Premenstrual Syndrome (PMS) – GYN 2

DEFINITION

A collection of diverse physical, emotional and/or behavioral symptoms that negatively impact interpersonal relationships and regular, day-to-day activities. Symptoms occur cyclically, developing during the luteal phase and dissipating when menses start. A symptom pattern occurring during the 5 days prior to menses, dissipating within 4 days of the start of menses, and actively affecting a client's routine activities is indicative of PMS if occurring for at least three cycles. PMS is a diagnosis of exclusion; all others must be ruled out, including multiple mood disorders, substance use disorders, chronic pain and fatigue disorders and endocrine disorders. Premenstrual Dysphoric Disorder (PMDD) is a more severe form of PMS with specific diagnostic criteria.

SUBJECTIVE

History should include:

1. LMP
2. Symptoms that recur cyclically in the luteal phase with a symptom-free period in the follicular phase

May include:

1. Psychological: Irritability, anxiety, decreased sexual drive, social withdrawal, angry outbursts, crying, confusion, forgetfulness, extreme sadness, difficulty concentrating, depression, sleep alterations or insomnia
2. Physical: fatigue, body aches, acne, headache, breast tenderness, bloating, nausea/vomiting, frequent urination, constipation/diarrhea, dysmenorrhea, fluid retention, edema, cyclical weight changes, food cravings

*To be clinically significant, PMS symptoms must interfere with a woman's work, lifestyle, or interpersonal relationships.

OBJECTIVE

May include:

1. Age-appropriate physical exam, as indicated
2. Define and identify symptom pattern(s). Encourage symptom charting for three months, or at least 1-2 menstrual cycles, to observe for cyclic patterns. Documentation of symptoms in a diary fashion is pertinent; retrospective recall must be more accurate
3. PHQ-2 or PHQ-9 to be completed.

LABORATORY

No lab testing confirms PMS; however, labs may be medically indicated to rule out other conditions., i.e., r/o hypothyroidism.

ASSESSMENT

Premenstrual Syndrome (PMS)

PLAN

Nonmedical management may include:

1. Reassurance may provide patient relief that no serious health threats exist, there are no quick cures, and that patience is key. Avoid known physical or emotional triggers
2. There is little evidence supporting the helpfulness of diet revisions or restrictions. Diet changes may include:
    a. Increase water intake to 6-8 glasses per day
    b. Limit salt intake to 3 gm or less per day
    c. Reduce refined sugars and increase intake of complex carbohydrates (fresh fruits, vegetables, whole grains, pasta, rice, and potatoes)

   d. Avoid caffeine, chocolate, tobacco, and alcohol intake
   e. Consume moderate amounts of protein and fat (decrease animal fats; increase vegetable oils).
   f. A complex carbohydrate diet during the luteal phase of the menstrual cycle
3. Stress reduction techniques (i.e., biofeedback, reflexology, meditation, or other relaxation techniques, mindfulness training); group therapy or support groups
4. Sleep hygiene (i.e., keeping a regular schedule, limiting caffeine after noon, limiting sedatives and limiting alcohol intake)
5. Light therapy may decrease the need for antidepressant medication
6. Exercise: Recommend aerobic activity 20 to 30 minutes at least 4x weekly, personal preference to be considered with a realistic achievable program; Yoga
7. For mood changes may include:
   a. Vitamin B6 50mg-100mg daily; continuous use (discourage high doses of over 200mg per day to avoid peripheral neuropathy)
   b. Calcium carbonate 1,200- 1,600 mg per day *Some resources note low-quality evidence for Vitamin B6 and Calcium use; study results may not be generalized to all women
   c. Saffron Extract 15 mg twice daily (minimal side-effects; considered safe in doses up to 1.5 g/day)

Medical management may include:

1. Spironolactone during the luteal phase may reduce swelling and bloating
2. NSAIDs administered before and during menstruation may relieve symptoms such as fluid retention and lower back, abdominal, pelvic and breast pain
3. Combined contraceptives suppress ovulation and may eliminate cyclic symptoms, although not in all women. Consider continuous or extended-use regimens. If using OCPs, monophasic is recommended. Drospirenone can decrease bloating and mastalgia
4. SSRIs have been shown to alleviate severe PMS; may consider administration during luteal phase of each month, starting on cycle day 14 and discontinuing at onset of menses or within the first few days of menstrual cycle. Sertraline, citalopram, escitalopram, and fluoxetine are the most studied and approved for use in premenstrual disorders. Paroxetine is also well-studied and effective, but more likely to cause weight gain

CLIENT EDUCATION

1. Provide client education handout(s). Review symptoms, complications and danger signs
2. Review safer sex education, as appropriate
3. Recommend client RTC annually, PRN for problems or appropriate per plan

CONSULT / REFER TO PHYSICIAN

1. Any client experiencing increasing depressive symptoms or suicidal tendencies
2. As appropriate if pharmacologic agents are used
3. Consider consult/referral for clients with symptoms of PMDD.

REFERENCES

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4. Medscape: Premenstrual Syndrome
5. Effect of Combined Use of Calcium and Vitamin B6 on Premenstrual Syndrome Symptoms: a Randomized Clinical Trial
6. Saffron for the Management of Premenstrual Dysphoric Disorder: A Randomized Controlled Trial