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# A review of treatment of premenstrual syndrome & premenstrual dysphoric disorder

Andrea Rapkin \*

*UCLA School of Medicine, Department of Obstetrics and Gynecology, Center for the Health Sciences,  
Room 27-165, 10833 Le Conte Avenue, Los Angeles, CA 90095-1740, USA*

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## Abstract

Severe premenstrual syndrome (PMS) and, more recently, premenstrual dysphoric disorder (PMDD) have been studied extensively over the last 20 years. The defining criteria for diagnosis of the disorders according to the American College of Obstetricians & Gynecologists (ACOG) include at least one moderate to severe mood symptom and one physical symptom for the diagnosis of PMS and by DSM IV criteria a total of 5 symptoms with 1 severe mood symptom for the diagnosis of PMDD. There must be functional impairment attributed to the symptoms. The symptoms must be present for one to two weeks premenstrually with relief by day 4 of menses and should be documented prospectively for at least two cycles using a daily rating form. Nonpharmacologic management with some evidence for efficacy include cognitive behavioral relaxation therapy, aerobic exercise, as well as calcium, magnesium, vitamin B<sub>6</sub>, L-tryptophan supplementation or a complex carbohydrate drink. Pharmacologic management with at least ten randomized controlled trials to support efficacy include selective serotonin reuptake inhibitors administered daily or premenstrually and serotonergic tricyclic antidepressants. Anxiolytics and potassium sparing diuretics have demonstrated mixed results in the literature. Hormonal therapy is geared towards producing anovulation. There is good clinical evidence for GnRH analogs with addback hormonal therapy, danocrine, and estradiol implants or patches with progestin to protect the endometrium. Oral contraceptive pills prevent ovulation and should be effective for the treatment of PMS/PMDD. However, limited evidence does not support efficacy for oral contraceptive agents containing progestins derived from 19-nortestosterone. The combination of the estrogen and progestin may produce symptoms similar to PMS, such as water retention and irritability. There is preliminary evidence that a new oral contraceptive pill containing low-dose estrogen and the progestin drospirenone, a spironolactone analog, instead of a 19-nortestosterone derivative can reduce symptoms of water retention and other side effects related to estrogen excess. The studies are in progress, however, prelimi-

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\* Tel.: +1-310-794-1981; fax: +1-310-206-3670.

*E-mail address:* arapkin@mednet.ucla.edu (A. Rapkin).

nary evidence suggests that the drospirenone-containing pill called Yasmin may be effective the treatment of PMDD.

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Tempestuous premenstrual behavior was described by Hippocrates, who attributed the symptoms to agitated blood seeking escape from the womb. However, it was in the 1930's that the premenstrual tension syndrome was first delineated, possibly coinciding with the entry of women into the workforce. In the 1950's, the term Premenstrual Syndrome (PMS) was applied to the physical and psychological symptoms occurring for up to 2 weeks prior to menses with relief seen after the onset of the menstrual period. In the 1990's, criteria were included in the Appendix of the Diagnostic and Statistical Manual for Mental Disorders, 3rd and then 4th edition, describing Late Luteal Phase Dysphoric Disorder (LLPDD) and finally Premenstrual Dysphoric Disorder (PMDD), a particularly severe form of Premenstrual Syndrome with an emphasis on the affective symptoms (DSM-IV, 1994). In April, 2000 the American College of Obstetricians and Gynecologists published a Practice Bulletin on the topic of PMS, that included criteria for diagnosis and recommendations for the treatment of clinically significant Premenstrual Syndrome ([ACOG Practice Bulletin, 2000](#)).

The development of evidence-based guidelines for the treatment of severe PMS/PMDD has been hampered for various reasons. Studies investigating the treatment of PMS have included subjects with a variety of different premenstrual symptoms. Often the inclusion and exclusion criteria differed among studies. Earlier studies also suffered from the use of retrospective recall as opposed to prospective daily recording to confirm the diagnosis of PMS. Retrospective recall correlates with prospective daily recording of symptoms in only 50% of the cases ([Rapkin et al., 1988](#)). Even in the setting of well-defined diagnostic criteria, such as currently exist for PMS/PMDD, the methodology employed to rule out underlying or coexisting psychiatric disorders and the specific daily rating scales utilized to record symptomatology vary among studies. Many of the early studies were not placebo controlled or suffered from a high placebo response rate. The latter outcome is often associated with evaluation of a large number of symptoms of mild to moderate severity. Furthermore, because the PMS patients studied in clinical trials may differ from the population of women suffering from PMS/PMDD as a whole, it is important that more than one treatment trial of a specific therapy demonstrate efficacy. Lastly by narrowly delineating a severe syndrome, such as PMDD, women who seek treatment for a less severe condition, such as moderate PMS, and those with primarily somatic symptoms and mild to moderate mood symptoms have been excluded from recent PMDD treatment trials.

ACOG criteria for PMS and DSM-IV criteria for PMDD both require the presence of at least one moderate to severe affective symptom and functional impairment

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