

Primary Dysmenorrhea



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Primary dysmenorrhea is a frequent and challenging problem in gynaecology that occurs in most, if not all, women. Dysmenorrhea, however, also has the connotation that it may be a first sign of endometriosis, which may progress and cause infertility and chronic or severe pain. Thus dysmenorrhea may require early treatment to prevent progression. Unfortunately, without a laparoscopy, diagnosis is difficult, except in the presence of a large ovarian endometriosis cyst or a large rectovaginal deep endometriosis. During diagnostic laparoscopy, surgery, if necessary, could or should be performed.

The “Primary Dysmenorrhea Consensus Guideline” in this issue of JOGC is a nice review of the literature, but clinically a missed opportunity.¹ The major problem is that evidence is limited to published evidence, and absence of evidence is not considered. Clinical practice is a comprehensive set of diagnostic and therapeutic rules that are built progressively by clinicians by trial and error, aided by discussions and meetings and adapted progressively by incorporation of research evidence. An added challenge is that the quality of evidence assessment relies heavily on RCTs. Although mathematically correct, the limitations of RCTs are not addressed. First, the results of an RCT are only applicable for the population as defined by the inclusion and exclusion criteria, and any extrapolation should be considered carefully. Second, an RCT is poorly suited for rare events; for example, a 1% event would

require an RCT of 6000 women to have 30 cases in the control group. Finally, because pain perception is known to be highly subjective, blinding is mandatory for any such trial. This is close to impossible for a treatment affecting menstruation because the patient will rapidly become aware whether she takes active medication or placebo.²

The summary statements and recommendations in this guideline confirm these considerations. In addition to the conclusion that pain killers/non-steroidal anti-inflammatory drugs decrease pain, it is assumed that dysmenorrhea disappears in the absence of menstruation, be that by medical treatment or by hysterectomy. It is unclear whether laparoscopic nerve ablation is still acceptable for dysmenorrhea, considering the potentially severe side effects.

Although each of the recommendations in this guideline were demonstrated in a trial, their clinical implementation is not that obvious. It appears strange that a positive diagnosis and/or the exclusion of major pathology is no longer necessary to initiate therapy (recommendations 1, 3, and 5). To the best of our knowledge, there is no evidence that during medical therapy, combined oral contraceptives, or other treatments, some endometriosis lesions do not progress in some women as suggested by the authors (recommendations 6, 7, 13, and 14). Surgical observation suggests that progression does occur in some women with severe endometriosis and frozen pelvis who had been taking oral contraceptives or progestogens for more than 10 years since menarche. The potential heterogeneity in endometriosis lesions with the potential growth during pregnancy is moreover supported by the occasional, although probably underreported, perforations of deep endometriosis during pregnancy.³

Whereas clinical medicine should be based as much as possible on evidence, RCTs are less suited for severe

endometriosis surgery. This is due to the heterogeneity of surgery and the discrepancy between the numbers available and the numbers required to detect rare events. Therefore, clinical guidelines should also incorporate the cumulative experience of surgeons.^{4,5}

Finally, based on our observations and the challenges of treating primary dysmenorrhea, we propose a recommendation that during consultation, women are provided with all available treatment options so that they are fully informed of all potential short- and long-term side effects/risks associated with each management strategy.

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