

Primary Dysmenorrhea Consensus Guideline

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Abstract

Methods: Members of this consensus group were selected based on individual expertise to represent a range of practical and academic experience both in terms of location in Canada and type of practice, as well as subspecialty expertise along with general gynaecology backgrounds. The consensus group reviewed all available evidence through the English and French medical literature and available data from a survey of Canadian women. Recommendations were established as consensus statements. The final document was reviewed and approved by the Executive and Council of the SOGC.

Results: This document provides a summary of up-to-date evidence regarding the diagnosis, investigations, and medical and surgical management of dysmenorrhea. The resulting recommendations may be adapted by individual health care workers when serving women who suffer from this condition.

Conclusions: Dysmenorrhea is an extremely common and sometimes debilitating condition for women of reproductive age. A multidisciplinary approach involving a combination of lifestyle, medications, and allied health services should be used to limit the impact of this condition on activities of daily living. In some circumstances, surgery is required to offer the desired relief.

Outcomes: This guideline discusses the various options in managing dysmenorrhea. Patient information materials may be derived from these guidelines in order to educate women in terms of their options and possible risks and benefits of various treatment strategies. Women who find an acceptable management strategy for this condition may benefit from an improved quality of life.

Key Words: Primary dysmenorrhea, pelvic pain, menstrual pain, crampy suprapubic pain, endometriosis, menorrhagia, menstrual cramps, length of cycles, regularity of cycles, duration of menses, pelvic examination, management of dysmenorrhea

Evidence: MEDLINE and Cochrane databases were searched for articles in English and French on subjects related to primary dysmenorrhea, menstrual pain and pelvic pain from January 1990 to December 2004 in order to prepare a Canadian consensus guideline on the management of primary dysmenorrhea.

Values: The quality of evidence is rated using the criteria described in the Report of the Canadian Task Force on the Periodic Health Examination. Recommendations for practice are ranked according to this method.

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Recommendations

Section 3: Diagnosis / Differential Diagnosis / Investigations

1. In adolescents experiencing dysmenorrhea in the first 6 months from the start of menarche, and when an anovulatory patient complains of dysmenorrhea, the diagnosis of obstructing malformation of the genital tract should be considered. (III-A)
2. The diagnosis of secondary dysmenorrhea should be considered when symptoms appear after many years of painless menses. (III-A)
3. In view of the high prevalence of dysmenorrhea, and evidence that many women do not seek medical attention for this problem, health care providers should include specific questions regarding menstrual pain when obtaining a woman's medical history. (III-B)
4. In an adolescent who has never been sexually active and has a typical history of mild to moderate dysmenorrhea, a pelvic examination is not necessary. (III-D)
5. A pelvic examination is indicated in all patients not responding to conventional therapy of dysmenorrhea or when an organic pathology is suspected. (III-B)

Section 4: Non-medicinal Therapeutic Options

1. Unlike low-frequency TENS, high-frequency TENS provides more effective dysmenorrhea pain relief compared with placebo. High-frequency TENS may be considered as a supplementary treatment in women unable to tolerate medication. (II-B)
2. Women who inquire about alternatives to relieve dysmenorrhea, may be instructed that, at the present time, there is limited evidence that acupuncture may be of benefit (II-B), there is no evidence to support spinal manipulation as an effective treatment (II-D), and there is limited evidence to support topical heat therapy (II-B).

Section 5: Medicinal Therapeutic Options

1. Women suffering from primary dysmenorrhea should be offered NSAIDs as a first-line treatment for the relief of pain and improved daily activity unless they have a contraindication to the use of NSAIDs. (I-A)

These guidelines reflect emerging clinical and scientific advances as of the date issued and are subject to change. The information should not be construed as dictating an exclusive course of treatment or procedure to be followed. Local institutions can dictate amendments to these opinions. They should be well documented if modified at the local level. None of these contents may be reproduced in any form without prior written permission of the SOGC.

Table 1. Criteria for quality of evidence assessment and classification of recommendations

Level of evidence*	Classification of recommendations†
I: Evidence obtained from at least one properly designed randomized controlled trial.	A. There is good evidence to support the recommendation for use of a diagnostic test, treatment, or intervention.
II-1: Evidence from well-designed controlled trials without randomization.	B. There is fair evidence to support the recommendation for use of a diagnostic test, treatment, or intervention.
II-2: Evidence from well-designed cohort (prospective or retrospective) or case-control studies, preferably from more than one centre or research group.	C. There is insufficient evidence to support the recommendation for use of a diagnostic test, treatment, or intervention.
II-3: Evidence from comparisons between times or places with or without the intervention. Dramatic results from uncontrolled experiments (such as the results of treatment with penicillin in the 1940s) could also be included in this category.	D. There is fair evidence not to support the recommendation for a diagnostic test, treatment, or intervention.
III: Opinions of respected authorities, based on clinical experience, descriptive studies, or reports of expert committees.	E. There is good evidence not to support the recommendation for use of a diagnostic test, treatment, or intervention.

*The quality of evidence reported in these guidelines has been adapted from the Evaluation of Evidence criteria described in the Canadian Task Force on the Periodic Health Exam.¹²⁶

†Recommendations included in these guidelines have been adapted from the Classification of Recommendations criteria described in the Canadian Task Force on the Periodic Health Exam.¹²⁶

- Oral contraceptives may be recommended for the treatment of primary dysmenorrhea. The added contraceptive advantage may make oral contraceptives a first-line therapy for some women. (1-A)
- Consideration may be given to continuous use of oral contraceptive pills for withdrawal bleeding and the associated dysmenorrhea. (1-A)
- Depot medroxyprogesterone acetate and levonorgestrel intrauterine system have been shown to be effective in the treatment of dysmenorrhea and therefore can be considered as treatment options in the management of primary dysmenorrhea. (II-B)

Section 6: Surgical Options

- Surgery constitutes the final diagnostic and therapeutic option in the management of dysmenorrhea. Laparoscopy should be considered in women who have persistent dysmenorrhea despite medical therapy of NSAIDs and/or oral contraceptives. (III-C)
- Hysterectomy may be considered for the management of dysmenorrhea when medical alternatives have been refused or failed and fertility is no longer possible or desired. (II-B)
- As there is limited evidence for use of presacral neurectomy in the management of primary dysmenorrhea, the risks must be carefully weighed against the expected benefits. (III-C)
- Laparoscopic uterosacral ligament resection has not been shown to reduce dysmenorrhea and therefore should not be advocated as a mainstream treatment option. (III-C)

Section 7: Complementary and Alternative Medicine (CAM)

- The following CAM has limited support and may be considered in the treatment of primary dysmenorrhea, though further study is required:
 - Vitamin B1 (I-B)
- The following CAMs showed an initial positive response for the treatment of primary dysmenorrhea and merit further study:
 - Vitamin E (I-C)
 - Fish oil / Vitamin B12 combination (I-C)
 - Magnesium (II-1 C)
 - Vitamin B6; (II-1 C)
 - Toki-shakuyaku-san (II-1 C)
 - Fish oil (II-3 C)
 - Neptune krill oil (II-3 C)
- The following CAMs have not been shown to have any benefit in the treatment of primary dysmenorrhea and may need further study:
 - Vitamin B6 / Magnesium combination (II-1)
 - Vitamin E (daily) in addition to Ibuprofen (during menses) (II-3)
 - Fennel (II-3)