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PMS or Perifollicular Phase Euphoria?

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What I am going to say about premenstrual syndrome (PMS) has little scientific basis; however, this is not unusual in the field of PMS. Much of the information on PMS published in medical journals is so lacking in scientific method that it would make many scientists (including myself) cry in despair.

Why is it that so little is known about PMS? First of all, there is no agreement on what PMS is. If investigators are referring to different sets of symptoms, how can studies be comparable? In fact, they are not. Not only are the symptoms different, but the timing of symptoms is different. Some studies describe symptoms that occur 7 to 10 days before the onset of menses, while others include symptoms that begin 14 days before the onset of menses and continue for 7 days after onset. This definition suggests that women may have PMS-related symptoms during 21 days of a 28-day cycle. I don't want to believe this—and I don't have to—because little scientific evidence exists to either support or refute this hypothesis.

Symptoms both physical and emotional are attributed to PMS, with most women having a combination. Symptoms include anxiety, depression, tension, labile emotions, irritability, difficulty in concentrating, increased energy, decreased energy, food cravings, headache, weight gain, fluid retention, insomnia, breast swelling and tenderness, and increased or decreased appetite. These symptoms alone are not specific for PMS; the diagnosis depends on their cyclical occurrence in relationship to menses. The cause of these varied symptoms has not been established—if indeed there is only one cause. Suggested causes include estrogen excess, progesterone deficiency, vitamin B6 deficiency, prostaglandin excess, prolactin effect, and multiple other guesses including, of course, psychosomatic origins. Suggested treatments include estrogen, progesterone, vitamins, nutritional supplements, a prolactin inhibitor, and psychotherapy. None of these treatments have proved convincingly more effective than placeboes in well-designed trials.

How could a scientist be suffering from something so unscientific? Although I clearly had symptoms described as PMS, I refused to believe that I was out of control or capable of killing, beating, or other violent behavior.

PMS has been a no-win situation for women, according to Anne Fausto-Sterling.[1] In the past if women complained about symptoms related to menses, they were often diagnosed as neurotic. With the advent of the women's movement, women became more assertive, insisting that their symptoms were real. More attention was paid to PMS, especially in the media. Several legal cases emerged in which women charged with murder or child abuse tried to use PMS as a defense, implying that PMS so affected them they were unable to control their behavior. Then feminist voices were heard pleading for caution in assuming that women may not be in control of their behavior several days each month, an idea consistent with the old "raging hormone" theory that cyclic hormone changes make women unreliable, unpredictable, and incapable of assuming important jobs. This is a myth that women have been trying to disprove for at least a century. Now comes PMS to say it's actually true. What a dilemma.

When I first heard about PMS in the 1970s, I was sure that this was just another variant of the raging hormone theory perpetuated by those who wanted to keep women out of positions of power. How could a woman ever be president if she were still menstruating? Had she ever had PMS? Was she likely to start World War III if, as president, she was out of control because of PMS? I had never experienced premenstrual symptoms, and I never really knew any women who did. Therefore, I simply just didn't believe in PMS.

Then in the early 1980s, I was at a local AMWA branch meeting talking to a friend about occasional insomnia I was experiencing. I had never had insomnia before in my life, and I was surprised and puzzled about being up one night every so often when I felt so wound up I couldn't sleep. My friend replied that she thought it might be PMS. I was shocked that she accepted the PMS theory. Several of the other physicians at the meeting chimed in to say that they themselves experienced PMS and occasionally diagnosed it in their patients. I couldn't accept it.

Subsequently, I kept track of my insomnia bouts and found that they occurred between 24 and 36 hours preceding onset of menses. I was forced to reevaluate my position. I reviewed all published books and articles I could find through a Medline search. What a mishmash they were. How could a scientist be suffering from something so unscientific? Although I clearly had symptoms described as PMS, I refused to believe that I was out of control and capable of killing, beating, or other violent behavior. But how could I be sure? I certainly wasn't an unbiased observer. Was I deluding myself? How could I possibly answer these questions objectively? I interviewed

all my close family and friends. None of them could recall my showing signs of violent behavior. I decided to keep my symptoms to myself.

I recently encountered a most intriguing theory of PMS. In *Understanding Your Body, Every Woman's Guide to Gynecology and Health,*[2] an anonymous gynecologist says, "Another way of thinking about the PMS emotional patterns my patients describe is that women tend to be abnormally pleasant and nice three weeks out of four. They fail to experience or express normal annoyances and anger a great deal of the time, and are dismayed when these emotions surface during premenstrual days." This is a wonderful theory guaranteed to make most PMS sufferers feel much better. And the cause of this abnormal euphoria during those three weeks is an excess of endorphins, naturally occurring opiate-like substances manufactured in the brain. Sudden decreases in endorphin levels may result in withdrawal-like symptoms—the same symptoms described for PMS: tension, anxiety, and irritability. I am entranced by this theory. The problem isn't premenstrual symptoms as we thought, these are normal. It's the other three weeks that we women PMS sufferers are abnormal, being nice, flexible, calm, loving creatures because we are addicted to our own naturally occurring endorphins.

But how are we going to tell the American Psychiatric Association? In a recent revision of the *Diagnostic and Statistical Manual of Mental Disorder* (DSM III), despite the lack of scientific evidence and the strong opposition from respected psychiatric, psychologic, and public health organizations,[3] the APA decided to include PMS (with some caveats) under the designation "late luteal phase dysphoria." Now someone has to tell them that the problem should really be named "perifollicular phase euphoria" (PPE), for the three weeks of every month that women are unnaturally nice and accommodating because of high levels of naturally occurring endorphins. This PPE theory has biologic plausibility and at least as much validity as the other theories embraced by experts in the field. I hope all AMWA members will lobby the APA to have this problem put in its proper perspective. Let's get the word out and encourage the Perifollicular Phase Euphoria Support Group in your area.

References

1. Fausto-Sterling A: *Myths of Gender.* New York, Basic Books, 1985.
2. Stewart F, Guest F, Stewart G, et al: *Understanding Your Body: Every Woman's Guide to Gynecology and Health.* New York, Bantam, 1987, p 551.
3. Braude M: Update: DSM-III diagnosis debate. *J Am Med Wom Assoc* 1988;43:30.

Pill/Cyst Link?

James C. Caillouette, MD, an obstetrician/gynecologist in Pasadena, California, believes there may be a link between low-dose phasic contraceptive pills and the development of functional ovarian cysts. Dr. Caillouette published an anecdotal report of seven cases from his practice in the August 1987 *American Journal of Obstetrics and Gynecology.* In response, he received a number of letters from physicians around the country who reported similar cases in their own practices. Right now, those concerned with this issue have two objectives: One is to alert physicians to this possible problem so that they will pay close attention to patients using phasic contraceptive pills. The other is to gather more information. AMWA members should send reports of patients who develop ovarian cysts—or have other adverse reactions—while on phasic contraceptive pills to: FDA, HFN-737, 5600 Fishers Lane, Rm 15B23, Rockville MD 20857.