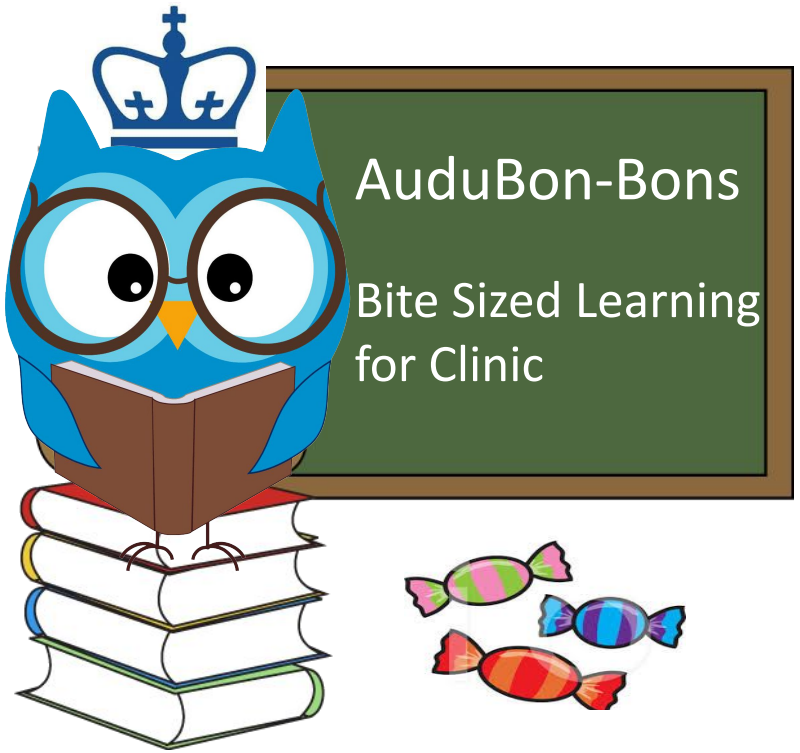
PREMENSTRUAL DYSPHORIC DISORDER



Week 2

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Reading Assignment:

Management of Premenstrual Dysphoric Disorder. *Pearls of Exxcellence*

LEARNING OBJECTIVES

- To review the definition of PMDD
- To understand the diagnostic criteria for PMDD
- To counsel patients on the management options for PMDD

CASE VIGNETTE

- Ms. Moody is a 18 y.o. G0 woman presenting for evaluation at the encouragement of her mom. She reports she is always moody around her cycles, since getting her period, but over the last year she has intense anger, depression, and is getting into fights with her parents in the week preceding her period.
- She also complains of having no energy, desiring to sleep all day, being unable to concentrate and feeling bloated. During this week, she typically misses 3-5 days of class due to feeling "so down". Her symptoms resolve by the 3rd day of her period. Outside of this, she is a happy, healthy, freshman in college.

FOCUSED HISTORY

What elements of the patient's history are most relevant?

- **PMH:** Mild intermittent asthma
- **PSH:** Tonsils and adenoids
- **POBH:** G0, sexually active previously, not currently
- **PGYNH:** No STIs, too young for pap, no cysts, or fibroids
- **MEDS:** Denies
- **All:** PCNs – rash
- **FH:** DM in Father
- **SH:** Denies tob, drug, EtOH use. Denies IPV. College freshman. Accepts blood products

PERTINENT PHYSICAL EXAM FINDINGS

What elements of the patient's physical exam are most relevant?

- **General:** Well appearing, VSS
- **CV:** RRR
- **Resp:** CTAB
- **Abd:** Soft, ND, NT, no rebound or guarding
- **Vulva:** Normal external female genitalia. No lesions.
- **Vagina:** Pink, healthy mucosa.
- **Cervix:** **Closed os. No lesions. No CMT. No blood in vault. Physiologic discharge**
- **Uterus:** **NT. Anteverted. Not enlarged. Mobile.**
- **Adnexae:** **NT. No masses palpable.**

PREMENSTRUAL DYSPHORIC DISORDER (PMDD)

- Severe form of PMS
- Behavioral, emotional, AND physical symptoms
- How does PMDD differ from PMS?
  - More severe symptoms
  - At least one “affective” symptom: markedly depressed mood or hopelessness, anxiety, affective lability, or persistent anger
- How common is it?
  - Approximately 2-6% of women in reproductive years will meet criteria

DIAGNOSTIC CRITERIA

When does it occur?

- With the majority of cycles
- Must be present in the final week before onset of menses
- Improve within a few days after onset of menses
- Become minimal or absent one week post-menses

Degree of impairment?

- Clinically significant distress or interference of life activities

Must rule out that disturbance is an exacerbation of another disorder

DIAGNOSTIC CRITERIA

At least five symptoms must be present

Must include one of the following:

- Affective lability
- Irritability/anger/increased interpersonal conflicts
- Depressed mood
- Anxiety, tension or feelings of self-deprecating thoughts

With additional:

- Decreased interest in usual activities
- Subjective difficulty with concentration
- Lethargy
- Marked change in appetite
- Hypersomnia or insomnia
- Sense of being overwhelmed or out of control
- Physical symptoms including: breast tenderness, swelling, joint pain, bloating or weight gain

DIAGNOSTIC CRITERIA

Daily Record of Severity of Problems

Symptoms	Day of menstrual cycle (day 1 should be the start of the menstrual period)														
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
Felt depressed, sad, down, or blue															
Felt hopeless															
Felt worthless or guilty															
Felt anxious, tense, keyed up, or on edge															
Had mood swings (e.g., suddenly felt sad or tearful)															
Was more sensitive to rejection or feelings were more easily hurt															
Felt angry, irritable															
Had conflicts or problems with people															
Had less interest in usual activities (e.g., work, school, friends, hobbies)															
Had difficulty concentrating															
Felt lethargic, tired, fatigued, or had a lack of energy															
Had increased appetite or overate															
Had cravings for specific foods															
Slept more, took naps, found it hard to get up when intended															
Had trouble getting to sleep or staying asleep															
Felt overwhelmed or that I could not cope															
Felt out of control															
Had breast tenderness															
Had breast swelling, felt bloated, or had weight gain															
Had headache															
Had joint or muscle pain															
At work, school, home, or in daily routine, at least one of the problems noted above caused reduced productivity or inefficiency															

How do you make the diagnosis?

- Daily Record of Severity of Problems (DRSP) form
  - Prospective, patient recorded
  - Validated tool

Diagnosis made with:

- 2 consecutive menstrual cycles demonstrating luteal phase symptoms
- and with the exclusion of other medical conditions

MANAGEMENT COUNSELING

- **Multi-modal treatment**
- **Lifestyle modifications:**
  - Aerobic exercise daily
  - Dietary changes with reduction of sugar, salt, red meat, caffeine, and alcohol
  - Supplement with calcium and Vitamin B6
- **Cognitive Behavioral Therapy**
- **Pharmacologic options:**
  - **SSRIs:** extremely effective, first line therapy
    - Favorable response in 60-70% of patients
    - Can use either continuously or in luteal phase
  - **Hormonal therapies:** COC's show mixed efficacy but can decrease physical symptoms through inhibited ovulation
    - **Drospirenone-containing COC's** have diuretic effects, so FDA approved for PMDD & bloating symptoms associated with PMDD
      - 48-60% of women report improvement in symptoms

MANAGEMENT COUNSELING

- **NSAIDS**
  - for physical symptoms
- **GnRH agonists (leuprolide)**
  - Effective of ovulation suppression
  - Treatment for refractory PMDD
  - Cautious use due to side effects and irreversible bone loss
- **Surgical Therapy**
  - Can consider oophorectomy for refractory symptoms
  - Should trial GnRH agonists 3-6 months prior to considering surgical therapy

SOCIAL DETERMINANTS OF HEALTH

- Perceived discrimination is associated with PMDD and premenstrual symptoms
- 2011 study of 2718 Asian, Latin, and black women of reproductive age found:
  - 83% of participants reported experiencing discrimination (due to race, gender, age, height or weight) in lifetime
  - Frequency of perceived discrimination was positively associated with PMDD (OR 1.08)
    - Racial discrimination had highest likelihood with OR of 4.14

EPIC .PHRASE

.BBonPMDD

Description: PMDD counseling and management

Patient was counseled on the evaluation for PMDD including the need for prospective data collection by the patient on symptoms for two months.

Treatment modalities including lifestyle modifications, CBT, and medication options were discussed. It was emphasized that PMDD often requires a multi-modal treatment approach.

CODING AND BILLING

- **ICD-10 Code**
  - F32.81
    - Premenstrual dysphoric disorder
  - N94.3
    - Premenstrual tension syndrome (synonyms: premenstrual syndrome, premenstrual swelling, premenstrual symptom)

EVIDENCE

- Mishra S, Elliott H, Marwaha R. Premenstrual Dysphoric Disorder. *StatPearls*. May 28, 2020. https://www.ncbi.nlm.nih.gov/books/NBK532307/. Accessed on 9/22/2020.
- Mendiratta V, Chiang S, Theiler R. Management of Premenstrual Dysphoric Disorder (PMDD). 2019. *Pearls of Exxcellence.* The Foundation for Exxcellence in Women's Health.
- Reid R. Premenstrual Dysphoric Disorder (Formerly Premenstrual Syndrome). In: Feingold KR, Anawalt B, Boyce A, et al. *Endotext.org.* South Dartmouth (MA): 2000-2020. https://www.ncbi.nlm.nih.gov/books/NBK279045/. Accessed on September 25, 2020.
- Mendiratta V. Primary and Secondary Dysmenorrhea, Premenstrual Syndrome, and Premenstrual Dysphoric Disorder. In: Lentz, G (Ed.). *Comprehensive Gynecology.* Philadelphia, PA: Elsevier/ Mosby. August, 2016.
- Pilver CE, Desai R, Kasl S, Levy BR. Lifetime discrimination associated with greater likelihood of premenstrual dysphoric disorder. *J Women's Health.* 2011 Jun:20(6):923-31