

Don't let PMS cramp their style



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Much can be done to assist women experiencing monthly symptoms

PREMENSTRUAL syndrome (PMS) encompasses an array of physical and psychological symptoms that can seriously affect the quality of life for more than one-third of women.

The updated 2017 guidelines from the Royal College of Obstetricians and Gynaecologists, UK, aim to address issues regarding the misdiagnosis of PMS and problems around the use of ineffective treatment options. The guidelines also examine the evidence for pharmacological and non-pharmacological treatments.

First published in 2007, the guidelines aim to help recognise, diagnose, classify and manage PMS.

PMS affects about 40% of menstruating women and GPs can manage the majority of cases. Referral to a gynaecologist or endocrinologist should be considered when first-line treatments have been explored and failed, or when the symptoms are severe.

DEFINITION OF PMS

PMS is the experience of physical and psychological symptoms that occur in the luteal phase of the menstrual cycle, which cease when menstruation starts, and are followed by a symptom-free week.

It is the timing, rather than the type of symptoms and the level to which daily activity is impaired, that suggests the diagnosis of PMS.

PMS only occurs in menstruating women and does not occur before menarche, after menopause or during pregnancy. The International Society for

Premenstrual Disorders divides PMS into core (see boxed criteria) and variant types, with the latter encompassing more complex features not discussed in this article.

PREVALENCE

Of the 40% of women who experience symptoms of PMS, about 5-8% have severe PMS that seriously affects their quality of life.

CAUSES OF PMS

Two main theories surround the cause of PMS. One suggests some women are sensitive to endogenous progesterone or progesterone-like treatments. The other suggests an interaction or responsiveness of the neurotransmitters serotonin and gamma amino-butyric acid, which are responsive to either oestrogen or progesterone or allopregnanalone, respectively.

SYMPTOMS

PMS encompasses a vast array of psychological and physical symptoms; more than

150 have been identified.

The common psychological and behavioural symptoms are:

- mood swings
- depression
- tiredness, fatigue or lethargy
- anxiety
- feeling out of control
- irritability, aggression or anger
- sleep disorders
- food cravings
- social isolation
- hopelessness
- libido (either lower or higher)

Common physical symptoms are:

- pain and aches
- mastalgia
- bloating
- weight gain
- clumsiness
- headaches
- fluid retention

One symptom may be dominant, and the symptoms may vary in severity from



one cycle to another. The duration of PMS symptoms differs from one person to another; some women do not experience relief from symptoms until the day of the heaviest flow.

DIAGNOSIS

Ask women to record any PMS symptoms over two to three cycles using a symptom diary. Retrospective recall is unreliable, so symptoms should always be recorded daily. The patient should complete a symptom diary for two months prior to starting any treatment.

The Daily Record of Severity of Problems form has been shown to be the most reliable questionnaire diary, and is simple for patients to use (see bit.ly/2s7b4iK).

Patients can also download a free Pain and Symptom Diary from the Jean Hailes website (see bit.ly/2hP5hgN).

There are a variety of symptom diary apps, such as the PreMenticS app for iPhone.

If the symptom diary alone is

inconclusive, gonadotrophin-releasing hormone (GnRH) analogues may be used for up to three months to suppress the menstrual cycle to see if this relieves symptoms.

TREATMENT OPTIONS

There are four levels of treatment for PMS, and patients are treated progressively using conservative options in the first instance.

Severe PMS cases may need third- or fourth-line treatment options if symptoms cannot be managed.

First-line

- Cognitive behavioural therapy, exercise, Vitex agnus-castus (chasteberry) herbal medicine, calcium, vitamin B6
- Combined oral contraceptive pill (cyclically or continuously) with drospirenone
- Continuous or luteal phase (days 15-28 of the menstrual cycle) low-dose selective serotonin reuptake inhibitors (SSRIs),

such as citalopram/escitalopram 10mg, or fluoxetine 20mg

Second-line

- Oestradiol patches (100µg) plus micronised progesterone (100mg vaginally or 200mg orally from days 15-28 of the menstrual cycle) or levonorgestrel-releasing intrauterine system (LNG-IUS) 52mg
- Higher dose SSRIs continuously or during luteal phase, such as citalopram/escitalopram 20-40mg or fluoxetine 20-40mg

Third-line

- GnRH analogues plus add-back menopause hormone therapy (continuous combined oestrogen plus progesterone, for example, 50-100µg oestradiol patches or 2-4 doses of oestradiol gel combined with micronised progesterone 100mg/day or tibolone 2.5mg).

Fourth-line

- Surgical treatment ± menopause hormone therapy (MHT)
- Surgery options:
- Hysterectomy plus bilateral salpingo-oophorectomy (BSO), when all medical management has failed including GnRH analogues
- Advise patients to use oestrogen replacement therapy post-operatively, especially if younger than 45
- BSO alone will necessitate the use of combined MHT and therefore reintroduces the possibility of PMS side effects.

Consider a referral to a gynaecologist or endocrinologist when first-line treatments have been explored and failed, or where the severity of symptoms warrants immediate referral.

For women with severe PMS, a multidisciplinary team may be necessary. The team should comprise a GP, a general gynaecologist or a gynaecologist/endocrinologist with a special interest in PMS, a mental health professional and a dietician.

See the guidelines at: bit.ly/2s1vcDX ■

References:
BJOG 2017;124:e73-e105
TOG 2015; 17: =99-104

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CRITERIA FOR DIAGNOSING CORE PREMENSTRUAL DISORDER

- It is precipitated by ovulation
- Symptoms are not defined, although typical symptoms exist
- Any number of symptoms can be present
- Physical and psychological symptoms are important
- Symptoms recur in the luteal phase
- Symptoms disappear by the end of menstruation
- A symptom-free week occurs between menstruation and ovulation
- Symptoms must be prospectively rated
- Symptoms are not an exacerbation of an underlying psychological or physical disorder
- Symptoms cause significant distress and impairment of daily activities, such as work or school commitments, social interactions and family activities

Source: TOG 2015;17:99-104