## DYSMENORRHEA

### DEFINITION
Dysmenorrhea means painful menses. It is usually characterized by cramping, abdomino-pelvic and/or back pain. Dysmenorrhea may be accompanied by other problems, such as severe headaches, nausea, vomiting or diarrhea just before and/or during menses. Primary dysmenorrhea is generally due to prostaglandin imbalances and symptoms generally start with onset of ovulatory cycles. Secondary dysmenorrhea is due to some other cause (such as endometriosis) and onset of symptoms is generally later in life.

### SUBJECTIVE
Must include: Complaints of cramping lower abdominal pain that occurs only during menstruation or is significantly worse during menses.

May include:
1. Complaints of other symptoms that occur only with menses or are significantly worsened during menses, such as nausea, vomiting, severe headaches, dysuria, dyschezia (pain on defecation).
2. History of pelvic abnormality (uterine malformation, cervical stenosis), other pathology (endometriosis, adenomyosis, infection) or prior abdominopelvic surgery.

Must exclude: New finding of pelvic pathology not previously assessed.

### LABORATORY
None required.

### ASSESSMENT
Dysmenorrhea, primary or secondary.

### PLAN
1. If etiology of secondary dysmenorrhea is identified, treatment of that problem may reduce woman’s symptoms. Those therapies may be supplemented with any of the options outlined in following section.
2. Treatment of dysmenorrhea may be based on control of prostaglandin release or of menses.
   a. Nonsteroidal anti-inflammatory medications* are effective treatments for both primary and secondary dysmenorrhea. There are few differences seen in the effectiveness or side effects of the different formulations of NSAIDs, however, adequate dosing is necessary. Typical treatments include one of the following:
      1) Ibuprofen* 200 mg 1-2 tablets orally every 6-8 hours, PRN pain (available OTC).
      2) Naproxen sodium* 275 mg 1 tab orally every 6-12 hours, PRN pain (available OTC).
      3) Mefenamic acid (Ponstel)* 500 mg initial dose then 250 mg 1 tab orally every 6 hours.
      * **Contraindicated in patients with history of ulcers, significant asthma or hepatic or renal failure.**
   b. Combined hormonal contraceptives have been given cyclically for years to reduce dysmenorrhea. Studies using 24/4 or shorter placebo intervals have shown good efficacy. Consider using extended cycle combination hormonal contraceptive (oral contraceptives or vaginal rings) to inhibit ovulation and to reduce or eliminate menstrual flow if patient has no US MEC category 3 or 4 conditions for the desired method.
   c. DMPA and the LNG-IUS 52 mg are more likely to eliminate menses and menstrual pain with longer duration of use. If the patient has copper IUD-related dysmenorrhea, rule out ongoing expulsions and consider changing to LNG-IUS.

### PATIENT EDUCATION
1. Exercise, especially aerobic exercise, may be helpful in alleviating discomfort.
2. Advise patient of the possible adverse side effects of NSAIDs, including gastrointestinal bleeding, indigestion, headaches and diarrhea.
3. Discuss some other treatments that have been found to be effective at times, including:
   a. Heat or cold packs to abdomen.
   b. Orgasm.
   c. Meditation.
   d. Massage or effleurage.
PATIENT EDUCATION (Continued)

e. Biofeedback.
f. Hypnotherapy.
g. Acupuncture.
h. Transcutaneous electric nerve stimulator.
i. Herbal and dietary therapy with magnesium and vitamin B1 may be helpful, but the dose and regimens have not yet been defined.

Advise patients that other treatments, such as spinal manipulation, have been shown to be ineffective.

REFER to MD/ER

1. Patients with abnormal findings on pelvic exam.
2. Patients with involuntary infertility.
3. Patients with dysmenorrhea not resolved by above treatments.
4. Patients with US MEC category 3 conditions requiring MD consult for desired method.
5. Patients who are not candidates for any of these therapies.

REFERENCES