Management of Premenstrual Disorders (2023)

About the Guideline

- An a priori protocol was used along with a three-person writing team consisting of two maternal-fetal medicine subspecialists and one external subject matter expert.
- An extensive literature search was performed with dates restricted to 2000-2021, and an additional literature search was conducted in June of 2023 to allow for the inclusion of any recently published high-level sources for the final guideline.

Key Clinical Considerations

Become familiar with the recommendations and best-practice statements provided in this guideline, especially if you work in a labor and delivery setting.

Incidence

- Premenstrual symptoms affect a majority of reproductive-aged women.
- 20% to 30% of those women experience symptoms meeting criteria for premenstrual syndrome (PMS).
- 2% to 5% of those women experience symptoms associated with premenstrual dysphoric disorder (PMDD).

Pathophysiology

- Premenstrual disorders are caused by fluctuation in estrogen and progesterone during the luteal phase of the menstrual cycle.
    - Fluctuation in these hormones is similar in those who experience premenstrual disorders and those who do not.
    - Individuals who have premenstrual disorders have increased sensitivity to changes in levels of estrogen and progesterone.
- Two theories on what causes premenstrual disorders are as follows:
    - A decline in estrogen levels exacerbates the serotonin system, or
    - Progesterone and its metabolite influence the GABAergic system.

Evaluation and Diagnosis

- Premenstrual disorders are diagnosed by exclusion.
- Encourage the patient to keep a symptom log through several menstrual cycles.

Selective Serotonin Reuptake Inhibitors (SSRIs)

- Recommended as a first-line pharmacologic intervention for treatment of premenstrual disorders.
- Symptom improvement occurs within days, allowing treatment to occur continuously or just during the luteal phase of menstruation.
- Adverse effects include nausea, decreased energy, decreased concentration, sexual dysfunction, and sweating.
- Monitor patients for suicidal ideation.

Hormonal Medical Management

- Combined oral contraceptives
  - Recommended for the overall management of premenstrual symptoms, to suppress ovulation and fluctuation in estrogen and progesterone.
  - May not be helpful with mood swings or depressive premenstrual symptoms.
  - Adverse effects include nausea, breast pain, and venous thromboembolism.
- Gonadotropin-releasing hormone (GnRH) agonists
  - Suggest GnRH agonists with adjunctive combined hormonal add-back therapy for adults as a long-term, low-dose hormonal add-back therapy (estradiol and vaginal progesterone) to stop symptom recurrence.
  - GnRH will induce anovulation.
  - Adverse effects include hypoestrogenic, vasomotor symptoms, and decreased bone density.
  - GnRH agonists are not suggested for adolescents due to lack of efficacy data.

Cognitive Behavioral Therapy (CBT)

- Recommended for management of premenstrual symptoms.
- Educate the patient on relaxation techniques, problem-solving skills, and stress management.
- Provide the patient with a list of mental health professionals for referral; ensure the patient has access to transportation and time available for treatment or access to the internet for online counseling.

Conditional Recommendations with Low-Quality of Evidence

- Exercise
- Calcium supplementation of 1000 to 1200 mg/day in adults
- Acupuncture
- *Vitex agnus castus* (chasteberry)
- NSAIDs
- Educational and self-help strategies

Reference

Management of Premenstrual Disorders: ACOG Clinical Practice Guideline No. 7. (2023). *Obstetrics and Gynecology*, *142*(6), 1516–1533. https://doi.org/10.1097/AOG.0000000000005426