Premenstrual Dysphoric Disorder

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KEYWORDS

- Premenstrual syndrome • Premenstrual dysphoric disorder • Etiology
- Antidepressant • Oral contraceptive • Treatment

KEY POINTS

- Premenstrual dysphoric disorder comprises psychological and somatic symptoms and functional impairment that lie on the severe end of the continuum of premenstrual symptoms.
- Etiologic theories include differential response to normal hormonal fluctuations that may involve the serotonin system, the neurosteroid allopregnanalone, or luteal phase changes in brain circuitry involving emotional and cognitive function.
- Serotonin reuptake inhibitors are considered the first-line treatment option and may be taken continuously, for the full premenstrual phase or as "symptom-onset" dosing.
- Second-line treatments include oral contraceptives containing drospirenone, other ovulation suppression methods, calcium, chasteberry, and cognitive-behavioral therapy.

DEFINITION

Premenstrual psychological and somatic symptoms lie on a continuum of severity. It is estimated that about 85% of women experience at least one mild premenstrual symptom; 20% to 25% experience moderate to severe premenstrual symptoms (premenstrual syndrome or PMS), and about 5% meet diagnostic criteria for premenstrual dysphoric disorder (PMDD),[1] the severest form of PMS.

Currently, the most liberal diagnostic criteria is found in International Statistical Classification of Diseases and Related Health Problems, 10th revision, from the World Health Organization, in which "Premenstrual Tension Syndrome" is met if at least one premenstrual symptom is present, without specification of severity and with no requirement of prospective ratings. The criteria from the American College of

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Obstetrics and Gynecology and the Royal College of Obstetricians and Gynecologists describe PMS as any number of psychological or physical symptoms; however, functional impairment is required and prospective ratings are recommended.[2] The International Society for Premenstrual Disorders defines Core Premenstrual Disorder as psychological and/or somatic symptoms that occur in the luteal phase of ovulatory cycles; the symptoms should cause functional impairment and be prospectively rated over 2 menstrual cycles.[2]

The American Psychiatric Association publishes the PMDD diagnostic criteria in the Diagnostic and Statistical Manual of Mental Disorders (DSM).[1] Symptoms must be present during the last week before the onset of menstruation, start to improve within a few days from the onset of menses, should be minimal or absent in the weeks after menses, and should be present most cycles of the past year. A minimum of 5 symptoms must be present, including one "core" symptom (marked affective lability, irritability, depressed mood, or anxiety) with other potential symptoms that include decreased interest in usual activities, difficulty concentrating, low energy, changes in sleep or appetite, sense of being overwhelmed or out of control, and physical symptoms. The premenstrual symptoms should be associated with significant distress or interference in functioning. The premenstrual symptoms should not be merely an exacerbation of the symptoms of another psychiatric disorder and should not be attributable to the effects of a medication, substance, or medical condition. The timing of the symptoms should be confirmed by prospective daily ratings for 2 menstrual cycles, and until prospective ratings are completed, the PMDD diagnosis should be considered "provisional."[1]

In prior editions of the DSM, PMDD was included in the Appendix because it was considered a condition for which additional research was needed before being confirmed as a psychiatric disorder. In the recent DSM-5 edition, PMDD was included for the first time in the main text, categorized as a depressive disorder.[1] This decision was based on evidence showing its distinctiveness from other disorders, specific antecedent validators, concurrent validators, and predictive response to treatment.[3] The change of status of PMDD in the DSM-5 has continued debates about potential negative consequences for women meeting criteria for the disorder.[4–6]

DIAGNOSTIC TOOLS

Rating scales of premenstrual symptoms include visual analogue scales and Likert scale rating forms, the most common of which is the Daily Record of Severity of Problems, in which women rate symptom severity and functional items daily.[7] Prospective ratings confirm the timing of the symptoms and rule out underlying psychiatric disorders that are premenstrually exacerbated. Prospective ratings are time consuming for women to complete and for clinicians to view and score. Steiner and colleagues[8,9] developed a self-report questionnaire, the Premenstrual Symptoms Screening Tool (PSST), which retrospectively assesses premenstrual symptoms and functional impairment over the last menstrual cycle. The PSST is available as adult and adolescent versions. A medical and gynecologic history, a physical examination, and an assessment for thyroid disorders and anemia are suggested as part of the initial evaluation before initiation of treatment.[10,11]

EPIDEMIOLOGY

Using prospective daily ratings, the estimated prevalence of PMDD in adults is 5% and of severe PMS is 20%. Prevalence figures of PMDD in adolescents may be somewhat

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