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Short Communication

Premenstrual Syndrome (PMS)/Premenstrual Dysphoric Disorder (PMDD): Let's Talk About

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Many women in their reproductive age experience transient physical and emotional changes around the time of their menses. For the majority of women, these symptoms are mild and tolerable. However, for a certain group of women, these symptoms can be disabling and may cause significant disruption in their lives. Around 3–9% of women having severe premenstrual syndrome seek medical attention. The general pattern of physical, emotional, and behavioral symptoms occurring 1-2 weeks before menses and remitting with the onset of menses simply called premenstrual syndrome (PMS). Some degree of PMS is experienced by almost 75% of women in their reproductive years [1,2]. PMS was first by Frank in 1931, but according to the modern concept it is named as premenstrual dysphoric disorders (PMDD) which is a severe form of premenstrual syndrome.

PMDD is distinguished from PMS by the severity of symptoms, predominance of mood symptoms, and role dysfunction [3]. According to the tenth edition of the International Statistical Classification of Diseases and Related Health Problems, PMS is defined as occurrence of one premenstrual symptom in a list of symptoms which include mild psychological discomfort, feelings of bloating and weight gain, breast tenderness, swelling of hands and feet, various aches and pains, poor concentration, sleep disturbances and changes in appetite, restricted to the luteal phase of menstrual cycle and cease with commencement of menstrual flow [4]. Several studies have shown a higher prevalence of PMS or PMDD among women with high-leveled education [5,6].

There have been several studies done for the cause of PMS/PMDD but the actual etiology is not clear yet. However, it has been hypothesized that it is basically due to a numerous biochemical changes like hormonal changes such as estrogen excess or progesterone deficiency in the luteal phase, Increased carbohydrate tolerance in the luteal phase, Pyridoxine deficiency, Increased production of vasopressin, aldosterone, Fluctuation in opiate peptide concentrations affecting endorphin levels [7]. Whatever the cause is, its prevalence is very high around the world. PMS/PMDD is related to high suicide and accident rate, employment and school absentee rates, poor academic/work performances and acute psychiatric problem. It has shown a negative impact on the quality of life, work efficiency, social interactions, lifestyle, and emotional well-being [8-10]. PMS is one of the factors that make women more susceptible than men to depression particularly during periods of rapid fluctuation of gonadal hormones [5].

Management of PMS and PMDD should include a multidisciplinary approach. Treatments could be employed from simple lifestyle changes to pharmacologic modalities in a stepwise fashion. Lifestyle modifications can include Health education, healthy eating habits, regular exercise, stress-reducing activities, nutritional supplements, etc. Treatment of specific physical symptoms can be considered for example; Bloating: Spironolactone (Aldactone), Headaches: nonprescription analgesic such as Acetaminophen, Ibuprofen, or Naproxen sodium, Fatigue and insomnia: instruction on good sleep hygiene and caffeine restriction, Breast tenderness: Vitamin E, evening primrose oil, luteal-phase Spironolactone, or Danazol (Danocrine). Treatment of psychologic symptoms of PMDD, continuous or intermittent therapy with an SSRI. Treatment failure may require Hormonal therapy to manipulate menstrual cycle [11].

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