

Dysmenorrhea, is the Diagnosis Neglected?

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Case Report

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Abstract

Dysmenorrhea is one of the most prevalent gynecological problems among women, affecting mainly adolescents. The general practitioner is usually the health professional first to have contact with this patient, therefore, should know these symptoms, since its prevalence is high and the diagnosis often overlooked. The knowledge and the correct diagnosis and lead to appropriate therapy with significant relief of symptoms. Other differential diagnoses should be investigated and behavioral and pharmacological guidelines are important in disease control monitoring, since the relief of symptoms improve the quality of life of patients.

Keywords: Dysmenorrhea; Teenager

Introduction

The menstrual pain syndrome is characterized as pelvic pain in the period before menstruation, whether or not related to systemic symptoms. The social and personal repercussions are many, such as reduced hours of work, school attendance and others [1].

Primary dysmenorrhea often arises a few hours before or soon after the onset of menstruation. Of variable degree, it may or may not occur along with other symptoms, such as vomiting, diarrhea, asthenia, headache or even episodes of syncope. There are no changes in vital signs, urinary tract or intestinal tract. In palpation of the uterus it is necessary to evaluate size, volume, shape and mobility, which are normal. There should be no changes to the clinical investigation of the uterine annexes, without mass or pain [2].

Dysmenorrhoea, according to its etiology may be essential, when there is no known organic disease that justifies it, and secondary when it occurs due to an organic cause and the most common organic cause seems to be pelvic endometriosis [3,4]. For the diagnosis of primary dysmenorrhea, it is necessary to exclude underlying pelvic pathologies and confirm the cyclical nature of the pain. Within the differential diagnosis of secondary dysmenorrhea is primary dysmenorrhea and acyclic pelvic pain. Although the diagnosis of primary dysmenorrhoeais based on anamnesis and the presence of a normal pelvic examination, the diagnosis of secondary dysmenorrhoea may require revision of a pain diary and an ultrasound or laparoscopy. In the pelvic examination, the size, shape and mobility of the uterus, the size and pain of palpation of the adnexal structures, and the nodularity or fibrosis of the utero sacral ligaments or the rectovaginal septum should be assessed.

Cervical studies for gonorrhoea and Chlamydia and, if relevant, a complete blood count with HSV is useful to exclude subacute salpingo-oophoritis. Thus, if no abnormalities are found, a provisional diagnosis of dysmenorrhoea can be established [5].

The cases of primary dysmenorrhoea occur during ovulatory cycles, being a diagnosis of exclusion. The diagnosis is made based on the clinical history, trying to identify the moment when the pain arose (primary or secondary dysmenorrhoea). The regularity of the menstrual pattern (ovulatory cycles), complete gynecological examination, laboratory tests (blood, urine and vaginal secretion) and imaging (resonance and ultra sonography) are also evaluated [6].

Thus, it is necessary to determine the date and characteristics of the last two menstrual periods and the presence of abnormal bleeding or discharge. One should address menstrual history, sexual and contraceptive as well as sexually transmitted diseases and prior gynecological disorders are important. It is important to take the pain history, including how and when it began; The presence of gastrointestinal symptoms, urinary symptoms and signs of infection⁵. The meticulous gynecological examination, especially the vaginal touch (and sometimes the rectal touch) complements the suspicion of the causal factor and reveals, or distances, the presence of certain pathologies. Complementary laboratory and imaging tests are required in order to better formalize a certain diagnosis that guides the appropriate form of treatment for dysmenorrhoea. In chronic cases, video laparoscopy or video hysteroscopy must be performed [7].

Specific therapy involves hormone therapy and prostaglandin synthesis inhibitors and symptom relief should be sought. Analgesics and NSAIDs are the first line of choice in the treatment of primary dysmenorrhoea. They act by inhibiting the production of prostaglandins by their action on the cyclooxygenase pathway. Regarding the gastrointestinal effects of NSAIDs, they are generally tolerable, but such drugs should be avoided in patients with gastric ulcers [8,4]. Specific COX-2 inhibitors are effective against dysmenorrhoea, but there are questions about its cardiovascular effects, which may restrict its use. We have already done a study to observe the possible differences in the therapy with selective COX-2 inhibitors (coxibes) in relation to the non-selective inhibitors (naproxen, ibuprofen), and no significant differences were observed between them [9,10].

In contrast, hormonal contraceptives act to inhibit ovulation and reduce endometrial proliferation, which

limits the production of prostaglandins. Absolute and relative contraindications should be respected. There is one study showing improvement with vaginal ring use when compared to oral hormonal contraceptives. There are also injectable contraceptives, which can be monthly or quarterly. In relation to levonorgestrel IUD (MIRENA), the reduction of dysmenorrhoea has been reported [4,7,11]. There are women who do not respond to single therapy, requiring association between the options [4].

In the painful crisis is recommended rest, can be used local heat, hot soak bath, analgesic medications, antispasmodics, psychotherapy and should always be reminded of the importance of non-drug therapy. A diet high in fiber and physical exercise are key. A study carried out in 2012, found that using the Pilates method as a practice of physical activity, a significant improvement of the symptoms associated with primary dysmenorrhoea was observed, interfering positively in the reduction of patients' pain. Be a promising non-pharmacological alternative. Acupuncture, however, has shown a favorable response in a few studies already performed [12].

Methodology

Case report and bibliographic review

Results

Patient JA, female, 15 years old, single, nulliparous, natural and resident of Valença-RJ, attended the Gynecology Service of the Hospital Escola Luiz Gioseffi Jannuzzi - Faculty of Medicine of Valença-RJ, for gynecological consultation in March 2015. At Examination, she complained of menstrual cramps. In the evaluation of the pain, she reported being of high intensity and on a scale of 0 to 10 she reported her pain, compromising the performance of her daily activities, also referred to abnormal uterine bleeding (metrorrhagia), with her cycles delaying or advancing in one week.

In the gynecological history menarche mentioned to the 12 years, still not having occurred sexarca. The date of the last menstruation was 11/03/2015 and was menstruating at the moment of the consultation. Do not use oral hormonal contraceptive. No history of previous pathologies, comorbidities, surgeries, allergies. It denies smoking and alcoholism.

The test was: stained, hydrated, acyanotic, anicteric, with good capillary perfusion, afebrile, normal heart rate, eupneic, and normotensive. Painful abdomen at deep palpation and absence of abdominal masses. In the pelvic evaluation, genitalia was identified with normal piloting,

trophic, intact hymen, moderate genital bleeding and patent uterus. Symmetrical, medium volume breast without retraction and / or bulging, without palpable lymph node enlargement and / or nodules.

Pelvic ultrasound and combined oral contraceptive (Level®) were ordered to regularize the cycle. Guidelines were made for its use, awaiting the return of the patient with the result of the examination to conclude the diagnostic hypothesis and exclusion of secondary dysmenorrhea.

Discussion

Dysmenorrhoea is one of the most prevalent gynecological problems among adolescents and young adults, being a condition usually primary, without being related to pelvic pathologies. It is estimated that 50% of women of reproductive age are affected, and in 10% of them there are reports of interference in daily activities [13,14].

The etiology is still not very well defined, and the theory is more considered to have the pain due to an excessive production of uterine prostaglandins, derived from the activity of cyclooxygenase, which explains a good part of the symptoms, among them the PGF2 Present in the menstrual fluid, which determines an abnormal uterine activity, reducing the blood flow to the uterus and sensitizing the nociceptors [15].

The treatment consists of analgesics, anti-inflammatory drugs (NSAIDs) and hormone therapy, in addition to non-drug measures such as proper diet and regular physical activities. The described patient probably fits the typical picture of primary dysmenorrhoea, which should be confirmed after all the differential diagnoses have been removed. The young age, the immaturity of its neuroendocrine axis and psychological factors may be involved.

Conclusion

The case in question demonstrates negligence or lack of knowledge on the part of the doctors regarding dysmenorrhea. The patient will continue the periodic treatment, since the pathology presents factors of progressive improvement and also classic psychosomatic factors that directly influence the prognosis. In the current analysis of the case, we highlight the hormonal treatment in which we hope to obtain improvements in symptoms, however, there is a need for regular outpatient follow-up, as well as behavioral, psychological and

pharmacological guidelines in the next consultations, to achieve a better prognosis in the disease and improve the symptoms thus reflecting, in better quality of life for the patient. It is a multifactorial pathology and one should take a different view of health professionals, considering its great psychosocial impact.

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