

Dyspareunia & Dysmenorrhea

Topic- based Uworld Questions

Block 1, 2, 7, 8



A 44-year-old woman comes to the office with a 6-month history of painful sexual intercourse. She has no associated itching or abnormal vaginal discharge. The patient has never had these symptoms before and has had no problems with sexual desire or orgasm. She has been monogamous with her husband for 15 years. The patient's menstrual periods are regular and are not associated with unusual pain. She has no urinary or gastrointestinal symptoms. Her medical history is notable for mild hypertension that has been well controlled with dietary changes and exercise. The patient has no history of pelvic inflammatory disease or gynecologic surgery. Her only medications include a daily multivitamin and saline eye drops for chronic dry eyes. The patient does not use tobacco, alcohol, or illicit drugs. Temperature is 36.5 C (97.7 F), blood pressure is 136/88 mm Hg, pulse is 72/min, and respirations are 12/min. The neck is supple. The patient has mild dental caries. Chest auscultation reveals no abnormalities. The abdomen is soft and nontender. Pelvic examination shows normal-appearing external genitalia and dry vaginal mucosa. The uterus and adnexa are normal with no cervical motion tenderness. Which of the following is the most likely cause of this patient's current condition?

- A. Endometriosis
- B. Estrogen deficiency
- C. Inadequate lubrication
- D. Interstitial cystitis
- E. Lichen sclerosus
- F. Vaginismus
- G. Vulvodynia

Submit

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- A. Endometriosis (0%)
- B. Estrogen deficiency (22%)
- C. Inadequate lubrication (67%)
- D. Interstitial cystitis (0%)
- E. Lichen sclerosus (1%)
- F. Vaginismus (5%)
- G. Vulvodynia (2%)

Omitted

Correct answer

C



67%

Answered correctly



01 sec

Time Spent



03/30/2020

Last Updated

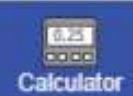
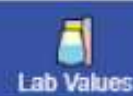
Sjögren syndrome	
Exocrine features	<ul style="list-style-type: none"> • Keratoconjunctivitis sicca • Dry mouth, salivary hypertrophy • Xerosis
Extraglandular features	<ul style="list-style-type: none"> • Raynaud phenomenon • Cutaneous vasculitis • Arthralgia/arthritis • Interstitial lung disease • Non-Hodgkin lymphoma
Diagnostic findings	<ul style="list-style-type: none"> • Objective signs of decreased lacrimation (eg, Schirmer test) • Positive anti-Ro (SSA) &/or anti-La (SSB) • Salivary gland biopsy with focal lymphocytic sialoadenitis • Classification: primary if no associated CTD, secondary if comorbid CTD (eg, SLE, RA, scleroderma)

CTD = connective tissue disease; RA = rheumatoid arthritis; SLE = systemic lupus erythematosus; SSA/SSB = Sjögren syndrome (antibody) A/B.

Sjögren syndrome (SS) is an autoimmune disorder characterized by inflammation of the exocrine glands. It can occur as an isolated phenomenon or as a manifestation of another autoimmune disease (eg, rheumatoid arthritis). Impaired function of salivary and other exocrine glands (eg, lacrimal glands) can produce **sicca syndrome**, characterized by generalized dryness of mucous membranes, leading to dry mouth with increased risk of dental caries, irritated/itchy eyes, and cough. Dryness of the vaginal mucosa commonly causes **dyspareunia**.

Extraglandular features of SS may include arthritis, **Raynaud phenomenon**, and cutaneous vasculitis. SS can also cause manifestations along the entire respiratory tract, including nonallergic rhinitis, bronchiectasis, large and small airway disease with impaired mucociliary clearance, and interstitial lung disease. In addition, SS is associated with a significant risk for non-Hodgkin lymphoma.

(Choice A) Endometriosis causes deep dyspareunia but is unlikely in a patient without dysmenorrhea. Vaginal dryness is not a feature of this



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(Choice A) Endometriosis causes deep dyspareunia but is unlikely in a patient without dysmenorrhea. Vaginal dryness is not a feature of this condition.

(Choice B) Estrogen deficiency is a common cause of dyspareunia in postmenopausal patients. This patient is premenopausal with regular menses and does not have a lack of estrogen.

(Choice D) Interstitial cystitis, also referred to as painful bladder syndrome, presents with chronic pelvic pain, urinary urgency, and dyspareunia. It is less likely to cause dry vaginal mucosa and would not affect the eyes or oral mucosa.

(Choice E) Lichen sclerosis may present with dyspareunia but more typically causes vulvar itching. Physical examination findings include white vulvar plaques rather than normal external genitalia with dry vaginal mucosa.

(Choice F) Vaginismus (eg, genitopelvic pain/penetration disorder) is dyspareunia due to muscle spasm that prevents vaginal penetration. Pelvic examination demonstrates involuntary muscle contraction but may be limited as muscle spasm may prevent speculum entry.

(Choice G) Vulvodynia, formerly termed vestibulodynia, is a cause of painful entry dyspareunia. Physical examination shows pain to superficial touch of the vaginal vestibule rather than dryness.

Educational objective:

Sjögren syndrome is an autoimmune disorder characterized by inflammation of the exocrine glands. Typical features include dry mouth, autoimmune sialoadenitis, and keratoconjunctivitis sicca. Extraglandular features include arthritis, Raynaud phenomenon, dyspareunia, cutaneous vasculitis, interstitial lung disease, and non-Hodgkin lymphoma.



Previous



Next



Full Screen



Tutorial



Lab Values



Notes



Calculator



Reverse Color



Text Zoom

An 18-year-old woman comes to the office due to lower abdominal pain that radiates to her lower back and thighs during menses. The patient had no pain while on oral contraceptives but stopped taking them 5 months ago due to unscheduled breakthrough bleeding. Menstrual periods now occur every 30 days with 5 days of bleeding. The pain and bleeding are worse on the second day, requiring the patient to change her pad every 4 hours. She also has nausea and fatigue during the first 2 days of menses. The patient is sexually active with a male partner and uses condoms inconsistently. She has no intermenstrual bleeding or pain with intercourse. Vital signs are normal. BMI is 19.5 kg/m². Pelvic examination reveals a small, mobile uterus and no palpable adnexal masses. Which of the following is the most likely diagnosis in this patient?

- A. Adenomyosis
- B. Endometriosis
- C. Intermittent ovarian torsion
- D. Pelvic congestion syndrome
- E. Primary dysmenorrhea
- F. Uterine leiomyoma

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- A. Adenomyosis (3%)
- B. Endometriosis (23%)
- C. Intermittent ovarian torsion (0%)
- D. Pelvic congestion syndrome (7%)
- E. Primary dysmenorrhea (61%)
- F. Uterine leiomyoma (3%)

Omitted

Correct answer
E61%
Answered correctly02 secs
Time Spent05/26/2020
Last Updated

Explanation

Primary dysmenorrhea

Primary dysmenorrhea	
Etiology	<ul style="list-style-type: none"> Excessive prostaglandin production
Risk factors	<ul style="list-style-type: none"> Age <30 BMI <20 kg/m² Tobacco use Menarche at age <12 Heavy/long menstrual periods Sexual abuse
Clinical features	<ul style="list-style-type: none"> Pain first 2-3 days of menses Nausea, vomiting, diarrhea Normal pelvic examination
Management	<ul style="list-style-type: none"> Nonsteroidal anti-inflammatory drugs Combination oral contraceptives

This patient, who had resumption of ovulation after discontinuing oral contraceptive use, now has increased painful lower abdominal cramping associated with menses, suggestive of **primary dysmenorrhea**. Primary (ie, physiologic) dysmenorrhea (painful menses) is common, particularly among adolescents. **Excessive prostaglandin production** during menses can stimulate uterine contractions and result in **lower abdominal pain** that can radiate to the back and thighs. Some patients may also develop gastrointestinal symptoms (eg, **nausea**, vomiting, bloating, diarrhea) from prostaglandin-induced gastrointestinal stimulation. Symptoms are typically worse during the first few days of menses and can interfere with daily activities. Patients have a **normal pelvic examination** because the pelvic pain occurs without an identifiable pathologic cause.

The first-line treatment for primary dysmenorrhea is **nonsteroidal antiinflammatory drugs** (NSAIDs), which reduce prostaglandin synthesis. For patients who are sexually active or in whom NSAIDs are ineffective or cannot be tolerated, **combination oral contraceptives** (COCs) can be used. Although this patient previously had unscheduled breakthrough bleeding as a side effect of COCs, she can be prescribed another formulation that limits this side effect.

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(Choice A) **Adenomyosis** can cause painful menses; however, this diagnosis is less likely because this patient does not have a tender, symmetrically enlarged (ie, "globular") uterus.

(Choice B) Endometriosis is a common cause of painful menses. However, patients often have additional pain during urination (dysuria), bowel movements (dyschezia), and sexual activity (dyspareunia). In contrast to this patient, those with endometriosis often have a fixed, immobile uterus or adnexal masses due to the ectopic endometrial glands and stroma.

(Choice C) Intermittent ovarian torsion can cause lower abdominal pain and nausea; however, patients typically have an adnexal mass, and symptoms are not confined to the menstrual period.

(Choice D) Pelvic congestion syndrome typically presents as a dull, ill-defined pelvic ache that worsens with intercourse or during long periods of standing. In contrast to this patient, those with pelvic congestion syndrome have pain prior to menses that is then relieved by menses.

(Choice F) Uterine leiomyoma can cause pelvic pain secondary to bulk symptoms. Most patients have heavy, prolonged menses (eg, soaking a pad every 1-2 hours, passage of clots) and an enlarged, irregular uterus.

Educational objective:

Patients with primary dysmenorrhea have cyclic, lower abdominal pain during menses and a normal pelvic examination. First-line treatment is