Dysmenorrhea – GYN 3

DEFINITION

Dysmenorrhea is painful menses, usually characterized by cramping and lower abdominal pain; pain may radiate to the back and thighs and occurs during or before menses and is most severe on the first day and usually lasts two to three days. It is further classified as primary or secondary. Primary dysmenorrhea is usually early onset, rarely begins after age 20, and results from 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, ovarian cysts/tumors, adenomyosis, fibroids, uterine polyps, bicornuate or subseptate uterus, or neoplasia.

SUBJECTIVE

May include:

1. Primary: Complaints of lower abdominal cramping pain described as colicky or spasmodic may radiate to the lower back and thighs, begins shortly before the onset of menses, and usually lasts no longer than 2 days. Risk factors for primary dysmenorrhea: menarche prior to age 12, nulliparity, heavy menstrual flow, smoking, obesity, family history
2. Secondary: Complaints of pain anytime during the menstrual cycle that is typically resistant to OTC analgesics
3. Risk factors that are typically associated with more severe bouts of dysmenorrhea include: early menarche, long menstrual cycles, heavy flow, smoking, and family history
4. Pain is associated with decreased quality of life; the patient report of disruption in the ability to complete ADLs or interference with school or work
5. Nausea, vomiting, headache, lightheadedness, low back pain, dysuria, altered bowel habits, bloating, malaise, fatigue, tachycardia and/or sweating
6. LMP and/or description of bleeding patterns; may report a change in duration and amount of menstrual flow
7. Medical, sexual, and contraceptive use history, as appropriate
8. 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; as indicated and age-appropriate

LABORATORY

May include:

1. Vaginitis/cervicitis, STI testing as indicated
2. Hgb, as indicated by the patient's report of blood loss and physical exam findings
3. Pap smear
4. Urinalysis

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/day unless directed by provider

OR prescription 400-800mg PO q6 hours not to exceed 3200mg/day
   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 the 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

Unless otherwise indicated, the above therapies 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, and diarrhea.) Contraindicated in clients with a history of ulcers, significant asthma or hepatic renal failure.

2. Combined hormonal contraceptive options, consider extended or continuous dosing regimens; CHC method of action to reduce prostaglandin and menstrual flow
3. Some progestin-only contraceptives may relieve symptoms by decreasing or eliminating menstrual bleeding; injectable medroxyprogesterone acetate, progestin-implant, and LNG-IUC (Refer to chosen hormonal method protocol.)
4. Dysmenorrhea generally improves with the Levonorgestrel Intrauterine System. (Refer to protocol.)
5. Self-help measures include regular exercise, warm heat compress, relaxation exercises, stress-reduction measures, smoking cessation (if applicable), and massage therapy.

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 the above treatments
2. Consider referral for diagnostic testing to evaluate pathologic cause for secondary dysmenorrhea; vaginal ultrasound and hysterosalpingogram, laparoscopy and lower GI evaluation

REFERENCES

1. Cason, P., Hatcher, R. A., Cwaik, C., Edelman, A., Kowal, D., Marrazzo, J. M., Nelson, A. L., & Policar, M. S. (2025). Reproductive Tract Infections (22nd ed.), *Contraceptive Technology* (pp. 62-65). Jones & Bartlett Learning
2. ACOG Committee Opinion 760: Dysmenorrhea and Endometriosis in the Adolescent. (November 2018)
3. Medscape: Dysmenorrhea
4. Kelsey, B. & Nagtalon-Ramos, J. (2021). *Midwifery & women's health nurse practitioner certification review guide*. Jones & Bartlett Learning