KISS: Premenstrual Syndrome

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 holisitic 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 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