Premenstrual syndrome

Once called just premenstrual tension, the symptoms complex associated with the few days immediately before the onset of menstruation is now more aptly given the name premenstrual (tension) syndrome (PMT). The wide variety of physical, psychological and behavioural changes noted vary considerably from woman to woman. The commonest physical symptoms include headache, backache, nausea, weight gain, tender breasts, a bloated feeling, and general aches and pains. Psychological effects such as tension, insomnia, anxiety, tiredness, irritability and depression are well known, while behavioural changes include clumsiness, accident proneness, lower intellectual and physical performance, missing school or work, and decreased efficiency. These symptoms overlap to a substantial degree those described by women who are psychiatrically ill or experiencing difficulties in social adjustment. Therefore, attempts to define premenstrual syndrome and to describe the associated complaints are fraught with methodological problems, and the assessment of the different ways of relieving symptoms is especially difficult.

It appears that up to 95 per cent of women experience some premenstrual symptoms, but that only a few of these women will consider that their problem merits discussion in the surgery. Of the studies that have been published, the great majority have used as their population either women in hospital (often a psychiatric hospital) or women who have been referred to one of the special clinics for the treatment of premenstrual symptoms.

Since these women will differ from the average person attending the surgery, the general practitioner is not in a good position to evaluate the various statements that have been made about premenstrual syndrome and the various methods of treatment that have been advocated.

The situation has now been remedied by the publication of a monograph on the subject by Anthony Clare.[1] Professor Clare's book includes not only a review of the literature, but also a well thought out and well presented study of premenstrual symptoms and associations. In this study general practice patients were compared with women attending the clinic where research into premenstrual syndrome is being carried out at St Thomas's Hospital in London. A 30-item general health questionnaire which also assesses psychiatric ill health[2] was administered and the women were also asked to complete a modified version of the menstrual distress questionnaire,[3] and some of them recorded symptoms throughout two menstrual cycles. There were standardized psychiatric and social interviews carried out and social dysfunction was assessed by a social maladjustment schedule. All of these instruments would seem to be of potential use to a general practitioner interested in assessing to what extent psychological, social and premenstrual difficulties are contributing to the problems presented by women in the surgery.

Clare's conclusions are interesting and, although not dealing with treatment, they may help us to decide upon the information needed for responding appropriately to the patient with a premenstrual complaint. His critical review of the literature reveals that most of the studies reporting on the physical, psychological or behavioural changes associated with the premenstruum are methodologically inadequate and leave the question of whether there is a true relationship still unanswered. However not all the reports are equally flawed. It seems that while the association between the premenstruum and accident proneness, criminal behaviour and decreased examination performance remains doubtful, the relationship with psychiatric ill health is much clearer: for example, women with a psychotic illness are more likely to be admitted to hospital shortly before menstruation. It also appears that an association exists between affective disorders and affective, but not physical, premenstrual symptoms. A relationship between premenstrual syndrome and personality remains uncertain. Even among those women with severe symptoms only a few seek treatment, and those who do are likely to score highly on tests in which women suffering from a neurosis also score highly.

Clare found that women who are psychiatrically ill report more premenstrual symptoms than healthy women and that the symptoms experienced are more severe. However, the extra symptoms are confined to psychological and behavioural areas. Physical discomfort is reported equally frequently by the psychiatrically ill and the healthy. No association was found between premenstrual syndrome and overall social maladjustment, but there was a relationship with disturbance of 'marital function' and this was independent of psychiatric status. Little evidence was found that women experiencing symptoms caused by social or personal problems were attributing them to the premenstruum. Some of the women had their hormone status investigated but no association was found between premenstrual syndrome and either lowered levels of progestogen or increased levels of prolactin in peripheral blood. Many general practitioners (and perhaps patients) may be surprised to learn that premenstrual symptoms were reported just as often by those women taking oral contraceptives as by those not on the Pill.

What help is all this in responding to women who

present in the surgery with premenstrual complaints? First, the research makes clear that different symptoms have different associations and the initial requirement is a careful record of the woman's experiences. Since the problem is likely to be recurrent and prolonged, and the benefits of treatment are uncertain, it may be worthwhile encouraging the women to keep a detailed diary of one or two complete menstrual cycles.

With a written record of the woman's experiences, doctor and patient are in a much better position to be sure that they are talking about the same thing and the diary becomes a useful baseline against which to judge the effect of treatment. Once the symptoms are made clear, severity can be assessed, remembering that it is only the women significantly troubled by their premenstrual symptoms who are likely to consult their general practitioner. Discussion of the fact that the great majority of women have symptoms and that premenstrual syndrome cannot be regarded as a disease may help some women, and the patient herself should take a major part in deciding whether or not she wishes to have treatment. The doctor should remain alert for clues to any underlying marital problems, as these may have had a bearing on the decision to consult. Where the symptoms described are mainly physical and treatment is desired, it seems reasonable to begin with well-known and non-toxic preparations — bearing in mind the variability of premenstrual syndrome, that there can be marked response to a placebo and that discussion of the problems may be the doctor's prime therapeutic tool. Where the symptoms reported are mainly in the psychological and behavioural fields the situation is rather different. The premenstrual syndrome itself might be of considerable severity but, in a substantial number of cases, the woman will be suffering from psychiatric illness too. Under these circumstances the doctor must be sure that he is treating the primary problem, or he must at least bear in mind, and discuss with the patient, the extent to which depression, for example, may be making her premenstrual symptoms worse.

Despite doubts about the efficacy of many of the preparations prescribed for premenstrual syndrome, a careful approach which assesses the symptoms over a period of time and involves the woman in the decision to treat is likely to yield the best results.

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References

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