Commentary on "Menstrually Related Disorders: Points of Consensus, Debate, and Disagreement"

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The discussion summarizes well the current state of thinking about Premenstrual Syndrome (PMS). It remains disappointing that so little consensus exists after so much investigative effort.

I am not quite sure why there is so much concern about the name for this or these disorder(s). The investigator or clinician with serious interest in the area is aware of the variety of symptom profiles and timing of symptoms present in PMS. At a clinical level, most of our patients know very well what people mean by PMS, unless they have been living in a cave for the last 10 years. The debate about nomenclature seems to imply that subtle changes in the name will carry unwanted political weight or mislead the naive. In my view, neither outcome is likely to be the case.

There is reasonable consensus regarding the diagnostic criteria. Although symptoms may certainly be diversified, I think we must be careful to distinguish between symptoms uniquely cyclic and part of PMS versus illnesses or disorders in other body symptoms which happen to be influenced by a hormonally normal menstrual cycle. For example, menstrual migraine should probably not be considered a part of PMS, because in my experience and view it often exists without significant premenstrual symptoms accompanying it. It seems to be a migraine like any other migraine that happens to be triggered by the normally physiologic decline of estrogen and progesterone premenstrually. By the same token, increased premenstrual dysregulation of diabetes and increased intraoccular pressure in glaucoma that occur premenstrually should not be considered a part of PMS but rather, again, the interaction of a normal menstrual cycle with other disorders or illnesses. It has been my frequent clinical experience to find that when I am confronted with a patient with an unusual cyclic symptom, I must be careful to look for another hidden disease that is not at all typically part of PMS. Examples in my practice have included benign spinal cord tumors and other curious phenomena.

Regarding etiology and pathophysiology, I think the points of consensus are well accepted. However, I think it should be made clear that no specific abnormality of the hypothalamo-pituitary-gonadal system has yet been discovered in PMS. The greater likelihood is that a physiologically normal hypothalamo-pituitary-gonal system impacts upon central neurotransmitter abnormalities. In terms of the environmental and psychologic factors, attributional styles, coping skills, and personality disorders would certainly figure prominently in the labeling and measuring of symptoms by the patient. My bias is that women afflicted with symptoms clearly limited only to the luteal phase will be shown to have a disorder more akin to the generalized anxiety disorders, with or without phobic features, and those with more predominantly depressive premenstrual symptoms will generally be shown to have mild continuous depressive disorder with premenstrual exacerbation. It is, therefore, not surprising that anxiolytic agents (perhaps including progesterone in occasional cases) are likely to be effective for symptoms of short duration, whereas serotonergic antidepressant agents are likely to be effective for more severe symptoms or those accompanied by mild follicular phase symptoms.

I have some concern about the notion of elimination of ovulation for treatment of PMS. In my experience, this is most often requested by those who fall

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into the category of being continually depressed with premenstrual exacerbation. Antidepressant treatments are therefore most often more appropriate. I am also concerned about this treatment because it may lead the unwitting gynecologist to perform oophorectomy before fully exploring all other therapeutic avenues. In 12 years of treating women with severe premenstrual syndrome, I have performed hysterectomy on only one person. In all other cases in which this was considered, obvious personality and psychosocial factors made me feel that surgery would be ill advised.

Finally, I am not so sure there is so much confusion about the sequence of treatment options that should be offered to patients. Clearly, dietary and lifestyle adjustments together with attention to psychosocial stresses within the family should receive primary attention. Oral contraceptives are reasonable for those who tolerate them sufficiently well; anxiolytics such as alprazalam for short duration symptoms, and serotonergic antidepressants for more severe or longer lasting symptoms taken together will leave relatively few patients with refractory problems.