Editorial

Menstrual Cycles: Who Cares? We All Should

The first and most obvious answer to the question, "Who cares about menstrual cycles?" is that at least half of the world's population cares. In keeping with my penchant for true facts, as opposed to alternative ones, I fact-checked that percentage and found that according to data from the United Nations Population Division, reported by the World Bank, in 2017, women made up 49.558% of the world's population—basically close enough to half.[1] Menstruation is a defining event for women, and its onset signals the beginning of the potential for reproduction. I've previously asked the question "What do we know about menstruation in young girls?" on a number of occasions.[2–4] Some of you might even think that I'm a bit stuck like a broken record on this topic, and I'll freely own that I campaign to consider the menstrual cycle as a vital sign.[5] As it turns out, there is actually quite a bit more that would be helpful for us to know about the menstrual cycle—from more information about the epidemiology of puberty and early menstrual cycles, to information about physiology and pathophysiology: when and how do menstrual cycles become regularly ovulatory for most, but remain anovulatory or oligo-ovulatory for some, as for example, with polycystic ovary syndrome.[6–9]

Menstrual cycles affect men too, as well as transgender and nonbinary people who menstruate, and I'm starting to see increasing evidence that menstruation is coming out of the closet. Antiquated ideas of cultural stigma that dictate that women shouldn't talk about menstruation, and that they should bear the burdens in silence, are dying. The *New York Times* recently published an article titled "It's Not Just the Tampon Tax: Why Periods are Political," addressing the concepts of menstrual equity, including the movement in the United States and internationally to abolish taxes on catamenial products.[10] The article is worth reading. Today, we less frequently hear menstrual euphemisms, even though I still smile when I occasionally hear an older phrase, such as referring to one's period as a "visit from Aunt Flo." The reader is referred to the Web site of the Museum of Menstruation and Women's Health for a list of expressions for menstruation around the world and other fun facts.[11]

Who else cares about menstruation? Typically, parents care about their daughters' menstrual cycles (assuming that the daughter is informing them—we've all seen daughters who are secretive about heavy bleeding until they unexpectedly have a syncopal episode and are anemic). Parents are particularly concerned if their daughter is experiencing heavy or prolonged or painful periods. Menstrual-related problems are one of the main concerns that my patients, and likely yours, experience.

In this issue of the *Journal of Pediatric and Adolescent Gynecology* (JPAG), Gunn and colleagues provide a systematic review summarizing published studies of menstruation in the first gynecologic year (the first year post menarche).[12] From the 22 studies that met the authors' criteria, the mean cycle length ranged from 32 to 61 days (combined mean of 34.5 days) and decreased throughout the first year. The mean number of bleeding days was 4.9-5.4 days, with "frequent" menstrual bleeding occurring in 11%, "infrequent" bleeding in up to one-third, and "irregular" bleeding in up to 43%, although definitions varied according to study. In studies that reported on the interval between the first and subsequent cycle, the first cycle was the longest with a mean of 41-66 days. The authors conclude that the evidence-based knowledge regarding early menstrual and ovulation patterns is suboptimal; many studies had relatively few participants in the first gynecologic year, and almost two-thirds of the studies were cross-sectional rather than longitudinal. In many studies, cycle length data were often interpreted using adult norms (21-35 days). However, the authors identify clinically useful findings. In the first gynecologic year: most girls menstruate for 4-5 days, with 90% of cycles being 7 days or less; most cycles are 21-45 days, with the first cycle typically the longest; 1 of 7 cycles are longer than 45 days; more than half of girls have at least 1 cycle longer than 45 days; more than one-fifth have irregular cycles; dysmenorrhea is common, occurring in up to 90% of girls. Evidence about ovulation is somewhat less well established, but some girls do ovulate from the first cycle; rates of ovulation increase throughout the year; ovulation is likely even with irregular or long cycles. The authors call for a future longitudinal study simultaneously evaluating menstrual patterns and ovulation in a large cohort of young women throughout the entire first gynecologic year (and I would add, ideally, beyond). I wholeheartedly agree with this call and with the statement that such a study "would provide a trove of clinically robust data to further illuminate this important transitional year."[12] I look forward to the submission of the report of such a study for publication in JPAG.

This issue of JPAG includes a couple of additional articles related to menstruation. One study investigated the question of which doctors care about menstrual cycles, as evidenced by documentation in the medical record, relying on the old adage, if something isn't documented in the medical record, it didn't happen. McShane and colleagues ask questions about the frequency of menstrual history-taking at annual well-visits for adolescent girls.[13] The authors searched physicians' well-visit notes for documentation of menstrual-related data, including last menstrual period (LMP), menarche, usual cycle length, and the presence or absence of menstrual symptoms such as pain and cramps.

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They concluded that records from adolescent medicine clinicians were more likely to document a complete menstrual history, compared with family medicine or pediatric clinicians. This finding will not be a major surprise to readers of this journal, but suggests that we all need to be better ambassadors to and teachers of our colleagues on behalf of our patients, noting the menstrual cycle's importance to the reproductive health and lives of young adolescent women.

Learners at my own institution know that when they are presenting a patient to me, I am an absolute stickler for "identifying data" for every teen. I insist on hearing the patient's age, gravidity, parity, date of LMP, information about sexual activity, method of contraception or hormonal therapy, and chief concern. I explain that without this information, I cannot think logically about the patient's concerns, and we cannot appropriately assess or manage her care. Even simply prescribing medication for acne could be an issue if her LMP was 8 weeks ago, and she was pregnant. I suspect that many of us who practice pediatric and adolescent gynecology are sticklers on these details.

An additional article in this issue of JPAG that relates to the menstrual cycle is a report by Kanner and colleagues of a multicenter case series of patients with noncytotoxic-related primary ovarian insufficiency (POI).[14] The strength of this study is that is a multisite case series, which is important when it comes to rare conditions, such as noncytotoxic-related POI. The authors conclude that there is a great deal of variability in the evaluation and management of these patients, as documented in the electronic medical records they reviewed. They call for a more uniform approach to making the diagnosis in young women with suspected POI, including ruling out rare specific causes and associations. In our own published case series, many patients had experienced partial evaluations at other institutions and this information was not easy to retrieve through the electronic medical record, and was not always summarized in one place.[15] A prospective registry would be extremely helpful in learning more about this very rare condition and its diagnosis and management.

Do clinicians in other specialties care about the menstrual cycle? I would suggest that for most clinicians in most other specialties, the answer is not so much. As pediatric and adolescent gynecologists, we are all very familiar with conditions that manifest with menstrual symptoms, including of course, primary dysmenorrhea, but also endometriosis, and uterovaginal anomalies. We regularly see young women whose menstrual cycle irregularities are caused by hyperandrogenism or an eating disorder. We are also aware of the menstrual cyclicity of other symptoms of chronic diseases, such as catamenial epilepsy or menstrual migraines.[16,17] We need to continue to talk with our colleagues in other specialties to encourage them to consider the menstrual cycle when it comes to symptoms of chronic diseases that might have menstrual cyclicity, such as type 1 diabetes and asthma.[18,19]

I'm working and teaching toward the day when all clinicians care about an event that happens monthly for half of their patients. The menstrual cycle matters for women's health and well-being. Let's all afford it the attention and importance that it deserves as we work toward improving the health of all young women.

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