

HOSPITAL PHYSICIAN®

OBSTETRICS AND GYNECOLOGY BOARD REVIEW MANUAL

PUBLISHING STAFF

PRESIDENT, GROUP PUBLISHER

Bruce M. White

EDITORIAL DIRECTOR

Debra Dreger

SENIOR EDITOR

Miranda J. Hughes, PhD

ASSISTANT EDITOR

Rita E. Gould

EDITORIAL ASSISTANT

Kara V. Warner

EXECUTIVE VICE PRESIDENT

Barbara T. White, MBA

EXECUTIVE DIRECTOR

OF OPERATIONS

Jean M. Gaul

PRODUCTION DIRECTOR

Suzanne S. Banish

PRODUCTION ASSOCIATES

Tish Berchtold Klus

Mary Beth Cunney

PRODUCTION ASSISTANT

Stacey Caizzo

ADVERTISING/PROJECT MANAGER

Patricia Payne Castle

MARKETING MANAGER

Deborah D. Chavis

NOTE FROM THE PUBLISHER:

This publication has been developed without involvement of or review by the American Board of Obstetrics and Gynecology.



The Association for Hospital Medical Education endorses HOSPITAL PHYSICIAN for the purpose of presenting the latest developments in medical education as they affect residency programs and clinical hospital practice.

Diagnosis and Management of the Premenstrual Syndrome; Developmental Anomalies of the Reproductive System

Series Editors: Paul B. Marshburn, MD, FACOG

Director, Division of Reproductive Endocrinology and Infertility, Department of Obstetrics and Gynecology, Carolinas Medical Center, Charlotte, NC

Jordan G. Pritzker, MD, MBA, FACOG

*Assistant Professor, Albert Einstein College of Medicine, Montefiore Medical Center, Bronx, NY
Obstetrics and Gynecology Faculty Practice, Women's Comprehensive Health Center, Long Island Jewish Medical Center, New Hyde Park, NY*

Contributors:

Michelle L. Matthews, MD

Assistant Director, Division of Reproductive Endocrinology and Infertility, Department of Obstetrics and Gynecology, Carolinas Medical Center, Charlotte, NC

Bradley S. Hurst, MD

Director, Assisted Reproduction, Division of Reproductive Endocrinology and Infertility, Department of Obstetrics and Gynecology, Carolinas Medical Center, Charlotte, NC

Table of Contents

Chapter 1—Diagnosis and Management of

the Premenstrual Syndrome 2

**Contributors: Michelle L. Matthews, MD
Bradley S. Hurst, MD
Paul B. Marshburn, MD, FACOG**

Chapter 2—Developmental Anomalies of

the Reproductive System 12

**Contributors: Bradley S. Hurst, MD
Michelle L. Matthews, MD
Paul B. Marshburn, MD, FACOG**

Cover Illustration by Scott M. Holladay

Copyright 2002, Turner White Communications, Inc., 125 Strafford Avenue, Suite 220, Wayne, PA 19087-3391, www.turner-white.com. All rights reserved. No part of this publication may be reproduced, stored in a retrieval system, or transmitted in any form or by any means, mechanical, electronic, photocopying, recording, or otherwise, without the prior written permission of Turner White Communications, Inc. The editors are solely responsible for selecting content. Although the editors take great care to ensure accuracy, Turner White Communications, Inc., will not be liable for any errors of omission or inaccuracies in this publication. Opinions expressed are those of the authors and do not necessarily reflect those of Turner White Communications, Inc.

Chapter 1—Diagnosis and Management of the Premenstrual Syndrome

Michelle L. Matthews, MD, Bradley S. Hurst, MD,
and Paul B. Marshburn, MD, FACOG

I. INTRODUCTION

Premenstrual syndrome (PMS) is a constellation of symptoms experienced by women in the week before the menses. PMS was first identified in medical literature as a clinical entity in the 1930s.¹ However, the first known documentation of PMS symptoms dates back to Hippocrates.² Approximately 80% of reproductive age women experience some premenstrual symptoms, including fatigue, irritability, bloating, or breast tenderness.³ In approximately 5% of women, the symptoms are significant enough to cause interference in daily functioning leading to marital discord, sexual dysfunction, and difficulties within families. PMS may also result in loss of work and dysfunction in professional relationships.

Although the symptoms of PMS are well documented, the underlying pathophysiology of the condition and the components necessary to establish a diagnosis are not well established. Because physical premenstrual symptoms overlap with PMS, it is often difficult to establish a diagnosis of PMS. However, it is critical for health-care providers to make an accurate diagnosis in order to provide appropriate treatment. Fortunately, most women can be successfully treated with specific therapies once the proper diagnosis is established.

II. ETIOLOGY

CASE PATIENT I PRESENTATION

Patient 1 is a 27-year-old, unmarried, Caucasian woman who states she has irritability and depression the week before her menses. She also notes difficulty concentrating, lack of energy, insomnia, and bloating that resolve by the end of her menstrual cycle. Her menstrual cycle length is 28 days with 3 to 5 days of bleeding. She denies symptoms during the cycle except for the week before her menses. She denies any history of medical problems

including psychiatric disease or any pertinent gynecologic history. She denies any history of physical or psychological abuse. She is occasionally sexually active. Her family history is unremarkable. She is not currently on any medications but is taking a multivitamin. Her premenstrual symptoms often interfere with her ability to function at work as well as interact with her friends and family.

- What is PMS?
- What are the risk factors for PMS?
- What causes PMS?

DEFINITION OF PMS

PMS includes physical and emotional symptoms occurring 1 or 2 weeks before menstruation. **Table 1** shows the most common symptoms, including emotional changes (such as irritability, anxiety, and depression) as well as physical symptoms (including breast tenderness and bloating). The symptoms range on a continuum from mild to severe. Although most reproductive age women experience some mild premenstrual symptoms, only those patients with symptoms significant enough to interfere with daily activities are considered to have PMS; otherwise, no criteria are universally accepted for diagnosing PMS. The diagnosis is subjective and determined by the healthcare provider based on patient self-report of symptoms.

RISK FACTORS

Several factors may increase a woman's risk of exhibiting PMS symptoms. Women are at risk of experiencing PMS during their late 20s to mid 30s, and symptoms may increase with age. Research has also shown a possible genetic predisposition to PMS. There is an increased likelihood of similar premenstrual symptoms between twins. In fact, one study reported that 35% of the similarity of PMS symptoms in twins is caused solely by genetic factors.⁴ Women often report a family history of PMS in a first-degree relative, which further reinforces the possibility of a genetic role. Environment is likely to play