Menstrual Issues: Compare and Contrast Table

	Primary Dysmenorrhea	Endometriosis	Peri-Menopausal Bleeding	Polycystic ovarian Syndrome
Epidemiology (Who gets this disease / risk factors / exposures etc.)	Begins with onset of ovulatory cycles 6 – 12 months after the menarche	Affect 10-15% of women of reproductive age	Usually women aged 42-55 years	Peripubertal period through to mid 20's
Time Course (How does it present in relation to time)	Pain at onset of the period and may last for 24-72 hours	Appearance or worsening of symptoms at the time of menstruation, or just prior to it	Can last 4-6 years	Intermittent symptoms
Clinical Presentation (What are the classic signs and symptoms: differentiating, key or rejecting features)	Painful periods in patients with no pelvic pathology from menarche	Common symptoms include dysmenorrhea, dyspareunia, cyclical / chronic pelvic pain and subfertility. Other symptoms may include bloating, lethargy, constipation and low back pain, cyclical rectal bleeding, menorrhagia, diarrhoea and haematuria.	Changes in menstrual pattern (menstruation longer than 8 days / cycle < 3 weeks or > 2 months apart); menorrhagia; dysmenorrhea ; inter-menstrual bleeding	Hirsutism, Male-pattern balding, alopecia, obesity, Acanthosis nigricans
Mechanism of disease (Known derangements in anatomy / physiology / micro)	Excess / imbalance of prostaglandins and leukotrienes in the menstrual fluid, which produces vasoconstriction in the uterine vessels, causing the uterine contractions and pain	Chronic oestrogen-dependent condition characterised by the growth of endometrial tissue in sites other than the uterine cavity, most commonly the pelvic cavity	Irregular ovulation with associated hormonal changes	The cause remains unclear. Polycystic ovaries develop when ovaries are stimulated to produce excessive amounts of male hormones, particularly testosterone
Diagnostic Tests (Tests that will differentiate one from the others)	None required unless clinically indicated	Laparoscopy is gold standard	None advised	Two of the three following criteria are diagnostic of the condition (Rotterdam criteria):

				Polycystic ovaries Oligo-ovulation or anovulation Clinical and/or biochemical signs of hyperandrogenism
Treatment	NSAID (mefenamic acid) COCP	Medical Mx: Suppress ovarian function - Hormonal treatments (e.g. mirena) Surgical options include removing severe and deeply infiltrating lesions	Various Mirena is a good option to manage menstrual disturbance	Medical management is targeted at individual symptoms, and in association with lifestyle changes e.g. Weight loss +- Metformin
Further reading / resources	http://www.australiandoctor.com.au/cmspages/getfile.aspx?guid=09510ff4-b668-4106-a79c-0939479851c3	http://www.australianprescriber.com/magazine/35/4/114/7	http://www.menopause.org.au/health-professionals/gp-hp-resources/16-diagnosing-menopause	https://jeanhailes.org.au/health-professionals