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Management of Premenstrual Syndrome

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Management of Premenstrual Syndrome

This is the second edition of this guideline, which was first published in 2007 under the same title.

Executive summary of recommendations

How is premenstrual syndrome (PMS) diagnosed?

When clinically reviewing women for PMS, symptoms should be recorded prospectively, over two cycles using a symptom diary, as retrospective recall of symptoms is unreliable. ✓

A symptom diary should be completed by the patient prior to commencing treatment. ✓

Gonadotrophin-releasing hormone (GnRH) analogues may be used for 3 months for a definitive diagnosis if the completed symptom diary alone is inconclusive. [*New 2016*] ✓

What aspects are involved in delivering a service to women with PMS?

When should women with PMS be referred to a gynaecologist?

Referral to a gynaecologist should be considered when simple measures (e.g. combined oral contraceptives [COCs], vitamin B6, selective serotonin reuptake inhibitors [SSRIs]) have been explored and failed and when the severity of the PMS justifies gynaecological intervention. ✓

Who are the key health professionals to manage women with severe PMS?

Women with severe PMS may benefit from being managed by a multidisciplinary team comprising a general practitioner, a general gynaecologist or a gynaecologist with a special interest in PMS, a mental health professional (psychiatrist, clinical psychologist or counsellor) and a dietician. [*New 2016*] ✓

How is PMS managed?

Are complementary therapies efficacious in treating PMS?

Women with PMS should be informed that there is conflicting evidence to support the use of some complementary medicines. C

An integrated holistic approach should be used when treating women with PMS. ✓

Interactions with conventional medicines should be considered. ✓

Is there a role for cognitive behavioural therapy (CBT) and other psychological counselling techniques?

When treating women with severe PMS, CBT should be considered routinely as a treatment option. A

Hormonal medical management of PMS

Which COC has the best evidence for managing PMS, including regimens delivering ethinylestradiol?

When treating women with PMS, drospirenone-containing COCs may represent effective treatment for PMS and should be considered as a first-line pharmaceutical intervention. [*New 2016*] B

What is the optimum COC pill regimen, e.g. continuous, cyclical or flexible?

When treating women with PMS, emerging data suggest use of the contraceptive pill continuously rather than cyclically. ✓

How efficacious is percutaneous estradiol?

Percutaneous estradiol combined with cyclical progestogens has been shown to be effective for the management of physical and psychological symptoms of severe PMS. A

When treating women with PMS, alternative barrier or intrauterine methods of contraception should be used when estradiol is used to suppress ovulation. ✓

How can the return of PMS symptoms be avoided during estrogen therapy with progestogenic protection?

When using transdermal estrogen to treat women with PMS, the lowest possible dose of progesterone or progestogen is recommended to minimise progestogenic adverse effects. [*New 2016*] A

Women should be informed that low levels of levonorgestrel released by the levonorgestrel-releasing intrauterine system (LNG-IUS) 52 mg can initially produce PMS-type adverse effects (as well as bleeding problems). [*New 2016*] ✓

Micronised progesterone is theoretically less likely to reintroduce PMS-like symptoms and should therefore be considered as first line for progestogenic opposition rather than progestogens. [*New 2016*] ✓

What is the optimum regimen for prevention of endometrial hyperplasia?

When treating women with percutaneous estradiol, a cyclical 10–12 day course of oral or vaginal progesterone or long-term progestogen with the LNG-IUS 52 mg should be used for the prevention of endometrial hyperplasia. [*New 2016*] ✓

When using a short duration of progestogen therapy, or in cases where only low doses are tolerated, there should be a low threshold for investigating unscheduled bleeding. [*New 2016*] ✓

What is the safety of estradiol on the premenopausal endometrium and breast tissue?

When treating women with PMS using estradiol, women should be informed that there are insufficient data to advise on the long-term effects on breast and endometrial tissue. ✓

For how long can estradiol be used safely and what is the risk of recurrence?

Due to the uncertainty of the long-term effects of opposed estradiol therapy, treatment of women with PMS should be on an individual basis, taking into account the risks and benefits. [*New 2016*] ✓

What is the evidence for efficacy and adverse effects of danazol in the treatment of PMS?

Women with PMS should be advised that, although treatment with low dose danazol (200 mg twice daily) is effective in the luteal phase for breast symptoms, it also has potential irreversible virilising effects. [*New 2016*] A

Women treated with danazol for PMS should be advised to use contraception during treatment due to its potential virilising effects on female fetuses. [*New 2016*] ✓

How effective are GnRH analogues for treating severe PMS?

GnRH analogues are highly effective in treating severe PMS. [*New 2016*] A

When treating women with PMS, GnRH analogues should usually be reserved for women with the most severe symptoms and not recommended routinely unless they are being used to aid diagnosis or treat particularly severe cases. [*New 2016*] ✓

How should women with PMS receiving add-back therapy be managed?

When treating women with severe PMS using GnRH analogues for more than 6 months, add-back hormone therapy should be used. [*New 2016*] A

When add-back hormone therapy is required, continuous combined hormone replacement therapy (HRT) or tibolone is recommended. A

Women should be provided with general advice regarding the effects of exercise, diet and smoking on bone mineral density (BMD). ✓

Women on long-term treatment should have measurement of BMD (ideally by dual-energy X-ray absorptiometry [DEXA]) every year. Treatment should be stopped if bone density declines significantly. [*New 2016*] D

Can GnRH analogues be useful in clarification of diagnostic category?

When the diagnosis of PMS is unclear from 2 months' prospective Daily Record of Severity of Problems (DRSP) charting, GnRH analogues can be used to establish and/or support a diagnosis of PMS. [*New 2016*] ✓

What is the role for progesterone and progestogen preparations in treating PMS?

There is good evidence to suggest that treating PMS with progesterone or progestogens is not appropriate. [*New 2016*] A

There is no evidence to support the use of the LNG-IUS 52 mg alone to treat PMS symptoms. Its role should be confined to opposing the action of estrogen therapy on the endometrium. ✓

Non-hormonal medical management of PMS

How do selective SSRIs work in PMS and how should they be given?

SSRIs should be considered one of the first-line pharmaceutical management options in severe PMS. [*New 2016*] A

What is the efficacy of SSRIs in treatment of PMS?

When treating women with PMS, either luteal or continuous dosing with SSRIs can be recommended. B

Is there any evidence on how SSRIs should be discontinued when used in PMS?

SSRIs should be discontinued gradually to avoid withdrawal symptoms, if given on a continuous basis. ✓

What are the risks and adverse effects of SSRIs?

Women with PMS treated with SSRIs should be warned of the possible adverse effects such as nausea, insomnia, somnolence, fatigue and reduction in libido. [*New 2016*] ✓

Is there evidence for improved efficacy with other SSRI regimens?

When using SSRIs to treat PMS, efficacy may be improved and adverse effects minimised by the use of luteal-phase regimens with the newer agents. [*New 2016*] A

What preconception and early pregnancy advice should be given regarding SSRIs/serotonin–noradrenaline reuptake inhibitors (SNRIs)?

Women should be provided with prepregnancy counselling at every opportunity. They should be informed that PMS symptoms will abate during pregnancy and SSRIs should therefore be discontinued prior to and during pregnancy. [*New 2016*] ✓

