

# DES ACTION VOICE

A Focus on DIETHYLSTILBESTROL Exposure

Issue #23

Winter 1985

## Important New Research Reports

Three reports in the medical journals during November and December, 1984, brought DES back into the news nationwide.

The *Journal of the American Medical Association* published reports on both daughters and sons in its December 7, 1984 issue. The first article concerns DES daughters' risk for dysplasia, or abnormal cells in the vagina or on the cervix. Dysplasia differs from adenosis in that, while adenosis is the presence of immature cells that are benign and generally mature as the daughter reaches her thirties, dysplasia refers to the growth of abnormal tissue that may or may not progress to a malignant condition. In many cases, dysplasia regresses and merely needs continued monitoring by someone experienced in DES related care. Aggressive treatment is often not necessary. However, because dysplasia can progress to malignancy, it needs to be carefully watched.

According to this latest study from the national DESAD project — the cooperative study funded for seven years by the government to follow DES daughters — DES exposed daughters are at least twice as likely to develop dysplasia and CIS (carcinoma in situ) as a group of "matched controls", or women who are just like the DES daughters in every way except that they were not exposed to the drug. The study followed 3,980 DES exposed women over a seven year period. It found that their risk of dysplasia was increased if the area of adenosis extended into the vagina, rather than being confined to the mouth of the cervix, or "os". The authors conclude:

The results of the prospective DESAD Project indicate that the incidence rates of dysplasia and CIS in the cervix and vagina are increased approximately two-fold to fourfold in women who have been exposed prenatally to diethylstilbestrol.

### Emphasis on careful exams

In conclusion, the authors state:

The observations in this article have a great practical impact on the maintenance of health in diethylstilbestrol-exposed women. Frequent screening for dys-

plasia and CIS must be a part of each exposed woman's medical care. At a minimum, an annual pelvic examination and cytological sample from the cervix and any areas of abnormal vaginal epithelium must be completed. If abnormal cells are identified, prompt referral to a colposcopist trained and experienced in the treatment of exposed women is indicated. In most cases, continued observation will suffice. In women with more severe lesions, early treatment should preserve fertility yet ensure ablation of the dysplasia and CIS.

### Decreasing Dysplasia

In an accompanying editorial, Dr. Cecilia Fenoglio points out that recent research has shown "that cervical cancer has many of the attributes of a [sexually] transmitted disease," although, "the nature of the material that is venereally transmitted and that is thought to be oncogenic [cancer-causing] is currently unclear..." This means that the development of dysplasia may be influenced by a number of factors, including how many sexual partners *either* partner has or has had. "The practical implication of this observation," Dr. Fenoglio concludes, "is that in young, sexually active females... some form of barrier contraception can be used that would interfere with venereal transmission of the oncogenic agent(s)... It also suggests that invasive cervical cancer in the diethylstilbestrol and nondiethylstilbestrol patient may be a preventable disease by (1) continuous cytological and colposcopic screening to detect and treat [dysplasia] before it progresses to invasive cancer and (2) the use of condoms to prevent venereal transmission of potentially oncogenic agents."

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## Lawsuit Won on Pregnancy Failure

Andrea Goldstein, DES Action National Board member from Boston, was awarded \$50,000 in damages against Eli Lilly for injuries related to her DES exposure. After three days of deliberation at the end of a four week trial, the jury decided on December 13, 1984, that one of Andrea's ectopic pregnancies and her T-shaped uterus were caused by her DES exposure. In the first such verdict in the nation concerning pregnancy problems related to DES exposure, the jury also found that "Eli Lilly

was negligent in not providing adequate warning to prescribing physicians on the potential effect of DES on the unborn children of mothers who used it."

Goldstein, a DES daughter, suffered two ectopic pregnancies and was found to have the T-shaped uterus found in many DES daughters. These conditions made it impossible for her to have children. Her suit was handled by attorneys Jean Baker and David Fine of Boston.

# An Introduction To The DES Cancer Network

*A talk given by Margaret Lee Braun at The DES Action National Annual Meeting; San Francisco, California; November 1983.*

The DES Cancer Network is a new organization within DES Action. Formed officially at the 1982 annual meeting, the Cancer Network exists to respond to the needs of at least five hundred DES daughters in the U.S. who have had clear cell adenocarcinoma of the vagina or cervix due to *in utero* exposure to diethylstilbestrol. The Network is a national support system that aims to provide medical and legal information and referrals, and to act as a channel of communication for its members.

The Network was formed because those of us who have had DES-related cancer felt that our unique concerns were not being addressed — by the medical establishment, the media, or even lay organizations like DES Action.

Many people involved with DES Action, through no fault of their own, had never met someone who has had this cancer. Few can know, beyond their darkest suspicions, how the cancer actually affects a woman's life.

There is little general information published about it. Vaginal cancer is a disease that reaffirms the natural privacy we feel about our genitals. It is not an easy experience to talk about. And it is an extremely rare cancer. Prior to 1971 only three cases of this type of cancer occurring in young women were recorded in all of western medical literature. Today we may read an article citing the incidence and treatment of this cancer. A set of facts whose underlying meaning is left to the imagination. Is it realized that for the "case-history" her cancer is not the end of a story — but just the beginning?

For this type of cancer victim there are few knowledgeable people to turn to for support. The medical professionals who are treating her may maintain a clinical distance. The medical staff, often near her age, (15–30), may be in awe of her problems or inexperienced in dealing with her concerns. In the midst of physical and emotional trauma the patient



may find it easiest to hide her own confused feelings from her family and friends; to protect them from the truth of how she feels.

Turning to the media to learn about her own feelings through others' experiences, she finds no true life stories quite like her own. She is not at all sure how she should feel about this sudden upheaval in her life. She knows she feels alone and different. But society has no guidelines for coping with this unprecedented circumstance.

What are the issues a DES "cancer daughter" faces? What has happened to her after the immediate trauma of cancer?

By all appearances she has dropped out of sight and is living happily ever after. By my own and many others' experience I know differently. In some cases she has dropped out of sight to heal herself — actively, and out of necessity — with the concentration, and sometimes privacy, that the healing process requires. Until recently she has been healing herself alone.

In 1971 I had this cancer. I was nineteen years old and had never heard the word DES. When I did hear it it was all mixed up with the words carcinoma, tumor, vagina, bladder, lymphnodes, hysterectomy, sterility, anaesthesia, surgery . . . words I had never paid much attention to before.

Twelve years later I still tremble at the memory of that innocent girl. Twelve years later I am sometimes so sick of the phrases DES and DES Daughter that I wish I'd never heard them. But the words have become a part of my everyday vocabulary because I have learned

to accept my history — it is always with me. In fact, twelve years later, I am still healing.

After the treatment for the cancer I was left to deal with the physical recovery on my own — the excruciating pain of the removal of the vagina, the burning rawness from the skin graft taken to form a new vagina, the pain from surgery cutting through my abdomen and pubis, the radical hysterectomy that cut out my uterus, fallopian tubes, an ovary, and too many lymph nodes. The catheter that remained in my bladder for months, the torment of having to wear a plastic mold around which the new vagina, hopefully, would shape itself.

As the physical healing progressed, far more dangerous injuries revealed themselves. I was horrified by what had happened to me. I was embarrassed by its intensity and intimacy. I felt that the most private parts of my body had been brutally attacked and wounded, and I dreaded telling anyone. I wished I'd had some kind of visible cancer — of the elbow or nose. Something I could point to and comment on. Instead of a cancer of the vagina — the very image of which brought up the most primitive terror, in myself, and others.

In short, I felt like a freak.

At no other time in history had women had to live with the results of such a disease. I had cancer because of medical ignorance. I lived because of medical technology. But I was a reluctant, and inexperienced survivor.

"They cut out my vagina," I would whisper to myself over and over again. Shocked, yet needing to get closer to it — to constantly, privately, acknowledge it.

I felt damaged. I felt unacceptable. I felt I was not a woman. Women have babies. Women have vaginas. Women have hormones that work, I felt confused and very alone.

I wrote to my doctor suggesting he put his DES cancer patients in touch with each other. Quite a while later he gave my name to one of his patients who was recuperating from surgery. She wrote

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## Book Review

*To Do No Harm: DES and the Dilemmas of Modern Medicine*, by Roberta J. Apfel, M.D., M.P.H. and Susan M. Fisher, M.D. Yale University Press, 1984.

### *Reviewed by Joyce Bichler*

For me, a book such as *To Do No Harm* by Drs. Roberta Apfel and Susan Fisher produces mixed reactions. On the one hand, I was delighted that finally someone is looking at the psychological, not just the medical or legal, effects of being DES exposed. Too often the medical community and the public think only about the effects of this drug on our bodies without an understanding that there may be long term effects on our minds and psyche.

On the other hand, I was disappointed in some of their assessments and analysis of the psychological effects, as I will explain below. These two psychiatrists have had contact with the DES exposed through individual client contacts as well as through their work at Boston's Beth Israel Hospital.

The authors start off with a review of DES history including the hows and whys of DES usage. They provide a historical context in recreating the atmosphere and pressures of the time when this drug was used.

The book then reviews the psychological effects on both DES mothers and daughters and, interestingly enough, doctors as well. Unfortunately, as too often happens in discussions about DES, DES sons are terribly neglected.

The book focuses on how DES exposed daughters view their bodies and the fantasies they can have about the mutilations and malformations they perceive DES has caused to their reproductive systems. The grieving process is explored, along with specific case examples of how people have coped or failed to cope with this trauma.

The authors make some interesting points that may help clarify what so many of us feel, yet may not have had the words to describe. For example, they make the analogy between the male castration complex theorized by Freud and the fears DES daughters can have regarding harm or loss to their va-

ginas. They argue that male physicians generally grossly underestimate or not even recognize the possibility that a "female castration anxiety" is at work here.

The authors rely on traditional psychoanalytic theories that girls strongly desire to grow up to "be mommies" to explain some of the psychological difficulties DES daughters experience. It is important to realize, however, that these widely disseminated theories are open to question and re-interpretation.

It is helpful that the authors examine not only the individual affected by DES but the whole constellation of relationships that are changed by one's exposure. Focusing on the mother-daughter-physician triad, Drs. Apfel and Fisher provide some interesting insights into the implications of how a drug can produce what they term a "quiet trauma":

The DES pill produced trauma in unique ways. DES as a medication is related to sexuality and fertility, to the past and the future. It touches on issues at the heart of the mother-child relationship. In all grieving, the childlike parts of us return, and we seek, literally and spiritually, the care of our mothers or of those who represent basic maternal care. But one of the most disturbing features of the DES experience is its isolating nature, because the usual sources of help are the very sources of pain. It is the providers of early tender care who have let down the DES daughters and sons — unwittingly, the mothers brought pain to their children; the physicians brought pain to their patients. The ultimate sources of help became the targets of all the feelings involved in mourning — denial, blame, self-accusation, rage, and sadness.

The burning questions that many of us have had about doctors' behaviors are discussed, including attempts to explain why physicians have not notified their patients and physician denial regarding the seriousness of exposure. For example, the authors note that doctors have a fear of facing their own mistakes, that they feel powerless, helpless, in the face of an overwhelming problem: "The contrast between the original purpose of DES, to create life, and its actual devastating effects suggest an explanation for the subdued, even paralyzed responses of practicing physicians in the

terms we applied to the responses of patients — in terms, that is, of trauma."

There is the expected focus on mother-daughter relationships and how they are changed and strained by the DES experience. In this regard, I found the analysis pat and stereotyped, with such comments as "DES undermines the bonds of experience between a mother and daughter and adversely affects the development of each" substituting for a closer look at this relationship. The total focus on harmed mother/daughter relationships is questionable — in many instances, in my experience, this is simply not the case. In reading the book, however, one gets the impression that the severely disturbed relationship is the norm.

Drs. Apfel and Fisher make it clear that they are on "no one's side" in the DES issue and repeatedly state that they lay no blame. On this point they bend over backwards to absolve anyone — including the pharmaceutical companies — of any wrongdoing. They claim that the societal atmosphere (the need to take control of nature and improve life) is what allowed the DES tragedy to occur. This gives the reader the false impression that there were no signs nor indications that could have stopped the production of this drug, when in fact we know this wasn't true. Not only, as the courts have shown, should the manufacturers have known that DES could cause cancer, but what about the fact that DES remained on the market for 20 years after it was proven ineffective in widely reported, controlled research studies? The most disturbing aspect of this thesis that no one is to blame is the sense of helplessness and powerlessness it leaves us all with. By, in effect, "blaming" the DES tragedy on an untouchable milieu, the authors remove all control that we have as consumers. They remove responsibility from the drug companies for not testing their product better, and they don't even touch on the economic incentive of the drug companies in marketing this drug even after it was proven ineffective. We must look at the past and learn from it, not brush it off. At the least we can try to prevent a tragedy such as this from happening again.

## **Mayo Clinic Report on Sons**

The article on sons comes from the Mayo Clinic in Rochester, Minnesota. There, physicians reviewed their medical records for DES sons and then selected for physical exams 265 DES sons and 274 young men of the same age and geographic area who were not exposed (controls). They found no significant differences between the two groups in any of the risks reported in previous studies of DES sons for genital/urinary abnormalities, infertility, or testicular cancer.

The study by Gill and others of the University of Chicago which did find more problems in the DES group was particularly mentioned. The current report states that "These differences between the findings reported by Gill et al and in the present study may be related to different doses of the drug. The mothers in the University of Chicago study received a mean dose of 12,046 mg [of DES], whereas the mean dose at the Mayo Clinic was 1,429 mg."

This same comment on a possible dose relationship had also been made in an earlier Mayo study on the breast cancer risk for DES mothers.

## **Mothers Risk for Breast Cancer is Increased**

On November 29th, the *New England Journal of Medicine* reported that women who had been given DES during pregnancy — "DES mothers" — are 40% to 50% more likely to develop breast cancer 20 or more years later than women who did not take the drug.

Dr. E. R. Greenberg of Dartmouth University compared a group of nearly 2,700 women who had taken DES between 1940 and 1960 with a comparable group of women who did not take the drug for pregnancy during that time. Of the DES women, 4.40 percent had breast cancer, compared with 3.12 percent of the control group.

Commenting on the article, Dr. Sidney Wolfe of the Health Research Group, a branch of Ralph Nader's Public Citizen, said that the figures from this study show that the use of DES has led to about 25,000 more cases of breast cancer than would have resulted without DES. Dr. Wolfe urged Health and Human Services Secretary Margaret Heckler to attempt to notify women

who received DES of their increased risk for breast cancer.

DES Action has also noted that many women were given DES who nevertheless miscarried, since DES was not effective in preventing miscarriage. These women also need to know of their DES exposure so that they can receive the same care as DES mothers.

At the present time, scientists identify the following as risk factors for breast cancer: early onset of menstrual periods, delayed childbearing, and a family history of breast cancer in a close female relative. DES exposure during pregnancy is now added to this list of factors that increase a woman's risk of breast cancer. Every woman needs to assess her own combination of risk factors to estimate the possible risk for herself.

## **Mothers need careful exams**

All women exposed to DES should perform monthly breast self-examination and receive at least annual breast exams from a professional. According to Patricia Kelly, Ph.D., a San Francisco geneticist specializing in breast cancer risk factors, women who do not know how to do a breast exam, or who feel uncomfortable examining their own breasts, should "treat themselves" to a professional exam as frequently as they feel is necessary for proper monitoring. She also advises that women seeking professional exams be sure that the person doing the exam is careful and thorough. Often, a nurse specially trained in breast examination may be able to take more time and be more thorough than an ob/gyn who does breast exams along with other care.

## **Dr. Herbst Comments**

Dr. Arthur Herbst, one of the original authors of the first study linking DES exposure to clear cell cancer in the daughters, took the occasion of the current article on breast cancer in DES mothers to comment on the current state of knowledge concerning DES exposure and to make suggestions for future needs. His comments accompany the *New England Journal* article on mothers.

Because of Dr. Herbst's authority in this field and because of the broad nature of his comments, we reprint many of them here:

## **On DES mothers:**

"It would appear prudent for [DES exposed] mothers to follow the general guidelines for breast-cancer screening — namely, monthly self-examination, yearly medical examination, and the option of yearly mammograms after the age of 50 years, unless other high-risk factors suggest regular mammographic evaluation even earlier."

## **On DES daughters and cancer:**

"...The oldest DES-exposed daughter with vaginal clear-cell adenocarcinoma was 33 at the time of diagnosis, and the upper age limit for the risk of cancer is not known... [There should be] continued and regular follow-up of DES-exposed daughters at least annually."

## **On pregnancy problems in DES daughters:**

"Overall, 82 percent of DES-exposed daughters who become pregnant have a healthy newborn, but because of the increased risk of an unfavorable outcome, they require more frequent surveillance antenatally than unexposed women."

## **On DES sons:**

"...a risk of infertility has not been demonstrated... there has been no clear-cut evidence of an increased risk of testicular cancer in DES-exposed sons."

## **On stress and DES exposure:**

"Although there have been no extensive studies of psychological issues among DES-exposed persons, stress and anxiety have accompanied the uncertainties regarding future health."

Dr. Herbst concludes his comments with a plea for more research concerning DES exposure:

The long-term effects of DES exposure on mothers, daughters, and sons are not known, and studies of well-documented cohorts of exposed and unexposed subjects must be continued. Such studies can identify potential new problems of increased health risks associated with exposure to DES, as suggested in the study by Greenberg et al., and can also prevent unnecessary anxiety among DES-exposed persons and their families in response to the frequent anecdotal reports of adverse health effects. Unfortunately, current restrictions on federal research funding have threatened the continuation of follow-up in some of these well-established cohort studies.

## Cancer Network

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me. I wrote back. She was young and positive and full of interests. We exchanged a couple of letters, then she stopped writing. Later I was notified that she had died. We never got far enough in our correspondence to talk about our feelings about DES, about cancer, or our own bodies.

Over time my questions and fears were faced — it has always been hard work, but also a matter of psychological survival. Through changing life experiences and a strong wish to heal myself, a new sense of myself slowly established itself and grew more confident.

Eight years after my surgery I met, through DES Action, a fellow survivor. Then another, and another. Wonder of wonders, I was not alone. We found immeasurable value in being able to express the array of emotions and worries about our common experience. I felt a whole new stage of healing begin.

Since the network began last year, approximately thirty women have contacted us. This is the largest record out-

side of the medical establishment of those who've had this cancer. Already we have a working "hotline" to alert each other about potential health problems, health care options, legislative action, and information sources. And many women in the network have been able to meet or correspond with others with similar concerns.

The women I have met through the network have been an inspiration to me. We come from many different backgrounds and have many different stories to tell — many of them more tragic than mine. But we have all coped with a tremendous range of emotions about our circumstances — from shock, grief, anger, and self-pity to the acceptance that has helped us to go on with our lives in as healthy a way as possible.

In the next few years I think we'll see a willingness among us to elucidate or "bear witness" to our DES history. The inner strengths once needed to heal ourselves personally will now be used to reveal ourselves as the survivors we are.

And if a survivor gains any hard-won

wisdom from her experience my wish is this: That our suffering from DES will keep us alert enough to go beyond the appearances of our everyday lives to examine the consequences of our actions.

What pills do we take now despite our experience with DES? What do we eat, drink, smoke, breathe, or expose ourselves to now despite our experience with DES? What do we contribute to or participate in that our society continues to pretend we can get away with no adverse consequences?

Our own bodies keep us from ever forgetting the lessons of DES. Yet I think we all recognize that DES "work" goes beyond personal healing. It is a responsibility each of us has to each other and to society to remind ourselves of what we must not forget.

## Letter to the Editor

DES Action,

I want to write this letter as an encouragement for DES daughters. I am a DES daughter and tried for four years to have a child. After a period of infertility, I became pregnant, only to have a miscarriage after three months. Then another miscarriage. My husband and I were very depressed and discouraged. We started looking into adoption but found long waiting periods in our state.

I again became pregnant, and was very afraid that it would not last. Fortunately, I had excellent medical care from understanding doctors which made all the difference. I was seen every week throughout the pregnancy, and even though I spotted in the beginning, the pregnancy progressed very well and I now have a three-month-old daughter.

Fear was my greatest enemy during pregnancy and I struggled to maintain a positive attitude. Therefore, I hope other DES women who want children and are having problems will remember that many of us do have normal pregnancies and healthy babies. It is well worth trying for and believing in. Often all the articles I read on DES complications in pregnancy and childbirth only made me more afraid.

Take heart! It can all go so perfectly well!

*Your Sister*

## How Can I Cope with Testicular Cancer?

*by Francis X. Lawler*

*Will I ever be able to have children again?*

*Will my sex life be destroyed?*

*How can I talk to anybody about this?*

*Will I die because of my testicular cancer?*

Those are just a few of the questions I asked myself when I found out I had testicular cancer. In my case, I was very lucky because of the help and support I received from family, friends, and medical professionals. Support is very important to have because testicular cancer can not only physically change your body, it can also be emotionally difficult to deal with. In many cases, men have trouble talking about this problem with just anybody. Therefore, I think it is important that all testicular cancer patients join together and give each other the help that in so many

cases is strongly needed.

Because the problem of testicular cancer is on the rise and more and more men need help, I am starting a nationwide network of testicular cancer patients who could be available to other patients to answer any questions or even just to talk and share their experiences.

If you or anyone you know would be interested in helping, or if you are a testicular cancer patient and would like to talk to someone, please send me your name, address, and telephone number (with convenient time to receive calls) at:

DES Action Pennsylvania  
Testicular Cancer Network  
340 Lenni Rd.  
Glen Riddle, PA 19037

By the way, you do not need to be a DES son to be part of this network.



## Dear Doctor

This issue's *Dear Doctor Column* is written by Dr. Ken Noller, gynecologist with the Mayo Clinic, Rochester Minnesota, and a principal author in many of the medical reports from the DESAD study.

**Q:** Is it necessary to have complete bedrest after a cerclage? I had a cerclage during my pregnancy and then was ordered to bed. The cerclage held the cervix closed with no problem. If I have another pregnancy and need a cerclage, could limited activity be in order instead of bedrest?

**A:** There is no easy answer to this question. Sometimes it is necessary for a woman to remain at bedrest after a cerclage and sometimes it is not. Although there are exceptions, generally when a cerclage is placed prophylactically around the fourth month of pregnancy it is not necessary to have complete bedrest. However, when a cerclage is placed in a cervix that is already dilated, then bedrest is sometimes necessary.

Each case is different and must be individualized. There are no answers that apply to each case.

**Q:** I have had three tubal pregnancies and one normal delivery. What are the chances of having a fourth tubal pregnancy?

**A:** Unfortunately, your chance of having another tubal pregnancy is quite high. I cannot give you an exact percentage. I would need to know

much more about the details of the procedures that were done. However, you stand a very good chance of once again having a tubal pregnancy. However, the fact that you delivered a normal infant at term after two ectopic pregnancies would seem to suggest that it would be possible (though not probable) for you to have another normal pregnancy.

## IS YOUR DOCTOR A 10?

We're compiling a national directory of DES-knowledgeable physicians. We'd appreciate getting names, addresses and phone numbers of doctors you've found competent: ob/gyns for mothers and daughters, urologists for sons. If an ob/gyn is experienced with high-risk pregnancy care, we'd like to know that too. We especially need referrals for:

Alabama  
Arkansas  
Delaware  
Idaho  
Indiana  
Kansas  
Kentucky  
Mississippi  
Montana  
New Hampshire  
New Mexico

North Dakota  
Oklahoma  
Oregon  
Rhode Island  
South Carolina  
South Dakota  
Tennessee  
Utah  
Vermont  
West Virginia  
Wyoming

Please send this information to Pat Cody at the West Coast Office of DES Action National, 2845 - 24th St., San Francisco, CA 94110.



## Membership Dues Increase

Money from subscriptions to the *DES Action Voice* supports much of our work, including providing information packets to thousands of people each year, informing physicians about DES related news, and maintaining up to date referral lists.

Our costs have been rising and, after six years, we need to catch up. Effective January 1, 1985, your tax-deductible membership contribution, which includes a subscription to the *Voice*, will increase to \$20 - \$40. We will, of course, continue providing the *Voice* to anyone who wishes to receive it, regardless of their ability to become a member.

## JOIN DES ACTION

Enclosed is my tax-deductible membership. All members receive a copy of the *DES Action Voice* four times a year. (Make checks payable to **DES Action** and mail to:

Long Island Jewish - Hillside Medical Center, New Hyde Park, NY 11040)

- ☐ Subscriber: \$20 - \$40  
☐ Friend: \$50 - \$250  
☐ Supporter: over \$250

Receives subscription to the *DES Action Voice* quarterly newsletter.  
Receives the *Voice* plus *DES: The Complete Story* by Cynthia Orenberg.  
Receives all of the above plus annual reports on the organization's progress.

NAME \_\_\_\_\_

ADDRESS \_\_\_\_\_

CITY/STATE/ZIP \_\_\_\_\_

I am a ☐ DES Daughter ☐ DES Son ☐ DES Mother ☐ Other

# DES Action National Gets a New President

Kari Christianson has been selected by the DES Action National Board of Directors to be the new National President. A DES daughter, Kari has been the President of DES Action Minnesota since 1982 and a member of the National Board of Directors since 1983. As President of the National Board, Kari will maintain strong ties with the DES Action local affiliates, and will lead the National Board of Directors in setting policy for the future of DES Action.

"I am honored to serve the organization in this capacity," Kari said on her appointment by the Board. "DES Action is not only the most important cause I've ever worked with, it is also my life and of great importance to my health and that of my entire family. Also, I'm looking forward to the opportunity to have more contact with the local DES Action affiliates."

Kari will serve as President through 1986.



Kari Christianson



Nancy Adess

## Outgoing President Remains as Executive Director

The name Nancy Adess has been synonymous with DES Action National since its inception. First as Vice President and for the past five years as President and Executive Director, Nancy has taken us from a small group of four isolated chapters to an international or-

ganization with over forty chapters and thousands of subscribers. Under her leadership we have identified thousands of DES exposed people, promoted legislation in a dozen states, and developed close ties to the medical community. Her dedication and vision have made DES Action one of the most successful grass roots organizations in the country.

Because of our phenomenal growth, it has become impossible for one person to hold the positions of both President and Executive Director. Therefore, the Board of Directors has chosen Kari Christianson to succeed Nancy as Board President. Nancy will continue as Executive Director, involved in the day to day operations of the organization and the continued planning for our future.

We thank her for her outstanding work in the past and offer our best wishes as she continues to work with DES Action in the future.

## DES Action National

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