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Invited Editorial

The diagnosis of premenstrual mood disorders: Do we have it backwards?

HIGHLIGHTS

- Premenstrual Dysphoric Disorder (PMDD) is experienced by between 1.2 and 10% of women
- The Daily Record of Severity of Problems (DRSP) is recommended to diagnose PMDD
- Often PMDD is diagnosed based on history and clinical impression
- DSRP might be useful for tracking response to treatment, as much as for diagnosis

Keywords:
Premenstrual mood disorders
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Repetitive cyclical physical/emotional symptoms prior to the onset of a menstrual cycle occur in up to 80% of women. However, clinically significant premenstrual mood disorders, which range from mild premenstrual syndrome (PMS) to disruptive premenstrual dysphoric disorder (PMDD), are experienced by 2–8% and 1.2–10% of women, respectively [1].

When women present to us with troublesome symptoms, especially the milder symptoms of PMS, as health care providers, we readily suggest calcium supplements, vitamin B6, exercise, dietary and lifestyle modifications. Without waiting for the recommended 2–3-month diary of symptoms (Daily Record of Severity of Problems-DRSP [2]), we will prescribe oral contraceptives, diuretics, or recommend counseling. However, when women present with more severe and disruptive symptoms, especially when less somatic and more mood/emotional disturbances, I wonder how many of us look for the recommended 5 of 11 symptoms as listed in the DSM-V to establish a diagnosis of PMDD. [3] Likely, the confusing array of diagnostic criteria seldom makes its way into our charts. We assume women give an accurate history of symptoms, and we render the diagnosis often based on our clinical impression. As clinicians, we want to help women in distress, and based on the woman's recall (although studies show that the cyclical relationship of symptoms is greatly overestimated by women [1]), and our general impression (which may be decided in a fraction of a 15-min appointment), we present management options. This approach, although not consistent with the recommendations, may not be incorrect. Of course, we should not neglect taking a good medical history or considering the possibility of an underlying psychologic disorder with premenstrual exacerbation. At initial presentation we should always ask about suicidal or homicidal ideation and screen for past or present abuse. Time constraints at this first encounter (frequently combined with an annual exam) seldom allow for adequate screening for conditions such as depression, dysthymic disorder, generalized anxiety disorder, and hypothyroidism, as recommended prior to treatment, so a single office visit should not be considered adequate for this patient population.

We know, though, that women would be unhappy walking out of their appointment with only our suggestion of the completion of a 2–3-month symptom diary, followed by another appointment, prior to initiation of therapy. The immediate prescription of combined oral contraceptives, SSRIs or cognitive behavioral therapy might be appropriate. However, maybe we should consider the DRSP as an adjunct to a current therapy, and not just disregard it, as so many of us most certainly do. Ongoing evaluation can be simultaneous with initial therapy. In addition to labs, and ultrasounds as indicated, post-treatment DRSP diaries could be prescribed to allow for objective recognition of non-responders, failed treatments and to potentially alter the diagnosis from PMDD to another psychiatric condition. More aggressive treatments such as the recommended 3 -month trial of GnRh agonists would be better justified, and oophorectomy, if it even remains an option in the most severe cases, would no doubt warrant more objective evidence prior to implementation. [4]

So maybe we have it backwards by not following the recommendations of the completion of a prospective symptom diary for the diagnosis of PMDD. But if we are going to have it backwards, we should go all the way: give the symptom diary after we make the diagnosis, to confirm, monitor and, maybe, be better off for it.

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References

[1] D.J. Budeiri, A. Li Wan Po, J.C. Dornan, Clinical trials of treatments of premenstrual syndrome: entry criteria and scales for measuring treatment outcomes, Br. J. Obstet. Gynaecol. 101 (1994) 689–695.

[2] J. Endicott, J. Nee, W. Harrison, Daily record of severity of problems (DRSP): reliability and validity, Arch Womens Ment Health, 9(1), Springer-Verlag, Wein 2006, p. 43.

[3] American Psychiatric Association, Diagnostic and Statistical Manual of Mental Disorders, 5th ed. American Psychiatric Association, Washington, DC, 2013.

[4] L.J. Green, P.M.S. O'Brien, N. Panay, M. Craig, On behalf of the Royal College of obstetricians and Gynaecologists, Management of premenstrual syndrome, BJOG 123 (2017) e73–e105.

Nancy Phillips
Rutgers Robert Wood Johnson Medical School, New Brunswick, NJ 08901, United States of America
E-mail address: Phillina@rutgers.edu

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