key points

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The term premenstrual syndrome (PMS) refers to a constellation of mood and physical symptoms that occur during the luteal phase of the menstrual cycle. The National Association for Premenstrual Syndrome suggests that: 'If PMS symptoms affect personal and/or social and/or professional quality of life then this should be regarded as being clinically significant PMS.'

Some women give a clear history of onset during the luteal phase of the menstrual cycle, with improvement taking place within a few days after the onset of menses. However, other women present with fluctuating symptoms without making a connection with their menstrual cycle. There are no diagnostic tests for PMS and diagnosis is dependent on the history.

Diagnosis of PMS is complicated by a number of conditions with overlapping symptoms. These include generalised anxiety disorder, mood disorders (e.g. bipolar disorder, major depressive disorder, dysthymia), dysmenorrhoea, iatrogenic use of hormonal treatments (e.g. the contraceptive pill), substance misuse, borderline personality disorder, chronic fatigue syndrome, irritable bowel syndrome, and thyroid disease. The most common conditions that overlap are anxiety and mood disorders, where the symptoms are present all month long. However, differentiation of these, and other, conditions can be very difficult if the physician relies solely on retrospective symptoms, as recall can be unreliable. Therefore, it is considered best practice to use a symptom diary.

PMS treatment should be considered within a biopsychosocial model. Adopting healthy lifestyle choices, such as regular exercise, is likely to have a beneficial effect on many core PMS symptoms and should be a first-line treatment. There is evidence from RCTs for mindfulness-based cognitive therapy and cognitive behaviour therapy in the treatment of PMS. Where possible women with severe PMS should be routinely considered for psychological therapy.

Studies support the use of continuous and luteal phase dosing of SSRIs and suggest that they should be considered as one of the first-line pharmacological interventions. There is also evidence to support the use of SNRIs. The COCP should be considered as a first-line pharmacological intervention when treating some women with PMS. This can be prescribed cyclically, but some women benefit from continuous (i.e. back-to-back) regimens. Currently, the strongest evidence supports the use of new (third) generation COCP preparations.

Women with confirmed PMS who fail to respond to first-line treatments should be referred to secondary care. The ideal multidisciplinary service includes gynaecologists and psychiatrists with a special interest in PMS, and access to other professionals including clinical psychologists/counsellors, dietitians and neurologists.