ROCK MY MENOPAUSE

Premenstrual disorders

This leaflet will help you to understand if you have the symptoms of a premenstrual disorder, what to discuss with your GP, and your treatment options.

Words by *Dr Hannah Short and Dr Jane Davis*

Do you feel your mood is linked to your menstrual cycle? Are you riding an emotional roller coaster? Are you bothered by any of these symptoms in the run-up to your period?

- Depressed mood, hopelessness, lack of pleasure in the things you'd normally enjoy
- Anxiety, tension, panic attacks
- Mood swings, tearfulness, sensitivity to rejection
- Irritability, anger, getting into arguments more often
- Suicidal thoughts or thoughts of disappearing
- Tiredness, low energy
- 'Brain fog', difficulty thinking clearly, lack of concentration
- Food cravings, overeating
- Insomnia, or sleeping too much
- Feeling overwhelmed or out of control
- Physical symptoms (e.g. headaches, bloating, breast tenderness, joint pain)

If so, you could be living with a form of Premenstrual Disorder. You are not alone. Premenstrual Dysphoric Disorder (PMDD) is thought to affect 5–8% of women and AFAB (assigned female at birth) individuals. Symptoms occur following ovulation and last anywhere from a few days to a couple of weeks, but begin to improve around the time the period starts, and fully resolve within a few days.

1 KEEP A DIARY OF YOUR SYMPTOMS

A diagnosis is made via symptom tracking. Recording symptoms alongside your menstrual cycle for 2–3 cycles gives you info to take to your GP to show them the cyclical pattern. Search for handy apps such as Me v PMDD, PreMentricS, Flo, or Clue. If you prefer pen and paper, there are printable alternatives that can be found on IAPMD.org and/or the NAPS Menstrual Diary.

Blood tests cannot detect PMDD but may be considered to rule out other potential causes e.g. thyroid disorder.

2 MAKE AN APPOINTMENT WITH YOUR GP

By taking your symptom tracker with you, it may help your GP to work out which type of premenstrual disorder you may have:

1. Physiological (mild) premenstrual disorder
2. Core premenstrual disorder (premenstrual dysphoric disorder, PMDD)
3. Premenstrual exacerbation (PME) – this is the worsening of a pre-existing disorder before a period
4. Premenstrual disorder with absent menstruation
5. Progestogen-induced premenstrual disorder.

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3 IS IT PREMENSTRUAL DYSPHORIC DISORDER?

For a diagnosis of PMDD to be made, symptoms must be severe enough to impact daily life, occur in the second half of your menstrual cycle, and resolve with, or soon after, your period starts.

4 GET SOME SUPPORT

The International Association for Premenstrual Disorders (IAPMD) www.iapmd.org has free one-to-one support and resources, and the National Association for Premenstrual Syndromes (NAPS) at www.pms.org.uk has useful information.

5 AGREE A TREATMENT PLAN THAT YOU ARE HAPPY WITH

Stay hopeful; there are several treatment options but it can be a case of trial and error to find what works for you. If you do not find relief through the treatments you can trial through your GP, then you may be referred to a gynaecologist and/or a psychiatrist.

Lifestyle

- Experts recommend a nutrient-rich diet high in fibre and complex carbohydrates (plant-based whole foods). Minimise saturated fat, processed carbohydrates, caffeine and alcohol.
- Engage in regular exercise and stress management techniques e.g. yoga, meditation.

Complementary therapies

- Evidence for complementary therapies is limited; the strongest evidence is for Agnus Castus 20–40mg/day. Please note that Agnus Castus should not be taken alongside hormonal contraception or HRT.

Cognitive Behavioural Therapy

- (CBT) has been shown to be effective for reducing functional impairment in PMDD.

SSRIs

- The SSRI family of antidepressants, e.g. sertraline, taken either continuously or in the second half of the menstrual cycle (the luteal phase) has been shown to significantly reduce symptoms in 60–75% of patients with PMDD. Again, trial and error may be needed to find the right method and dosage for you.

HORMONAL TREATMENTS

- The drospirenone-containing contraceptive pill is used to prevent ovulation and reduce hormone-related fluctuations.
- Oestrogen patches at high doses along with progesterone tablets or a progestogen-releasing IUS (coil). This is a sort of 'mix and match' HRT and can work well – especially during the perimenopause – for some. If these do not work, a specialist may be able to offer:
- Injections to switch off ovarian activity and induce menopause, with add back HRT.
- Hysterectomy and removal of the fallopian tubes and ovaries, with careful choice of HRT post-operatively (see patient information leaflet on 'Surgical menopause' at www.rockmymenopause.com). This option is for treatment-resistant PMDD and would only be offered as a last resort.

Remember that PMDD often goes 'off the scale' when menopausal symptoms bite. The PCWHF's Rock My Menopause website (www.rockmymenopause.com) offers sound evidence-based advice, and the Facebook group is a supportive network of women going through menopause.