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Royal College of Obstetricians & Gynaecologists

Information for you

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Managing premenstrual syndrome (PMS)

What is PMS?

Premenstrual syndrome or PMS is the name given to a collection of physical and emotional symptoms that can occur in the two weeks before you have your period. These symptoms usually get better once your period starts and often disappear by the end of your period.

Nearly all women have some premenstrual symptoms. Each woman's symptoms are different but the most common symptoms include:

- mood swings
- feeling depressed, irritable or bad-tempered
- feeling upset, anxious or emotional
- tiredness or trouble sleeping
- headaches
- changes in appetite and food cravings
- feeling clumsy, possibly leading to increased accidents
- fluid retention and feeling bloated
- changes to skin or hair
- having sore or tender breasts.

Most women do not have all these symptoms, only certain ones. Sometimes the symptoms are the same each month and sometimes they are different. The symptoms form a pattern over time.

Between one and two in 20 (5–10%) women get PMS which is severe enough to prevent them from getting on with their daily lives. PMS usually improves after the menopause. A very small number of women get a more intense form of PMS, known as premenstrual dysphoric disorder (PMDD). This leaflet gives general information about PMS. For more detailed information see **Useful organisations**.

What is the cause of PMS?

The exact cause of PMS is not known. One or more factors may be involved including:

Changes in hormone levels

The levels of the female sex hormones estrogen and progesterone vary naturally during a woman's menstrual cycle (the time from the first day of your period to the day before your next period starts). The symptoms of PMS are likely to be related to the cyclical fluctuation of these hormones. Women who use some methods of hormonal contraception are less affected by PMS.

Weight and exercise

Research has shown that the likelihood of PMS is increased in women who are obese – a body mass index (BMI) over 30 – and in women who do little exercise. BMI is the measurement of weight in relation to height. To calculate your own BMI follow this link: www.nhs.uk/Tools/Pages/Healthyweightcalculator.aspx. An excess of foods with a high salt content (crisps, convenience meals and fast food), alcohol (over 14 units a week) and caffeinated drinks have been shown to affect mood and energy levels.

Stress

Some women find that their PMS is worse when they are feeling stressed.

How do I know I have PMS?

There is no special test for PMS. If you are getting symptoms each month and are finding these difficult to cope with, you should see your GP. Your doctor or nurse will ask you to keep a diary or chart of your symptoms and when these occur, over at least two consecutive menstrual cycles. They will then review your diary with you to see if your symptoms fit the pattern of PMS. Seeing the same doctor or nurse will be helpful if your symptoms are distressing or vary a lot.

What are my treatment options?

There is a wide range of options to help you to manage your symptoms and allow you to get on with your daily life. Your doctor or nurse will talk with you about these.

Whatever option you choose, you will be advised to continue to keep a diary of your symptoms for at least two to three months, as this can help you to see if a particular treatment is working.

Changing your lifestyle

In the first instance you can take some positive steps to try and improve your symptoms by:

- taking more exercise
- eating a healthy balanced diet – decrease sugar, salt, caffeine and alcohol and increase fruit and vegetables. Eat wholefoods (wholemeal bread, wholegrain cereals, brown rice, wholewheat spaghetti, nuts and seeds). Eat lean meat, fish and chicken. The Food Standards Agency (see **Useful organisations**) can provide more information about a healthy diet
- finding ways to reduce stress
- talking with your partner or someone else you trust.

Speak with your nurse or GP if you would like further information about ways to change your lifestyle and treatments that can help.

If your symptoms persist despite changing your lifestyle, you should be referred for more specialist help. A team of health professionals may be involved in your care, including a GP, nurse specialist, a dietician, a counsellor, a psychologist and a gynaecologist. The team will depend on the hospital you attend.

Psychological support and therapy

Talking about your situation may help. Cognitive behavioural therapy (CBT) involves you being able to talk one-to-one with someone specifically trained in this area over several appointments. This can help you learn new ways of managing some of your symptoms to help reduce their impact on your daily life.

Drug treatment

There are a number of medicines for PMS, including:

Antidepressants

- There are many different types of antidepressants. Two types have been shown to help PMS symptoms in some women. These are SSRIs (selective serotonin reuptake inhibitors) and SNRIs (serotonin-norepinephrine reuptake inhibitors).
- Like all medicines, antidepressants can have side effects. Common side effects include nausea (feeling sick), insomnia (difficulty in sleeping) and low libido (not being interested in having sex).
- Antidepressants can be taken continuously, or every day for two weeks before your period and during your period.
- When you want to stop taking antidepressants it is important that you do so gradually. Your body can get used to these medicines, so if you stop taking them suddenly it can cause withdrawal symptoms such as headaches. Your doctor or specialist nurse will advise you.

Oral contraception – the combined pill

- Some women find using the combined pill helps with PMS. Newer types of contraceptive pills have been shown to improve PMS symptoms.

Patches and implants

- Using estrogen-only hormone patches or implants can improve your symptoms.
- Unless you have had a hysterectomy (removal of your uterus) these need to be used with a low dose of the hormone progestogen for a minimum of 10 days each month. This may be in the form of progestogen tablets or by using the progestogen-releasing intrauterine system (IUS) known as Mirena®. Mirena is also a very effective contraceptive.
- Estrogen hormone patches or implants do not work as contraceptives.
- It is important not to become pregnant while using patches or implants, so you will need to use contraception as well.

Danazol

- Danazol has been shown to reduce PMS symptoms. The side effects can be permanent (virilisation effects such as the voice deepening and clitoris enlarging), so only some women should use it. It is important to use contraception while using Danazol.

GnRH (gonadotrophin-releasing hormone) analogues

- GnRH analogues are injections (monthly or three-monthly) which should only be used by women with severe PMS and when all other treatments have failed.
- The drugs work by blocking the production of natural estrogen and progesterone and cause a temporary menopause, so you will not ovulate and you will not have any periods.
- You should only use GnRH analogues alone for up to six months. If they are used for longer than this you will be advised to take hormone replacement therapy (HRT) to reduce menopausal complications, such as osteoporosis (thinning of the bones).
- You should have a bone density scan each year to check for osteoporosis if you use these GnRH analogues for more than two years.

Progesterone or progestogen

- Taking natural progesterone or synthetic progestogen hormones does **not** improve PMS symptoms.

It can take up to three months for you to feel the benefits of newer treatments, which is why it is important to complete your symptom diary before and during treatment.

Complementary therapy

There several alternative or complementary therapies for PMS. Many women find these helpful, although there is little evidence to show that they are effective. There is also little evidence that they do no harm.

- Ask your doctor for advice before using a complementary therapy.
- Inform your doctor if you are using any medicine or supplement. This is because some complementary therapies may react with other medicines. For example, St John's Wort can make some hormonal methods of contraception (such as the pill) less effective.

Some complementary therapies help only one or two symptoms. There is evidence that supplements of calcium and Vitamin D, magnesium or Agnus castus (a herb known as chasteberry) may be helpful. Evening primrose oil can reduce breast tenderness. Some women say they find vitamin B6 helpful.

Surgery

Removal of your ovaries, sometimes combined with removal of your uterus (hysterectomy) results in you having the menopause and can improve PMS symptoms.

- This is a major operation and your doctor will only suggest it if you have severe symptoms and all other treatments have failed.
- If you are younger than 50 years old you are likely to get menopause symptoms (hot flushes, drier skin) and you will be more at risk of osteoporosis after the operation. Taking HRT until the age of 50 can help menopause symptoms and protect your bones.
- If you are considering this option, your doctor may suggest you use GnRH analogues and HRT for three to six months. GnRH analogues have a similar effect on your hormones as having your ovaries removed and will give you an idea of how you will feel after the operation. By improving your symptoms, therefore, it will give you a chance to see if you will benefit from surgery. You will also be able to see if taking HRT after the operation will suit you.

Moving forward

PMS is common and many women are affected by its symptoms. Treatment, information and support are available to enable you to manage your symptoms and move forward with your life.

A list of useful organisations is available on the RCOG website at: www.rcog.org.uk/womens-health/patient-information/useful-links.

Sources and acknowledgements

This information has been developed by the RCOG Patient Information Committee. It is based on the Royal College of Obstetricians and Gynaecologists (RCOG) guideline *Management of Premenstrual Syndrome* (December 2007). This information will also be reviewed, and updated if necessary, once the guideline has been reviewed. The guideline contains a full list of the sources of evidence we have used. You can find it online at: www.rcog.org.uk/womens-health/clinical-guidance/management-premenstrual-syndrome-green-top-48.

The RCOG produces guidelines as an educational aid to good clinical practice. They present recognised methods and techniques of clinical practice, based on published evidence, for consideration by obstetricians and gynaecologists and other relevant health professionals. This means that RCOG guidelines are unlike protocols or guidelines issued by employers, as they are not intended to be prescriptive directions defining a single course of management.

This information has been reviewed before publication by women attending clinics in Salisbury, Paisley and Bolton.

A glossary of all medical terms is available on the RCOG website at http://www.rcog.org.uk/womens-health/patient-information/medical-terms-explained.

A final note

The Royal College of Obstetricians and Gynaecologists produces patient information for the public. The ultimate judgement regarding a particular clinical procedure or treatment plan must be made by the doctor or other attendant in the light of the clinical data presented and the diagnostic and treatment options available. Departure from the local prescriptive protocols or guidelines should be fully documented in the patient's case notes at the time the relevant decision is taken.

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