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Newson Clinic Knowledge Factsheet

PMS and PMDD: what's the difference, and when to seek help

A guide to PMS and PMDD symptoms and treatment options
To discuss PMS, PMDD and general hormone health, you can book an appointment to speak to a Newson Clinic clinician.

What is premenstrual syndrome (PMS)?

PMS refers to a wide range of physical and emotional symptoms that you may experience before your periods.
The most common include:
Mood swings
Low mood
Anxiety
Irritability
Tiredness or trouble sleeping
Bloating or tummy pain
Breast tenderness
Headaches
Skin breakouts
Greasier hair
Changes in appetite
Change to sex drive.
These symptoms are usually due to changes in hormone levels – especially progesterone and oestradiol (the main type of oestrogen) – during the second half of your menstrual cycle, also known as the luteal phase.
About 90% of women will experience some PMS symptoms. To be classed as PMS, symptoms occur in the luteal phase and usually resolve within a few days of your period starting.

What is premenstrual dysphoric disorder (PMDD)?

PMDD is a severe form of PMS, which is thought to affect around 5% of women[1]. Symptoms are similar to PMS: however, they are more intense and have a much greater negative impact on the life of those affected.
Definitions vary slightly, but the most commonly used is the Diagnostic and Statistical Manual of Mental Disorders, which says a woman must experience at least five out of 11 distinct psychological premenstrual symptoms, one of which must include mood[2].
Other symptoms on the list include marked anxiety, lethargy and decreased interest in usual activities.
These five symptoms should:
Be present in the two weeks before your periods
Start to improve within a couple of days of your periods starting
And be minimal in the week after your period.

What can I do to help manage my symptoms?

It is worthwhile keeping a dairy of your symptoms and menstrual cycle for a month or even a few months, if possible. The free period tracker on the balance app is a good option for this, and the National Association of Premenstrual Syndrome (NAPS) also has an online menstrual diary.

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Guidance for healthcare professionals says women with PMS should be advised on ways to improve diet and sleep, increase exercise, stop smoking, reduce alcohol intake and reduce stress. These lifestyle changes, particularly increasing movement, can have a beneficial impact, but should not be regarded as a substitution for treatment – which is often with hormones.

What about treatment options?

As PMS and PMDD are usually caused by changes in hormones, replacing the missing hormones with the right dose and type can really improve symptoms. Sometimes hormones are given in a way to suppress your changing hormone levels, so you have a constant level of hormones in your body each day.

Many women with PMS and PMDD are prescribed the contraceptive pill. However, although the contraception stops ovulation, it contains synthetic types of oestrogen and progestogen, which have different effects in your body than natural, body identical, hormones.

This means that synthetic hormones can lead to side effects occurring, such as low mood, anxiety, reduced libido and low energy, and also are associated with risks including blood clots and increased breast cancer risk over time.

Antidepressants

If you have severe PMS or PMDD leading to depression, you may also be prescribed a type of antidepressant called a selective serotonin reuptake inhibitor (SSRI). SSRIs are useful for some women, and they may work better in conjunction with hormone replacement therapy (HRT).

Newson Clinic GP and Menopause Specialist Dr Hannah Ward says of this approach: 'You can take both, and often antidepressants work better when someone takes HRT as well.'

HRT

The Royal College of Obstetrics and Gynaecology and NAPS guidance agree that HRT, through an oestrogen skin patch combined with cyclical progestogen, is a good way to manage the physical and psychological symptoms of severe PMS. And it's worth pointing out that often women will be prescribed oestrogen or progesterone separately, and some women's symptoms will improve with natural, body identical, progesterone alone.

Progesterone is produced following ovulation and for most women it has calming, anti-anxiety (anxiolytic) properties when it acts on the GABA receptors in the brain. But some women are particularly sensitive to progesterone, known as progesterone intolerance, and the hormone can have a paradoxical effect of worsening mood and anxiety.

In the last week of your cycle, known as the late luteal phase, progesterone levels drop off rapidly and this fall in progesterone may well be one of the underlying causes of PMS and PMDD. This theory was originally suggested by Dr Katharina Dalton, author of several books on PMS including the PMS Bible and Once a Month.

Using high doses of body identical progesterone in the form of Cyclogest 400mg vaginal pessaries twice (or sometimes more) daily may improve symptoms more than oral progesterone for some women.

Some women also benefit from testosterone if they have symptoms of testosterone deficiency and a blood test shows low levels of testosterone.

What if my PMDD still can't be controlled well?

For the most severe cases, the surgical removal of your womb and your ovaries is an option, but this should only be considered after all other options have been unsuccessful. Removal of your womb and ovaries will trigger what is known as a surgical menopause.

As the hormones oestradiol, progesterone and testosterone are made in your brain as well as your ovaries, some women find they still experience symptoms after this operation.

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Newson Clinic Knowledge Factsheet

Most women are under the age of 51 years when they have surgery to remove their ovaries; their body's requirements for hormones are greater compared to that of older women going through menopause naturally, so it is important to consider taking hormones until at least the usual age of menopause for the long-term health benefits.
It's important that treatment is individualised, and your healthcare team work with you considering your medical history, symptoms and preferences.

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References

1. Gudipally P.R., Sharma G.K. (2022), 'Premenstrual Syndrome' [Updated 2023 Jul 17]. In: StatPearls. Treasure Island (FL): StatPearls Publishing

2. Reid R.L. (2017), 'Premenstrual dysphoric disorder (formerly premenstrual syndrome)'. In: Feingold K.R, Anawalt B., Blackman M.R., et al., eds. Endotext. South Dartmouth (MA): MDText.com, Inc