

Chapter Seventeen

Endometriosis Pain

“Often, I pass out from the pain.”

- *Jane*

“Between the endometriosis and the adhesions, I have already had seven surgeries.”

- *Gretel*

“I double up from the pain; then my husband takes me to the emergency room.”

- *Ariel*

“Sex is not even a consideration.”

- *Summer*

“I’m having about one surgery a year.”

- *Alexandra*

Initially, we were surprised to hear patient complaints like the ones above. While our physical therapy clinics were treating complex musculoskeletal and neurological symptoms (most of our earliest caseload consisted of chronic pain patients whose symptoms had not resolved at other facilities) patients with endometriosis presented new challenges for us. Truth be told, we knew very little about the causes of endometriosis pain. As we were to learn over the next few years, neither did anyone else — including medical experts in the field.

Once again, unexpected improvements in patients with unusual symptoms (this time, women with severe endometriosis) were to lead us into yet another path of investigation, using the Wurn Technique® to address the adhesions, and pain associated with this debilitating condition.

Searching for the Cause of Pain

Endometriosis is a common and often painful disorder. Estimates of the prevalence of endometriosis range from 2-4% of all women and girls to 10-15% of all women in their reproductive years.⁴³ Part of the confounding nature of these estimates is the fact that the diagnosis of endometriosis is often delayed or missed – sometimes for a decade or longer. In place of a diagnosis, many women and girls with endometriosis are told that their pain is normal, or imagined.

We do not believe that pain is normal anywhere in the body. To tell a patient that her pain is imagined seems to us to be a double insult: first, that she must endure the trauma of undiagnosed (often debilitating) physical pain, and second, that she and her family may begin to question her mental capacity because her physician cannot find a reason for her pain.

The overwhelming extent of this “inability to diagnose” was underlined by a large and important study which compiled data from over

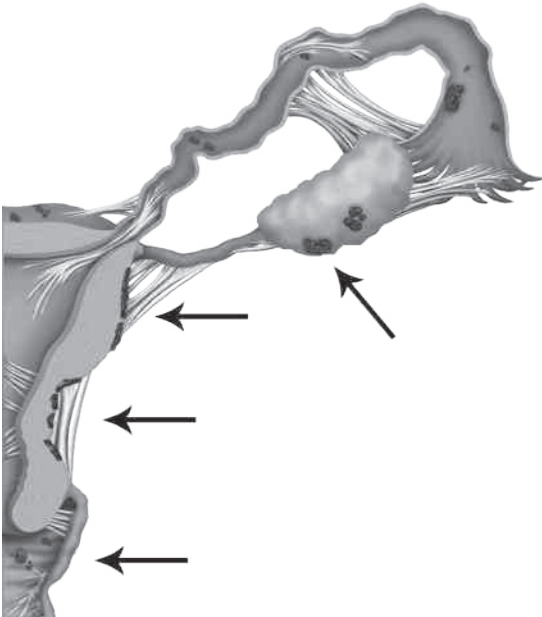
Endometriosis Stages

- **Stage One** - few endometrial implants, most often in the cul-de-sac (the space between the uterus and the rectum).
- **Stage Two** - mild to moderate levels of endometrial implants (usually with a few small areas of scar tissue or adhesions).
- **Stage Three** - moderate levels of superficial and deep endometrial implants in several reproductive areas (often with several areas of scar tissue or adhesions).
- **Stage Four** - widespread superficial and deep endometriosis implants often throughout the pelvic area (usually with large adhesions).

7,000 confirmed cases of endometriosis. Results of the study showed that average time to diagnosis of endometriosis was *over nine years*. One conclusion of that study seems to be a significant understatement: "the impact of endometriosis, a disease that already produces intense symptoms, is worsened by a current lack of understanding of the disease"⁴⁴

Endometriosis is associated with significant dysfunction and pain. It may be present in 30-50% of women with infertility⁴⁵ and in 69% of teenagers with chronic pelvic pain which does not respond to anti-inflammatory medication or birth control pills.⁴⁶

In this condition, the tissue that lines the inside of the uterus, called the endometrium, is found outside of the uterus. Endometriosis is most commonly found on the structures of the lower pelvis (e.g., the reproductive organs, lower bowel, and bladder).



Adhesions are intimately associated with endometriosis forming at sites of endometrial implants.

Endometriosis may also appear at the cervix, within the vagina, and at sites of surgical incision. Because endometriosis may spread via the interstitial spaces of the body (between structures), it has been found in remote areas including the hips, shoulders, and even in the eye.

Understanding the Pain: Endometriosis and Menstruation

During a normal menstrual cycle, hormones signal the lining of the uterus to thicken in preparation for a possible pregnancy. If pregnancy does not occur, hormone levels decrease and the thickened lining sheds. This produces bleeding that normally exits through the vagina during menstruation.

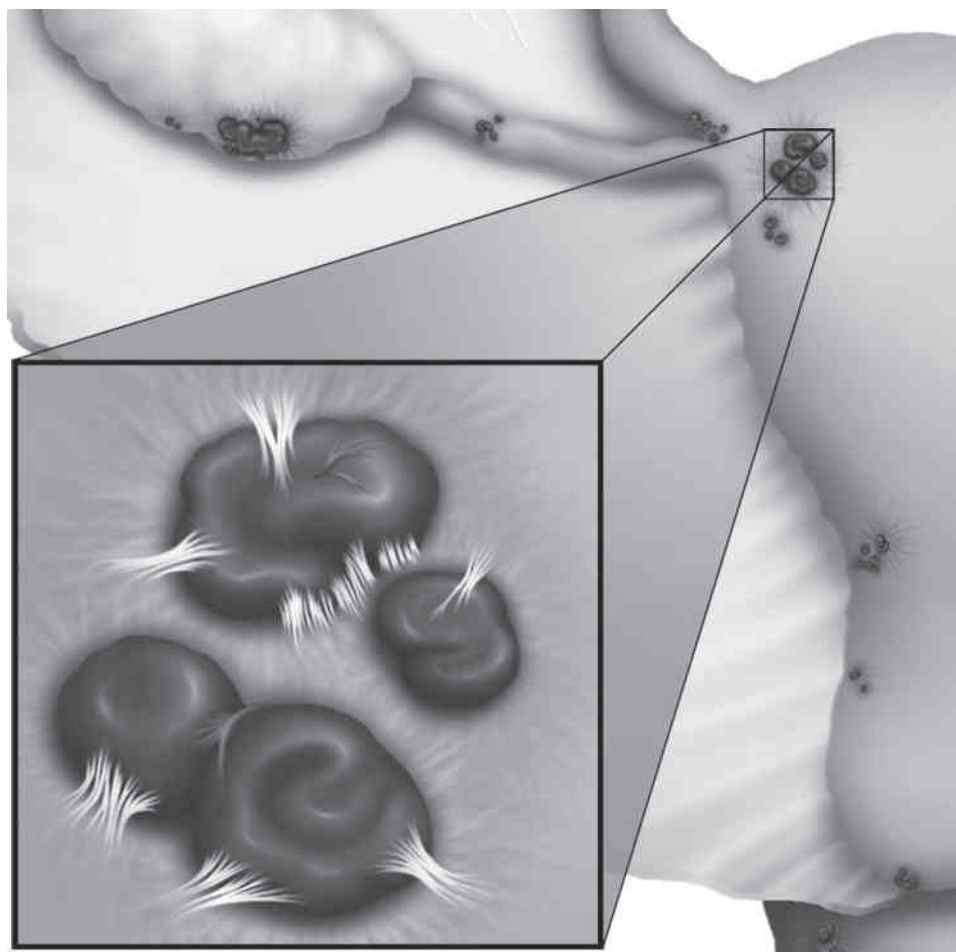
When endometrial tissue is located in other parts of the body, it responds to hormone levels in the same way. It thickens, breaks down, and bleeds each month. But trapped as it is between and within the structures of the body, there is no way for the blood and tissue to exit, as it does from the vagina during menstruation. The trapped blood and tissue can irritate surrounding tissue, cause swelling, and trigger inflammatory responses that lead to scarring and adhesions. In fact, adhesions are frequently found in and near sites of endometrial implants.

Women with endometrial implants often report a great deal of pain, which may occur

- before and during menstruation (dysmenorrhea),
- with ovulation (mittelschmerz),
- with sex (dyspareunia),
- with urination, bowel movements, diarrhea, or constipation.

There is also a strong relationship between endometriosis and infertility, which is discussed in Chapter Seven.

While physicians do not know the exact cause of endometriosis pain, they recognize that an intimate relationship often exists between endometriosis and adhesions; when they find endometriosis, they often find adhesions nearby.

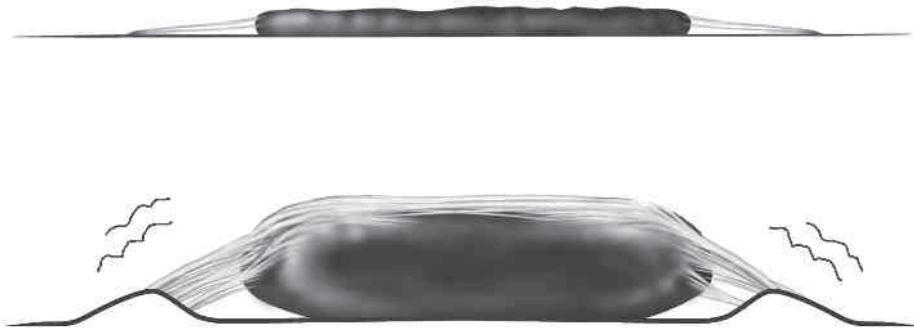


Tiny adhesions bind endometrial tissue to underlying pain-sensitive tissue.

As we have witnessed patient response to our therapy over the years, we have come to believe that the significant pain reported by some women with endometriosis is due to the accompanying adhesions. Here's why:

When endometrial tissue attaches to underlying surfaces, it generally causes irritation and inflammation. The word "endometriosis" literally means a condition (osis) that occurs within (endo) the womb (metra).

The body's response to inflammation is to form adhesions to contain the inflamed area. Over our decades of treating women with endometrial pain, we have come to believe that the adhesions create tiny, but powerful attachments at the sites of endometrial inflammation. As they blanket the inflamed implant, their rope-like fibers attach the endometrial tissue to the underlying organ or structure.



In this conceptual side view, endometrial tissues pull on tiny adhesions when the endometrial tissue swells, with every menstrual period.

Each month when the endometrial tissue swells, we believe that it pulls on those adhesive attachments, causing pain. In severe cases, the adhesions pull on pain-sensitive structures at times other than

menstruation — such as when a woman is walking, moving, or even simply breathing.



We believe this therapy detaches adhesions, so endometrial tissue can swell without the resulting pull, relieving pain.

Treatment Options

Passing Out from Endometriosis Pain

- Sara's Story

We met our first patient with endometriosis, Sara, when she was just 23. She complained of debilitating pelvic pain during her periods. In fact, her pain was so excruciating that she would regularly pass out from the pain. She marked two days off of her calendar each month when she knew she could not possibly go to school or work. She just hoped she would not have to go to the emergency room for pain treatment — which she did quite often.

After hearing Sara talk about her debilitating pain, her poor quality of life two days a month, and the limited treatment

She hoped she would not have to go to the ER for pain treatment — which she did quite often.

options available to her (drugs or surgery), we were determined to help if we could.

Nearly 20 years ago, we had never treated a patient with endometriosis, but we felt our work treating adhesions might help. As we palpated, we could feel adhered tissues deep within Sara's pelvis, beneath our hands. As we did, we could tell that some tissues were moving freely, while others were stuck and virtually immobile. It felt like strong glue had been poured inside of her body.

Slowly and cautiously, we began to unpeel the glue-like adhesions that were tying Sara's organs together. Within the first few hours of treatment, we were able to decrease her pain significantly.

Unfortunately, we were unable to continue Sara's therapy because her insurance provider cut her treatment off, saying, "We have our own physical therapists who can exercise you, if you need physical therapy."

It is frustrating being among the first in the field to make new discoveries. It was doubly frustrating for Sara, because we were making progress with her so quickly. Nevertheless, it opened our eyes to the profound pain some women experience with endometriosis, and to the fact that this non-surgical therapy to address adhesions seems to hold a profound relief for some of them.

Excruciating Endometriosis Pain

- Mary's Story

A few months later, Mary, a PhD researcher, came to see us. She also had days when she could not go to work and was forced to stay home in bed because of pelvic pain due to endometriosis. She told us that on those days she could not even stand upright and had to walk backwards when she wanted to go down stairs. Sex was excruciating no matter what stage of her menstrual cycle, so she and her husband had stopped that activity altogether. Her quality of life was slowly being robbed from her, she told us.

***Sex was excruciating
no matter what
stage of her
menstrual cycle.***

It was hard to hear Mary's stories of terrible pain, but we were encouraged by our experiences with Sara. We treated Mary in our 20 hour treatment program, the amount we were finding to be most effective for our pelvic pain and infertility patients. Once again, we palpated and found, like Sara, that the soft tissues of Mary's pelvis were stuck and adhered, the organs glued down and unable to glide with normal mobility.

We engaged the tissues with our hands, sinking deep into areas that had become hardened by adhesive glue. Slowly and steadily, pulling out the run in her three-dimensional fascial sweater, we felt the glue-like bonds of the adhesive cross-links began to break, as mobility began to return to her structures.

Mary's next period came without incident, and actually surprised her because she did not have her usual pain and spasm.

Mary's next period came without incident, and actually surprised her because she did not have her usual pain and spasm.

She found she was able to return to an active sex life at all times of the month. In fact, intercourse pain decreased to "near zero," accompanied

by a noted increase in desire and lubrication.

These were profound findings. In Chapters Twelve and Thirteen, we discuss more of our findings treating intercourse pain and sexual dysfunction.

Our experiences with Sara and Mary inspired our ongoing investigation into non-surgical treatment of endometriosis pain. Like many healthcare providers, we were initially unaware of the prevalence of endometriosis and the accompanying pelvic pain that plagues women like Mary and Sara.

As therapists, we were beginning to understand the terrible suffering of so many of our patients with endometriosis. However, we had not really grasped the full significance of the relief our patients were experiencing, in comparison to the options that were being offered to them. Then Carol called us.

Carol was a patient at one of our outlying clinics. She experienced such profound relief from endometriosis pain after therapy that she felt compelled to call our home office and urge us to get more

involved with national and international experts in endometriosis care. She felt strongly that the world needed to hear about our work, and that we needed to become familiar with experts in the field.

While we were humbled by her suggestion, we did not imagine that we would have much to add to the hundreds of physicians that were already treating endometriosis around the world. Nevertheless, we agreed to attend the Endometriosis Association conference, which is held every five years in Milwaukee, Wisconsin, the home of that organization. Not knowing what to expect, but wanting to share and gather information, we packed our data and headed north.

During the conference, we were struck by three things:

- 1) The prevalence of the problem. The conference was attended by scientists, physicians, and patients from around the world. Mothers and daughters from England and Eastern Europe were there, searching for answers. Physicians from the US, Mexico, Turkey, and Russia joined colleagues from Japan and South America as they came together to compare notes in their search for a cure — or at least to help women find some relief from the pain and return to a more normal, functional life.
- 2) The overwhelming need to find answers. These patients knew what they felt, and understood the toll it was taking on their lives monthly, or even daily. They knew that there had to be an answer for them and the thousands of new women who are struck every year by the toll that endometriosis takes on their bodies and their quality of life.
- 3) The limited treatment choices patients faced. It became quickly apparent to us that the choices offered to women who suffered from endometriosis were often inadequate to address the problem. These choices largely fell into several categories, which we will touch on briefly below.

Lifestyle changes

Several lifestyle changes are showing promise in the non-surgical management of endometriosis pain. Among these are changes in environment, diet and exercise regimes. It is not the purpose of this book to list all of the latest science and findings in these areas. We suggest that readers who have interest in learning more of what they can do to help themselves consult their physician or a respected national support or research organization, such as the Endometriosis Association at www.endometriosisassn.org.

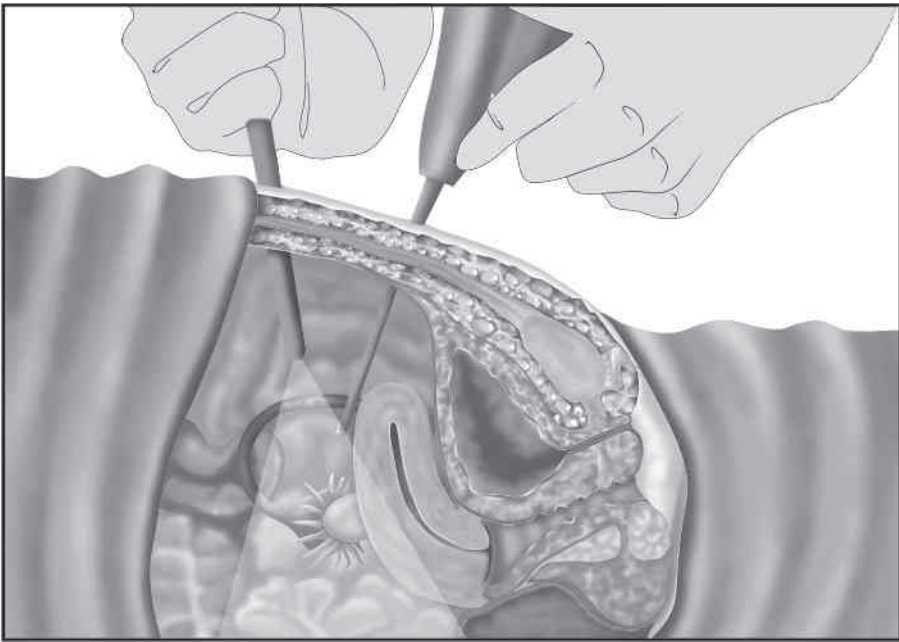
Medication

Hormone drug therapy is used to reduce or stop the production of estrogen, a hormone that exacerbates the growth of endometrial tissue. One commonly prescribed drug is Lupron, which slows or stops the production of estrogen, thus preventing menstruation. Some women tolerate Lupron well, while others complain of side effects, such as mood swings. Lupron is often prescribed for a maximum of six months. Other forms of medication include anti-inflammatory drugs, pain-killers, and hormone treatments designed to shrink endometrial tissues such as danazol, gestrinone, GnRH agonist analogs, progesterone derivatives, and progesterone-estrogen combinations.

Surgery

Surgical intervention is generally prescribed as a treatment of last resort to treat the mechanical aspect of endometrial implants. Surgery is typically intended to cut or burn adhesions and to remove endometrial cell clumps. In addition, some surgeons choose to sever the nerves that are transmitting pain.

Surgery to remove endometrial cells appears to have about the same effectiveness as drug treatments, but both are usually temporary measures, as they do not generally eliminate all of the troublesome cells. As a last resort, a hysterectomy to remove the uterus can be performed, sometimes with removal of both ovaries.

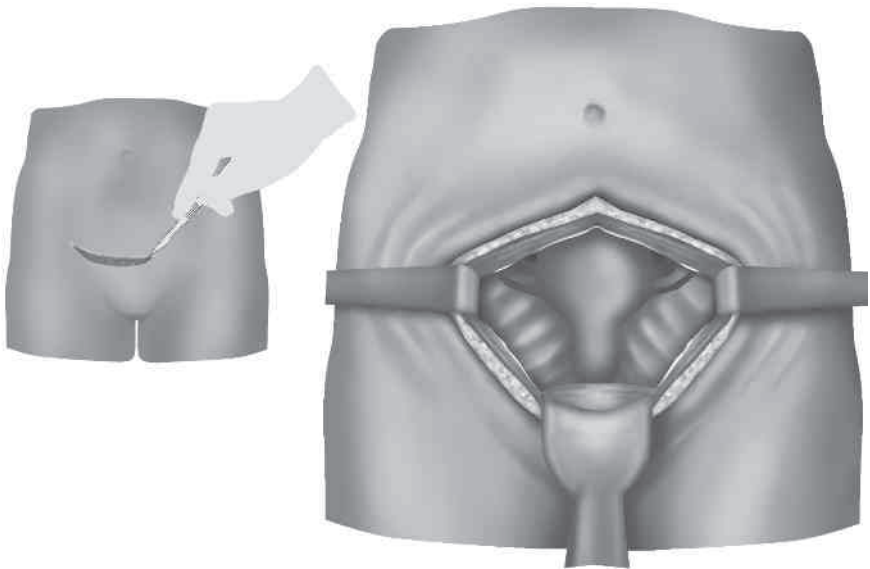


Laparoscopy can cut adhesions and remove endometriosis, but the finest surgeon cannot prevent recurrent adhesion formation.

In essence, medical methods to treat endometrial pain vary considerably. As in most western medicine treatments, the focus has been on medications (to mask pain or to stop periods) and surgery (to destroy endometrial implants, and cut, burn, or remove the adhesions which so often form with this condition). While menstruation-suppressing drugs have been hailed as a great relief for many patients, many women and their physicians (especially those interested in achieving a pregnancy) find that pharmaceuticals are not the answer for them. Many feel that long-term management of a condition using drugs to suppress the body's natural functions may not be the ideal long-term treatment of choice. When pharmaceuticals or changes in diet,

environment, and exercise fail to bring lasting relief, many women and their physicians turn to surgery as a last resort.

Most surgeons take the traditional approach of cutting or burning endometrial implants, cauterizing those tissues, and sealing the area. Conscientious surgeons are careful to avoid the delicate areas where they might create further damage to underlying structures, such as the ovaries, bowel, bladder, or fallopian tubes.



Laparotomy (open surgery) can remove endometriosis and adhesions, but has been implicated as a major cause of adhesion reformation.

Some surgeons choose to dig deeply into the organ from which they are removing the endometriosis. These physicians feel that they can actually find the bottom of the endometrial implantation and cut it out, and that by doing so, they can give a permanent or more lasting effect with their surgical excision. Naturally, the scars they create from the surgeries are much more extensive than less invasive surgeries.

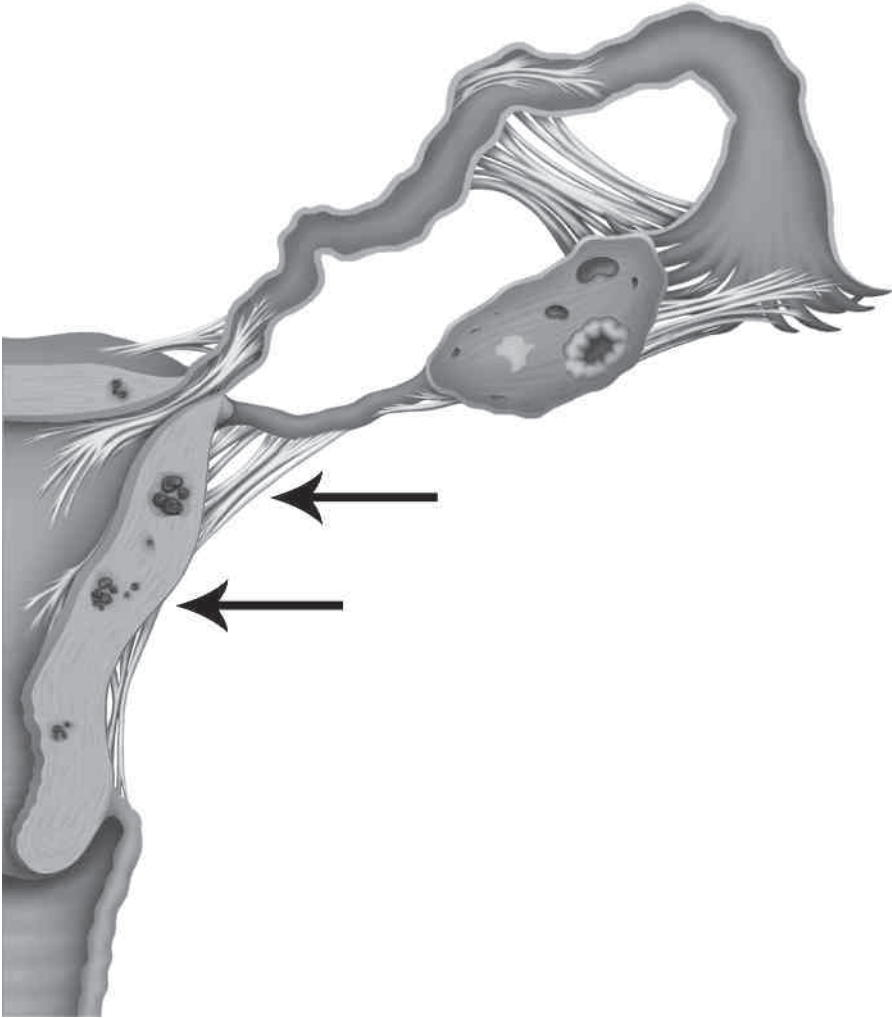
Other surgeons have found success with milder surgical techniques, such as the Helica thermal ablation unit. This device, used in 120 hospitals in the UK, employs helium gas and electricity to cauterize endometrial tissue. Dr. King has had the opportunity to work with this minimally invasive surgical instrument. The designers of this device tell us that the Helica burns only one millimeter deep. They claim, and Dr. King has confirmed in surgery, that if the Helica grazes the tissue with a light cauterization, the surgical damage is mild, but the effects can be profound.

Some women find good resolution of symptoms after surgery, with no recurrence of pain. They go on to lead normal lives like their friends, and may even become pregnant with little or no problem. Other women do not have success with surgery. In fact, despite the best intentions, training, and skills of their doctors, some women are distressed to find that they emerge from surgery with the same or worse pain than before they underwent the procedure.

Part of the problem may be that, being appropriately conservative, the surgeon was unable to access one or more of the areas that caused the pain. For example, the surgeon may feel it is too dangerous to burn or cut endometrial tissue that is found on the intestinal wall, where an errant cut could cause serious damage. Similarly, surgeons may have concerns that they would unduly impair fertility if they were to excise endometrial tissue attached to an ovary or fallopian tube.

In other cases, endometrial tissue may be found deep within the tissues of a muscle or organ, as happens in a condition called adenomyosis (endometrial tissue within the muscle mass of the uterine wall). While the cause of adenomyosis is unknown, the condition has been associated with any sort of uterine trauma or surgery that breaks the barrier between the endometrium (which lines the uterus) and the myometrium (the muscle of the uterine body). Examples of this could include a C-section, D & C, tubal ligation, pregnancy termination or pregnancy itself.

Adenomyosis presents problems for both patients and physicians. While the condition can be very painful to the patient, a surgeon may be reluctant to excise deep endometrial implants for fear of creating greater organ damage than the internal endometrial implants that comprise this condition.



Adenomyosis: endometriosis deep within the muscle of the uterine wall.

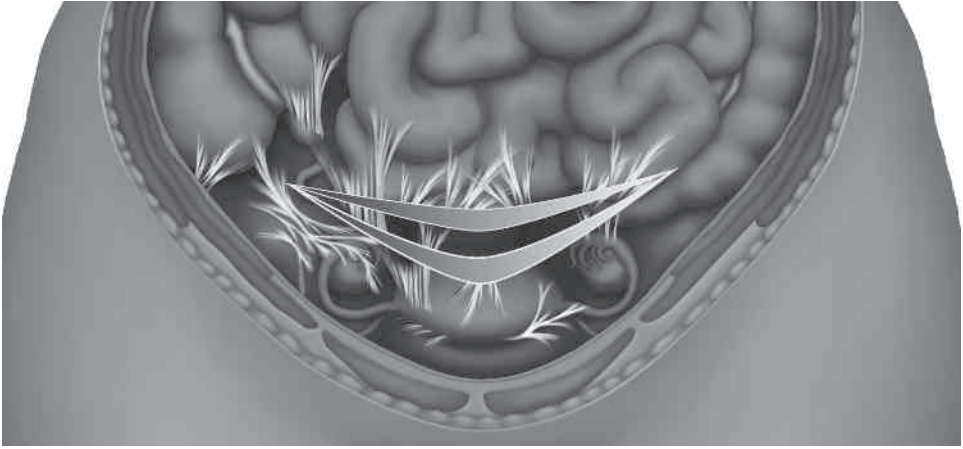
Adenomyosis is typically found in women between the ages of 35 and 50, when women often have an excess of estrogen. Near the age of 35, women generally cease to create as much natural progesterone, which counters the effects of estrogen. After the age of 50, women do not create as much estrogen due to menopause.

A final concern is that no matter how gifted the surgeon, adhesions are a nearly inevitable by-product of surgery. Despite the surgeon's best efforts and skills, adhesions form naturally, as the first step in the healing process. This includes surgery to treat endometriosis, and surgery to remove adhesions. In fact, results of an extensive study published in *Digestive Surgery* found that⁵¹

- adhesions occur in more than 90% of the patients following major abdominal surgery,
- adhesions occur in 55-100% of the women undergoing pelvic surgery, and
- small-bowel obstruction, infertility, chronic abdominal and pelvic pain, and reoperative surgery are the most common consequences of peritoneal adhesions (the peritoneum is the lining of the abdominal cavity).

The article concluded that “despite elaborate efforts to develop effective strategies to reduce or prevent adhesions, their formation remains a frequent occurrence after abdominal surgery.”

When living tissue is cut or burned by a scalpel or laser, hundreds of tiny collagen fibers rush in to contain the area that has been traumatized. Like a blanket or the tiny strands of a nylon rope, these fibers lie down next to each other in a random pattern, creating a scar to seal off the area that has been traumatized, much as a scrape on your skin would be healed by scar tissue on the outside of your body.



Adhesion formation after surgery

Over time, the scarring tends to bind and pull on the original structure, causing immobility in the area where the healing took place. If the inflammation is more extensive, the adhesions may spread from the surgical site into neighboring structures. Whenever those tiny adhesions attach to any of the extensive network of nerves in the body, they can cause pain. We discuss post-surgical adhesions, pain, and dysfunction extensively in Chapter Sixteen.

My husband and I were elated to find that there was no longer any pain with sex. Another amazing outcome was that I no longer experienced pain from my endometriosis.

— Madison, mother of two after attending CPT for treatment of endometriosis and infertility.



Powerful adhesions can attach to delicate organs within the pelvis.

Driven by pain, the desire to find relief, and frustration with failed surgical results, some women choose to undergo successive invasive surgeries in attempts to address their pain and dysfunction. This can become a vicious circle. Before long, many women eventually find themselves searching for relief from post-surgical adhesions in addition to relief from their endometriosis pain.

From Pain to Pain-Free

When we first began hearing stories from our endometriosis patients of significant pain relief after therapy, we were a bit dumbfounded. Neither we nor anyone else had ever proposed in any scientific setting that a non-invasive manual physical therapy could be used to treat a condition which hitherto had only been treated with surgery or drugs.

But as more and more women with endometriosis pain came to our clinic, we began to take interest in the clinical results. We found that

My pain decreased precipitously during my menstrual cycle. In fact, I didn't even know I started my period until I saw it!

– Danielle, mother of two after attending CPT for treatment of endometriosis and infertility.

when we treated the adhesions that we felt were attaching endometrial tissue to the underlying organs, mobility of those organs would improve. Along with this, we often witnessed a dramatic decrease of pain and an increase in function in these women.

As patients began telling their friends and fellow sufferers, the ranks of our patients with endometriosis grew significantly. We have lost count of the number of patients who came to us saying that they would routinely black out due to severe pain once or twice a month during their period or ovulation. These women scheduled their lives so they would not be debilitated or black out while driving during their cycle.

Some wanted to make sure they were near a hospital, in case they had to be admitted to the emergency room for the pain, or to control spasm.

Yet after we treated them, many of them called us, very excited. "I had no pain with my period," or "I had little pain with my period," or in some cases, "My period came and I didn't even know it was coming," they told us. A typical first reaction was "I must have stopped ovulating," but the period came, ovulation came, another period came — and still no pain. So many of these women had

The first thing that happened following my therapy was that the endometriosis pain I had lived with for over ten years completely disappeared.

– Ava, mother of two after 13 years of infertility and endometriosis pain

experienced such severe pain from the time they first began menstruating that they seriously felt something was wrong with them when they had no pain with their periods. Naturally, when we heard these reports we thought they were wonderful, and we were very happy for the women.

Three Prior Laparoscopic Surgeries for Endometriosis

- Kimberly's Story

I have struggled with painful periods since the age of twelve. I would have terrible cramps and have to miss school. At the age of 16 I got on a birth control pill to help with the severe cramps. But I still suffered with painful periods all through college. Over the years the pain increased and became more and more debilitating.

I married at age 23 and knew that my pain was getting worse. I went to my family doctor, my gynecologist, and a nurse practitioner about experiencing painful sex and my worsening period pain. Each medical professional would examine me and then act like I was just crazy and that nothing was wrong. I suggested I might have endometriosis, but they did an abdominal ultrasound and couldn't find anything wrong.

All at once, I would have this stabbing pain like someone was jabbing a knife into my pelvis, and I would fall down.

When I turned 28, my cramps became more severe and felt like intense stabbing pain. I would be standing and all

at once, I would have this stabbing pain like someone was jabbing a knife into my pelvis and I would fall down. I turned to my family doctor for help. He sent me for an ultrasound and found that I had ovarian cysts.

From there it seemed to go downhill. I continued to get worse and worse. Instead of having pain one week a month,

I (got) worse and worse. Instead of having pain one week a month, I was experiencing it all the time.

I was experiencing it all the time. I decided I would go to a male Ob/Gyn a friend recommended. I told him of my experiences and he gave me some pain medication and sent me on my way.

I continued to see him almost weekly with debilitating pain. By Christmas I was getting where I couldn't function. I went to his office and he said, "I don't know if you have endometriosis, but I can do a laparoscopy and find out." The day after Christmas he did the laparoscopy and found that I had severe endometriosis. In the recovery room, he apologized for the pain I had been living with and said other women he had treated had nothing as severe as I had. He put me on birth control to decrease the pain and told me I could later go off the medication for a while to try and become pregnant.

Later, when my husband and I tried to get pregnant, we were unsuccessful and sought the help of a specialist. With the endocrinologist, we tried fertility medications and intrauterine inseminations, but the medication aggravated my endometriosis

and pretty soon the pain was just too much to continue with that.

I continued to see my endocrinologist and had surgery for endometriosis again in 2004. Afterwards she told me she couldn't get it all because it was just too invasive.

My pain only worsened after surgery. I went on Lupron and had worsening pain still. I told the physician it felt like hot pokeres were being stabbed into my ovaries and that I felt like my ovaries were on the outside of my body. She finally switched me to Danazol, but I bled during treatment. My specialist said she didn't know why Lupron and Danazol had not provided relief. She said she only knew of one person it had not worked for in the past. I went back on the old standby — birth control.

During this time my doctor recommended acupuncture. I went to an acupuncturist and got some pain relief. I also tried herbs like Red Clover and Evening Primrose, but nothing helped.

I continued to experience terrible pain; none of my doctors knew what to do.

I spent the next three years in pain without any further recommendations from doctors that provided me relief. My husband and I felt at a loss of what to do. We still wanted to become pregnant and my specialist said our best option was to proceed with IVF.

She referred us to her counterpart. Nine months later, we completed an IVF cycle. During the cycle the pain was horrible and I almost couldn't stand it. Unfortunately, the IVF was also unsuccessful.

I continued to experience terrible pain, but none of my doctors knew what to do. They knew a hysterectomy might help, but I still wanted to have a child.

I became isolated because friends didn't understand the pain I was experiencing. I went on medical leave from my job because I couldn't work. I went from having a social life to doing nothing besides sleeping on my heating pad and sitting in our hot tub or the bathtub to help the pain.

I finally convinced my doctor to perform a third laparoscopy. My doctor said my endometriosis was severe and everything was glued together — my ovaries, uterus, and bladder.

***I told (my doctor)
I was tired of
covering the pain;
I wanted to find
the source.***

I had two endometriomas (endometriosis tumors) on each ovary. He had to take 30% of one ovary and 40% of the other to get all of the endometriomas. I had a balloon catheter placed in my uterus so the sides wouldn't grow together from all the scraping out of the endometriosis.

Following surgery I went on several medications, but nothing seemed to help my pain. I continued to call the doctor and finally I had a meltdown on the phone with him. I told him I was tired of covering the pain and I wanted to find the source.

When he offered no solutions, I went to a pelvic pain clinic. They helped me identify some of my problems and helped decrease some of my pain, but then I became worse. I was seeing a physical therapist through the clinic, and she recommended I try Clear Passage Therapies (CPT). Ironically,

my sister-in-law had read about CPT and told me about it before.

I read about CPT on their website and called them to send me some info. After getting the info and reading the medical info they wanted, I knew they understood my pain from the questions they asked on the forms. My husband and I booked our appointment and headed to Florida for treatment with hope that this would work.

After getting there I got the most thorough medical evaluation I have ever experienced. They could tell that I was guarding and compensating from the way I walked and stood, due to years of pain. They listened to me about my body, my pain, and what wasn't working properly. I felt like I had finally found the people that could help me and it didn't involve trying some kind of medicine! They knew so much about endometriosis, adhesions, and the pain I was experiencing. They could feel tightness in areas that I felt it. It's amazing, all the techniques they have learned and developed to help heal the body.

After treatment my body was more mobile than it had been before because the therapists were able to break up the cross-links of the adhesions. It didn't hurt anymore to go to the bathroom after therapy and sex was less painful. They were able to break up adhesions in my navel area that prevented me from tasks as simple as cutting a piece of meat. The therapy I experienced was finally starting to free up my frozen pelvis!

I can't say enough about CPT. If I had not found them I would not have found the right treatment. Without them I would not have found pain relief or be able to move around. I would recommend this treatment to anyone with endometriosis, experiencing pain, or adhesions.

With the clinical results we were seeing, we knew that we needed scientific review before we could ethically state that our work was helping patients with endometriosis, and quantify success rates, so people might judge the extent to which our therapy might or might not help them.

Our physician and scientific advisors suggested we conduct one or more controlled studies to help in this regard.

At the time, we were working with a highly respected reproductive endocrinologist near our southern California clinic who had become

My first ovulation after treatment was pain-free. I usually experienced one day of sharp pain because of endometriosis, but this time I didn't feel anything.

– Andie, mother of one after struggling with endometriosis pain and infertility

interested in our results. He felt our theories about adhesions made sense, and he had seen positive results from our treatment in patients we shared. He kindly offered to help us quantify our results scientifically, in a publishable format.

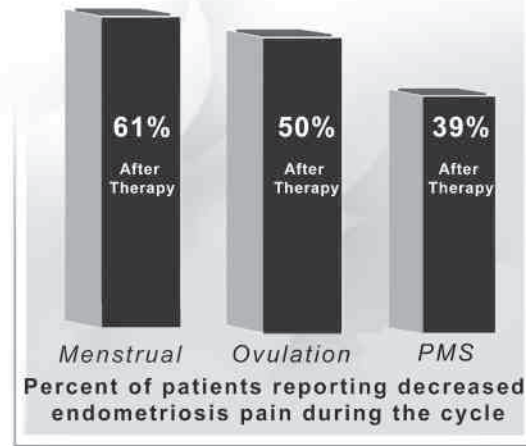
At his urging, we joined the American Society for Reproductive Medicine (ASRM), a group of several thousand physicians and scientists, with a large base of gynecologists and reproductive endocrinologists. He suggested we con-

duct a scientific study on our results treating women who came to our clinics with endometriosis-based pain or sexual dysfunction, and submit our data to ASRM.

As it happened, we had already begun two separate studies on treating patients with endometriosis pain. The results of those studies (shown below) revealed that by addressing adhesions with our

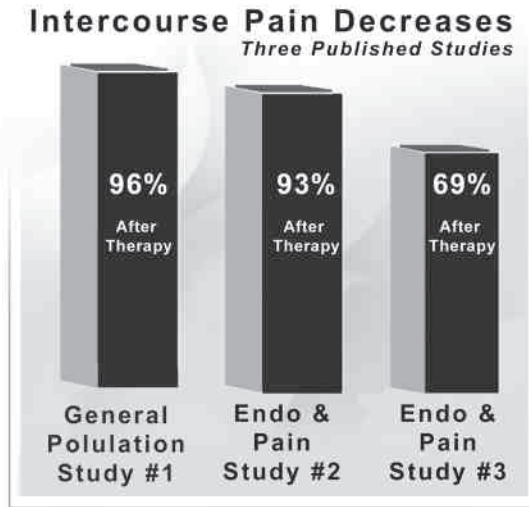
therapy, we were able to decrease endometriosis pain at all times during the cycle, with the greatest reduction during menstruation.

Endometriosis Pain Decreases



Results reported in "Fertility and Sterility" in 2006

In addition, intercourse pain was reduced or eliminated in nearly every subject that we treated who came to us with that condition. These were very encouraging statistics.



Results reported in “Medscape General Medicine” (2004)
and “Fertility & Sterility” (2006)

Put into scientific framework by mid-2006, two of our endometriosis investigations (intercourse pain and period pain) were accepted for

My primary goal was to become pregnant and one week after treatment – I was! My pregnancy went very well and I was also blessed to no longer experience painful intercourse or lower abdominal pain.

– Jasmine, mother of one who struggled with endometriosis pain and infertility

presentation at the national conference of ASRM. By September of that year, the abstracts of those two studies (along with one on opening and returning function to severely blocked fallopian tubes) had been published in *Fertility and Sterility*,⁵² one of the most prestigious medical journals in gynecologic and reproductive medicine.

With data and published citations behind us, we can now confidently offer treatment and relief of period and intercourse pain to women with endometriosis.

Breaking free from endometriosis pain

By the time patients with endometriosis arrive at our door, they have generally been searching for relief for years. In essence, patients who have been shuffled from their family physicians to gynecologists, internal medicine, reproductive specialists, and even mental health counselors report relief of symptoms after just a few hours of our manual physical therapy.

The experiences we undergo with our patients and their reactions to our various treatments have placed us and our patients on the forefront of discovery in treating the pain and dysfunction of endometriosis. Spurred by the reliability of scientific testing, we feel we are on the cutting edge for treating this debilitating condition. Having developed and tested our work, we now confidently provide a non-surgical treatment to decrease pain and return quality of life for women and girls who suffer from endometriosis pain.

***The last day of therapy
was the first day of my
period. Immediately, I
felt a difference.
All my abdominal pain
was gone without a trace!***

*– Neveah, now pregnant after
struggling with endometriosis
pain and 10 years of infertility*