Management in Primary Care for PMS

Women with :

**Mild physiological premenstrual symptoms that have no substantial impact on their functioning may need no more than support and reassurance of normality**

* advise good nutrition, exercise , and stress reduction

**Debilitating symptoms with a symptom-free week:**

* likely to have premenstrual syndrome (PMS)
* see 'Consider treatment options'

**Debilitating symptoms but no symptom-free week:**

* may have an underlying psychological, psychiatric, or physical condition that is not related to the ovarian cycle and which is unlikely to be a premenstrual disorder
* explore alternative diagnoses and refer to psychiatric services if necessary
* symptoms of the perimenopause can be similar to PMS but are non-cyclical − consider menopause

**A premenstrual syndrome-like cycle associated with progestogen treatment:**

* may be managed easily by changing type, dose, or duration of the treatment
* consider administration of progesterone via a levonorgestrel releasing intrauterine system
* if symptoms are caused by the oral contraceptive, consider changing the pill or changing to an intrauterine system

**Substantial premenstrual impairment with only partial relief after menstruation:**

* could have an underlying psychological or physical condition with exacerbations related to ovarian function
* consider either:
* treating the underlying condition adequately, in which case the premenstrual phase may become tolerable; or
* suppressing ovulation to reduce luteal phase symptoms to the level of the follicular phase
* psychological interventions and psychotropic agents may achieve both aims simultaneously in these patients or in those with both a psychiatric disorder and PMS

General practitioners should deal with most cases of premenstrual syndrome (PMS).

**When treating women with PMS:**

* general advice regarding exercise , diet, and stress reduction should be considered before starting treatment
* women with marked underlying psychopathology as well as PMS should be referred to a psychiatrist
* symptom diaries should be used to assess the effect of treatment

**Non-medication based treatments:**

**Lifestyle:**

* education about PMS
* cognitive behavioural therapy (where available) should be considered routinely as a treatment option. A set of 10 sessions has been shown to have comparable effects to the selective serotonin reuptake inhibitor (SSRI) fluoxetine
* relaxation techniques − stretching and breathing exercises (eg yoga, pilates) may help reduce stress levels and improve sleep
* regular aerobic exercise – at least 20-30 minutes, 3 times a week

combined new-generation contraceptive pill Yasmin contains drospirenone (an anti-mineralocorticoid and anti-androgenic progestogen) and ethinylestradiol

* treatment with the lowest possible dose of progestogen is recommended to minimise adverse effects

In general, complementary therapy recommendations are not evidence-based and should not be recommended

However, limited evidence exists to support the use of the following:

• magnesium

• calcium

• vitamin D

• vitamin B6 − daily dose restricted by Department of Health (DH) to decrease risk of peripheral neuropathy

• fruit extract of Vitex agnus-castus

Other complementary therapies (eg St John's wort) should **not** be routinely recommended (require further investigation)

If the patient is age 18 years or older, and clinician is confident in PMS diagnosis (and has sufficient prescribing experience), also consider prescribing continuous or luteal phase (day 15-28) low-dose selective serotonin reuptake inhibitor (SSRI) eg fluoxetine , paroxetine , citalopram , sertralin

* woman should be informed that this indication is outside the marketing authorisation (product licence) of SSRIs in the UK
* lower doses used than for mood disorders
* possible (reversible) adverse effects include]:
* nausea,insomnia, reduction in libido, fatigue, headache, sweating, tremor
* side effects are less common with luteal phase only treatment
* symptoms may improve within 48 hours
* prescribe for 3 months initially

If a continuous SSRI is prescribed, it should be withdrawn gradually (over a few weeks) to avoid withdrawal symptoms

* serotonin and noradrenaline reuptake inhibitor (SNRI) eg venlafaxine; effective at reducing mood and physical symptoms when used continuously for 14 days before menses
* used at a lower dose than that recommended to treat a mood disorder

If the patient is younger than age 18 years, or diagnosis is uncertain, refer to a gynaecologist for consideration of treatment options

**The following should not be initiated in primary care for PMS (due to ineffectiveness and/or a significant adverse effects profile)**

• progesterone or progestogens used alone

• antidepressants other than SSRIs − however, the Royal College of Obstetricians and Gynaecologists and expert recommendations suggest that SNRIs may be prescribed in primary care

• alprazolam

• diuretics

• danazol

• transdermal oestrogen

• gonadotrophin-releasing hormone analogues

Progress should be monitored using the patient's symptom diary

Selective serotonin reuptake inhibitor (SSRI) treatment withdrawal should occur gradually

Follow-up should occur to check on symptom progress and assess for features of treatment withdrawal

**Features of abrupt selective serotonin reuptake inhibitor (SSRI) treatment withdrawal include:**

• gastrointestinal disturbances

• headache

• anxiety

• dizziness

• paraesthesia

• sleep disturbances

• fatigue

• influenza-like symptoms

• sweating

Referral to a gynaecologist should be considered when simple measures have been explored and failed and when the severity of the premenstrual syndrome (PMS) justifies gynaecological intervention