

HerLife HerHealth



PRIMARY CARE
WOMEN'S HEALTH FORUM

Premenstrual disorders

Share this patient information leaflet with your patients to help them identify if they have a premenstrual disorder and what to do next.

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For more resources visit
www.pcwhf.co.uk/HLHH

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Premenstrual disorders

Do you feel your mood is linked to your periods? Are you riding an emotional roller coaster? Are you perimenopausal? Are you bothered by any of these symptoms some weeks and yet symptom-free in others?

- Depressed mood, hopelessness, lack of pleasure in the things you'd normally enjoy
- Anxiety, tension, panic attacks
- Mood swings, tearfulness, sensitivity to rejection
- Irritability, anger, getting into arguments more often
- Suicidal thoughts
- Tiredness, low energy
- 'Brain fog', difficulty thinking clearly, lack of concentration
- Food cravings, overeating
- Insomnia, or sleeping too much
- Feeling overwhelmed or out of control
- Physical symptoms (e.g. headaches, bloating, breast tenderness, joint pain)

Then this could be a form of premenstrual disorder.

You are not alone. Core Premenstrual Disorder (or Premenstrual Dysphoric Disorder, PMDD) is thought to affect 5-8% of women (and those assigned female at birth, AFAB). It is a condition of abnormal hormone sensitivity. Symptoms occur in the week or two following ovulation and begin to improve when the period starts.



CLINCHING A
DIAGNOSIS IS
ALL ABOUT
YOUR STORY

THE UNDERLYING CAUSE
IS BELIEVED TO BE A
COMPLICATED MIXTURE OF
SOME OR ALL THIS LIST:

- 1 You are prone to it because of your genes
- 2 Your body and brain may have difficulties with handling the hormone progesterone
- 3 Changes in interactions in the brain between oestrogen, serotonin and other chemicals
- 4 Changes in brain structure and function
- 5 The potential effects of trauma, stress and inflammation on your brain's hormonal signalling.

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Step 1.

Keep a diary of your symptoms

Clinching a diagnosis is all about your story. Blood tests are of no value but may be considered to rule out other potential causes e.g. thyroid disorder.

There is no right or wrong way to do this, but recording for 2-3 cycles is essential. Bringing this info to your GP will make diagnosis much easier. It is much harder to try to work out what is going on by looking backwards.

Use apps: Search for useful apps such as Me v PMDD, Prementrics, Flo, Clue. Or if you prefer pen and paper, there are printable alternatives that can be found by searching the internet, such as the American Academy of Family Physicians' daily record of severity of symptoms and the NAPS Menstrual Diary.



Step 2.

Make an appointment with your GP

With the aid of the record that you have kept, it may be possible to work out which type of premenstrual disorder you have:

- ❶ Physiological (mild) premenstrual disorder
- ❷ Core premenstrual disorder (premenstrual dysphoric disorder, PMDD)
- ❸ Premenstrual exacerbation (PME)
- ❹ Premenstrual disorder with absent menstruation
- ❺ Progestogen-induced premenstrual disorder.



Step 3.

Is it Premenstrual Dysphoric Disorder?

For a diagnosis of PMDD to be made, symptoms must be severe enough to impact daily life, occur in the second half of your menstrual cycle and resolve with, or soon after, your period starts.



Step 4.

Get some support

The International Association for Premenstrual Disorders www.iapmd.org and National Association for Premenstrual Syndrome (NAPS) www.pms.org.uk have useful resources.

Remember that PMDD often goes 'off the scale' when menopausal symptoms bite. The PCWHF's Rock My Menopause website (www.rockmymenopause.com) offers sound evidence-based advice, and the Facebook group is a supportive network of women going through menopause.

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Step 5.

Agree a treatment plan that you are happy with

Stay hopeful; there are several treatment options. If one doesn't work there are others to work through with your GP, or you may be referred to a gynaecologist.

Lifestyle

- Experts recommend a nutrient-rich diet high in fibre and complex carbohydrates (plant-based whole foods). Minimise saturated fat, processed carbohydrates, caffeine and alcohol.
- Engage in regular exercise and stress management techniques e.g. yoga, meditation.

Complementary therapies

- Evidence for complementary therapies is scanty; the strongest evidence is for Agnus Castus 20-40mg/day. Please note that Agnus Castus should not be taken alongside hormonal contraception or HRT.
- Cognitive behavioural therapy (CBT) has been shown to be effective for reducing functional impairment.

Anti-depressants

- The SSRI family of antidepressants e.g. sertraline, taken either continuously or in the second half of the menstrual cycle (the luteal phase) have been shown to significantly reduce symptoms in 60-75% of patients with PMDD.

Hormonal treatments

- The drospirenone-containing contraceptive pill is used to prevent ovulation and reduce hormone-related fluctuations.
- Oestrogen patches at high doses along with progesterone tablets or a progestogen-releasing IUS (coil). This is a sort of 'mix and match' HRT and can work brilliantly during the perimenopause for some.

If these do not work, a specialist may be able to offer:

- Injections to switch off ovarian activity and induce menopause, with add back HRT.
- Hysterectomy and removal of the fallopian tubes and ovaries, with careful choice of HRT post-operatively (see patient information leaflet on 'Surgical menopause' at www.rockmymenopause.com). This option is for treatment resistant PMDD and would only be offered as a last resort. ♀

