Dysmenorrhea

DEFINITION	Dysmenorrhea is painful menses, usually characterized by a cramping, and lower abdominal pain. It is further classified as primary or secondary. Primary dysmenorrhea is usually early onset and a result of excessive amounts of prostaglandins released in the endometrium which in turn causes ischemia and cramping. Secondary dysmenorrhea is caused by uterine or pelvic pathology such as endometriosis, pelvic infections, adhesions, cervical stenosis, adenomyosis, fibroids, or neoplasia. It may begin a few days before menses and get worse over time.
SUBJECTIVE	May include: 1. Complaints of lower abdominal cramping pain that only occurs during or is significantly worse during menses. 2. Nausea, vomiting, headache, lightheadedness, low back pain, dysuria, altered bowel habits, bloating, malaise, fatigue, tachycardia, and/or sweating 3. LMP and/or description of bleeding patterns 4. Medical, sexual, contraceptive use history, as appropriate 5. History of pelvic abnormalities, pathology, or surgery Should exclude: 1. A new finding of pelvic pathology not previously assessed.
OBJECTIVE	May include: 1. Physical and/or pelvic exam
LABORATORY	May include: 1. Vaginitis/cervicitis, STI testing as indicated 2. Hgb 3. Pap smear
ASSESSMENT	Dysmenorrhea, primary or secondary
PLAN	Treatment options may include one or more of the following: 1. Provide nonsteroidal anti-inflammatory medications such as: a. Ibuprofen OTC 200-400 mg PO q4-6 hours not to exceed 1200 mg/24 hours unless directed by provider OR prescription 400-800mg PO q6 hours not to exceed 3200mg/24 hour b. Naproxen Sodium OTC 220-440 PO initially; followed by 220 PO q12 hours OR prescription 500mg PO initially, then 250mg PO q6-8 hours not to exceed 1250mg/day on first day, subsequent doses should not exceed 1000mg/day c. Ketoprofen immediate-release 25- 50 mg q6-8 hrs. d. Mefenamic Acid 500mg PO initially followed by 250mg PO q 6 hrs. usually not to exceed 3 days. e. Meclofenamate 100mg PO TID for up to 6 days; initiate at the onset of menstrual flow f. Diclofenac immediate-release 100mg PO once then 50mg PO q8 hours prn Above therapies, unless otherwise indicated, are most effective if a loading dose is given 1-2 days before onset of menses or first sign of bleeding, and then on a regular schedule for 2-3 days. Advise patient of possible adverse GI symptoms with NSAIDS (GI bleed, indigestion, h/and diarrhea.) Contraindicated in clients with history of ulcers, significant asthma, or hepatic renal failure. 2. Hormonal contraceptive options, including extended OC or vaginal ring use, injectable medroxyprogesterone acetate, to inhibit ovulation and reduce menstrual flow. (Refer to chosen hormonal method protocol.) 3. Dysmenorrhea generally improves with the Levonorgestrel Intrauterine System. (Refer to protocol.)

CLIENT EDUCATION	1. Provide client education regarding causes and palliative treatments (i.e., heat therapy, TENS, exercise, especially aerobic) 2. Encourage nicotine cessation 3. Recommend client RTC annually and PRN for problems
CONSULT/ REFER TO PHYSICIAN	1. Clients with dysmenorrhea not resolved by above treatments

References:

1. Hatcher RA, Nelson, A, Trussell J, Cwiak, C, Cason, P, Policar, M, Edelman, A, Aiken, A, Marrazzo, J, Kowal, D. Contraceptive Technology. 21st edition. Atlanta GA: Ardent Media, Inc., 2018. Pp. 41-45, 272-273.
2. ACOG Committee Opinion 760: Dysmenorrhea and Endometriosis in the Adolescent. (November 2018). Search Results | ACOG
3. Dysmenorrhea: Practice Essentials, Background, Pathophysiology (medscape.com) Medscape, Dysmenorrhea K. Atom Calis, PharmD MPH, FASHP, Updated 9/23/2019