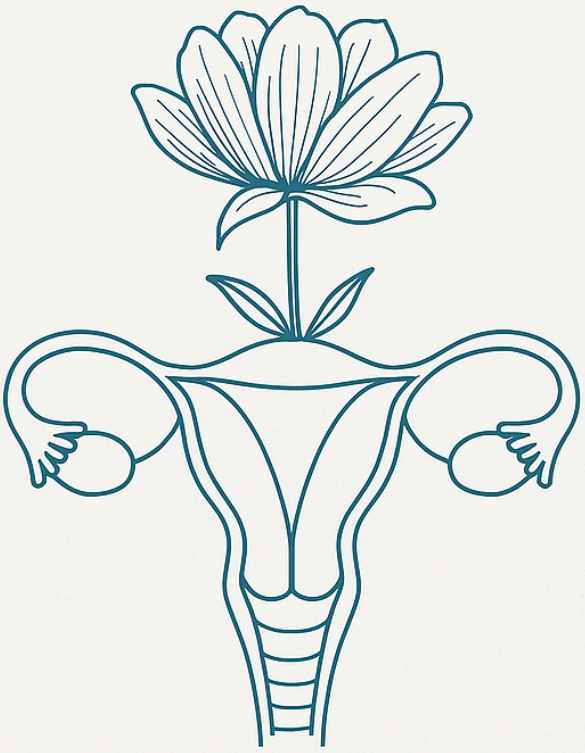
THE ENDOMETRIOSIS REPAIR MANUAL



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Start Here

If you read nothing else, read this page

You do not have to do all of this. Here is the whole guide in nine lines.

> **These three, starting today. They are free.**

1. **Open your bowels every day.** Estrogen leaves your body in your stool. If you are not going daily, you are recycling the hormone that feeds this condition. Ground flaxseed, magnesium, water, cooked vegetables.
2. **Protein, fat and fibre at every meal.** Never eat carbohydrate on its own. Do not skip meals.
3. **Five minutes of slow breathing daily.** Breathe in for four, out for six. Your body will not repair while it thinks it is in danger.

> **These two, for three months.**

4. **No gluten. No dairy.** Whole foods, not gluten-free substitute products.
5. **Much less added sugar and packaged food.**

> **These four, if you can afford supplements.**

6. Magnesium glycinate at night
7. Ground flaxseed, one tablespoon daily
8. NAC
9. Oily fish three to four times a week, or a fish oil supplement

That is the guide. Everything else in this book explains why these work, what to add once these feel normal, and how to adapt it to your own body.

And one expectation to set now: most people feel very little in the first two weeks. Bloating, energy and sleep improve around weeks two to four. Pain is usually the last thing to shift, often around weeks eight to twelve. Chapter 22 explains why. Do not judge this at day ten.

How to use this guide

This is not a book you need to read cover to cover before you can start.

Here is the honest truth about most endometriosis advice: there is too much of it, it arrives all at once, and it leaves you feeling like you are failing before you have begun. I am not going to do that to you.

So here is how this works.

If you are in pain right now, go straight to Chapter 17. It tells you what to do in the next 24 to 72 hours. Come back to the rest later.

If you want to start today, go to Chapter 23. It gives you three things to do in your first two weeks. Three. Not thirty.

If you want to understand what is happening in your body, start at Chapter 1 and read in order. Understanding *why* something helps is what makes you stick with it when week four feels hard.

If you are trying to conceive, read Chapter 19 early. Some of the advice in this guide changes when you are trying for a baby, and I have flagged every one of those places.

If you have surgery coming up, read Chapter 20 now. Some of the supplements in this guide must be stopped before an operation.

You do not need to do everything. You need to do the right things in the right order. That is what this guide is for.

A note on the science in this guide

I want to be straight with you about how much we actually know.

Endometriosis research is patchy. Some of the things in this guide have been tested in proper clinical trials on women with endometriosis. Some are based on how the body works, but have not been tested directly. Some come from clinical experience and traditional medicine.

Those are three very different levels of confidence, and most guides blur them together. I am not going to. Throughout this book you will see one of three labels:

[Tested in endometriosis] — There is at least one human clinical trial in women with endometriosis showing a benefit.

[Mechanism-based] — We understand the biological pathway and there is good research in related conditions, but it has not been tested directly in endometriosis.

[Clinical and traditional] — This comes from practice, patient experience, or traditional systems of medicine. It may work well. It has not been proven in a trial.

[Trialled — results mixed or negative] — This has been properly tested in women with endometriosis and the results were disappointing or inconsistent. I have kept a small number of these in the guide where I think there is still a good reason to use them, and in each case I explain exactly what the trials found and why I still include it.

That fourth label is unusual in a book like this, and I have included it deliberately. Two of the most widely recommended supplements for endometriosis fall into it. If I only showed you the flattering evidence, you would have no way of knowing which parts of this guide to trust.

None of these labels means "don't bother." Plenty of things that work have never been studied, because nobody profits from studying turmeric. But you deserve to know which is which, so you can decide where to spend your money and your effort.

Medical disclaimer

This guide is for education only. It is not medical advice, and it is not a substitute for care from a qualified health professional.

I am not a doctor. Nothing here is intended to diagnose, treat, cure, or prevent any medical condition.

Talk to your doctor, gynaecologist, or a functional medicine practitioner before you start any new supplement, make a major change to your diet, or stop any medication. This matters especially if you are pregnant, breastfeeding, trying to conceive, taking prescribed medication, or have a diagnosed medical condition.

Every woman is different. What helps one person may not help you. If something makes you feel worse, stop it and get help.

Part One: Understanding What Is Happening

Chapter 1: What endometriosis actually is

Endometriosis is usually explained like this: tissue that belongs inside your uterus grows outside it instead.

That is true. It is also far too small an explanation.

Here is a fuller one. Endometriosis is a **whole-body inflammatory condition**. Tissue similar to your uterine lining grows in places it should not be — on your ovaries, your fallopian tubes, the lining of your pelvis, your bowel, your bladder, sometimes further afield. But those patches of tissue are not the whole disease. They are the visible part of a much larger imbalance.

Think of it like mould in a house. You can scrub the black spots off the wall. But if the house is still damp, the mould comes back. The lesions are the mould. The dampness is everything else: your immune system, your hormones, your gut, your liver, your nervous system.

This is why two women can have the same surgical findings and completely different lives. One has mild patches and is bedridden. One has extensive disease and barely notices. The tissue is not what determines your experience. The terrain around it is.

What the standard model misses

Conventional medicine mostly treats endometriosis as a mechanical problem. Bad tissue, wrong place, cut it out or shut down the hormones that feed it.

Surgery and medication have their place. I am not against either, and for some women excision surgery is genuinely life-changing. But they do not change the conditions that let the tissue grow in the first place. That is why recurrence rates are high, and why pain so often continues even after a successful operation.

Functional medicine asks a different question. Not "how do we remove this?" but "why is this body letting this happen, and what would need to change?"

The answers usually involve some combination of:

- An immune system that is not clearing misplaced cells the way it should
- Hormones out of balance, especially estrogen without enough progesterone to counter it
- A gut that has become leaky and is feeding constant low-grade inflammation
- A liver that cannot keep up with clearing hormones and toxins
- Mitochondria — your cells' energy factories — that are struggling
- A nervous system stuck in a state of alarm

The energetic view

Traditional Chinese Medicine has been describing something very like endometriosis for centuries. It calls it **blood stasis**, **cold in the uterus**, or **liver qi stagnation**.

In plain terms: things that should be flowing have stopped flowing. Blood, energy, emotion. That stagnation is often linked to long-held stress, suppressed feeling, weak digestion, or chronic cold.

You do not have to believe in qi to find this useful. Notice that both models — the functional one and the traditional one — are describing the same thing from different angles. Something has become stuck. Warmth, movement, and flow are part of the answer.

The most important thing in this chapter

Your body is not broken.

This is not your fault. You did not cause this by eating the wrong thing or being too stressed or not wanting a baby enough. Endometriosis is your body signalling that something is out of balance, in the only language it has.

And terrain can change. That is the whole premise of this guide.

Chapter 2: Why it hurts

Endometriosis pain does not match the pictures. A woman with a few small patches can be in agony. A woman with extensive disease can have almost no symptoms.

That confuses doctors and it makes women feel like they are exaggerating. You are not exaggerating. Here is what is actually generating the pain.

Four things happening in your body

1. Trapped blood and inflammation. The misplaced tissue responds to your hormones just like your uterine lining does. It thickens. It bleeds. But it has no way out. Your immune system treats that trapped blood as a threat and floods the area with inflammatory chemicals. That swelling and irritation is pain.

2. Nerves growing into the lesions. This is the part most people have never been told. Endometriosis lesions grow their own nerve supply. They do not just sit near nerves — they recruit them. Inflammatory chemicals then make those nerves hypersensitive. A tiny lesion with a rich nerve supply hurts more than a large one without.

3. Scar tissue and adhesions. Your immune system tries to wall off the problem areas. Sometimes that means organs get stuck together — an ovary fused to the bowel, the uterus pulled to one side. Then every movement, bowel motion, or act of sex tugs on tissue that no longer moves freely. That is the sharp, stabbing, pulling pain.

4. Estrogen adding fuel. Estrogen is a growth signal. In endometriosis it tells the tissue to grow and it increases inflammation at the same time. Without enough progesterone to balance it, each cycle turns the volume up.

The fifth thing: your nervous system

This is the piece conventional care almost always misses, and it explains more of your pain than anything above.

When your body has been in pain for a long time, your nervous system adapts. It gets better at detecting pain. The alarm system becomes so sensitive that it fires at things that should not hurt at all — a full bladder, ovulation, a gentle stretch, sometimes just the *expectation* of pain.

This is called **central sensitisation**. It is a real, measurable, physical change in the nervous system. It is not psychological and it is not imagined.

It also explains why pain can continue after successful surgery. The surgeon removed the lesions. Nobody turned down the alarm.

The good news is that a sensitised nervous system can be turned back down. That is why this guide spends real time on breathing, sleep, and nervous system work. Those chapters are not filler. For some women they are the single biggest lever.

The emotional layer

The womb holds stories. Grief. Pressure to conceive. Shame about sex. Years of being told the pain was normal, or in your head, or something you should just manage.

The body keeps the score. Many women find their endometriosis pain is tangled up with things that were never processed. That does not mean the pain is emotional. It means emotion and physiology are not separate systems, and treating one while ignoring the other leaves work on the table.

The bottom line: your pain is real, it is multi-layered, and pain is a messenger — not a malfunction. It is telling you something needs attention.

Chapter 3: Where you can feel it

Endometriosis pain often shows up in places that make no anatomical sense. Here is why, and where.

The usual places

Pelvis and lower belly. Deep, dull, stabbing or cramping. Usually worse around ovulation and your period.

Lower back and hips. Your organs are wrapped in fascia — think of it as cling film that connects everything to everything. When one area inflames, the fascia tightens and pulls. That tension refers pain into your sacrum, glutes and hips.

Legs and down the back of the thigh. If lesions involve the pelvic nerves, pain can travel down your leg. It often feels like nerve pain: burning, tingling, heavy.

Bowel and bladder. Pain when you pee or open your bowels, or pain that comes with digestion. This is why so many women with endometriosis are told they have IBS or interstitial cystitis first. Sometimes they have both.

During or after sex. Deep penetration can hit inflamed tissue or adhesions. But it is often also the pelvic floor — years of clenching against pain, or bracing in anticipation of it, leave those muscles chronically tight. A pelvic floor physiotherapist can help enormously here and is one of the most underused resources in endometriosis care.

Pain that travels

Pain does not stay where the lesion is. Inflammation activates nearby nerves. Fascia tightens to protect inflamed organs and pulls on distant structures. Over time your brain begins to expect pain in a wider and wider area.

This is why a scan showing "only a small amount" of endometriosis tells you very little about how much it hurts.

Pain in unexpected places

Some women feel it in the chest, the throat, or the jaw. From an energetic view, the body stores tension where it has had to hold the most. Grief in the chest. Unspoken things in the throat. Held rage in the jaw.

You can take that literally or as a metaphor. Either way, if you clench your jaw at night and have endometriosis, they are probably related.

Chapter 4: What is actually driving this

Endometriosis does not happen at random. It is not bad luck and it is not a punishment.

It is the end result of several upstream problems that have been building, often for years. Here is what is usually underneath it.

Immune system dysfunction

Your immune system should clear away cells that end up in the wrong place. In endometriosis, that clean-up crew is not doing its job. The cells that should be removed are allowed to settle and grow.

This also means inflammation gets started but never properly resolved. And it is why endometriosis so often travels with autoimmune conditions.

Estrogen dominance

Too much estrogen, or estrogen your body cannot clear properly, acts like fertiliser on endometriosis tissue.

But this is not simply "high estrogen." It is usually about:

- Not enough progesterone to balance it
- A liver that cannot process estrogen fast enough
- Gut bacteria that reactivate estrogen your liver already dealt with, sending it back into circulation
- Tissue that is unusually sensitive to estrogen even at normal levels

That last point matters. Some women with severe endometriosis have perfectly normal blood estrogen. The problem is at the receptor, not in the bloodstream.

Gut problems

The lining of your gut is meant to be selective. When it becomes too permeable — "leaky gut" — bacterial fragments cross into the bloodstream and keep your immune system permanently switched on.

Your gut also contains a collection of bacteria called the **estrobolome**. Its job is to help estrogen leave your body. When it is out of balance, it does the opposite: it reactivates estrogen that your liver had already packaged for removal, and sends it back into circulation.

If your gut is not right, nothing else you do about estrogen will fully work.

Liver congestion

Your liver is the main site where estrogen is processed. If it is overloaded — by alcohol, medication, plastics, pesticides, poor nutrition — it cannot keep up.

Estrogen then either sits around or gets converted into the more harmful forms rather than the safer ones.

Environmental toxins

Certain chemicals mimic estrogen in the body. They bind to your estrogen receptors like a key that fits the lock but should not.

The main culprits are plastics (BPA and phthalates), pesticides, some personal care products, flame retardants, and thermal receipt paper. Studies have linked dioxins and PCBs to endometriosis risk specifically.

You cannot avoid all of these. You can reduce the load meaningfully with a few simple swaps, and Chapter 16 tells you which ones give the biggest return.

Trauma and nervous system dysregulation

This is the most overlooked driver of all.

Many women with endometriosis have a history of trauma. Sexual, emotional, medical, birth-related, or inherited. Many more have simply lived for years in a state of high alert.

A nervous system stuck in fight-or-flight promotes inflammation, suppresses digestion, blocks detoxification, and disrupts hormones. Your body will not prioritise repair or reproduction while it believes it is in danger.

Until your nervous system feels safe, everything else in this guide works at half power.

Genetics

Endometriosis runs in families. If your mother or sister has it, your risk is higher.

But genes load the gun. Environment and lifestyle pull the trigger. Having a genetic predisposition does not mean nothing you do matters — it means the terrain work matters more, not less.

Theories you will hear that explain less than you think

Retrograde menstruation — the idea that period blood flows backwards through the tubes. It happens in around 90% of menstruating women. Only about 10% develop endometriosis. So it cannot be the whole answer. The question is not why blood goes backwards. It is why some women's immune systems fail to clear it.

Embryonic cell transformation — interesting, but it does not explain the systemic inflammation, the immune dysfunction, or why lifestyle changes help.

Spread through blood or lymph — probably explains how tissue reaches distant sites like the lungs. Does not explain why it thrives there.

The Chinese medicine view

TCM sees the root as blood stasis, liver qi stagnation, and cold invasion — usually caused by suppressed emotion, chronic stress, weak digestion, or cold exposure.

Treatment focuses on warming the womb, moving blood, releasing stuck liver energy, and restoring flow. If you have ever noticed that your pain is worse when you are cold, stressed, or holding something in, you have already observed this.

Chapter 5: Why we start with inflammation and estrogen

You have just read about seven or eight different drivers. That is overwhelming, and it raises a fair question: where do I actually start?

Here is my answer, and my reasoning.

We start with **inflammation** and **estrogen clearance**, for three reasons:

1. They show up in almost every case. Whatever else is going on, these two are nearly always part of it.

2. They respond quickly to food, supplements and lifestyle. You do not need a prescription or a specialist to change them. You can start this week.

3. They open the door to everything else. Lower inflammation improves gut healing, hormone balance, energy and nervous system function. Better estrogen clearance reduces the growth signal to the tissue. Both create room for deeper work.

Some of the other drivers — trauma patterns, toxin load, genetic factors — are slower and harder to measure. We do not ignore them. But they are not where you get your first win, and you need a first win.

What we are actually doing

Think of endometriosis as a fire in a room.

Inflammation is the fire itself. It is what causes the pain, drives the scarring, sensitises the nerves, and fuses organs together.

Estrogen is the fuel being poured on it. It tells the tissue to grow and increases inflammation at the same time.

And they feed each other. Estrogen raises the enzymes that produce inflammation. Inflammation raises the enzyme that produces more estrogen. Left alone, that loop tightens every month.

Our job is to lower the fuel and cool the fire at the same time. Then we open the windows — the liver, the gut, the lymph — so the smoke can get out.

That is the entire strategy. Everything else in this book is detail.

Chapter 6: Inflammation, in plain terms

Inflammation is not the enemy. It is your body's repair crew. Cut your finger and inflammation is what brings healing to the area.

The problem in endometriosis is that the crew never leaves. Repair that should take days runs for years. And instead of healing tissue, it starts damaging it.

What keeps the fire burning

The tissue bleeds with nowhere to go. Every cycle, misplaced tissue responds to your hormones by thickening and bleeding. That blood irritates everything around it and triggers a fresh immune response.

Your immune system cannot resolve it. Instead of clearing the area and standing down, it keeps attacking. It releases cytokines, prostaglandins and histamine — chemicals that increase swelling, pain and tissue damage.

Nerves grow in and become hypersensitive. Inflammatory chemicals like TNF-alpha and IL-6 stimulate nerve growth into the lesions and make those nerves fire more easily.

Estrogen makes it worse. Estrogen increases COX-2, the enzyme that produces inflammatory prostaglandins. Inflammation then increases aromatase, the enzyme that makes more estrogen. Round and round.

Where inflammation actually comes from

This is the part that changes what you do about it.

Your pelvic inflammation is not only a pelvic problem. It is fed from elsewhere in the body:

- **Your gut.** A leaky gut lining lets bacterial fragments into the bloodstream. Your immune system responds as if to an infection, constantly.
- **Your blood sugar.** Every spike and crash generates inflammation. So does insulin resistance.
- **Your mitochondria.** When your cells' energy factories are struggling, they produce more oxidative stress — a form of cellular damage that drives inflammation.
- **Your environment.** Plastics, pesticides, mould, air pollution.
- **Your nervous system.** Chronic stress raises inflammatory signalling directly. This is not a metaphor. It is measurable.
- **Unprocessed emotional stress.** Grief and threat that have nowhere to go keep the body in an alarm state, and alarm states are inflammatory.

Which means: healing happens from the inside out and from the whole body inward. Treating the pelvis alone will never be enough.

Signs you are inflamed (beyond period pain)

- Severe bloating, especially the swollen "endo belly" that appears out of nowhere
- Fatigue that feels like dragging yourself through the day
- Joint or muscle aches that are not from exercise
- New food sensitivities, or reactions to fermented foods, wine, aged cheese and leftovers (this points to histamine)
- Mood swings, anxiety or brain fog, particularly in the week before your period
- Slow wound healing, or a big flare after surgery
- Waking between 2am and 4am
- Skin flare-ups around your period

You do not need all of these. Three or four is a strong signal.

The mind-body view

Chinese medicine reads inflammation as internal heat, liver qi stagnation, or blood stasis. It arises from suppressed emotion (particularly anger and grief), a life that burns too hot, or weak digestive fire.

The useful question is not only "how do I cool this fire?" It is "why was the fire lit, and what keeps relighting it?"

What to do with this chapter

Your one action this week: for seven days, write down what you ate, how you slept and how stressed you felt — and rate your pain and bloating out of ten each evening.

You are not changing anything yet. You are looking for your own pattern. Most women find one within a fortnight, and it is almost always more useful than any general advice, including mine.

Chapter 7: Estrogen dominance explained

Estrogen is not the villain. You need it. It builds your uterine lining, supports your bones, keeps your skin and vaginal tissue healthy, and lifts your mood.

The problem is estrogen **without balance**.

Three different problems with the same name

"Estrogen dominance" actually describes three separate situations. Knowing which one you have changes what you do.

1. Too much estrogen overall. From environmental exposures, higher body fat (fat tissue makes estrogen), or poor clearance.

2. Not enough progesterone to balance it. From chronic stress, cycles where you do not ovulate, or perimenopause. Your estrogen may be perfectly normal — there is just nothing holding it in check.

3. Estrogen that cannot get out. A sluggish liver, poor bile flow, constipation, or imbalanced gut bacteria mean estrogen your body processed simply comes back around again.

All three end in the same place: more estrogen signal, more tissue growth, more inflammation.

There is a fourth version worth knowing about: **receptor hypersensitivity**, where endometriosis lesions respond to normal estrogen levels as if they were high. This is why a "normal" blood test does not rule estrogen out as a driver.

How estrogen is supposed to leave your body

This is the most important thing in this chapter, and almost nobody explains it properly. Estrogen leaves in three stages. A blockage at any stage backs up the whole system.

Stage 1 — Liver, phase one. Your liver converts estrogen into intermediate forms called metabolites. Some of these are protective. Some are more harmful than the estrogen you started with. Which ones you make depends on your enzymes, your nutrient status, and your toxin load.

Stage 2 — Liver, phase two. Your liver then packages those metabolites so they can be safely removed. This step needs specific raw materials: B vitamins, magnesium, sulphur compounds, amino acids like glycine and taurine.

Here is the trap: if phase one is running fast (from alcohol, toxins, medication) but phase two is slow (from missing nutrients), you generate more harmful metabolites than you can package. This is worse than doing nothing. It is why aggressive detox protocols can make women feel dreadful.

Stage 3 — Out through bile and stool. Packaged estrogen binds to bile, travels into your intestines, and leaves in your stool. A smaller amount exits through urine.

This is the stage everyone forgets. If your bile is thick and sluggish — common with low-fat diets, gallbladder problems, or a congested liver — estrogen gets stuck at the door.

And if your gut bacteria are imbalanced, an enzyme called **beta-glucuronidase** unwraps the package your liver so carefully made and releases the estrogen straight back into circulation.

In one sentence: you cannot clear estrogen without a working liver, flowing bile, and a daily bowel movement. All three. Every day.

What creates estrogen dominance

- **Poor liver detox** — especially the phase one / phase two mismatch above
- **Low SHBG** — a protein made by your liver that binds excess estrogen and neutralises it. It drops when insulin is high, which means blood sugar control is directly a hormone issue
- **Gut dysbiosis** — imbalanced bacteria reactivating cleared estrogen
- **Chronic stress and low progesterone** — if you are not ovulating well, you are not making much progesterone
- **Constipation** — estrogen exits in stool. If you are not going daily, you are recycling hormones
- **Endocrine disruptors** — plastics, pesticides, personal care products

About SHBG

SHBG stands for sex hormone binding globulin. Think of it as a sponge that soaks up excess hormones so they cannot act on your tissues.

High SHBG means less free estrogen and usually fewer symptoms. Low SHBG means more free estrogen circulating.

What raises SHBG: better insulin sensitivity, healthy thyroid function, lower body fat, adequate protein.

What lowers SHBG: insulin resistance, high sugar and processed food, hypothyroidism, PCOS, liver dysfunction.

A note on the pill: it raises SHBG, which is one reason it can reduce symptoms. But it also suppresses ovulation, lowers your own progesterone, and affects gut and liver function. It manages the symptom while the root cause continues. That is not an argument against ever using it — sometimes you need relief now. It is an argument for not mistaking it for a solution.

Quick self-check: signs of estrogen dominance

- Heavy periods, or clots
- Sore or lumpy breasts before your period
- Irritability, anxiety or mood swings in the week or so before bleeding
- Migraines or headaches that follow your cycle
- Spotting for a day or two before your period properly starts
- Trouble sleeping around mid-cycle
- Bloating and fluid retention
- Fibroids, or a history of them

Four or more of these makes estrogen dominance likely. It does not confirm it — for that you would want a DUTCH test, which measures estrogen metabolites rather than just levels.

> **The goal is not to eliminate estrogen. It is to restore the pathways that process and clear it.**

What to do with this chapter

Your one action: answer three questions honestly.

10. Do you open your bowels every single day?
11. Do you eat fat at most meals? (You cannot make bile without it, and estrogen leaves in bile.)
12. Do you eat cruciferous vegetables — broccoli, cabbage, kale, rocket — most days?

Every "no" is a blocked exit. Fixing those three costs nothing and does more for your estrogen clearance than any supplement in this book.

Part Two: Food

Chapter 8: Before you change anything, read this

This is the chapter where most guides lose people. They hand you a list of twelve foods to remove, you last nine days, and then you feel like you have failed at something as basic as eating.

That is not a personal failing. That is a badly designed plan.

So before I tell you what to remove, I want to tell you how to remove it — and what I expect to be hard.

This is going to be hard on your head, not just your plate

I want to name this properly, because pretending otherwise helps nobody.

Removing foods is not really about food. It is about the coffee you have with your sister. It is about the birthday cake you do not eat in front of people who then ask why. It is about standing in a supermarket reading labels while your life goes on around you. It is about the low, grinding effort of thinking about every single meal when you are already exhausted and in pain.

Some women find that food restriction stirs up old and difficult feelings about control, or their body, or their worth. If that is you, please go gently, and please tell someone. This work is not worth doing at the cost of your relationship with food.

You are allowed to find this hard. Finding it hard does not mean you are doing it wrong.

You are not at war with your body

Here is the mindset I want you to carry through this chapter.

You are not fighting your body. You are not punishing it. You are not on a diet, and this is not about being good or bad.

You are running an experiment to find out what your particular body needs. That is all. Some foods will turn out to be a problem for you. Some will not. Nobody knows which until you test.

If you approach this as a war, you will lose — because the person you are fighting is you, and because a body that feels under threat does not heal. Chronic stress raises inflammation. Being at war with yourself over broccoli is, biochemically speaking, counterproductive.

Approach it as curiosity instead. *Let's see what happens*. That is a completely different nervous system state, and it is the one your body heals in.

Prepare yourself for this: it may be more than one or two things

I need to be honest with you about something, because I would rather you hear it from me now than discover it at month four and feel crushed.

For many women, gluten and dairy are enough. Their pain drops, the bloating settles, and that is the answer.

For others, it is not enough. They remove gluten and dairy, feel a bit better, and then find they also react to eggs, or soy, or corn, or high-histamine foods. Sometimes it takes a few rounds of testing to find the real culprits.

If that turns out to be you, I want you to hear this clearly: **that is not failure and it is not bad news.** It means your body is more specific in what it needs, and you are getting closer to knowing exactly what that is. Most women never find out. You will.

Go in expecting a process, not a single answer. That way, if you need to remove a third thing, it feels like progress rather than collapse.

Focus on what is improving, not what is missing

This is the single most useful habit I can give you.

When you remove foods, your attention naturally goes to the gap. What you cannot have. What everyone else is eating. The bread.

Deliberately move your attention to the other side of the ledger.

Keep a note — on your phone is fine — and every week write down anything that is better, no matter how small:

- Slept through the night twice this week
- Did not need painkillers on day two
- Jeans did up in the evening
- Woke up without brain fog
- Only cried once during PMS instead of every day
- Had energy after work

These small improvements are the actual evidence that this is working. Pain improvements often come last, which means if pain is your only measure, you will conclude nothing is happening for weeks — while three other things are already better.

Write them down. On a hard day, read them back.

The three rules of doing this well

> **Rule 1: Remove things one at a time, not all at once.**

If you remove six foods on Monday and feel better on Friday, you have learned nothing. You now have to keep avoiding all six forever, or start again.

Removing one thing at a time takes longer but tells you something true.

The one exception is gluten and dairy, which I ask you to remove together at the start. I will explain why in a moment.

Rule 2: Give each trial enough time.

Three days is not a trial. Gut lining takes weeks to repair. Antibodies take months to fall. Your cycle needs to turn over at least twice before you can judge anything cycle-related.

Three full months for gluten and dairy. **Four weeks** for anything you test after that.

Rule 3: Reintroduce properly, or you have wasted the whole experiment.

Most women never reintroduce. They just avoid things forever, based on a hunch, and end up with an unnecessarily narrow diet.

Reintroduction is how you find out what is actually true. Chapter 10 shows you exactly how.

Chapter 9: What to remove, and in what order

Step one: gluten and dairy, together, for three months

This is my main ask of you, and it is worth doing properly.

Why together? Because they are the two most common triggers in endometriosis by a wide margin, they affect the body through different mechanisms, and removing one while keeping the other often produces a muddy result that convinces women neither matters. Three months of both gives you a clear answer.

Why gluten?

Gluten increases intestinal permeability — leaky gut — in a large proportion of people, not only those with coeliac disease. A leakier gut means more bacterial fragments crossing into your bloodstream, which means more systemic inflammation, which lands in your pelvis along with everywhere else.

There is a well-known Italian study in which women with endometriosis followed a gluten-free diet for twelve months. A substantial majority reported meaningful reductions in pelvic pain, and none reported worsening. **[Studied in endometriosis — no control group]**

I want to be precise about that study, because it gets quoted everywhere. It followed women over time but had no placebo group, so some of the improvement will be the natural effect of paying close attention to your diet and your symptoms. It is encouraging, not proof. What makes me confident enough to ask you for three months anyway is the combination of that study, the mechanism, and what I see repeatedly in practice.

Why dairy?

Dairy is more nuanced, and I want to be accurate rather than dramatic. The issues are:

- **A1 casein**, the dominant protein in most conventional cow's milk, can be pro-inflammatory in sensitive people
- Dairy raises **IGF-1**, a growth signal, and endometriosis is a growth-driven condition
- Dairy is a common trigger for **histamine** reactions and bloating

Note that the research on dairy and endometriosis is genuinely mixed — some studies show no association or even a protective effect from certain dairy foods. **[Mechanism-based]** But in clinical practice, dairy removal helps a meaningful number of women, particularly those with bloating, sinus congestion, or skin flare-ups alongside their endometriosis.

If after three months dairy makes no difference to you, bring it back. That is a perfectly good result.

A note on what "gluten free" and "dairy free" mean here. Not gluten-free bread, gluten-free biscuits, gluten-free pizza and dairy-free ice cream. Swapping wheat for a highly processed rice-and-starch substitute usually leaves you no better off and sometimes worse — those products spike blood sugar hard.

What I mean is: whole foods that never contained gluten or dairy in the first place. Vegetables, meat, fish, eggs, fruit, nuts, seeds, rice, quinoa, potatoes, buckwheat, olive oil.

Step two: sugar and processed food

I have put this second, but for some women it matters more than either gluten or dairy.

High sugar intake and heavily processed foods are triggers for a good number of women with endometriosis. Here is why:

- They spike insulin. High insulin lowers SHBG. Lower SHBG means more free estrogen.
- They feed inflammation directly through oxidative stress.
- They disrupt the gut bacteria you need for estrogen clearance.
- They come with industrial seed oils, which increase inflammatory prostaglandins — the exact chemicals driving your cramps.

You do not need to be perfect about this. But if your pain is worse in the week after a run of sugar and takeaway, that is data, and it is worth taking seriously.

Practical version: cut the obvious added sugar and the ultra-processed packaged food. Keep whole fruit. Do not turn this into a purity project.

Step three: only if you need it

If, after three honest months without gluten and dairy, you have improved but not enough, it is time to test further.

These are the next most common culprits, in rough order of how often I see them matter:

Eggs. Common trigger, especially where there is autoimmune activity alongside the endometriosis. Test whole eggs first — some women react only to the white.

Soy. Complicated. Soy contains plant compounds that interact with estrogen receptors, and the research genuinely cuts both ways. Whole fermented soy (miso, tempeh, natto) behaves differently in the body than soy protein isolate and soybean oil, which are in almost everything processed. If you are testing soy, test the processed forms first — they are the more likely problem.

Corn. Frequently missed because it hides everywhere: cornflour, corn syrup, maltodextrin, dextrose, "vegetable starch," most gluten-free products. Common trigger in people with existing gut permeability.

High-histamine foods. If your symptoms include flushing, itching, headaches, racing heart, or reactions to wine, aged cheese, fermented food, leftovers and tinned fish — look here. Estrogen increases mast cell activity, which increases histamine, which increases estrogen. It is another loop, and it explains a lot of otherwise confusing food reactions.

Nightshades. Tomato, potato, capsicum, eggplant, chilli. Less commonly a problem, but worth testing if you have significant joint pain alongside your endometriosis.

Alcohol. Strictly speaking not a food trial — it burdens liver detox, increases gut permeability, and directly interferes with estrogen clearance. Most women do best keeping it minimal throughout. If you drink regularly, this may be your highest-return single change.

What this looks like on a calendar

Months	What you are doing
Months 1–3	Gluten and dairy out together. Reduce added sugar and processed food. Nothing else changes.
Month 4	Reintroduce dairy properly (see Chapter 10). Then, separately, gluten. Record everything.
Months 5–6	If needed, test the next most likely trigger for you — four weeks out, then reintroduce.
Ongoing	You now know your actual triggers. Eat accordingly, and stop guessing.

Notice what this is not. It is not a permanent list of forbidden foods. It is a six-month process that ends with you knowing something specific and useful about your own body — after which most women find their diet gets wider again, not narrower.

Chapter 10: How to reintroduce food properly

This is the step almost everyone skips, and skipping it is how women end up eating twelve foods and terrified of the rest.

The method

1. **Pick one food. Only one.**

2. Eat a normal amount of it, twice a day, for three days. Not a nibble. If you are testing dairy, have yoghurt at breakfast and cheese at dinner. A tiny test dose can produce a false negative.

3. Then stop it completely and wait four more days. Reactions are often delayed by 48 to 72 hours. The waiting period is where you find them.

4. Record every day for all seven days. Rate each of these out of ten:

- Pelvic pain
- Bloating
- Energy
- Mood
- Sleep quality
- Bowel movements (how many, and what type)
- Skin
- Any joint pain, headache, congestion

5. Wait until symptoms settle before testing the next food. If you reacted, allow a week or two of calm before you start again.

Reading the result

Clear reaction — symptoms noticeably worse within three days, settling once you stop. That food is a trigger for you. Leave it out for six months, then consider retesting once your gut has had time to heal.

Mild or delayed reaction — a small change, or something you only notice on day four or five. Worth retesting once before you conclude anything.

No reaction — bring it back into your diet. Genuinely. Fewer restrictions means better nutrition, easier social life, and less stress, all of which help you heal.

Timing matters

Do not reintroduce a food in the week before your period. Symptoms rise premenstrually anyway, and you will not be able to tell what caused what.

Best window: days 6 to 13 of your cycle, counting day one as the first day of proper bleeding. This is your most symptom-stable stretch.

Chapter 11: What to actually eat

Removing things is only half the job. What you add matters just as much.

The core principles

- **Lower the inflammatory load.** Fewer foods that trigger cytokines, histamine, or gut permeability.
- **Feed estrogen clearance.** Give your liver, bile and gut bacteria what they need to break estrogen down and get it out.
- **Heal the gut.** Less leakiness means less inflammation and better estrogen clearance.
- **Steady your blood sugar.** High insulin lowers SHBG, which raises free estrogen. Protein, fat and fibre at every meal.
- **Load up on antioxidants.** Endometriosis is driven by oxidative stress. Colour, polyphenols and sulphur-rich foods are the antidote.

The foods that do the most work

Cruciferous vegetables — broccoli, kale, cabbage, bok choy, rocket, Brussels sprouts, cauliflower.

These contain sulforaphane, which supports phase two liver detox, plus fibre that binds estrogen in the gut so it leaves rather than recirculates. **Broccoli sprouts are the most concentrated source by a wide margin** — a small handful two or three times a week is worth more than a large serve of regular broccoli.

Colourful vegetables — carrots, beetroot, pumpkin, sweet potato.

Antioxidants, liver support, fibre for your gut bacteria. Beetroot specifically supports bile flow.

Low-sugar fruit — berries, citrus, pomegranate, kiwi.

High in antioxidants and vitamin C without a big blood sugar hit.

Healthy fats — extra virgin olive oil, avocado, flaxseed, chia, hemp seeds.

Hormone building blocks, and they calm inflammation. You also need fat to make bile, and you need bile to clear estrogen. Very low-fat diets work against you here.

Oily fish — wild salmon, sardines, anchovies, mackerel, herring.

The best food source of EPA and DHA, which directly reduce the prostaglandins driving your cramps. Three or four servings a week meaningfully reduces your need for a fish oil supplement.

Clean protein — pasture-raised eggs, wild-caught fish, good quality poultry and red meat, lentils and beans if you tolerate them.

Protein is the raw material for liver detox enzymes, hormone production and tissue repair. It is the single most common thing missing when a protocol is not working. Aim for a palm-sized portion at every meal.

Zinc and magnesium foods — pumpkin seeds, tahini, spinach, oysters, dark chocolate at 70% or above.

Ovulation, nervous system regulation, cramp reduction.

Choline foods — eggs, liver, salmon.

Choline is essential for liver detox and estrogen metabolism, and it is very commonly low. **Three eggs a day gives you a solid choline base.** Liver once a week is even better if you can stomach it.

Anti-inflammatory herbs and spices — turmeric, ginger, cinnamon, parsley, rosemary, garlic.

Use them generously. Ginger tea during your period is genuinely therapeutic, not just comforting.

Ground flaxseed — one tablespoon daily.

Binds estrogen in the gut so it leaves in your stool. Grind it fresh or buy pre-ground and keep it in the fridge, or the oils go rancid.

The foods that work against you

Gluten grains — wheat, barley, rye, spelt. Increased gut permeability, immune activation.

Dairy, particularly A1 cow's dairy — inflammation, IGF-1, histamine, bloating.

Refined sugar and processed carbohydrate — insulin spikes, lower SHBG, direct inflammation.

Industrial seed oils — canola, soybean, sunflower, safflower, grapeseed, "vegetable oil." High in omega-6, which converts into the arachidonic acid that produces inflammatory prostaglandins. These are in nearly all takeaway food and packaged snacks.

Alcohol — burdens liver detox, increases gut permeability, disrupts hormone clearance.

Processed meat and conventionally raised animal products — added hormones, inflammatory fats, poorer nutrient profile.

How to structure your day

> **Morning: protein, fat and fibre.**

This sets your blood sugar for the whole day and calms your nervous system. It is the highest-leverage meal you have.

Example: two or three eggs cooked in olive oil with kale, half an avocado, a small serve of sweet potato.

> **Midday: your biggest meal.**

Digestion is strongest around the middle of the day. Include liver-supportive foods.

Example: baked salmon, roasted beetroot and carrot, rocket salad with olive oil and lemon, a small serve of quinoa.

> **Evening: lighter, warm and cooked.**

Raw food in the evening is harder work for a tired digestive system. Warm, cooked food calms the nervous system and supports sleep.

Example: ginger and carrot soup, grilled zucchini, turmeric chicken.

Doing this on a budget

Eating this way is often assumed to be expensive. Some of it is. Most of it does not have to be.

> **The cheapest things here are also among the most effective:**

- **Ground flaxseed** — a large bag costs very little and lasts weeks. One of the highest-return items in this whole guide.
- **Eggs** — the best affordable source of choline, which your liver needs to clear estrogen.
- **Tinned sardines and mackerel** — the cheapest oily fish there is, and better value than most fish oil capsules.
- **Frozen vegetables and berries** — nutritionally equal to fresh, often better, and a fraction of the price. Frozen spinach and broccoli are excellent.
- **Dried lentils and beans**, if you tolerate them.
- **Cheaper cuts of meat**, slow-cooked. Also gives you broth.
- **Chicken carcasses or bones** for broth — often free or nearly free from a butcher.
- **Pumpkin seeds** — magnesium and zinc, cheap in bulk.
- **Roasted dandelion root tea** — replaces a supplement entirely.

Where to spend if you have a little extra: oily fish, eggs from a source you trust, and the produce highest in pesticides — berries, spinach, apples, grapes.

Where not to bother: gluten-free packaged products, most superfood powders, organic avocados and bananas (thick skin, low residue), and expensive branded supplements when a basic third-party-tested version does the same job.

If money is genuinely tight, this is your version: eggs, frozen vegetables, tinned sardines, lentils, oats or rice, olive oil, pumpkin seeds, ground flaxseed, and magnesium. That covers most of what matters.

The bowel rule

Aim for **one to two bowel movements every day.**

This is not a side note. Estrogen leaves your body in your stool. If you are not going daily, you are recycling hormones you have already worked to clear.

If you are not going daily, the fixes are: more magnesium, one tablespoon of ground flaxseed, more water, more cooked vegetables, and enough fat in your diet to stimulate bile.

Chapter 12: Eating with your cycle

Your hormones are not the same all month. Your food does not need to be either.

This chapter is optional. If you are just starting, ignore it and focus on Chapter 11. Come back when the basics feel automatic — usually around month two or three.

Why bother

Different phases of your cycle have different needs. Early on, your body is more insulin-sensitive and better able to handle lower carbohydrate. Later, you need more carbohydrate to make progesterone and keep your mood and sleep stable.

Eating the same way all month means you are working against your body for half of it.

Menstruation, days 1 to 4: repair

Hormones are at their lowest. Energy is down. Your body is shedding tissue and losing blood.

Goal: anti-inflammatory support, gentle nourishment, warmth.

Focus: moderate protein and fat, with slightly more complex carbohydrate.

Best foods: bone broth, soft-cooked greens, sweet potato, soups and stews, oily fish, turmeric, ginger.

Avoid: fasting, and any kind of aggressive restriction. This is not the week for it.

Follicular phase, days 5 to 13: clear and reset

Estrogen begins to rise. Energy and motivation come back. You are at your most insulin-sensitive.

Goal: support estrogen clearance, lower inflammation.

Focus: higher fat, moderate protein, lower carbohydrate. This is the window for a lower-carb approach if it suits you.

Best foods: eggs, oily fish, good quality meat, avocado, olive oil, coconut oil, ghee, flax, chia, zucchini, kale, cauliflower, cucumber, mushrooms, spinach.

Hydration: bone broth, dandelion root tea, water with a pinch of sea salt.

About lower-carb and keto in the follicular phase

A lower-carbohydrate approach in the first half of your cycle can reduce inflammation quite quickly, improve insulin sensitivity (which raises SHBG and lowers free estrogen), and lift the brain fog that often lands after your period. **[Mechanism-based]**

But it is not for everyone, and I want to be clear about that.

> **Do not do a ketogenic or very low-carb phase if:**

- You are actively trying to conceive this cycle
- You are underweight, or have lost weight recently without meaning to
- You have hypothalamic amenorrhoea, or your periods have stopped or become irregular from stress or under-eating
- You have a history of disordered eating
- Your thyroid is borderline or you have Hashimoto's
- You are exhausted, or in a period of high life stress
- You have tried it before and your cycle got worse

If any of those apply, use the food principles in Chapter 11 and skip this entirely. You will do just as well. Restriction is a tool, not a virtue, and in the wrong body it does real harm.

Ovulation, around days 14 to 20: transition

Estrogen peaks, LH surges, ovulation happens. Your body is doing something energetically expensive.

Goal: ease out of lower carb, support ovulation.

Focus: start bringing carbohydrate back, drop fat slightly.

Carbs to reintroduce: sweet potato, pumpkin, cooked carrot and beetroot, quinoa, lentils if tolerated, berries, banana, stewed apple.

Think of this as the bridge. You are preparing for the progesterone-driven second half.

Luteal phase, days 15 to 28: progesterone and mood

Progesterone takes over. Appetite rises. If your blood sugar, magnesium or serotonin are low, PMS shows up here.

Strict low-carb in this phase backfires. It causes mood swings, insomnia and cravings, and it can lower progesterone.

Goal: steady blood sugar, ease PMS, support hormone production.

Focus: moderate protein and fat, more complex carbohydrate.

Key nutrients: magnesium, vitamin B6, tryptophan, electrolytes.

Best foods: roasted root vegetables, quinoa, millet, oats if tolerated, slow-cooked meat and stews, dark leafy greens, pumpkin seeds, tahini, sunflower seeds, dark chocolate at 70% or above, bone broth, coconut water.

Give yourself permission to eat more carbohydrate in this phase. It supports progesterone, calms your nervous system, and helps you sleep. Craving carbs in the week before your period is not weakness. It is a signal.

Coming out of a low-carb phase without a crash

If you have been eating low-carb, do not swing straight back to a big bowl of pasta. Add 10 to 20 grams of carbohydrate per day over five to seven days. Favour cooked, gentle carbohydrate — squash, sweet potato, stewed fruit. Keep your fat intake up initially and lower it gradually. Keep an eye on your electrolytes, especially magnesium and potassium, because as you add carbs your body holds more water.

Signs you are moving too fast: bloating, energy crashes, sugar cravings, trouble sleeping. Slow down and add carbohydrate mainly in the evening.

> **This is not falling off the wagon. It is responding to your body. You are not breaking rules — you are learning to read signals.**

Chapter 13: The minerals nobody mentions

You can eat perfectly and still feel flat, foggy and exhausted if your minerals are off.

Electrolytes run your fluid balance, nerve signalling, muscle function and energy. Micronutrients run your detox, hormone and immune pathways. If these are depleted, your body stays in survival mode no matter how good the rest of your diet is.

The big three electrolytes

Sodium

Supports adrenal function, nerve signalling and hydration. Low sodium is the main reason people feel dreadful on a low-carb diet.

Sources: sea salt, bone broth, olives, mineral water.

Simple habit: a quarter to half a teaspoon of good sea salt in water first thing in the morning.

Potassium

Balances sodium, supports your nervous system, and reduces the fluid retention and bloating that peak in the luteal phase.

Sources: avocado, spinach, Swiss chard, mushrooms, salmon, pumpkin seeds, coconut water.

Low potassium looks like: fatigue, constipation, muscle cramps, cravings.

Magnesium

Involved in over 300 reactions in the body, including estrogen metabolism, blood sugar control, mood, sleep and cramp reduction. It is depleted by stress, menstruation, alcohol and low-carb eating — which is to say, by having endometriosis.

Sources: pumpkin seeds, almonds, spinach, avocado, dark chocolate at 70% or above.

Which form of magnesium to take:

Form	Best for
Glycinate	Sleep, anxiety, PMS, cramping, nervous system
Citrate	Constipation
Malate	Fatigue, muscle pain
L-threonate	Brain fog

Avoid magnesium oxide. It is poorly absorbed and is essentially a laxative.

The micronutrients that matter most in endometriosis

Zinc — ovulation, immune function, tissue repair. Frequently low in women with endometriosis. *Pumpkin seeds, oysters, red meat, tahini.*

Vitamin D — modulates inflammation and immune tolerance. Get tested rather than guessing; aim for a level of 40 to 60 ng/mL (100 to 150 nmol/L — Australia, the UK and most of Europe report in nmol/L, the US in ng/mL). If you supplement, take it with vitamin K2 and with a meal containing fat. Magnesium is required to convert vitamin D into its active form, which is another reason magnesium sits at the base of everything.

Vitamin B6 (as P5P) — needed to make progesterone and to clear estrogen. Calms PMS. *Turkey, salmon, banana, avocado, sunflower seeds.* Never exceed 100mg a day from all sources combined.

Vitamin C — antioxidant, supports detox, lowers prostaglandin-driven pain, and dramatically improves iron absorption. *Kiwi, citrus, capsicum, broccoli, berries.*

Choline — essential for liver detox and estrogen metabolism. *Egg yolks, liver.* Three eggs a day covers a good base.

Selenium — thyroid function and estrogen clearance. *One or two Brazil nuts a day is enough. More is not better.*

Iodine — thyroid function and healthy estrogen metabolism in breast and uterine tissue. *Nori, dulse, a small amount of kelp.* Do not exceed 500mcg a day without monitoring.

In short: if macronutrients are the builders, minerals are the project managers. Nothing gets built without them.

Part Three: Supplements

Chapter 14: How to think about supplements

Supplements are not magic and they are not a substitute for food, sleep or nervous system work. But chosen well and layered in the right order, they do real work.

Most supplement advice for endometriosis is a long alphabetical list. That tells you what to buy. It does not tell you what each thing is *for*, or which ones you actually need.

So this chapter is organised differently. Everything is grouped by the **job it does**. Each job maps to something you read about in Part One.

The seven jobs

13. **Cool the inflammation** — reduce the prostaglandins and cytokines driving your pain
14. **Clear estrogen, stage one and two** — help your liver process it
15. **Clear estrogen, stage three** — get bile flowing so it can actually leave
16. **Fix the gut and the estrobolome** — stop reactivating estrogen you have already cleared
17. **Calm mast cells and histamine** — for the flushing, itching, reactive version of endo
18. **Support mitochondria and egg quality** — the energy layer, and the fertility layer
19. **Settle the nervous system** — reduce the pain amplification

Three important rules before you buy anything

Rule 1: Start with three, not thirteen. Add a new layer every two to three weeks. If you start everything at once and feel worse, you will have no idea which thing did it.

Rule 2: Nothing runs forever. As a general rule, take a break from any supplement every three to six months. Some — DIM, vitex, adaptogens — need cycling more often than that.

Rule 3: Read the surgery and pregnancy warnings at the end of this chapter before you start. Several of these thin the blood, and their effects stack.

Job 1: Cool the inflammation

Omega-3 (EPA and DHA) **[Trialled — results mixed]**

Dose: 2,000mg combined EPA and DHA daily.

Why: Lowers the prostaglandins that cause cramping and modulates inflammatory cytokines. This mechanism is well established.

An honest word on the evidence: you will see omega-3 described everywhere as proven for endometriosis. The trial data does not support that strongly. A UK pilot trial found no significant difference in pain or quality of life against placebo, and a trial in younger women found fish oil produced roughly half the pain reduction of the comparison arms. The encouraging findings come mostly from observational studies — women who eat more omega-3 have lower endometriosis risk and report less pain — which cannot prove cause.

So why is it still here? Because the mechanism is sound, the safety profile is excellent, it supports egg quality and lining independently of pain, and correcting a genuinely poor omega-3-to-omega-6 ratio is worth doing regardless. But if your budget is tight, buy oily fish rather than capsules, and do not expect it to be the thing that changes your pain.

Notes: Choose a fish oil in triglyceride form, third-party tested. If it smells fishy, it has oxidised — throw it out. Mild blood-thinning effect.

Food alternative: Genuinely skippable if you eat oily fish three to four times a week.

Curcumin **[Trialled — standalone result was negative]**

Dose: 1,000mg daily of a **phytosome, liposomal or nanomicelle** form.

Why: Blocks NF-kB, a master switch for inflammation. Reduces the vascular growth factor that lets lesions build a blood supply. The laboratory and animal evidence is genuinely impressive.

An honest word on the evidence: the best-designed human trial of plain curcumin in endometriosis — triple-blind, 68 women, 500mg twice daily for eight weeks — found **no significant improvement** in pain or quality of life. I would rather you heard that from me.

Where it did work: the positive trials used highly absorbable nanomicelle curcuminoids, and mostly as an add-on alongside medical treatment. One showed improved pain, sexual function and quality of life when added to dienogest. Another showed reduced oxidative stress and inflammatory markers in women with endometriosis going through IVF.

What I take from this: absorption is probably the whole story. Ordinary curcumin capsules barely reach the bloodstream, which is likely why the standalone trial failed. If you use curcumin, use a genuinely high-absorption form, and think of it as support alongside your other treatment rather than a treatment on its own.

Notes: The form matters more than the number on the label. Plain turmeric extract at the same milligram dose delivers a fraction of the active compound. Take with food. Avoid with gallstones or blood thinners. Curcumin binds iron, so keep two hours away from iron supplements.

Food alternative: No. Cook with turmeric anyway, but do not count it.

Melatonin **[Tested in endometriosis]**

Dose for pain: 10mg at night. **Dose if trying to conceive:** 3mg, cycle days 1 to 12 only.

Why: This has the strongest human trial evidence of anything in this chapter for endometriosis pain. A randomised trial found meaningful reductions in daily pain and period pain, better sleep, and reduced need for painkillers.

Notes: Stop after eight to twelve weeks of continuous use. If you get vivid dreams or morning grogginess, lower the dose. Do not combine with other sedatives or alcohol.

Ginger **[Tested for period pain]**

Dose: 1,500mg daily during your bleed, split across the day.

Why: Head-to-head trials in period pain show ginger performing comparably to standard anti-inflammatory medication.

Food alternative: Yes. Strong fresh ginger tea — two centimetres of sliced root, steeped ten minutes — three times a day is a real alternative.

Vitamin C with vitamin E **[Tested in endometriosis]**

Dose: 1,000mg vitamin C plus 200 to 400 IU vitamin E with mixed tocopherols.

Why: Trial evidence in endometriosis for reduced pelvic pain, period pain and pain with sex, alongside lower markers of oxidative stress in pelvic fluid.

Notes: Check your multivitamin or prenatal — many contain significant vitamin E already, and it is easy to overshoot. Vitamin E adds to blood-thinning effects.

PEA (palmitoylethanolamide) **[Mechanism-based, small clinical studies]**

Dose: 300 to 600mg daily, often combined with polydatin.

Why: This one is worth knowing about because it targets exactly the mechanism described in Chapter 2. PEA calms mast cells and glial cells — the immune cells of the nervous system that drive central sensitisation. Small clinical studies in endometriosis pelvic pain and painful sex have been promising.

Notes: Less well known and harder to source than the others. Ask a practitioner. Worth trying if your pain has become widespread, constant, or persists after surgery.

Job 2: Clear estrogen — liver stages one and two

N-acetyl cysteine (NAC) **[Tested in endometriosis]**

Dose: 1,200mg daily, split into two.

Alternative dosing for endometriomas: the published endometriosis trial used a pulsed schedule — 600mg three times daily, for three consecutive days per week, then four days off. If shrinking a cyst is your main goal, this is the schedule that was actually studied.

Why: The single most endometriosis-relevant supplement here. Precursor to glutathione, your body's master antioxidant. Supports phase two liver detox, lowers oxidative stress in pelvic fluid, and improves insulin sensitivity.

Notes: Avoid with paracetamol, nitroglycerin or warfarin. Reduce to 600mg if pregnant.

Sulforaphane (broccoli sprout extract) **[Mechanism-based]**

Dose: Follow product directions — look for one that includes active myrosinase, the enzyme needed to convert it.

Why: The most potent food-derived activator of phase two liver detox. This is the compound doing the work when we tell you to eat cruciferous vegetables.

Food alternative: Yes, and it is a genuinely good one. A small handful of fresh broccoli sprouts two or three times a week.

B vitamins, particularly B6 and B2 **[Mechanism-based]**

Dose: B6 as P5P, 20 to 50mg. Never exceed 100mg daily from all sources.

Why: Phase two liver detox runs on B vitamins. B6 is also required to make progesterone.

Notes: Stop B6 immediately if you feel tingling, burning or numbness in your hands or feet. A good methylated multivitamin usually covers this — do not stack a B-complex on top of one.

Calcium D-glucarate **[Mechanism-based]**

Dose: 400mg daily with food.

Why: Blocks beta-glucuronidase, the gut enzyme that unwraps estrogen your liver already packaged. This is the estrobolome lever.

Notes: Only use with clear signs of estrogen dominance. Keep four hours away from thyroid medication.

DIM **[Mechanism-based]**

Dose: Start at 100mg, build slowly. Do not rush to a high dose.

Why: Shifts estrogen metabolism toward the protective pathway.

Notes — please read these: This is the item on this list most likely to cause a problem. Watch for vaginal dryness, reduced fertile mucus, delayed ovulation or a thinning lining. Those mean you have pushed estrogen down too far — reduce or stop. **Do not use DIM if you have low ovarian reserve, a thin uterine lining, absent periods, or are in an**

IVF cycle. If you are trying to conceive, use cruciferous vegetables and broccoli sprouts instead. They do a similar job with a far wider safety margin.

Job 3: Clear estrogen — stage three, bile and elimination

This section is the one most guides leave out entirely, and it is why so many estrogen protocols underdeliver. You can process estrogen perfectly and still recirculate it if it cannot physically leave.

Taurine **[Mechanism-based]**

Dose: 500 to 1,000mg daily.

Why: Binds to bile acids, which is what makes bile flow. Also calming, and supports insulin sensitivity.

Glycine **[Mechanism-based]**

Dose: 3g before bed.

Why: Glutathione precursor, supports bile conjugation, and deepens sleep.

Food alternative: Yes. Two cups of bone broth daily, or 10 to 20g of collagen peptides.

Bitter herbs — dandelion root, artichoke, gentian **[Clinical and traditional]**

Dose: Dandelion root 500mg, or two to three cups of roasted dandelion root tea daily.

Why: Stimulates bile production and flow. Traditional, effective, and cheap.

Notes: Best used as a six-week course rather than indefinitely. Avoid alongside prescription diuretics.

Milk thistle **[Mechanism-based]**

Dose: 500mg daily, as a six-week course.

Why: Protects liver cells and supports both detox phases.

Notes: May interact with medications processed by the liver. This is a reset, not a permanent supplement.

Ground flaxseed **[Mechanism-based]**

Dose: One tablespoon daily.

Why: Binds estrogen in the gut so it leaves in your stool instead of being reabsorbed.

> **This is food, it is cheap, and it is one of the highest-return things in this whole chapter.**

Job 4: Fix the gut and the estrobolome

Probiotics **[Tested in endometriosis — strain-specific]**

Dose: 10 to 50 billion CFU daily.

Why: Supports estrogen clearance, immune balance and reduced bloating.

Notes: Strain matters. **Lactobacillus gasseri** is the strain with actual endometriosis-specific research behind it, though the human studies are small. Look for a product containing it rather than buying on CFU count alone.

Food alternative: Yes, if tolerated — sauerkraut, kimchi or kefir daily. Skip fermented foods entirely if you are histamine-reactive; use a capsule instead.

L-glutamine **[Mechanism-based]**

Dose: 5g daily on an empty stomach, for eight to twelve weeks.

Why: Repairs the gut lining. Less leakiness means less systemic inflammation.

Food alternative: Bone broth daily covers a good part of this.

Zinc **[Mechanism-based]**

Dose: 15 to 30mg with food.

Why: Gut lining integrity, immune function, ovulation and tissue repair. Zinc runs low in women with endometriosis, and estrogen drives copper retention which pushes the zinc-to-copper ratio the wrong way.

Notes: Do not run high-dose zinc past three months without including 1 to 2mg of copper — long-term zinc without copper causes anaemia. Keep two hours away from iron.

Food alternative: Yes. Oysters are outstanding. Also pumpkin seeds, beef, tahini.

Job 5: Calm mast cells and histamine

Skip this section unless you recognise yourself in it. Signs you need it: flushing, itching, hives, headaches, racing heart, or reactions to wine, aged cheese, fermented food, leftovers and tinned fish.

Estrogen increases mast cell activity. Mast cells release histamine. Histamine increases estrogen. It is a self-reinforcing loop and it explains a lot of confusing food reactions.

Quercetin **[Mechanism-based]**

Dose: 500 to 1,000mg daily, often paired with bromelain.

Why: Stabilises mast cells. A natural antihistamine with anti-inflammatory action.

Notes: Stop in pregnancy — limited safety data. Bromelain adds to blood-thinning effects.

Vitamin C **[Mechanism-based]**

Already listed above. It also degrades histamine, so it does double duty here.

Low-histamine eating trial

If you suspect this pattern, a four-week low-histamine trial will tell you more than any supplement. It is restrictive, so do it as a short diagnostic experiment, not a way of life.

Job 6: Mitochondria and egg quality

This section matters for everyone, and it matters enormously if you are trying to conceive.

CoQ10 (ubiquinol) **[Mechanism-based, strong fertility evidence]**

Dose: 200 to 400mg daily, with a meal containing fat.

Why: Powers energy production inside your cells, including your eggs. Endometriosis drives mitochondrial dysfunction and oxidative stress in the fluid surrounding the egg. This is the direct counter.

Notes: Use ubiquinol, the reduced form, especially over 35. It absorbs far better than ubiquinone.

> **If you are trying to conceive, this is the most important supplement in this chapter.**

Myo-inositol **[Mechanism-based, strong fertility evidence]**

Dose: 2 to 4g daily, split into two doses. Do not exceed 4g.

Why: Improves insulin sensitivity — which raises SHBG and lowers free estrogen. Also improves egg quality and progesterone production by the ovary, regardless of whether you have insulin resistance.

Acetyl-L-carnitine **[Mechanism-based]**

Dose: 1,500mg daily.

Why: Transports fatty acids into mitochondria for energy. Supports egg quality and helps with fatigue.

Notes: Space four hours from thyroid medication.

Alpha lipoic acid **[Mechanism-based]**

Dose: 300 to 600mg daily.

Why: Regenerates other antioxidants including vitamin C, vitamin E and glutathione. Supports insulin sensitivity.

Notes: Keep away from thyroid medication and from zinc, magnesium and iron.

Job 7: Settle the nervous system

Magnesium glycinate **[Mechanism-based]**

Dose: 200 to 400mg in the evening.

Why: Calms the nervous system, relaxes uterine muscle, improves sleep, keeps bowels moving.

> **If you only take one supplement, take this one.**

L-theanine **[Mechanism-based]**

Dose: 100 to 200mg as needed.

Why: Increases GABA, your calming neurotransmitter, without sedation.

Adaptogens **[Clinical and traditional]**

Use only if you are genuinely burnt out, and cycle them — four to six weeks on, then a break.

Herb	Best for	Dose
Ashwagandha	High cortisol, poor sleep, wired-and-tired	300–500mg, morning
Rhodiola	Low energy, poor focus	100–300mg, morning. Avoid if anxious
Holy basil	Anxiety, blood sugar swings	Tea, or 300mg extract

Notes: Use ashwagandha with caution if you have any autoimmune thyroid condition. Stop any adaptogen if you feel wired, anxious or get palpitations. Avoid in pregnancy unless supervised.

Vitex (chasteberry) **[Clinical and traditional]**

Dose: 400 to 1,000mg in the morning.

Why: Raises progesterone indirectly by acting on the pituitary.

Notes: Only use if you have a documented short luteal phase (under 11 days), spotting before your period, or high prolactin. If you already ovulate well with good progesterone, vitex can make things worse. Not for PCOS with high LH. Avoid alongside Clomid or an IVF cycle. Give it three months before judging it.

Chapter 15: Which supplements, and in what order

Here is how to actually stage this, plus what to do if the budget is tight.

Tier 1 — Start here (weeks 1 to 4)

Four things. That is all.

20. **Magnesium glycinate** 200–400mg at night
21. **Omega-3** 2,000mg daily *(or oily fish three to four times a week)*
22. **Curcumin phytosome** 1,000mg daily
23. **NAC** 1,200mg daily

If money is tight, this is the whole protocol. Add one tablespoon of ground flaxseed daily and you have covered inflammation, glutathione, estrogen binding and nervous system support for a modest monthly cost.

Tier 2 — Estrogen clearance (weeks 4 to 8)

Add once Tier 1 feels settled:

24. **Milk thistle and dandelion root** — a six-week course only
25. **Taurine** 500–1,000mg
26. **Glycine** 3g at night *(or bone broth daily)*
27. **Probiotic** with *L. gasseri*

Tier 3 — Personalise (weeks 8 to 12)

Choose based on what is still bothering you:

- **Still in significant pain?** → Melatonin, and consider PEA
- **Flushing, itching, food reactions?** → Quercetin
- **Trying to conceive?** → CoQ10 and myo-inositol *(move these to Tier 1 if TTC — see Chapter 19)*
- **Confirmed estrogen dominance on a DUTCH test?** → Calcium D-glucarate, and possibly DIM
- **Exhausted and wired?** → Adaptogens, cycled
- **Short luteal phase or premenstrual spotting?** → Vitex and B6

Tier 4 — Test first, then supplement

Never take these blind. Get bloodwork.

Supplement	Test first	When to take it
Iron	Ferritin and CRP	Only if ferritin is genuinely low
Vitamin D	25-OH vitamin D	Only if below 30 ng/mL (75 nmol/L). Target 40–60 ng/mL, or 100–150 nmol/L
Iodine	Thyroid panel	Only with monitoring
Zinc	Zinc, and copper if possible	If low, or if the zinc-to-copper ratio is off

A specific warning about iron. Heavy bleeding depletes iron, so it is tempting to supplement on symptoms. Do not.

Free iron in pelvic fluid is itself a driver of oxidative stress in endometriosis. Supplementing when you do not need it makes things worse.

Also: inflammation falsely raises ferritin. A ferritin of 45 alongside a high CRP may be masking a real deficiency. That is why you test both.

If you do need iron, use iron bisglycinate, take it on alternate days (it absorbs better than daily), take it with vitamin C, and keep it two hours away from calcium, coffee, tea, magnesium and zinc, and four hours from thyroid medication.

Chapter 16: Safety — read before surgery or a positive test

Blood thinning stacks up

These all have mild blood-thinning effects, and taken together they add up:

- Omega-3
- Curcumin
- Vitamin E
- Quercetin with bromelain
- High-dose ginger
- Nattokinase and serrapeptase, if you use them

Women with endometriosis have laparoscopies, excision surgery and egg retrievals. This matters.

Procedure	When to stop all of the above
Laparoscopy or excision surgery	10 to 14 days before
Egg retrieval	10 to 14 days before
IVF embryo transfer	7 days before

Procedure	When to stop all of the above
Any dental surgery	7 days before

Tell your surgeon and your fertility clinic exactly what you are taking. Write it down and hand it over. "It's only a supplement" is not a reason to leave it off the list.

If you might be pregnant

Stop immediately on a positive test: DIM, calcium D-glucarate, vitex, quercetin, adaptogens, high-dose melatonin, milk thistle, dandelion root, berberine, alpha lipoic acid, high-dose NAC (reduce to 600mg or stop).

Generally continue: a good prenatal, omega-3, magnesium, vitamin D at a sensible dose, probiotics.

If in doubt, stop it and ask.

Other interactions worth knowing

- **Thyroid medication:** keep calcium, iron, magnesium, zinc, vitamin D and multivitamins four hours away. Take your thyroid medication alone with water and wait 60 minutes before food or coffee.
- **Blood thinners:** talk to your prescriber before starting anything in this chapter.
- **Antibiotics:** space probiotics at least two hours apart.

Part Four: Living It

Chapter 17: When it hurts right now

This chapter is for a bad day. It assumes you have not read the rest of the book, cannot think straight, and need something in the next hour.

The first hour

Heat, on your belly or your lower back. A hot water bottle or heat pack. Heat has been shown to relieve period pain about as well as standard painkillers. Use it early, not once the pain is established.

Magnesium. 400mg. It relaxes uterine muscle.

Ginger. Strong fresh ginger tea, or 1,000 to 1,500mg in capsules.

Get horizontal, and get warm. Knees up toward your chest, or on your side with a pillow between your knees. Take the pull off your pelvis.

Slow your breathing out. Breathe in for four, out for six or eight. A longer exhale switches your nervous system out of alarm. Ten rounds. This sounds too simple to work. Do it anyway.

The first 24 hours

- **Eat warm, cooked, simple food.** Soup, stewed vegetables, bone broth. Nothing raw, nothing cold, nothing that takes work to digest.
- **Salt and water.** Electrolytes, not just plain water.
- **Skip the coffee.** It tightens blood vessels and raises the stress hormones already flooding your system.
- **Skip the alcohol.** It makes tomorrow worse.
- **Castor oil pack** on the lower abdomen, with heat — **but not while you are actively bleeding.**
- **Take your painkillers if you need them.** This is not a failure of the protocol. Pain that is allowed to escalate sensitises your nervous system further, which makes next month worse. Managing pain early is part of the strategy, not a departure from it.

The next 72 hours

- Cancel what you can. Whatever you are pushing through is almost certainly less important than it feels.
- Gentle heat and gentle movement. A slow walk. Legs up the wall. Nothing more.
- Sleep as much as you can get.
- Write down what was happening in the week before. Food, stress, sleep, where you were in your cycle. Flares carry information.

For next month: start before it starts

The single most effective change most women make is beginning flare support **before** the pain arrives rather than after.

From day 21 of your cycle, or three days before your pain usually starts:

- Increase magnesium
- Start ginger daily
- Start cramp bark, if you use it — it works best taken at the first twinge, not once you are on the floor
- Reduce sugar, alcohol and processed food in that week specifically
- Protect your sleep

Pain that never fully establishes is easier to manage than pain you are chasing.

When to seek urgent medical help

Go to a doctor or emergency department if you have:

- Sudden, severe pain unlike your usual pain
- Pain with fever
- Heavy bleeding that soaks through a pad an hour for more than two hours
- Fainting or feeling like you will faint
- Severe pain with vomiting that will not stop
- Sudden one-sided pain with shoulder tip pain, especially if there is any chance you are pregnant

Endometriosis pain is real, but not all pelvic pain is endometriosis. Do not talk yourself out of getting checked because you have been dismissed before.

Chapter 18: Working with your doctor

I have written eighteen chapters about food, supplements and lifestyle. This one is about the other half of your care, and I want to be straightforward about where I sit.

Nothing in this guide replaces medical treatment. The best outcomes I see are almost always in women who do both — good medical care and good terrain work. The worst outcomes are in women who chose one and rejected the other, in either direction.

An honest look at the medical options

You may have been offered some of these. It helps to know what each one actually does, and what it does not do.

The combined pill and other hormonal contraception

What it does: suppresses ovulation and thins the lining, which reduces bleeding and often reduces pain. It also raises SHBG, which lowers free estrogen.

What it does not do: change the underlying condition. It manages symptoms while you take it.

Honest view: it works for a lot of women, and relief now has real value. But it suppresses your own progesterone, affects gut and liver function, and can mask progress so you cannot tell what is improving. If you are taking it and it is helping, you do not have to stop to start this guide. If you are trying to conceive, it is obviously not an option.

The hormonal IUD (Mirena)

What it does: delivers progestin locally, thinning the lining. Often reduces bleeding and pain substantially with fewer whole-body effects than the pill.

Honest view: one of the better-tolerated options for many women, especially where heavy bleeding is the main problem.

Progestins (dienogest, norethisterone)

What they do: suppress lesion activity directly. Dienogest has good evidence in endometriosis specifically.

Honest view: often effective. Side effects vary a lot between women. Worth noting that the positive curcumin trial in Chapter 14 tested curcumin *alongside* dienogest, not instead of it.

GnRH agonists and antagonists

What they do: put you into a temporary medical menopause.

Honest view: effective for pain, but with significant side effects including bone density loss. Usually reserved for severe cases or short-term use before surgery. If you are offered one, ask about the duration, add-back therapy and bone monitoring.

Excision surgery

What it does: physically removes the disease. Performed by an experienced excision surgeon, it is the most effective single intervention for many women.

Honest view: worth pursuing if your disease is significant. Ablation (burning the surface) is not the same as excision (cutting it out), and the difference in outcomes is meaningful — ask which one your surgeon performs. See Chapter 20 for how to get the most from it.

Pain medication

Taking painkillers is not a failure of this protocol. Pain that is allowed to escalate month after month sensitises your nervous system further, which makes next year worse. Managing pain properly is part of the strategy.

How to be heard at your appointment

Women with endometriosis wait an average of seven to ten years for a diagnosis. Most have been told at some point that their pain is normal, or anxiety, or something they should manage. If that has happened to you, it was not your failure of communication. But there are things that measurably improve how these conversations go.

Before you go:

- **Bring your tracking data.** Three months of daily pain scores, bleeding, painkiller use and days affected is the single most powerful thing you can put in front of a doctor. It converts "it's really bad" into a chart. Chapter 24 shows you what to record.
- **Write down your top three questions** and put them at the top of the page. Appointments are short and it is easy to leave without asking the thing you came for.
- **Quantify the impact.** "I missed four days of work last month and could not stand up on day one" lands differently from "my periods are painful."
- **Bring a written list of everything you take**, including supplements. Give them the list rather than reciting it.
- **Take someone with you** if you can, especially if you have been dismissed before. A second person in the room changes the dynamic more than it should.

Useful things to ask:

- "What do you think is causing this, and what would change your mind?"
- "What are my options, including the ones you are not recommending?"
- "If this treatment does not work, what happens next?"
- "Do you perform excision or ablation?" (if surgery is discussed)
- "Can we check my ferritin, full thyroid panel and vitamin D?"

If you are not being heard:

- Ask for your concern to be recorded in your notes. Say it plainly: "I would like it noted that I raised this." It changes the conversation.
- Ask directly for a referral to a gynaecologist with a specialist interest in endometriosis. Not all gynaecologists have one.
- Get a second opinion. This is normal and reasonable, not rude.
- Endometriosis patient organisations in most countries maintain lists of specialist centres. They are worth finding.

How to talk about the nutrition work

Some doctors will be interested. Some will not. Both are survivable.

What helps: framing it as something you are doing *alongside* their treatment, not instead of it. What does not help: presenting it as a cure, or arriving with a printout arguing against their recommendation.

If your doctor is dismissive of the dietary work, you do not have to convince them. You do have to tell them what you are taking, because some of it interacts with medication and surgery. That is a safety issue, not a debate.

The one thing worth insisting on: if you have significant pain, heavy bleeding, or difficulty conceiving, you deserve proper investigation. Do not let good nutrition become a reason to delay it.

Chapter 19: Endometriosis and trying to conceive

If you are trying to conceive, this chapter changes things. Read it before you start any protocol in this book.

What endometriosis actually does to fertility

Around 30 to 50% of women with endometriosis experience difficulty conceiving. Understanding *why* helps you know where to put your effort.

Inflammation in the pelvic fluid. The fluid around your ovaries and tubes contains raised inflammatory chemicals. This affects egg quality, sperm survival and early embryo development.

Adhesions and mechanical distortion. Scar tissue can block or kink the tubes, or fix an ovary in a position where the tube cannot reach it.

Egg quality. Oxidative stress in the fluid surrounding the developing egg damages the egg's mitochondria. This is the mechanism CoQ10 addresses.

Implantation. Endometriosis is associated with reduced endometrial receptivity — the lining is less able to accept an embryo, partly through progesterone resistance.

Ovulation. Inflammation and stress can disrupt ovulation directly.

Note that most of these are terrain problems, not structural ones. Terrain can change. Structure needs surgery. Knowing which one you are dealing with matters, and it is a conversation to have with a specialist.

What changes in this protocol if you are TTC

> **Move these to the top of your list:**

- **CoQ10 (ubiquinol) 200–400mg** — the most important addition. Eggs take about 90 days to mature, so start at least three months before you want to conceive.
- **Myo-inositol 2–4g** — egg quality, ovulation, progesterone production
- **A methylated prenatal** with active folate, B12 and choline — start now, not when you get a positive test

- **Omega-3** — egg quality and lining
- **Vitamin D** — if low, correcting it improves outcomes

Be cautious with these:

- **DIM** — can suppress estrogen too far, thin the lining and dry up fertile mucus. Use cruciferous vegetables and broccoli sprouts instead.
- **Melatonin** — reduce to 3mg and use in the first half of your cycle only. The 10mg pain dose is not appropriate while trying.
- **Vitex** — only with a documented short luteal phase. Never alongside Clomid or an IVF cycle.
- **Aggressive low-carb or keto** — do not do a ketogenic phase in a cycle you are actively trying in. Your body needs adequate carbohydrate to ovulate well and to make progesterone.
- **Resveratrol** — there is published concern about resveratrol supplementation before IVF and pregnancy outcomes. I do not recommend it for women trying to conceive.
- **Fasting** — skip it while trying.

Stop these on a positive test: DIM, calcium D-glucarate, vitex, quercetin, adaptogens, milk thistle, dandelion root, high-dose NAC, alpha lipoic acid, berberine, high-dose melatonin.

The 90-day window

Both eggs and sperm take about three months to develop. That means:

What you do today affects the egg you release in three months. Not this month's. That one was already committed.

This is genuinely good news. It means a bad month does not undo everything, and it means consistency over three months matters far more than perfection over three weeks.

It also means: **your partner should be doing this too.** Sperm quality is a factor in roughly half of fertility difficulties and it responds to the same things — antioxidants, omega-3, CoQ10, less alcohol, less heat, better sleep. A sperm analysis is cheap, quick and non-invasive. Do it early.

Before you start IVF

If IVF is on the horizon, the three months before your cycle are the highest-value window you will get.

- **Start CoQ10 at least 90 days before egg collection**
- **Correct iron, vitamin D and thyroid before you begin.** Thyroid should ideally be optimised to a TSH under 2.5.

- **Stop blood-thinning supplements 10 to 14 days before egg retrieval, and 7 days before transfer**
- **Tell your clinic everything you are taking.** Some clinics will ask you to stop everything. Ask them which and why, rather than either arguing or silently continuing.

A word about time

Endometriosis and fertility both involve time pressure, and time pressure makes everything harder.

You may not have three months to spare before starting treatment. That is a real constraint and I am not going to pretend otherwise.

If that is you: do Tier 1 supplements plus CoQ10, remove gluten and dairy, sleep, and let the rest go. Partial is not nothing. A woman who does four things consistently for eight weeks does better than one who attempts twenty and abandons them in week three.

Chapter 20: Surgery — before and after

Excision surgery is the gold standard surgical treatment for endometriosis, and for many women it is life-changing. This chapter is not an argument against it. It is about getting the most from it.

Before surgery

Six to eight weeks before:

- Work on inflammation. Going in with lower systemic inflammation improves how you heal.
- Optimise protein intake — you cannot repair tissue without it. Aim for a palm-sized serve at every meal.
- Correct iron if it is low. Surgery plus existing anaemia is a hard combination.
- Get vitamin D into range. It affects wound healing.
- Fix your bowels. Post-surgical constipation on top of pelvic pain is miserable.

Ten to fourteen days before:

- Stop omega-3, curcumin, vitamin E, quercetin, high-dose ginger, and any enzyme supplements.
- Give your surgical team a written list of everything you take, including supplements.

The week before:

- Prepare food and freeze it. You will not want to cook.

- Set up your recovery space: heat pack, pillows, easy food, a way to get comfortable sitting up.
- Arrange help for at least the first week, more if you can.

After surgery

The first two weeks:

- Protein at every meal. This is the priority.
- Wait for your surgeon's clearance before restarting blood-thinning supplements — usually one to two weeks, longer if there was bowel involvement.
- Magnesium and adequate water for bowel movements. Anaesthetic and painkillers both cause constipation.
- Gentle walking as soon as you are allowed. Movement reduces adhesion formation.
- Sleep. Actual sleep. This is when repair happens.

Weeks two to twelve — the window that matters most:

This is the part almost nobody tells you. **Adhesions form in the weeks and months after surgery.** The surgeon removed the disease; what happens next determines partly whether it comes back as scar tissue.

- Restart your anti-inflammatory protocol once cleared
- Consider **pelvic floor physiotherapy**, and consider it seriously. Years of guarding against pain leave those muscles dysfunctional, and surgery does not fix that. This is one of the most underused interventions in endometriosis care.
- Gentle scar massage once healed, as advised by your physiotherapist
- Keep moving. Adhesions form in tissue that stays still.
- Keep going with the terrain work. Surgery removed the mould. It did not fix the damp.

A realistic expectation: surgery gives you a window. What you do in that window influences how long it stays open. Women who use the post-surgical period to change the terrain tend to hold their results longer than women who assume the operation was the whole answer.

If pain continues after surgery

This happens, and it does not mean the surgery failed or that you imagined the pain.

Common reasons:

- **Central sensitisation.** The nervous system alarm was never turned down. See Chapter 2 and Chapter 21.
- **Pelvic floor dysfunction.** Muscular, not lesional. Very treatable with physiotherapy.

- **Adhesions** forming post-operatively.
- **Bladder or bowel conditions** existing alongside the endometriosis.
- **Ongoing inflammatory terrain.**

Nervous system work, pelvic floor physiotherapy and terrain work are where the answers usually are. Do not accept "the surgery was successful so this must be in your head."

Chapter 21: Lifestyle — the parts that are free

You can take every supplement in this book and eat perfectly, and still stay stuck if your daily life keeps sending your body threat signals.

Support your exits

Liver

- Lemon water on waking
- Castor oil packs over the liver or lower abdomen, three times a week — **not while bleeding**
- Bitter foods daily: beetroot, rocket, dandelion greens, radicchio, artichoke
- Reduce alcohol. This is the biggest single liver lever most women have.

Gut

- **Open your bowels daily. No exceptions.** Estrogen leaves in stool.
- One tablespoon of ground flaxseed daily
- Plenty of cooked vegetables and fibre
- Avoid relying on laxatives — they damage the gut lining over time

Lymph

- Rebounding on a mini trampoline, three to five minutes daily
- Dry brushing before you shower, always toward the heart
- 2 to 2.5 litres of water daily, with a pinch of good salt or trace minerals
- Legs up the wall for ten minutes

Nervous system: the biggest free lever you have

If your body does not feel safe, it will not digest, detoxify or ovulate properly. Chronic pain wires your nervous system into a stress loop. Breaking that loop takes daily, deliberate practice.

Things that genuinely work:

- **Extended exhale breathing.** In for four, out for six or eight. Three to five minutes a day. The exhale is the part that does the work.
- **Grounding.** Walk barefoot outside. No phone. Feet on earth, ten minutes.
- **Somatic release.** Gentle shaking, tapping, or slow stretching, especially before bed.
- **Vagus nerve stimulation.** Humming, singing, gargling, splashing cold water on your face.
- **Evening downshift.** No screens for an hour before bed. Dim light or candlelight.

Match the practice to your phase: breathwork and journaling in the luteal phase, guided meditation and rest during bleeding.

Reduce your toxin load — the swaps worth making

You cannot avoid everything. Do the high-return ones and stop worrying about the rest.

28. **Never heat food in plastic.** Glass or ceramic. This is the single biggest one.
29. **Use a glass or steel water bottle.**
30. **Change your deodorant, and whatever you use most on your skin.** Skin is an absorptive organ and you use these daily.
31. **Ventilate your home.** Open windows daily. Indoor air is usually worse than outdoor.
32. **Buy organic for the highest-pesticide produce** — berries, spinach, apples, grapes. Do not stress about avocados and onions.
33. **Decline paper receipts** where you can. Thermal paper is coated in BPA.
34. **Filter your drinking water** if you can afford to.

Movement that helps rather than harms

Forget no pain, no gain. You need movement that drains lymph, lowers cortisol, improves circulation and builds strength without adding stress.

Good:

- Walking daily, especially after meals
- Rebounding, five minutes a day
- Pilates, resistance bands or strength training, two to three times a week
- Gentle yoga or stretching, especially while bleeding and in the luteal phase

Avoid:

- Long high-intensity sessions in your luteal or menstrual phase

- Chronic cardio
- Training hard while under-eating or under-sleeping

A note on strength training. Many women with endometriosis avoid it out of fear of flaring. Done sensibly, resistance training improves insulin sensitivity, which raises SHBG, which lowers free estrogen. It is one of the more useful things you can do. Start light and build.

Sleep

Sleep is where repair happens, where hormones are regulated, and where your nervous system resets.

- Same bedtime and wake time, as much as you can manage
- Dark room, no screens for an hour beforehand
- Magnesium glycinate at night
- Get daylight into your eyes in the morning — it sets the rhythm that produces melatonin at night
- Keep the room cool

If you sleep badly, fix that before you add another supplement. It will do more.

Part Five: Putting It Together

Chapter 22: When to expect improvements

This is the chapter I wish someone had given me to hand to every woman I have worked with.

Almost everyone who gives up does so in weeks three to six. Not because it was not working — but because they expected results faster than biology can deliver, concluded it had failed, and stopped just before things changed.

So here is a realistic timeline. Print it. Stick it somewhere you will see it.

What to expect, and when

Weeks 1 to 2 — Often worse before better

Some women feel great immediately. Many do not. In the first two weeks you may notice:

- Headaches, fatigue, irritability (usually caffeine, sugar or gluten withdrawal — it passes)
- Changes in bowel habits as fibre and fat intake shift
- Feeling deprived, frustrated and slightly obsessed with food
- No change in pain at all

None of this means it is not working. This phase is about consistency, not results. If you can hold on to week three, the picture usually changes.

Weeks 2 to 4 — The first real signals

The earliest wins are almost never pain. They are:

- Bloating settling, particularly after meals
- More stable energy across the day
- Better sleep, or fewer 3am wake-ups
- Clearer thinking, less brain fog
- More regular bowel movements
- Fewer blood sugar crashes and less desperate hunger

These are the improvements people dismiss because they were hoping for pain relief. Do not dismiss them. They are the terrain changing, and pain relief comes from the terrain changing.

Weeks 4 to 8 — Your first meaningful cycle

Your first full cycle on the protocol is your first real data point.

Common improvements by now:

- Less premenstrual breast tenderness
- Less severe mood swings before your period

- Somewhat lighter bleeding, or fewer clots
- Period pain that starts later, or is less intense on day one
- Spotting before your period reducing

Be careful here. One cycle is not a trend. Cycles vary. Judge the direction after two.

Weeks 8 to 12 — Where pain usually starts to shift

This is the window most women report as the turning point.

- Noticeably less period pain, or fewer days of it
- Less pain between periods
- Less pain during or after sex
- Less bowel and bladder pain
- Reduced need for painkillers
- Bloating markedly better

If you are going to see change from inflammation and estrogen work, this is generally when it becomes undeniable.

Months 3 to 6 — Consolidation

- Cycles becoming more predictable
- Fewer bad days between periods
- Better recovery after a flare — the flares that do come are shorter
- Energy that holds through the luteal phase
- If trying to conceive, this is when egg quality work starts to show

Months 6 to 12 — The deeper changes

- More durable remission of symptoms
- More resilience — a bad week does not undo a month
- Tissue-level change, where it is going to happen, happens over this timescale
- Many women find they can widen their diet again by this point

Two things that need saying

First: healing is not a straight line.

You will have a brilliant month and then a bad one. That does not mean you have gone backwards. Cycles vary, life happens, stress happens, illness happens. Judge yourself over three months, not three days.

Second: pain is a lagging indicator.

Pain is usually the last thing to improve because it involves nerves that took years to become sensitised, and nerves are slow to change. Bloating, energy, sleep and mood improve first because they are faster systems.

If you are only tracking pain, you will conclude nothing is working while four other things are already better. Track everything.

When to conclude something is not working

Give it twelve weeks of honest, consistent effort before you change course.

If at twelve weeks nothing at all has moved — not pain, not bloating, not energy, not sleep, not mood — then the answer is not more supplements. The answer is testing. Go to Chapter 24.

Common reasons a good protocol does not work:

- **Undiagnosed gut infection or significant dysbiosis** — you are clearing estrogen and your gut is sending it straight back
- **Untreated thyroid dysfunction** — everything runs slow, including detox
- **Iron deficiency** — no energy for repair
- **A nervous system that has never come out of alarm** — this is the most common one
- **Not actually doing it consistently** — said with no judgement. Life is hard. But three days a week is not a trial.
- **The wrong food triggers** — you removed gluten and dairy and the real problem was eggs

Chapter 23: Your first twelve weeks

Here is the whole thing, staged.

Before you begin: the three non-negotiables

If you do nothing else, do these. They are free and they underpin everything.

> **1. Open your bowels every day.**

Estrogen leaves in your stool. Flaxseed, magnesium, cruciferous vegetables, water, enough fat.

> **2. Steady your blood sugar.**

Protein, fat and fibre at every meal. No naked carbohydrate. Do not skip meals.

> **3. Create nervous system safety.**

Five minutes of extended-exhale breathing daily. Screens off an hour before bed. This lowers cortisol, improves detox and supports ovulation.

Weeks 1 and 2 — Foundation

- Remove gluten and dairy. Together. Whole foods, not substitute products.
- Reduce added sugar and ultra-processed food.
- Start protein, fat and fibre at breakfast.
- Add **magnesium glycinate** at night.
- Five minutes of breathwork daily.
- Start your tracker (Chapter 24).

That is it for two weeks. Do not add anything else.

Weeks 3 and 4 — Anti-inflammatory layer

- Add **omega-3** and **curcumin phytosome**.
- Add one tablespoon of ground flaxseed daily.
- Add cruciferous vegetables daily. Broccoli sprouts two to three times a week if you can get them.
- Start walking after meals.

Weeks 5 and 6 — Detox layer

- Add **NAC**.
- Start a six-week course of **milk thistle and dandelion root**.
- Castor oil packs three times a week, not while bleeding.
- Dry brushing before showering.
- Do a bathroom swap: deodorant, then your most-used skincare product.

Weeks 7 and 8 — Estrogen clearance

- Add **taurine** and **glycine** (or bone broth daily).
- Add a **probiotic containing* L. gasseri***.
- Review with your tracker: what has changed?

Weeks 9 to 12 — Personalise

Now use your tracker to choose:

- **Pain still dominant?** → Add melatonin, consider PEA, and give the nervous system chapter serious attention
- **Flushing, itching, food reactions?** → Add quercetin, trial low-histamine for four weeks
- **Trying to conceive?** → CoQ10 and myo-inositol should already be in from week one

- **Strong estrogen dominance signs?** → Consider a DUTCH test before adding calcium D-glucarate or DIM
- **Exhausted?** → Test iron, vitamin D and thyroid before reaching for adaptogens
- **Short luteal phase or spotting?** → B6, and consider vitex

At week 12: stop milk thistle and dandelion root. They were a course, not a lifestyle.

Month 4 — Reintroduce and reassess

- Reintroduce dairy properly, using the method in Chapter 10. Then, separately, gluten.
- Review three months of tracking. What actually changed?
- Consider testing if progress has stalled.
- If you have been on everything for three months, take a break from at least some of it.

Months 4 to 6 — Refine

- Test any remaining suspect foods, one at a time
- Add cycle-synced eating if the basics feel automatic
- Add strength training two to three times a week
- Reduce your supplement load to what is actually earning its place

Chapter 24: What to track

You cannot tell what is working if you are not measuring. But most tracking is either too complicated to sustain or too vague to be useful.

Here is the minimum that tells you something real. Two minutes a day.

Daily, out of ten

- Pelvic pain (0 = none, 10 = worst)
- Bloating
- Energy
- Mood

Daily, yes or no

- Bowel movement? How many?
- Slept well?
- Any new symptom?

Each cycle

- Cycle length
- Days of bleeding
- Heaviness (light, moderate, heavy, flooding)
- Clots (yes or no, and size)
- Days of pain, and worst pain score
- Painkillers taken — how many, which days
- Spotting before the period? How many days?
- Luteal phase length (ovulation to the day before your period)
- Fertile mucus present? What quality?
- Pain with sex?

Every month, in your own words

Write three sentences on what is better than last month. Even if it is small.

This is the part that keeps people going. Memory is unreliable and pain is loud. Written evidence of improvement is what gets you through a bad week.

Reviewing it

Look back at week 4, week 8 and week 12. Compare month to month, never day to day. You are looking for direction, not perfection.

Chapter 25: Testing and deeper work

You do not need any testing to start. Everything in the first twelve weeks is safe and useful without it.

But if you are twelve weeks in and stuck, testing stops guessing.

Worth doing early, and usually available through your GP

- **Full iron panel** — ferritin, iron studies, and CRP alongside (inflammation raises ferritin falsely)
- **Full thyroid panel** — TSH, free T4, free T3, and thyroid antibodies. Not just TSH.
- **Vitamin D** (25-OH)
- **Vitamin B12 and folate**
- **HbA1c and fasting insulin** — insulin resistance directly lowers SHBG
- **Full blood count**

Functional tests, if you can access them

DUTCH test — measures estrogen *metabolites*, not just estrogen levels, plus your cortisol pattern across the day. This is the test that tells you whether estrogen dominance is really your problem and, if so, which kind. It is the one I would prioritise.

GI-MAP or comprehensive stool test — gut bacteria, beta-glucuronidase activity, inflammatory markers, and any infections. Do this if you have significant digestive symptoms or if progress has stalled.

Organic acids test — mitochondrial function, nutrient status, gut markers.

What testing does not do

It does not replace the basics. I have seen women spend a great deal of money on testing while still not sleeping, still eating gluten, and still going three days without a bowel movement.

Test when you are stuck, not when you are starting.

Chapter 26: A seven-day meal plan

Gluten free and dairy free throughout. Every meal has protein, fat and fibre. Swap anything you do not like or cannot get — this is a template, not a prescription.

Day 1 — Follicular phase start

Breakfast: Zucchini and spinach cooked in ghee or olive oil, two poached eggs, half an avocado, lemon and sea salt.

Lunch: Grilled salmon with rocket, beetroot, pumpkin seeds and dill, dressed with olive oil.

Snack: Small handful of walnuts, green tea with lemon.

Dinner: Turmeric and coconut chicken soup with bok choy, mushrooms and cauliflower rice.

Day 2 — Follicular

Breakfast: Chia pudding with coconut milk, cinnamon, blueberries and a scoop of collagen.

Lunch: Leftover soup, cucumber and hummus.

Snack: Hard-boiled egg with sea salt and olive oil.

Dinner: Zucchini noodles with grass-fed beef mince in tomato and basil sauce, rocket on the side.

Day 3 — Approaching ovulation

Breakfast: Green smoothie — spinach, cucumber, parsley, lemon, avocado, hemp seeds, protein powder.

Lunch: Grilled chicken, roasted sweet potato, kale with lemon dressing. *(Carbohydrate comes back in here.)*

Snack: Carrot sticks with guacamole.

Dinner: Baked cod, roasted cauliflower, sautéed rainbow chard.

Day 4 — Early luteal

Breakfast: Scrambled eggs with kale, mushrooms and ghee.

Lunch: Leftover cod and vegetables with tahini and lemon sauce.

Snack: Pumpkin seeds and ginger tea.

Dinner: Lamb and root vegetable stew — parsnip, carrot, celery, thyme.

Day 5 — Mid luteal

Breakfast: Coconut yoghurt with chia, kiwi and cinnamon.

Lunch: Tuna salad with olives, greens, cucumber and olive oil, plus sweet potato wedges.

Snack: Turkey and avocado roll-up.

Dinner: Chicken fajita bowl — grilled chicken, capsicum and onion, avocado, cauliflower rice.

Day 6 — Late luteal

Breakfast: Bone broth with MCT oil, a boiled egg, steamed spinach.

Lunch: Beef and pumpkin patties with sauerkraut and salad with tahini dressing.

Snack: Sunflower seeds and a square of 70% dark chocolate.

Dinner: Slow-cooked turkey meatballs in tomato and rosemary sauce with quinoa.

Day 7 — Menstruation begins

Breakfast: Certified gluten-free steel-cut oats *(see note below)* with stewed apple, cinnamon, flaxseed and almond butter.

Lunch: Butternut squash soup with chicken and turmeric, spinach salad with olive oil.

Snack: Golden milk — turmeric and coconut milk.

Dinner: Beef liver pâté on seed crackers, sautéed kale, roasted carrots.

Making it work

- **A note on oats.** Oats do not contain gluten, but almost all standard oats are processed alongside wheat and carry enough cross-contamination to undo a gluten trial. During your first three months, use oats labelled certified gluten-free, or skip them and use quinoa flakes or buckwheat instead. A small number of people also react to avenin, the protein in oats itself.

- Cook once, eat twice. Every dinner above makes tomorrow's lunch.
- If digestion slows in your luteal or menstrual phase, lean into soups and stews.
- Reheat leftovers with olive oil or broth rather than dry.
- You do not need to follow this exactly. You need protein, fat and fibre at every meal.

Chapter 27: Optional — tracking your nutrients

For some women, seeing their actual nutrient intake is empowering. For others it becomes another source of anxiety.

If you are the first kind, **Cronometer** tracks micronutrients as well as calories — vitamins, minerals, fatty acid ratios, amino acids, fibre and protein quality. It is useful for spotting a genuine gap in magnesium, zinc, B6 or omega-3.

> **How to use it well:**

- Track for a few days, learn something, then stop. It is a diagnostic tool, not a way of life.
- Do not log exercise. It inflates your targets.
- Look at micronutrients, not calories.

Skip this entirely if you have any history of disordered eating, or if tracking makes you anxious. In that case, focus on food quality and how your body feels. You do not need data to heal.

Glossary

Terms you will meet in this book and in your appointments, in plain language.

Adhesion — Scar tissue that sticks organs together that should move freely.

Adenomyosis — A related condition where endometrial-like tissue grows into the muscle wall of the uterus itself. Often occurs alongside endometriosis and causes heavy bleeding and a bulky, tender uterus. Ask about it if heavy bleeding is your main symptom.

Ablation — A surgical technique that burns the surface of endometriosis lesions. Different from excision, and generally less effective.

Beta-glucuronidase — A gut enzyme that unwraps estrogen your liver has already packaged for removal, releasing it back into your bloodstream.

Central sensitisation — A physical change in the nervous system where the pain alarm becomes oversensitive and fires at things that should not hurt. Explains pain that continues after successful surgery.

Cytokines — Signalling chemicals your immune system uses. Some drive inflammation.

Dysmenorrhoea — Period pain.

Dyspareunia — Pain during or after sex.

Endometrioma — A cyst on the ovary filled with old blood. Sometimes called a chocolate cyst.

Estrobolome — The collection of gut bacteria that influence how estrogen is processed and removed from your body.

Excision — Surgery that cuts endometriosis out at the root, rather than burning the surface. Generally the more effective approach.

Fascia — Connective tissue that wraps and links all your organs and muscles. When one area inflames, fascia tightens and pulls, referring pain elsewhere.

Follicular phase — The first half of your cycle, from the start of bleeding until ovulation.

Ferritin — A blood marker of your stored iron. Can read falsely high when inflammation is present, which is why CRP is measured alongside it.

IGF-1 — A growth signalling hormone. Raised by dairy, among other things.

Luteal phase — The second half of your cycle, from ovulation until your period starts.

Mast cells — Immune cells that release histamine. Activated by estrogen, which is why some women with endometriosis have histamine symptoms.

Metabolite — What a substance is broken down into. Estrogen metabolites can be protective or harmful depending on which pathway your liver uses.

Phase one and phase two liver detox — The two stages your liver uses to break down and package hormones and toxins. Phase one converts them, phase two makes them safe to remove.

Progestin — A synthetic form of progesterone used in medication. Not the same as the progesterone your body makes.

Prostaglandins — Inflammatory chemicals that cause uterine cramping. The main target of both anti-inflammatory medication and omega-3.

Retrograde menstruation — Period blood flowing backwards through the tubes. Happens in most women. Does not by itself explain endometriosis.

SHBG (sex hormone binding globulin) — A protein made by your liver that binds excess hormones so they cannot act on your tissues. Falls when insulin is high.

Sulforaphane — A compound in cruciferous vegetables, most concentrated in broccoli sprouts, that activates phase two liver detox.

Final Words

You are not broken. You are not weak. You are not too far gone.

Your body is not attacking you. It has been overwhelmed, undernourished and misunderstood for a long time — often by the very system that was meant to help you.

What I have given you here is not a cure. I am not going to promise you one, and you should be sceptical of anyone who does. What I have given you is a way to change the conditions your body is working in. Lower the inflammation. Clear the estrogen. Feed the terrain. Let the nervous system stand down.

Some women find their symptoms largely disappear. Many find them significantly better. A few find that this work makes surgery or medication far more effective than it would have been alone. All of those are good outcomes.

Please go gently. Do not try to do all of this at once. Pick the three things in Chapter 22 and start there. Add the next layer when the first feels normal.

And on the days when it feels like nothing is changing, go back and read what you wrote in your tracker four weeks ago. That is the evidence. Not how you feel today.

You have already started.

Sending you much healing and love,

> **Carmen**

Keep going with support

If you would like company for this work, I run **The Fertility Circle** — a warm, science-backed, cycle-synced membership where I answer questions each week, run live group sessions, and help you adapt this work to your real life.

Doing this alone is harder than it needs to be. I would love to support you inside the Circle.

carmenmair.com

Quick Reference

The three non-negotiables

35. Open your bowels every day
36. Protein, fat and fibre at every meal
37. Five minutes of extended-exhale breathing daily

Tier 1 supplements

Magnesium glycinate · Omega-3 · Curcumin phytosome · NAC · Ground flaxseed

Stop before surgery — 10 to 14 days

Omega-3 · Curcumin · Vitamin E · Quercetin · High-dose ginger · Enzymes

Stop on a positive pregnancy test

DIM · Calcium D-glucarate · Vitex · Quercetin · Adaptogens · Milk thistle · Dandelion root · High-dose melatonin · Berberine · Alpha lipoic acid · High-dose NAC

Trying to conceive — start these 90 days ahead

CoQ10 (ubiquinol) · Myo-inositol · Methylated prenatal · Omega-3

When to expect what

Timeframe	What usually shifts
Weeks 1–2	Often nothing, or temporarily worse
Weeks 2–4	Bloating, energy, sleep, digestion, brain fog
Weeks 4–8	First cycle changes — PMS, breast tenderness, bleeding
Weeks 8–12	Pain begins to shift
Months 3–6	Cycles stabilise, flares get shorter
Months 6–12	Deeper, more durable change

Get urgent help if

Sudden severe pain unlike your usual · Pain with fever · Soaking a pad an hour for over two hours · Fainting · Severe pain with persistent vomiting · Sudden one-sided pain with shoulder tip pain

Medical Disclaimer

The information provided by Carmen Mair is for educational purposes only and is not a substitute for professional medical advice, diagnosis, or treatment. Always consult your physician or a qualified healthcare provider before making changes to your diet, lifestyle, or health regimen, especially if you have a medical condition, are pregnant, breastfeeding, or taking medications. Carmen Mair is not a licensed medical professional, and her services do not replace medical care. Individual results may vary, and you are responsible for your health decisions. Discontinue use and seek medical attention if you experience adverse effects.