Premenstrual Dysphoric Disorder

Code: 625.4 (N94.3)

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Diagnostic Criteria 625.4 (N94.3)

A. In the majority of menstrual cycles, at least five symptoms must be present in the final week before the onset of menses, start to improve within a few days after the onset of menses, and become minimal or absent in the week postmenses.
B. One (or more) of the following symptoms must be present:
1. Marked affective lability (e.g., mood swings; feeling suddenly sad or tearful, or increased sensitivity to rejection).
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2. Marked irritability or anger or increased interpersonal conflicts.
3. Marked depressed mood, feelings of hopelessness, or self-deprecating thoughts.
4. Marked anxiety, tension, and/or feelings of being keyed up or on edge.
C. One (or more) of the following symptoms must additionally be present, to reach a total of five symptoms when combined with symptoms from Criterion B above.
1. Decreased interest in usual activities (e.g., work, school, friends, hobbies).
2. Subjective difficulty in concentration.
3. Lethargy, easy fatigability, or marked lack of energy.
4. Marked change in appetite; overeating; or specific food cravings.
5. Hypersomnia or insomnia.
6. A sense of being overwhelmed or out of control.
7. Physical symptoms such as breast tenderness or swelling, joint or muscle pain, a sensation of "bloating," or weight gain.
Note: The symptoms in Criteria A–C must have been met for most menstrual cycles that occurred in the preceding year.
D. The symptoms are associated with clinically significant distress or interference with work, school, usual social activities, or relationships with others (e.g., avoidance of social activities; decreased productivity and efficiency at work, school, or home).
E. The disturbance is not merely an exacerbation of the symptoms of another disorder, such as major depressive disorder, panic disorder, persistent depressive disorder (dysthymia), or a personality disorder (although it may co-occur with any of these disorders).
F. Criterion A should be confirmed by prospective daily ratings during at least two symptomatic cycles. (Note: The diagnosis may be made provisionally prior to this confirmation.)
G. The symptoms are not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication, other treatment) or another medical condition (e.g., hypothyroidism).

Recording Procedures

If symptoms have not been confirmed by prospective daily ratings of at least two symptomatic cycles, "provisional" should be noted after the name of the diagnosis (i.e., "premenstrual dysphoric disorder, provisional").

Diagnostic Features

The essential features of premenstrual dysphoric disorder are the expression of mood lability, irritability, dysphoria, and anxiety symptoms that occur repeatedly during the premenstrual phase of the cycle and remit around the onset of menses or shortly thereafter. These symptoms may be accompanied by behavioral and physical symptoms. Symptoms must have occurred in most of the menstrual cycles during the past year and must have an adverse effect on work or social functioning. The intensity and/or expressivity of the accompanying symptoms may be closely related to social and cultural background characteristics of the affected female, family perspectives, and more specific factors such as religious beliefs, social tolerance, and female gender role issues.
Typically, symptoms peak around the time of the onset of menses. Although it is not uncommon for symptoms to linger into the first few days of menses, the individual must have a symptom-free period in the follicular phase after the menstrual period begins. While the core symptoms include mood and anxiety symptoms, behavioral and somatic symptoms commonly also occur. However, the presence of physical and/or behavioral symptoms in the absence of mood and/or anxious symptoms is not sufficient for a diag-
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nosis. Symptoms are of comparable severity (but not duration) to those of another mental disorder, such as a major depressive episode or generalized anxiety disorder. In order to confirm a provisional diagnosis, daily prospective symptom ratings are required for at least two symptomatic cycles.

Associated Features Supporting Diagnosis

Delusions and hallucinations have been described in the late luteal phase of the menstrual cycle but are rare. The premenstrual phase has been considered by some to be a risk period for suicide.

Prevalence

Twelve-month prevalence of premenstrual dysphoric disorder is between 1.8% and 5.8% of menstruating women. Estimates are substantially inflated if they are based on retrospective reports rather than prospective daily ratings. However, estimated prevalence based on a daily record of symptoms for 1–2 months may be less representative, as individuals with the most severe symptoms may be unable to sustain the rating process. The most rigorous estimate of premenstrual dysphoric disorder is 1.8% for women whose symptoms meet the full criteria without functional impairment and 1.3% for women whose symptoms meet the current criteria with functional impairment and without co-occurring symptoms from another mental disorder.

Development and Course

Onset of premenstrual dysphoric disorder can occur at any point after menarche. Incidence of new cases over a 40-month follow-up period is 2.5% (95% confidence interval = 1.7–3.7). Anecdotally, many individuals, as they approach menopause, report that symptoms worsen. Symptoms cease after menopause, although cyclical hormone replacement can trigger the re-expression of symptoms.

Risk and Prognostic Factors

Environmental. Environmental factors associated with the expression of premenstrual dysphoric disorder include stress, history of interpersonal trauma, seasonal changes, and sociocultural aspects of female sexual behavior in general, and female gender role in particular.
Genetic and physiological. Heritability of premenstrual dysphoric disorder is unknown. However, for premenstrual symptoms, estimates for heritability range between 30% and 80%, with the most stable component of premenstrual symptoms estimated to be about 50% heritable.
Course modifiers. Women who use oral contraceptives may have fewer premenstrual complaints than do women who do not use oral contraceptives.

Culture-Related Diagnostic Issues

Premenstrual dysphoric disorder is not a culture-bound syndrome and has been observed in individuals in the United States, Europe, India, and Asia. It is unclear as to whether rates differ by race. Nevertheless, frequency, intensity, and expressivity of symptoms and help-seeking patterns may be significantly influenced by cultural factors.

Diagnostic Markers

As indicated earlier, the diagnosis of premenstrual dysphoric disorder is appropriately confirmed by 2 months of prospective symptom ratings. A number of scales, including the
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Daily Rating of Severity of Problems and the Visual Analogue Scales for Premenstrual Mood Symptoms, have undergone validation and are commonly used in clinical trials for premenstrual dysphoric disorder. The Premenstrual Tension Syndrome Rating Scale has a self-report and an observer version, both of which have been validated and used widely to measure illness severity in women who have premenstrual dysphoric disorder.

Functional Consequences of

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Symptoms must be associated with clinically meaningful distress and/or an obvious and marked impairment in the ability to function socially or occupationally in the week prior to menses. Impairment in social functioning may be manifested by marital discord and problems with children, other family members, or friends. Chronic marital or job problems should not be confused with dysfunction that occurs only in association with premenstrual dysphoric disorder.

Differential Diagnosis

Premenstrual syndrome. Premenstrual syndrome differs from premenstrual dysphoric disorder in that a minimum of five symptoms is not required, and there is no stipulation of affective symptoms for individuals who have premenstrual syndrome. This condition may be more common than premenstrual dysphoric disorder, although the estimated prevalence of premenstrual syndrome varies. While premenstrual syndrome shares the feature of symptom expression during the premenstrual phase of the menstrual cycle, it is generally considered to be less severe than premenstrual dysphoric disorder. The presence of physical or behavioral symptoms in the premenstruum, without the required affective symptoms, likely meets criteria for premenstrual syndrome and not for premenstrual dysphoric disorder.
Dysmenorrhea. Dysmenorrhea is a syndrome of painful menses, but this is distinct from a syndrome characterized by affective changes. Moreover, symptoms of dysmenorrhea begin with the onset of menses, whereas symptoms of premenstrual dysphoric disorder, by definition, begin before the onset of menses, even if they linger into the first few days of menses.
Bipolar disorder, major depressive disorder, and persistent depressive disorder (dysthymia). Many women with (either naturally occurring or substance/medication-induced) bipolar or major depressive disorder or persistent depressive disorder believe that they have premenstrual dysphoric disorder. However, when they chart symptoms, they realize that the symptoms do not follow a premenstrual pattern. Women with another mental disorder may experience chronic symptoms or intermittent symptoms that are unrelated to menstrual cycle phase. However, because the onset of menses constitutes a memorable event, they may report that symptoms occur only during the premenstruum or that symptoms worsen premenstrually. This is one of the rationales for the requirement that symptoms be confirmed by daily prospective ratings. The process of differential diagnosis, particularly if the clinician relies on retrospective symptoms only, is made more difficult because of the overlap between symptoms of premenstrual dysphoric disorder and some other diagnoses. The overlap of symptoms is particularly salient for differentiating premenstrual dysphoric disorder from major depressive episodes, persistent depressive disorder, bipolar disorders, and borderline personality disorder. However, the rate of personality disorders is no higher in individuals with premenstrual dysphoric disorder than in those without the disorder.
Use of hormonal treatments. Some women who present with moderate to severe premenstrual symptoms may be using hormonal treatments, including hormonal contraceptives. If such symptoms occur after initiation of exogenous hormone use, the symptoms
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may be due to the use of hormones rather than to the underlying condition of premenstrual dysphoric disorder. If the woman stops hormones and the symptoms disappear, this is consistent with substance/medication-induced depressive disorder.

Comorbidity

A major depressive episode is the most frequently reported previous disorder in individuals presenting with premenstrual dysphoric disorder. A wide range of medical (e.g., migraine, asthma, allergies, seizure disorders) or other mental disorders (e.g., depressive and bipolar disorders, anxiety disorders, bulimia nervosa, substance use disorders) may worsen in the premenstrual phase; however, the absence of a symptom-free period during the postmenstrual interval obviates a diagnosis of premenstrual dysphoric disorder. These conditions are better considered premenstrual exacerbation of a current mental or medical disorder. Although the diagnosis of premenstrual dysphoric disorder should not be assigned in situations in which an individual only experiences a premenstrual exacerbation of another mental or physical disorder, it can be considered in addition to the diagnosis of another mental or physical disorder if the individual experiences symptoms and changes in level of functioning that are characteristic of premenstrual dysphoric disorder and markedly different from the symptoms experienced as part of the ongoing disorder.
Substance/Medication-Induced Depressive Disorder

Diagnostic Criteria

A. A prominent and persistent disturbance in mood that predominates in the clinical picture and is characterized by depressed mood or markedly diminished interest or pleasure in all, or almost all, activities.
B. There is evidence from the history, physical examination, or laboratory findings of both (1) and (2):
1. The symptoms in Criterion A developed during or soon after substance intoxication or withdrawal or after exposure to a medication.
2. The involved substance/medication is capable of producing the symptoms in Criterion A.
C. The disturbance is not better explained by a depressive disorder that is not substance/medication-induced. Such evidence of an independent depressive disorder could include the following:
The symptoms preceded the onset of the substance/medication use; the symptoms persist for a substantial period of time (e.g., about 1 month) after the cessation of acute withdrawal or severe intoxication; or there is other evidence suggesting the existence of an independent non-substance/medication-induced depressive disorder (e.g., a history of recurrent non-substance/medication-related episodes).
D. The disturbance does not occur exclusively during the course of a delirium.
E. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.
Note: This diagnosis should be made instead of a diagnosis of substance intoxication or substance withdrawal only when the symptoms in Criterion A predominate in the clinical picture and when they are sufficiently severe to warrant clinical attention.
Coding note: The ICD-9-CM and ICD-10-CM codes for the [specific substance/medication]-induced depressive disorders are indicated in the table below. Note that the ICD-10-
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CM code depends on whether or not there is a comorbid substance use disorder present for the same class of substance. If a mild substance use disorder is comorbid with the substance-induced depressive disorder, the 4th position character is "1," and the clinician should record "mild [substance] use disorder" before the substance-induced depressive disorder (e.g., "mild cocaine use disorder with cocaine-induced depressive disorder"). If a moderate or severe substance use disorder is comorbid with the substance-induced depressive disorder, the 4th position character is "2," and the clinician should record "moderate [substance] use disorder" or "severe [substance] use disorder," depending on the severity of the comorbid substance use disorder. If there is no comorbid substance use disorder (e.g., after a one-time heavy use of the substance), then the 4th position character is "9," and the clinician should record only the substance-induced depressive disorder.

ICD-10-CM			
With use			
With use disorder, mild	Without disorder, moderate use	ICD-9-CM mild or severe disorder	
Alcohol	291.89	F10.14	F10.24 F10.94
Phencyclidine	292.84	F16.14	F16.24 F16.94
Other hallucinogen	292.84	F16.14	F16.24 F16.94
Inhalant	292.84	F18.14	F18.24 F18.94
Opioid	292.84	F11.14	F11.24 F11.94
Sedative, hypnotic, or anxiolytic	292.84	F13.14	F13.24 F13.94
Amphetamine (or other stimulant)	292.84	F15.14	F15.24 F15.94
Cocaine	292.84	F14.14	F14.24 F14.94
Other (or unknown) substance	292.84	F19.14	F19.24 F19.94

Specify if (see Table1 in the chapter "Substance-Related and Addictive Disorders" for diagnoses associated with substance class):
With onset during intoxication: If criteria are met for intoxication with the substance and the symptoms develop during intoxication.
With onset during withdrawal: If criteria are met for withdrawal from the substance and the symptoms develop during, or shortly after, withdrawal.

Recording Procedures

ICD-9-CM. The name of the substance/medication-induced depressive disorder begins with the specific substance (e.g., cocaine, dexamethasone) that is presumed to be causing the depressive symptoms. The diagnostic code is selected from the table included in the criteria set, which is based on the drug class. For substances that do not fit into any of the classes (e.g., dexamethasone), the code for "other substance" should be used; and in cases in which a substance is judged to be an etiological factor but the specific class of substance