The American College of Obstetricians and Gynecologists
WOMEN'S HEALTH CARE PHYSICIANS

ACOG COMMITTEE OPINION SUMMARY

Number 760

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Committee on Adolescent Health Care

This Committee Opinion was developed by the American College of Obstetricians and Gynecologists' Committee on Adolescent Health Care in collaboration with committee members Geri D. Hewitt, MD and Karen R. Gerancher, MD.

Dysmenorrhea and Endometriosis in the Adolescent

ABSTRACT: Dysmenorrhea, or menstrual pain, is the most common menstrual symptom among adolescent girls and young women. Most adolescents experiencing dysmenorrhea have *primary dysmenorrhea*, defined as painful menstruation in the absence of pelvic pathology. When the patient's history suggests primary dysmenorrhea, empiric treatment should be initiated. When a patient does not experience clinical improvement for her dysmenorrhea within 3–6 months of therapy initiation, her obstetrician–gynecologist should investigate for possible secondary causes and for treatment adherence. Secondary dysmenorrhea refers to painful menses due to pelvic pathology or a recognized medical condition. Endometriosis is the leading cause of secondary dysmenorrhea in adolescents. Endometriosis should be considered in patients with persistent, clinically significant dysmenorrhea despite treatment with hormonal agents and nonsteroidal antiinflammatory drugs, particularly if no other etiology for chronic pelvic pain or secondary dysmenorrhea has been identified based on history, physical examination, and pelvic ultrasonography. The appearance of endometriosis may be different in an adolescent than in an adult woman. In adolescents, endometriotic lesions are typically clear or red and can be difficult to identify for gynecologists unfamiliar with endometriosis in adolescents. Endometriosis in adolescents is considered a chronic disease with potential for progression if left untreated. The goals of therapy include symptom relief, suppression of disease progression, and protection of future fertility. Therapy must be individualized, and obstetrician–gynecologists should consider patient choice, the need for contraception, contraindications to hormone use, and potential adverse effects and counsel the adolescent and her family on treatment options.

Recommendations and Conclusions

The American College of Obstetricians and Gynecologists makes the following recommendations and conclusions:

- Most adolescents experiencing dysmenorrhea have *primary dysmenorrhea,* defined as painful menstruation in the absence of pelvic pathology. Primary dysmenorrhea characteristically begins when adolescents attain ovulatory cycles, usually within 6–12 months of menarche.
- Secondary dysmenorrhea refers to painful menses due to pelvic pathology or a recognized medical condition.
- The most common cause of secondary dysmenorrhea is endometriosis.
- Most adolescents who present with dysmenorrhea have primary dysmenorrhea and will respond well to empiric treatment with nonsteroidal antiinflammatory drugs (NSAIDs) or hormonal suppression, or both. However, some patients either present initially with symptoms suggesting secondary dysmenorrhea or they fail empiric treatment for primary dysmenorrhea and require further evaluation.
- Pelvic imaging with ultrasonography, regardless of findings on pelvic examination, also should be considered during evaluation for secondary dysmenorrhea.

- Any obstructive anomaly of the reproductive tract, whether hymenal, vaginal, or müllerian, can cause secondary dysmenorrhea.
- Although the true prevalence of endometriosis in adolescents is unknown, at least two thirds of adolescent girls with chronic pelvic pain or dysmenorrhea unresponsive to hormonal therapies and NSAIDs will be diagnosed with endometriosis at the time of diagnostic laparoscopy.
- The appearance of endometriosis may be different in an adolescent than in an adult woman. In adolescents, endometriotic lesions are typically clear or red and can be difficult to identify for gynecologists unfamiliar with endometriosis in adolescents.
- If a patient is undergoing a diagnostic laparoscopy for dysmenorrhea or chronic pain, or both, consideration should be given to placing a levonorgestrel-releasing intrauterine system (LNG-IUS) at the time of laparoscopy to minimize the pain of insertion.
- Recommended treatment for endometriosis in adolescents is conservative surgical therapy for diagnosis and treatment combined with ongoing suppressive medical therapies to prevent endometrial proliferation.
- Patients with endometriosis who have pain refractory to conservative surgical therapy and suppressive hormonal therapy often benefit from at least 6 months of gonadotropin-releasing hormone (GnRH) agonist therapy with add-back medicine.
- Nonsteroidal antiinflammatory drugs should be the mainstay of pain relief for adolescents with endometriosis.
- Adolescents should not be prescribed narcotics long-term to manage endometriosis outside of a specialized pain management team.

Full-text document published online on November 20, 2018.

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Official Citation
Dysmenorrhea and endometriosis in the adolescent. ACOG Committee Opinion No. 760. American College of Obstetricians and Gynecologists. Obstet Gynecol 2018;132:e249–58.