An estimated 75% of women experience symptoms of premenstrual syndrome (PMS) (Steiner and Pearlstein, 2000). Around 5% have severe symptoms such as depression, anxiety, irritability and breast tenderness to an extent that profoundly disrupts their everyday life. The Royal College of Obstetricians and Gynaecologists has issued an update and best-practice resource for the diagnosis and management of the condition (RCOG, 2008a). The morbidity associated with PMS is considerable and often poorly managed. The RCOG (2008b) highlighted shortcomings in care provision, identifying a lack of NHS clinics, NICE guidelines and effective licensed treatments in the UK, while the National Association for Premenstrual Syndrome says limited GP awareness has led to misdiagnosis and wrong prescription (NAPS, 2008). 

**DEFINITION**

PMS is a condition with distressing physical, behavioural and psychological symptoms, in the absence of organic or underlying psychiatric disease. It appears to be more common in women who are obese and have low levels of exercise while incidence is lower in those using hormonal contraception. The condition regularly recurs in the luteal phase of the menstrual cycle and disappears or significantly regresses by the end of menstruation. Typically, it presents with psychological (mood swings, irritability, depression), physical (breast tenderness, bloating and headaches) and behavioural (reduced visuospatial and cognitive ability, and increased accidents) symptoms.

**DIAGNOSIS AND TREATMENT**

Why PMS occurs remains uncertain. Diagnosis requires that no symptoms be present in the days between the end of menstruation and ovulation. Women need to use a diary to record their symptoms for two cycles. The RCOG recommends using the Daily Record of Severity of Problems as it is well established and easy to use. The majority of PMS cases are dealt with in general practice but severe cases should be managed by a multidisciplinary team including a gynaecologist, psychiatrist or psychologist, dietitian and counsellor. Unfortunately this approach is rarely available. The treatment of severe PMS focuses on suppressing ovulation and treating progesterone sensitivity (Yonkers et al, 2008). An outline for a staged approach is given in the guidance with a detailed breakdown of the different management options.

**Lifestyle advice**

Exercise, diet, glycaemic control and stress reduction can help to manage symptoms before resorting to any treatment. Where a woman has an underlying pathology as well as PMS, the guidance recommends referral to a psychiatrist.

**Cognitive behavioural therapy**

Cognitive behavioural therapy has been shown to be effective for women with severe PMS, also known as premenstrual dysphoric disorder (PMDD), and should be used as a routine treatment option.

**Pharmacological management**

The guidelines recommend the use of the antidepressants, selective serotonin reuptake inhibitors (SSRIs) and selective serotonin and noradrenaline reuptake inhibitors (SNRIs). These drug treatments form the first line in pharmacological management of severe PMS. They are
Hormonal treatment

The newer type of contraceptive pill appears to be effective in treating PMS and should be considered as a first-line intervention. This is an important development as the combined pill was not shown to improve PMS symptoms. Treatment duration has been found to be important. Evidence now suggests that the contraceptive pill may be more effective in treating PMS if given continuously rather than cyclically. Percutaneous estradiol, either as an implant or a patch, combined with cyclical progesterone, is also effective and can be used to manage severe PMS.

The lowest possible dose of progesterone should be prescribed to minimise adverse effects. There is insufficient evidence to advise women on the long-term effects of estradiol on breast and endometrial tissue. The guidance also flags up the fact that although treatment with low-dose danazol may be effective, its effects as a steroid can lead to irreversible virilisation.

The guidance places gonadotrophin-releasing (GnRH) analogues as a second- or third-line treatment. They should not be considered before this because, while they are effective, they profoundly suppress ovulation and ovarian steroid production. The report concludes that, at present, there is insufficient evidence to recommend the routine use of progesterone or progestogens for women with PMS. Surgical interventions, although shown to be of benefit, should be reserved for extremely severe cases of PMS where other treatment has failed.

Complementary therapies

While there is limited evidence on the effectiveness of complementary therapies, many healthcare professionals agree that they have a place in an integrated approach to PMS treatment. Of the available data, there is most evidence supporting the use of vitamin D/calcium, magnesium and the herb agnus castus.

The nurse’s role

Nurses can support women emotionally by demonstrating that their worries about PMS are taken seriously. A person-centred approach allows the nurse to deal with individuals’ symptoms. Adolescents are prone to moderate to severe symptoms of PMS which they may be reluctant to report, while the mental health symptoms of PMS can wrongly suggest depression.

Occupational health nurses are well placed to help, as women suffering from PMS are unlikely to be absent because of their symptoms which, nevertheless, can cause them problems at work.

The guidance gives nurses the opportunity to take a fresh look at their practice and update their knowledge of PMS. They have a valuable part to play in the multidisciplinary care offered to women which can be developed in primary and secondary care.

Well-women clinics have the scope to address PMS more specifically than at present and to offer health promotion and lifestyle advice in every consultation. The hospital models of nursing care and care plans should reflect the increased awareness of the importance of PMS and PMDD.

CONCLUSION

The RCOG states that its recommendations should be further developed with research into key areas such as the use of new SSRIs/SNRIs; the collection of data on the new contraceptive pills and the long-term effects of estradiol and larger studies on the use of progesterone and progestogen in the treatment of PMS. There is a need for multidisciplinary services and evidence-based treatment so that the considerable morbidity and health burden caused by PMS can be treated effectively.

POSSIBLE TREATMENT REGIMENS FOR THE MANAGEMENT OF SEVERE PMS

First line
- Exercise, cognitive behavioural therapy, vitamin B6
- Combined new-generation pill, cyclically or continuously
- Continuous or luteal phase (days 15–28) low-dose SSRIs

Second line
- Estradiol patches (100mcg) and oral progestogen such as duphaston 10mg D17–D28 or Mirena
- Higher-dose SSRIs continuously or luteal phase

Third line
- GnRH analogues and add-back HRT (continuous combined oestrogen and progestogen or tibolone)

Fourth line
- Total abdominal hysterectomy and bilateral oophorectomy and HRT (including testosterone)

Source: RCOG (2008)

REFERENCES


