Management of Premenstrual Syndrome RCOG 2016

Diagnosis:

- Symptoms occur in ovulatory cycles and must be present during the luteal phase and abate as menstruation begins, which is then followed by a symptom-free week.
- Symptoms may be psychological (e.g. depression, anxiety, irritability, loss of confidence and mood swings) and/or physical (e.g. bloating, mastalgia) and must be significant enough to affect daily functioning or interfere with work, school or relationships.
- Women who have symptoms that do not appear to be influenced by the menstrual cycle should not be diagnosed with PMS.
- Symptoms should be recorded prospectively over two cycles using a symptom diary - click here for an example diary.
- Premenstrual dysphoric disorder (PMDD) is a severe form of PMS in which women get both severe physical and psychological symptoms; symptoms must strictly occur in the luteal phase and must be severe enough to disrupt daily functioning.

Management options in PMS:

- Take a holistic approach to management and consider a MDT approach (e.g. GP, gynaecologist, psychologist/psychiatrist) for women with severe PMS or PMDD.
- Complementary therapies - evidence is generally conflicting and likely to be a large placebo response, but there is some evidence for the use of calcium supplements, Vitex (also known as chasteberry) and evening primrose oil; may have a role in women in whom hormonal treatment is contraindicated.
- COCs:
  - There is good evidence for the use of COCs containing drospirenone 3mg plus ethinyl estradiol 20μg, especially in women with severe PMS/PMDD.
  - Emerging evidence suggests continuous regimens rather than 21/7 regimen may be more effective.
- SSRIs:
  - There is good evidence to support the use of all of the commonly prescribed SSRIs, especially in women with severe PMS/PMDD.
  - Side effects are common (nausea, asthenia/decreased energy, somnolence, fatigue, decreased libido, sweating) with NNH of ~7-14.
  - Luteal phase regimens may improve efficacy and reduce adverse effects.
- CBT - should be considered and should routinely be offered in severe PMS/PMDD.
- Patient information - excellent resources from RCOG (click here) and NAPS (click here).

Referral:

- Consider referral when simple measures (e.g. COCs, SSRIs, CBT) have been explored and failed and when the severity of the PMS justifies gynaecological intervention.
- Further treatment options that may be offered through secondary care include percutaneous oestrogen combined with cyclical progestogens, GnRH analogues, danazol, spironolactone and surgery.