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PRE MENSTRUAL DYSPHORIC DISORDER (PMDD)

Q: **How do I know if I have premenstrual syndrome? (PMS)**
A: Premenstrual syndrome (PMS) is characterised by a combination of physical and psychological symptoms that occur in a cyclic pattern, *appearing in time before a menstrual period* and improving with the onset of bleeding or in the time immediately *after a period*. The symptoms can be mild or extremely distressing and must include irritability, anxiety or depression, diminished self-esteem, difficulty concentrating, sleep problems, appetite changes, low energy, bloating, headache, breast swelling and tenderness, joint pain and social impacting symptoms.

The types and severity of symptoms vary from one woman to another and sometimes, from one cycle month to another and are varied according to some cultural and ethnic communities.

In general to make a diagnosis of PMS I recommend that you keep a *chart or diary* of those symptoms that you believe may be due to PMS for not less than two months and preferably three. Up to 50% of women discover that their problems are NOT premenstrual when they scrutinise them in this way. This record will also become very important if you commence any form of treatment because it will be your objective evidence of any changes or improvements that occur as the result of treatment.

Q: **How common is PMDD?**
A: Research suggests that as many as seventy-five percent of menstruating women ie 3 women out of 4, have some PMDD symptoms. Of these, most have psychological symptoms including oversensitivity to events that are not so upsetting at other times, episodes of crying during the premenstrual week, irritability, tension, and moodiness. Appetite changes are also very common and approximately 75% of women report sweet or salt cravings. Some women experience hot flushes, palpitations, dizziness, and gastrointestinal upset. The majority of these symptoms are fairly mild and do not need treatment. Indeed, because the symptoms are so common, they should be regarded as “normal”. They may however hint at the kind of symptoms the woman may eventually feel at menopause.

A much smaller number of women, (probably no more than three to eight in every 100) have a more severe syndrome that can be disabling.

Q: **What is the Cause of PMDD?**
A: Much research has been done into this question and no simple explanation has emerged. What is certain is that PMS, even in its severe form, is not caused by any measurable disorder of reproductive or female hormones. It is better to regard it as an exaggerated response of brain neurotransmitters (chemical signals) to normal levels of female hormones that change up and down with each menstrual month perhaps Estradiol and/or progesterone withdrawal.

Q: **What treatments are available for severe PMDD?**
A: Many treatments have been tried for alleviating the symptoms of PMS but no treatment has been found that is consistently effective. Treatments include lifestyle and stress management, dietary restrictions (salt or carbohydrate), diuretics, prostaglandin inhibitors (such as Ponstan, Naprogesic or Nurofen), ovulation inhibitor (the most important of which is the oral contraceptive pill), Vitamins (B group and particularly pyridoxine or Evening Primrose Oil), lithium and antidepressants, SSRI notably Prozac and Citalopram.

At least 75% of women with disabling PMS will respond to an oral contraceptive (the Pill). However, for a few women, the side effects of the Pill will prove disabling and impossible to continue with. In general one should have tried the Pill for at least 3 cycles (3 months) before abandoning this important option. Others may require an implant of oestrogen and a progestin-releasing intrauterine device (Mirena) to suppress ovulation and control periods.

There is some evidence to suggest that a brain chemical, serotonin, plays a role in severe forms of PMS. Antidepressants that alter the serotonin system have been shown to help many women with severe forms of PMS who have failed with other treatments. Occasionally, in women who have completed their families, ovarian removal (with the uterus) may stop the hormone fluctuations and hormone (estrogen) replacement may offer a dramatic solution.