CLINICAL GUIDELINE

Premenstrual Syndrome Management, Gynaecology

A guideline is intended to assist healthcare professionals in the choice of disease-specific treatments.

Clinical judgement should be exercised on the applicability of any guideline, influenced by individual patient characteristics. Clinicians should be mindful of the potential for harmful polypharmacy and increased susceptibility to adverse drug reactions in patients with multiple morbidities or frailty.

If, after discussion with the patient or carer, there are good reasons for not following a guideline, it is good practice to record these and communicate them to others involved in the care of the patient.

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Lead Author:	Kay McAllister
Approval Group:	Gynaecology Clinical Governance Group

Important Note:

The Intranet version of this document is the only version that is maintained.
Any printed copies should therefore be viewed as 'Uncontrolled' and as such, may not necessarily contain the latest updates and amendments.

Greater Glasgow and Clyde Gynaecology Guidelines

Premenstrual Syndrome: management guideline

Premenstrual syndrome (PMS) is a condition in which distressing physical, behavioural and psychological symptoms regularly occur in the luteal phase of the menstrual cycle. There is an absence of organic or underlying psychiatric disease. Symptoms disappear by the end of menstruation.

Psychological: depressed mood, mood swings, loss of confidence, anxiety, irritability, food cravings
Physical: bloating, breast pain, headaches, backache, weight gain, acne
Behavioural: reduced cognitive/visuospatial ability, aggression, increased accidents

It is important to differentiate between these cyclical symptoms and those that are always present eg in some cases of depression

PMS is classified depending on the severity of symptoms:

Mild	interferes with personal/social/professional life
Moderate	interferes but still able to function and interact
Severe	unable to interact and withdraws from activities (affects 3-30% of women)

Diagnosis

Based on prospective recording using a symptom diary over at least 2 cycles (example in appendix 1)
If the symptom diary is inconclusive, Gonadotrophin-Releasing hormone (GnRH) analogues may be used for 3 months for a definitive diagnosis.

Treatment

Management should be tailored according to the severity and type of symptoms, the woman's preferences and fertility options. There are many treatment options available for PMS but no general consensus or evidence for optimum management.
Symptom diaries are useful in assessing the effect of treatment.

All women should be offered general lifestyle advice. This should cover:
Regular exercise
Smoking cessation
Alcohol restriction
Regular sleep
Stress reduction
Regular, frequent (2-3 hourly) well balanced meals rich in complex carbohydrates

Mild PMS

- Lifestyle advice as above

- Paracetamol or NSAID (for headaches or general aches/pains)
- Limited benefit of agnus castus, vitamin B6, St Johns Wort (please consider drug interactions)

Moderate PMS

- Lifestyle advice as above
- Continuous combined hormonal contraception especially a preparation containing drospirenone eg Yasmin (inform the woman that this is an unlicensed use unless she also requires contraception)
- Cognitive behavioural therapy
- Continuous or luteal phase low-dose SSRI eg fluoxetine 20mg, citalopram 10mg daily. Inform the woman that this is an off-license indication and there are side effects including reduced libido, fatigue and nausea. Provide pre-pregnancy counselling and advise the woman to discontinue prior to and during pregnancy
- Spironolactone (50-100mg daily) can be used to treat physical symptoms

Severe PMS - management of severe PMS should be discussed with a consultant or referral made to the gynaecology clinic at Sandyford.

- Any of the treatment options above
- Increase SSRI dose eg fluoxetine 40mg, citalopram 20mg
- Oestradiol patches (100mcg) plus *either* oral progestogen (eg medroxyprogesterone 10 mg days 17-28) *or* Levonorgestrel-IUS (eg Mirena or Levosert). If an IUS is not in place, barrier method must be used if contraception is required. Discuss micronized progesterone as an alternative for endometrial protection with senior doctor (eg uterogestan)
- GnRH analogues. HRT must be added if this treatment is for longer than 6 months, using a continuous combined preparation or tibolone. If on long term treatment, bone mineral density should be checked annually, preferably by dual-energy x-ray absorptiometry (DEXA) scan.
- Bilateral salpingo-oophorectomy (+/- hysterectomy) with post-op HRT, especially in those under 45 yrs. The woman must first have had a trial of GnRH analogue as a 'test of cure'

Complementary therapies

There are many complementary therapies available for women. Whilst many may confer individual benefit, it should be remembered that there is limited data and that some therapies may interact with conventional treatments. **The referring clinician retains legal responsibility for a patient's well-being when they refer them to complementary therapists.** Any woman wishing complementary treatment should initiate this herself.

Patient support

National Association for premenstrual syndrome. www.pms.org.uk

NHS. www.nhs.uk/conditions/Premenstrual-syndrome

RCOG patient information booklet. Managing premenstrual syndrome (PMS) patient information leaflet

References

RCOG. Management of pre-menstrual syndrome. Green-top guideline 48. February 2017. Accessed online June 2017
Premenstrual Syndrome, Management (Green-top Guideline No. 48)

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Approval: Dr R Jamieson, Clinical Director

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Appendix 1

Premenstrual Symptom Diary

Complete the chart by:
a) Rating the symptoms as follows: 0 - No symptoms 1 - Mild 2 - Moderate 3 - Severe
b) Day 1 of your cycle is when your period begins

Day of cycle	Sad or tearful	Angry or irritable	Tense or anxious	Reduced interest	Tired	Reduced concentration	Over-eating	+ or - sleep	Aches or pains	Headache	Bloating	Breast tenderness
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2												
3												
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Date of first day of period: