube, or a *hydrosalpinx*. Occasionally, the enlarged tube can twist and worsen pelvic pain.

Ovarian cysts and tumors may also cause pain or pressure. The ovary normally forms a fluid-filled cyst (*follicle*) containing an egg each month. These follicles occasionally fill with blood after the release of the egg. Leakage of fluid from the cyst can potentially cause pain, although typically these

cysts go away without causing long-term problems. Rarely, an ovarian cyst or tumor can twist the ovary on its supporting ligament (torsion) and cause sudden, severe pain.

Pelvic Problems

Endometriosis is a disease that can cause pelvic pain. In this disease, the tissue usually found in the lining of the uterus (endometrium) attaches to the surfaces of other organs in the pelvis and abdomen. The cause(s) of endometriosis is not fully understood. Endometriosis may cause painful menstruation, secondary dysmenorrhea, or pain during other times of the cycle. It can cause pain during intercourse, called *dyspareunia*, which occurs when the penis pushes against the back of the vagina. The back of the uterus is a common site for endometriosis (Figure 3), and this area is often tender during intercourse or a pelvic exam.

Endometriosis can be mild, involving small implants of endometrial tissue on pelvic organs. However, larger and deeper areas can develop and cause more severe adhesions or ovarian cysts (*endometriomas*) containing endometriosis. Interestingly, the amount of pain caused by this disease is not always related to the amount of endometriosis or scar tissue present. Sometimes, a very minimal amount of endometriosis can cause severe pain, while a large amount of endometriosis and scar tissue will cause no discomfort. A surgical procedure called *laparoscopy* is necessary to diagnose endometriosis. For more information on endometriosis and laparoscopy, refer to the ASRM patient information booklets titled *Laparoscopy and Hysteroscopy and Endometriosis*.

Adhesions caused by endometriosis are associated with pain in some women. Another important cause of adhesions in the pelvis or abdomen is previous surgery on the uterus, tubes, ovaries, or bowel. Women with a history of a ruptured appendix may have adhesions which affect the pelvic organs. Usually a laparoscopy is used to diagnose the presence of pelvic adhesions, but a *hysterosalpingogram* may be performed as well.

Other Causes of Pain

Bowel problems can cause pain which may affect the pelvis and abdomen. Common problems include *irritable bowel syndrome (IBS)*, a condition which is also associated with diarrhea, constipation, and bloating and may be related to stress. Inflammatory bowel diseases, such as *Crohn's Disease*, can cause pelvic pain. In middle-aged women, *diverticulosis*, an outpouching of the bowel wall, can cause pelvic discomfort. These diverticula can become infected and may cause worsening pain (diverticulitis). Occasionally, symptoms from a *hernia* cause pelvic pain.

Urinary tract problems can also cause pelvic pain. Bladder infections usually cause pain with urination and increased frequency of urination, as do

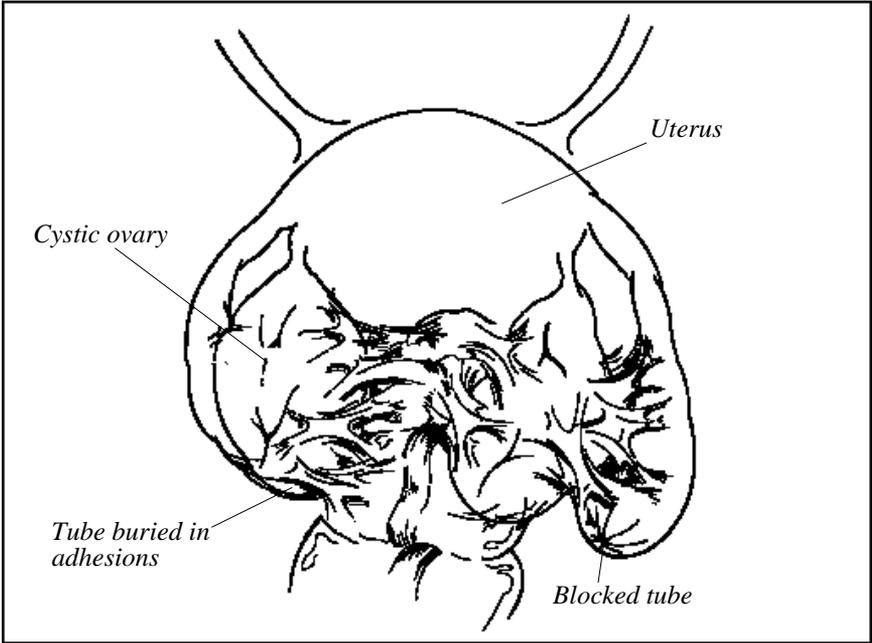


Figure 3. *Endometriosis.*

kidney stones. Chronic bladder problems, such as *interstitial cystitis*, are also associated with pelvic pain. In some women, muscle injuries of the abdominal wall can cause pain.

Women who have been abused or sexually assaulted in the past are more likely to experience subsequent severe pelvic pain. Abuse may alter a woman's perception of pain, and pelvic pain may bring back difficult memories and affect her ability to undergo evaluation and treatment. It is important that any woman who has experienced sexual abuse share this information with her health care provider. Counseling is an important component of treatment for women who have been assaulted or abused.

DIAGNOSTIC TESTS

A thorough history is the first step in determining the source of the pain. Women may be asked to keep a record of: when the pain occurs; what triggers it, such as meals, bowel activity, urination, intercourse, and/or movement; its intensity and duration; its location(s); its nature (i.e. dull, aching, stabbing, sharp, crampy); and its relationship to the menstrual cycle. The physician should also be told about things which relieve the pain such as certain activities or medications. In addition, the physician should be informed

of any prior surgeries, pelvic infections, infertility, previous pregnancy events, and treatments for stress, anxiety, and depression.

The physical examination is a very important aspect of the evaluation and should include a detailed abdominal and pelvic examination, including a rectal exam. The physician will try to map where the pain is located and whether it radiates to different areas. This may be a clue to the source of the pain. Blood tests and cultures of the *cervix* and urine may be taken to look for infection.

Additional Tests

- Ultrasound is a test that uses sound waves to form a picture of the pelvic organs. A probe can be placed into the vagina to evaluate the uterus, tubes, and ovaries. Alternatively, a probe can be placed on the abdomen to view the pelvic organs as well as the kidneys and other abdominal structures.
- Computerized tomography (CT scan) or magnetic resonance imaging (MRI) are tests used to obtain detailed images of the abdomen and pelvis.
- *Barium enema* or *colonoscopy* are tests that use x-ray or direct visualization of the colon (lower bowel). Colonoscopy also provides an opportunity to biopsy tissues within the bowel.

Unfortunately, none of the above tests are able to diagnose common problems such as pelvic adhesions or endometriosis. Even pelvic infections can be difficult to diagnose in some situations. When preliminary testing is unable to determine the cause of pain, a laparoscopy may be required (Figure 4). During the surgery, the physician places a small viewing instrument, called a *laparoscope*, through a small incision near the naval to examine the contents of the abdominal cavity including the uterus, tubes, and ovaries. During the laparoscopy, a number of pelvic problems can be treated, as will be described below in the section on treatment.

Women with pelvic pain may be referred to other health care providers and/or a therapist either during or following a gynecologic evaluation. Physicians such as urologists or gastroenterologists may be recommended to perform specialized tests or evaluations. Pelvic pain can produce significant stress, depression, and/or anxiety. Sometimes other stresses can complicate or alter a woman's response to pain. It is important that the interaction between the physical and emotional aspects of the pain is evaluated. Neurologists, psychologists, psychiatrists, and physical therapists may be helpful in evaluating these aspects of pelvic pain. It is also helpful to discuss the pain's effect on emotional well-being and lifestyle.

Pelvic pain may affect a woman's desire and ability to enjoy sex. Dyspareunia, or painful intercourse, can be both a cause and an effect of pelvic pain. There may be physical reasons that intercourse is painful, such as fibroids or endometriosis. Pelvic pain may cause loss of sexual desire and fear that sex may cause more pain. Discussing these concerns with a physician or therapist can be helpful.

Frequently, no cause can be identified for pelvic pain. This does not mean that the pain is not real, but the inability to determine the precise cause of pelvic pain can be very frustrating to the patient. Fortunately, even if an exact cause of pain cannot be determined, treatment may still be successful. Pain medications, counseling, and other treatments are generally successful even when the source of the pelvic pain is unclear.

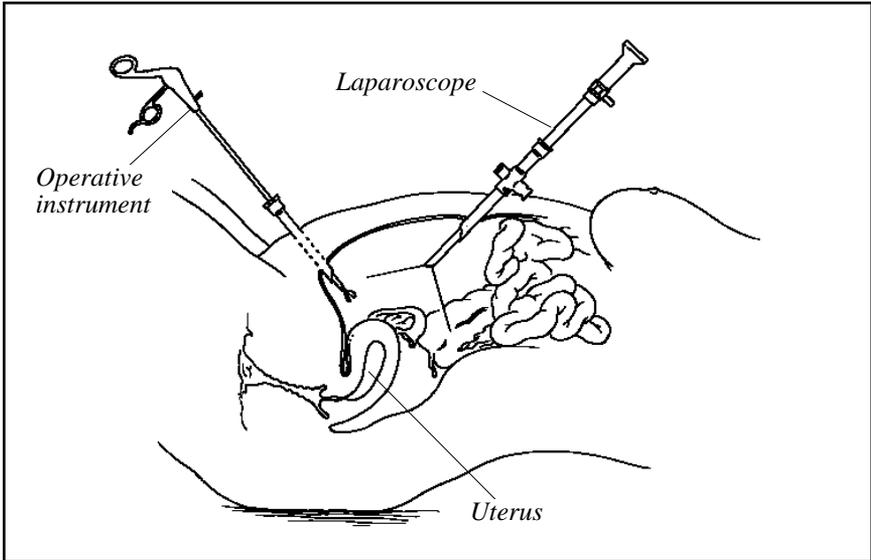


Figure 4. *Laparoscopy.*

TREATMENT

The treatment of pelvic pain depends on the cause. If bowel or urinary tract problems are discovered, specific causes can be treated appropriately. Some specific treatments which may be suggested are described below.

Medications

Pain caused by normal cyclic events during the menstrual cycle, such as menstrual cramps and ovulation pain, can often be controlled with medications that decrease the production of prostaglandins. Medications of this type, often called NSAIDs (nonsteroidal anti-inflammatory drugs), include naproxen sodium and ibuprofen and are available without a prescription. Other NSAIDs may require a prescription.

People can develop a dependence on some types of narcotic pain medications, so they are generally only used for short periods of time or in very limited ways. Narcotics can affect a person's ability to work and perform normal activities. They should only be used as instructed.

Hormonal medications, which limit the production of ovarian hormones, can reduce pain during the menstrual cycle. *Birth control pills* or *progestin* agents (pills or long-acting injections) are also used to decrease dysmenorrhea and discomfort related to endometriosis. Danazol is an androgenic medication (contains synthetic male hormones) which can be used to control pain due to endometriosis.

Gonadotropin releasing hormone agonists (GnRH agonists) are another important category of medication used to control pain caused by endometriosis. This medication temporarily reduces ovarian production of *estrogen* and *progesterone*. The reduction in blood levels of these ovarian hormones usually causes the implants of endometriosis to shrink, and often the pain from this disorder will decrease. GnRH agonists are usually used for three to six months in most patients because bone loss can occur with prolonged use. In addition, GnRH agonists can also induce temporary shrinkage of uterine fibroids. This medication may be given to decrease the size of the uterus prior to surgery. Unfortunately, fibroids regrow after GnRH agonists are stopped, so long-term treatment of fibroids with this medication is not currently recommended. Studies have been completed which suggest that GnRH agonists, given along with low doses of estrogens and/or progestins, may allow longer treatment periods for endometriosis with *gonadotropin releasing hormone analogs (GnRH analogs)*.

There is evidence that pain signals that go to the brain can be controlled by anti-depressant medications. Depression and pain are often effectively treated with a combination of medication and counseling.

Other Treatments

People who suffer from chronic pain may benefit from nerve blocks that affect the nerves carrying the pain signals, stress management techniques, physical therapy, relaxation methods, and *biofeedback*. Electronic nerve stimulation and acupuncture have also been used to help control pelvic and abdominal pain. Some therapists have group sessions to assist individuals in coping and managing chronic pain problems. Talking with others about the pain and the frustrations that accompany it can be therapeutic for many people.

Surgical Therapy

As described above, a laparoscopy may be performed to evaluate and treat certain causes of pain such as endometriosis and scar tissue. This surgery is done using a laparoscope which is placed into the abdominal cavity through an incision in or near the navel. Additional instruments can be placed into the pelvic area through incisions at or above the pubic hair line. Tools such as scissors, electric current, or laser energy can be used to remove scar tissue and endometriosis implants.

Major surgery with possible removal of the uterus (*hysterectomy*) and/or ovaries (*salpingo-oophorectomy*) may be suggested as treatment for long-

standing pelvic pain that has not been treated successfully with other methods. Before undergoing hysterectomy, it is important that a woman has completed her childbearing and fully understands the risks and potential benefits of such an operation. Although many women have significant pain relief after hysterectomy, not all women have complete pain relief following this procedure. Hysterectomy should be the last resort only if medical management is unsuccessful and ideally in a woman who has completed her childbearing.

SUMMARY

There are many potential causes of pelvic pain. Multidisciplinary evaluation and extensive testing may be required to determine the cause. Therapy often involves trial and error and more than one treatment may be tried before pain is relieved. Surgical management is often effective, but is generally performed only if medical therapy is unsuccessful.

GLOSSARY

Adenomyosis. A benign (non-cancerous) invasion of endometrial tissue into the muscular wall (myometrium) of the uterus; can be associated with painful or heavy menses.

Adhesions (scar tissue). Bands of fibrous scar tissue that may bind the pelvic organs and/or loops of bowel together. Adhesions can result from previous infections, endometriosis, or surgeries.

Barium enema. Test using a radio opaque medium and x-ray to identify any blockages in the lower bowel or intestinal tract using dye placed through the rectum.

Benign. Non-cancerous.

Biofeedback. A self-regulation technique in which a patient learns to control anxiety/stress with the aid of equipment provided in the form of visual or auditory signals.

Birth control pills. Also known as oral contraceptives. The pills contain a mixture of synthetic estrogen and progestin. Proper usage prevents pregnancy by suppressing ovulation and decreasing the ovarian secretion of hormones, including androgens.

Bowel. The small bowel (intestines) and large bowel (colon).

Cervix. The lower narrow end of the uterus that connects the uterine cavity to the vagina.

Colonoscopy. Passage of a lighted scope through the rectum into the colon to visualize the lining of the large bowel (colon).

Computerized tomography (CT). An x-ray imaging technique that creates a three-dimensional image of internal organs.

Crohn's disease. Inflammatory bowel disease which causes painful ulcers to form within the bowel.

Diverticulosis. Benign condition of the intestine characterized by outpouching of the bowel wall.

Dysmenorrhea. Painful menstruation.

Dyspareunia. Pain with intercourse; sometimes a symptom of endometriosis.

Endometriomas. Blood-filled cysts that can occur when endometrial tissue develops in the ovary.

Endometriosis. A condition where patches of endometrial-like tissue implant outside of the uterine cavity in abnormal locations such as the ovaries, fallopian tubes, and abdominal cavity. Endometriosis can grow with hormonal stimulation causing pain, inflammation, and scar tissue. It also may be associated with pelvic pain and infertility.

Endometrium. The lining of the uterus that is shed each month with the menstrual period. As the monthly cycle progresses, the endometrium thickens and thus provides a nourishing site for the implantation of a fertilized egg.

Estrogens. The female sex hormones produced by the ovaries which are responsible for the development of female sex characteristics. Estrogens are largely responsible for stimulating the uterine lining to thicken during the first half of the menstrual cycle in preparation for ovulation and possible pregnancy. They are also important for healthy bones and overall health.

Fallopian tubes. A pair of hollow tubes attached on each side of the uterus through which the egg travels from the ovary to the uterus. Fertilization usually occurs in the fallopian tube. The fallopian tube is the most common site of ectopic pregnancy.

Fibroids. Benign (non-cancerous) tumors of the uterine muscle wall that can cause abnormal uterine bleeding. Also called leiomyomas or myomas.

Follicle. A fluid-filled sac located just beneath the surface of the ovary, containing an egg (oocyte) and cells that produce hormones. The sac increases in size and volume during the first half of the menstrual cycle. At ovulation, the follicle matures and ruptures, releasing the egg. As the follicle matures, it can be visualized by ultrasound.

Gonadotropin releasing hormone agonists (GnRH agonists). Synthetic hormones similar to the naturally occurring gonadotropin releasing hormones (GnRH) secreted by the hypothalamus. GnRH agonists, when given in short pulses, stimulate FSH and LH production by the pituitary gland. However, when given in more prolonged doses, they decrease FSH and LH production by the pituitary, which in turn decreases ovarian hormone production.

Gonadotropin releasing hormone analog (GnRH analog). A long-acting drug that blocks the release of hormones, stops ovulation, and decreases the body's production of estrogen. Prolonged use of GnRH analogs causes de-

creased hormone production and menopausal levels of estrogen. Some brand names include Lupron®, Depo Lupron®, Synarel®, and Zoladex®.

Hernia. The protrusion of an organ, especially the intestine, through a weakened portion of the abdominal wall.

Hydrosalpinx. A blocked, dilated, fluid-filled fallopian tube.

Hysterosalpingogram (HSG). An x-ray procedure in which a special iodine-containing solution is injected through the cervix into the uterine cavity to illustrate the inner shape of the uterus and degree of openness (patency) of the fallopian tubes.

Hysterectomy. The surgical removal of the uterus. Hysterectomy may be performed through an abdominal incision (laparotomy), through the vagina (vaginal hysterectomy), or through laparoscopy-assisted vaginal hysterectomy (LAVH). Sometimes the ovaries and fallopian tubes are also removed.

Hysteroscopy. The insertion of a long, thin, lighted telescope-like instrument, called a hysteroscope, through the cervix and into the uterus to examine the inside of the uterus. Hysteroscopy can be used to both diagnose and surgically treat uterine conditions.

Interstitial cystitis. Irritation of the bladder wall which causes pain with urination.

Irritable bowel syndrome (IBS). A common gastrointestinal condition associated with alternating diarrhea and constipation and bowel discomfort. IBS may be aggravated by stress and may improve with diet changes.

Kidney stones. Small solid stones which form inside the kidney and can travel down the ureter (tube between the kidney and bladder) causing pain.

Laparoscopy. A thin, lighted, telescope-like viewing instrument that is inserted through the navel into the abdomen to examine the internal organs and abdominal cavity. Other small incisions may also be made and additional instruments inserted to facilitate diagnosis and allow surgical correction of pelvic abnormalities. The laparoscope can be used as both a diagnostic and operative instrument.

Laparoscopy. The insertion of a long, thin, lighted, telescope-like instrument called a laparoscope into the abdomen through an incision in the navel to visually inspect the organs in the abdominal cavity. Other small incisions may also be made and additional instruments inserted to facilitate diagnosis and allow surgical correction of pelvic abnormalities. The surgeon can sometimes remove scar tissue and open closed fallopian tubes during this procedure.

Magnetic resonance imaging (MRI). A diagnostic procedure that absorbs energy from specific high-frequency radio waves. The picture produced by measurement of these waves can be used to form precise images of internal organs without the use of x-ray techniques.

Mittelschmerz. A pain in the lower abdomen that is associated with ovulation.

Ovaries. The two female sex glands in the pelvis, located on each side of the uterus. The ovaries produce eggs and hormones including estrogen, progesterone, and androgens.

Ovulation. The release of a mature egg from its developing follicle in the outer layer of the ovary. This usually occurs approximately 14 days preceding the next menstrual period (the 14th day of a 28-day cycle).

Pelvic inflammatory disease (PID). An infection in the uterus, fallopian tubes, and ovary which may cause pain and scar tissue formation (adhesions). PID is usually due to sexually transmitted bacteria.

Polyps. A general term that describes any mass of tissue which bulges or projects outward or upward from the normal surface level.

Primary dysmenorrhea. Lower abdominal pain associated with menstrual periods. The pain decreases with age.

Progesterone. A female hormone normally secreted by the corpus luteum after ovulation during the second half of the menstrual cycle (luteal phase). It prepares the lining of the uterus (endometrium) for implantation of a fertilized egg and also allows for complete shedding of the endometrium at the time of menstruation. In the event of pregnancy, the progesterone level remains stable beginning a week or so after conception.

Progestin. A synthetic hormone that has an action similar to progesterone. Synonymous with progestational hormones.

Prostaglandins. A group of hormone-like chemicals found throughout the body, that stimulate smooth muscle and affect blood pressure, metabolism, body temperature, and other body processes. In women, prostaglandins are hormone-like chemicals produced in large amounts by endometrial cells. They stimulate the uterine muscles to contract and are largely responsible for menstrual cramps.

Salpingo-oophorectomy. Removal of the fallopian tube and ovary on one side of the uterus.

Secondary dysmenorrhea. Lower abdominal pain associated with menstrual periods that begins later in a woman's reproductive lifespan. It may be due to an abnormal condition such as endometriosis or infection.

Ultrasound. A picture of internal organs produced by high frequency sound waves viewed as an image on a video monitor; used to monitor growth of ovarian follicles, retrieve eggs, or monitor growth and development of a fetus. Ultrasound can be either performed abdominally or vaginally.

Urinary tract. The kidneys, ureters, bladder, and urethra that store and transport urine.

Uterine leiomyoma. Abnormal masses of smooth muscle tissue (non-cancerous tumors) that grow within the uterine wall. Also called fibroids or myomas.

Uterus (womb). The hollow, muscular female organ in the pelvis where an embryo implants and grows during pregnancy. The lining of the uterus, called the endometrium, produces the monthly menstrual blood flow when there is no pregnancy.

NOTES

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