

Dysmenorrhea & Endometriosis

Dysmenorrhea

Dysmenorrhea (painful menstrual cramping) is extremely common, particularly in adolescent women. This disorder may present primarily as painful menses in women with normal pelvic anatomy (primary), or secondarily to specific organ pathology. The relationship between dysmenorrhea and endometriosis has not been clearly established (French, 2005).

Common causes (National Library of Medicine, 2005a) of dysmenorrhea include:

- Premenstrual syndrome
- Stress and anxiety
- Some sexually transmitted diseases, such as chlamydia and gonorrhea
- Fibroids or ovarian cysts
- Intrauterine devices
- Pelvic inflammatory disease

Endometriosis

Endometriosis is a relatively common gynecologic disorder, characterized by the presence of endometrial glands and stroma outside the uterine cavity and uterine musculature (National Library of Medicine, 2005b). The lesions associated with endometriosis occur most commonly in the dependent areas of the pelvis, including ovaries, bowel, rectum, and bladder (Olive & Schwartz, 1993). The disorder often may cause pain, bleeding, and/or infertility. Very little is known about the etiology of endometriosis.

Clinical Presentation and Diagnosis

Endometriosis is associated with a wide variety of symptoms, but often patients remain asymptomatic. Symptoms, when present, include painful menstruation, pain with bowel movements, premenstrual spotting, backaches, dyspareunia, and worsening primary dysmenorrhea. Atypical locations for endometrium growth may cause symptoms such as pleuritic chest pain, pleural effusion, pneumothorax, or cyclic hemoptysis. Physical findings specific to endometriosis are rare. Tender nodules may be revealed during pelvic examination, particularly on the posterior vaginal wall, adnexa, or in healed scars (National Library of Medicine, 2005b).

Definitive diagnosis may be made by laparoscopy. Other useful diagnostic tools include magnetic resonance imaging, pelvic ultrasonography, and measurement of serum proteins such as placental protein 14 (Olive & Schwartz, 1993).

Treatment

Current medical treatment strategies focus on hormonal regulation of the patient's menstrual cycle. Severity of symptoms, including pain, extent of the disease, and the patient's desire for future childbearing should be considered before initiating a treatment plan (National Library of Medicine, 2005b). Pain management may be achieved through the use of nonsteroidal anti-inflammatory drugs. Most other symptoms can be relieved through the inducement of pseudopregnancy via oral contraceptives containing estrogen and progesterone. Danazol treatment may be superior to the pseudopregnancy-inducing drug regimens, though it has many androgenic (and often irreversible) side effects (Olive & Schwartz, 1993).

The efficacy of a variety of surgical techniques, ranging from conservative laparoscopic endometrial ablation to hysterectomy, has not been established. Studies assessing symptom reduction and treatment of infertility have produced conflicting results. Advanced reproductive techniques may increase fecundity in patients, depending on the severity and/or progression of the disorder (Olive & Schwartz, 1993).

French, L. (2005). Dysmenorrhea. *American Academy of Family Practitioners*, 71, 285-29.

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