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Premenstrual Syndrome and Postnatal Depression

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Abstract: In 1855 Marce recognised that as patients with puerperal psychosis improved they tended to have recurrences of symptoms at menstruation. Women, who had previously suffered from postnatal depression or psychosis and had received progesterone prophylactic treatment, were questioned six months after the birth. Menstruation had restarted in 129 of whom 71 (53%) already recognised they suffered from premenstrual syndrome. This suggests that women who have suffered postnatal depression or psychosis should remain under observation for at least six months after menstruation has returned, and if necessary receive treatment for premenstrual syndrome.

Zusammenfassung: *Prämenstruelle Syndrome und nachgeburtliche Depression.* Im Jahre 1855 entdeckte Marce, daß Patientinnen mit Wochenbettpsychose dazu neigten, bei der Menstruation zum Wiederauftreten dieser Symptome neigten. Frauen, die nachgeburtliche Depressionen oder Psychosen hatten und vorbeugend mit Progesteronen behandelt wurden, wurden sech Monate nach der Geburt befragt. Von 129 Frauen, bei denen die Menstruation wieder einsetzte, gaben 71 (53%) prämenstruelle Syndrome an. Dies führt zum Schluß, daß Frauen, die nachgeburtliche Depressionen oder Psychosen hatten, mindestens sechs Monate, nachdem die Menstruation wieder einsetzte, unter Beobachtung stehen sollten, um falls nötig die prämenstruellen Syndrome zu behandeln.

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It was in 1971 that I first discussed the similarity of postnatal depression and premenstrual syndrome[1]. But Marce[2] recognised in 1855 that as patients with postnatal depression improved they would have recurrences at menstruation. Initially there is an improvement in the postmenstruum with exacerbation in the premenstruum, that is "menstrual magnification" or "menstrual distress". As improvement continues there is normality in the postmenstruum with premenstrual exacerbation, in short PMS develops.

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Dr. Joan Mallison[3] in 1953 noted that: "it is commonly found that if menstruation returns before the psychosis is resolved, excerbations occur repeatedly in the premenstrual phase."

Hegarty[4] in 1955 suggested the name "postpuerperal recurrent depression" for the syndrome of "recurrent depression, irritability and tension dating from an attack of mild but typical puerperal depression." There seemed little point in differiating this disorder from PMS, for the aetiology, symptoms, signs and treatment are similar.

PMS is defined as "recurrent symptoms in the premenstruum with absence of symptoms in the postmenstruum." The diagnostic points to note are recurrence in each cycle, presence in the premenstruum and absence in the postmenstruum. Symptoms must be of sufficient severity to cause disruption of social, family or occupational life.

In a survey for the FDA I did in 1982[5] it was noted that among 769 severe and well diagnosed parous PMS sufferers 59% had previously suffered from postnatal depression and 12% attributed the onset of PMS to a previous postnatal depression.

In the last survey into the response of progesterone prophylaxis for a recurrence of postnatal depression[6] questions on the presence of PMS were included in the patient's questionnaire. It was not a random sample, the women were self selected. Menstruation had restarted in 129 women, of whom 71 (55%) suffered from PMS.

Treatment had not been sought by 18, presumably because their symptoms were too mild, however among the others hormone treatment (53%) was the commonest, followed by dietary treatment in 34%.

Breast feeding was not attempted by 12%, and only 37% continued after six months.

In a previous survey of postnatal depression[7] it was noted that PMS started within six weeks of delivery in 40%. However, among those whose illness started after six weeks 20% noted it started on stopping lactation, and 20% when menstruation restarted. Oral contraception was blamed by 14%. Other causes for the onset of postnatal depression are a weight reducing diet and starting night work.

If an individual's personal symptoms are recorded daily when menstruation returns it is those same symptoms which recur in the premenstruum in PMS sufferers.

There are many points of similarity between postnatal depression and PMS. Both illnesses start at a time of hormonal change, and in both there is a marked family history. The same symptoms predominate in the puerperium and premenstruum. Patients of both PND and PMS are intolerant of oral contraceptives, intolerant of long food intervals and intolerant of upsets of their day/night rhythm. More important both respond to prophylactic progesterone therapy, started either at the completion of labour or from ovulation to menstruation.

Having mentioned progesterone I must also mention the rules of progesterone therapy[8]. It must be used prophylactically before symptoms appear, either at the completion of labour to prevent postnatal depression, or from ovulation to menstruation for PMS. Systemic medication is necessary, (intramuscular, vaginal or

rectal) and a high dose is needed. A stable blood glucose level is essential and if any thrush infection is present this should be treated.

In conclusion PMS is a common sequelae of postnatal depression and therefore the message is that patients with postnatal depression should remain under observation for at least six months after normal menstruation has restarted. It all depends on you.

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