

PMDD (Premenstrual Dysphoric Disorder)

TREATMENT ALGORITHM



STEP 1: CONFIRM DIAGNOSIS

- Use prospective daily symptom charting for ≥ 2 menstrual cycles
- Symptoms must be present in luteal phase and remit after menses
- Rule out other psychiatric or medical conditions
- Assess severity and impact on functioning



STEP 2: FIRST-LINE THERAPY – SSRI

SSRIs are first-line and have the strongest evidence.

Options for dosing:

- Continuous daily dosing
- Luteal phase dosing (start ~14 days before menses)
- Symptom-onset dosing (start when symptoms begin)

Common SSRIs:

- Sertraline
- Fluoxetine
- Paroxetine
- Escitalopram



Expected benefits:

- Rapid onset (within days)
- Improves mood, irritability, anxiety, and physical symptoms
- Response rate: ~60–75%



KEY PRINCIPLES

- ✓ Individualize treatment based on symptom profile, severity, comorbidities, and patient preference.
- ✓ Start with the least invasive, evidence-based therapy.
- ✓ Treat for adequate duration (≥ 2 –3 cycles) before assessing response.
- ✓ Combination therapy is often needed.
- ✓ Psychological + lifestyle approaches improve outcomes.

Good Response
($\geq 50\%$ improvement)
→ Continue SSRI at effective dose for ≥ 6 –12 months

Partial or No Response
($< 50\%$ improvement after 2–3 cycles)
→ Proceed to Step 3



STEP 3: HORMONAL THERAPY

Aim: suppress ovulation and stabilize hormone fluctuations.



A. Combined Oral Contraceptive (First choice)

- Ethinyl estradiol 20 μ g + Drospirenone 3 mg (24/4 regimen)
- Reduces mood and physical symptoms
 - Response rate: ~50–60%

OR

B. Combine SSRI + COC

- Useful for moderate–severe PMDD or partial SSRI response
- May provide additive benefit
 - Monitor for side effects

Good Response
($\geq 50\%$ improvement)
→ Continue current regimen

Partial or No Response
→ Proceed to Step 4



STEP 4: OVULATION SUPPRESSION

For persistent, severe symptoms despite Steps 2–3



A. Continuous Estrogen Therapy

- Transdermal estradiol (e.g., 100 μ g patch twice weekly)
- Add cyclic or continuous progesterone for endometrial protection

OR

B. GnRH Agonist Trial (e.g., Leuprolide)

- Induces temporary menopause
- Eliminates hormonal cycling
- Add-back estrogen/progestin to reduce menopausal and bone effects

Symptoms Resolved
→ Confirms hormone sensitivity
• Continue lowest effective therapeutic approach
• Consider long-term plan

Incomplete Response
→ Proceed to Step 5

LONG-TERM MAINTENANCE

- Continue the lowest effective therapy
- Regular follow-up (every 3–6 months)
- Monitor side effects, bone health, metabolic health
- Reassess treatment goals periodically



STEP 5: SEVERE REFRACTORY PMDD

For debilitating, treatment-resistant PMDD

- Long-term GnRH agonist with hormone “add-back”
- Bilateral oophorectomy (last resort; permanent)
- Requires multidisciplinary care and informed consent

Indications

- Severe functional impairment
- Multiple failed treatments
- Strong hypothalamic–pituitary–gonadal axis confirmed by GnRH trial



ADJUNCT & LIFESTYLE INTERVENTIONS

- Cognitive Behavioral Therapy (especially emotion regulation CBT)
- Regular aerobic exercise
- Sleep optimization
- Stress management / mindfulness
- Reduce caffeine, alcohol, and refined sugar
- Maintain balanced diet



ADJUNCT SUPPLEMENTS (Evidence: Moderate)

- Calcium (1200 mg/day)
- Vitamin B6 (50–100 mg/day)
- Magnesium (200–400 mg/day)
- Vitamin D (if deficient)
- Supplements are adjuncts, not primary therapy.



OTHER PHARMACOLOGIC OPTIONS (Selected Cases)

- Benzodiazepines (e.g., alprazolam) – short term for severe anxiety
- Spironolactone – helpful for bloating and physical symptoms
- Other investigational agents (e.g., ulipristal acetate, neurosteroid modulators)



EXPECTED OUTCOMES

With appropriate treatment, most women (60–80%) achieve significant symptom reduction and improved quality of life.

Abbreviations

SSRI: Selective Serotonin Reuptake Inhibitor
COC: Combined Oral Contraceptive
GnRH: Gonadotropin-Releasing Hormone

Note: This algorithm is based on current evidence and expert guidelines (ACOG 2023, ISPM 2017, recent reviews). Clinical judgment and patient preference are essential in treatment decisions.