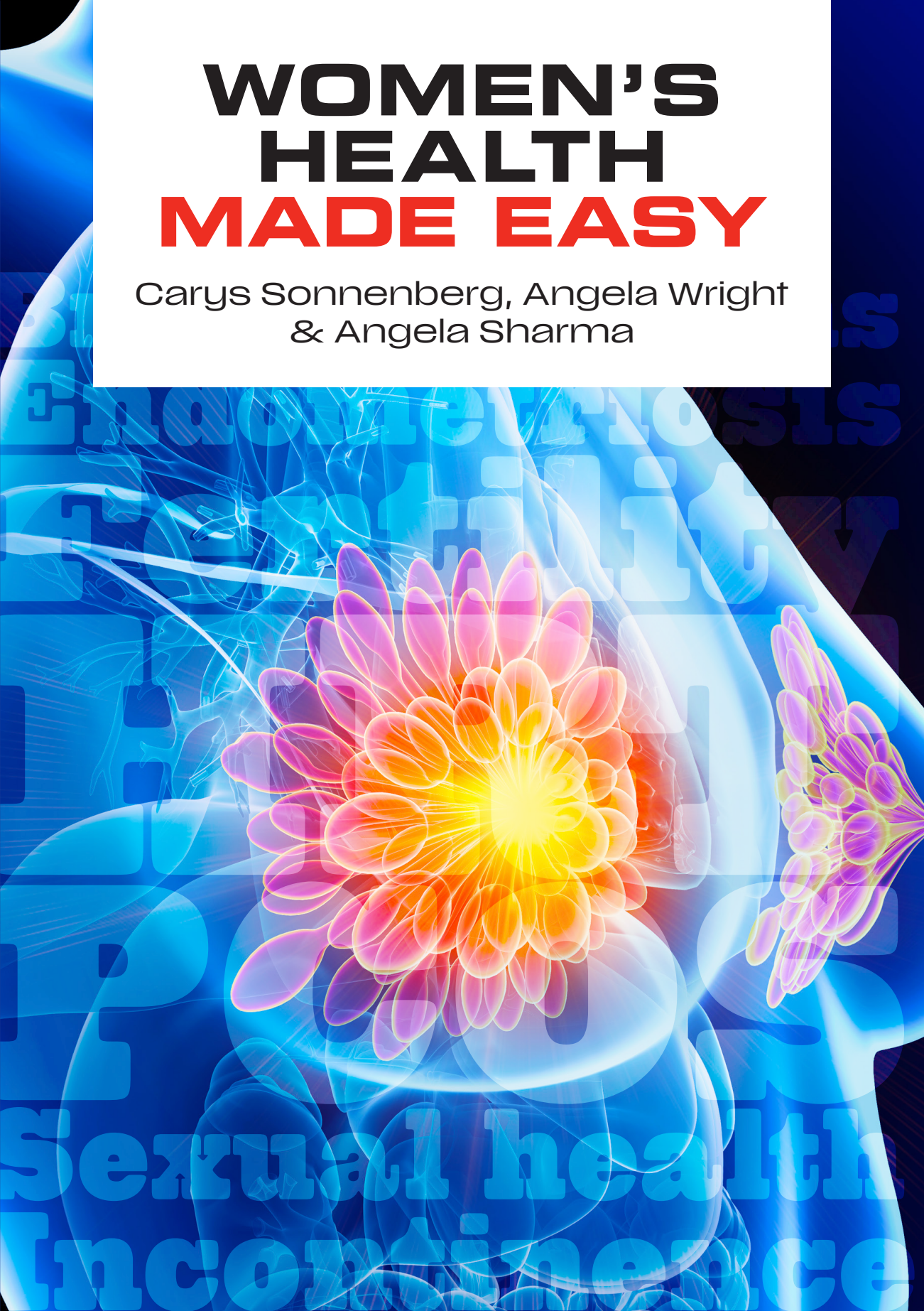
WOMEN'S HEALTH MADE EASY

Carys Sonnenberg, Angela Wright & Angela Sharma



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Scion

First published 2026

A CIP catalogue record for this book is available from the British Library.

ISBN 9781914961649

Scion Publishing Limited
Long Hanborough, Oxfordshire, UK

www.scionpublishing.com

Cover design by Andy Magee
Typeset by Dataworks in India
Printed in the UK

Last digit is the print number: 10 9 8 7 6 5 4 3 2 1

Contents

Detailed contents

Preface

Women's health is often described as "complex". It is probably more accurate to say it has been made so by decades of under-research, under-teaching, and historical bias within medicine.

For too long, women's symptoms have been minimised, normalised, or attributed to psychology. At the same time, clinicians have been expected to manage high-impact, intimate areas of care with limited formal training, patchy evidence and inconsistent guidance. This has created significant and systemic challenges in women's health: shown through delayed diagnoses, fragmented care and a growing sense of loss of trust in healthcare.

Women's Health Made Easy was written in response to these gaps. Invited to develop this text through the Primary Care Women's Health Society, we set out to create a practical, clinically useful resource that was grounded in real consultations. Drawing on our combined experience as GPs, menopause specialists and sexologists, we focus on areas historically underrepresented in training, including sexual health, vulval conditions, menstrual disorders, fertility and menopause, alongside communication, safeguarding, perinatal mental health and the interaction between hormonal and psychological wellbeing.

Improving women's healthcare requires better education, better support, and access to safe, pragmatic advice based on good evidence. This book is one contribution towards that change.

Note: throughout the text we use the words 'woman' and 'women', but the information and advice in these pages is intended to include all those assigned female at birth.

Carys Sonnenberg
Angela Wright
Angela Sharma

Acknowledgements

We are grateful for the mutual support we have given one another through the long hours of writing and proofreading, and want to extend our thanks to the Primary Care Women's Health Society for giving us the opportunity to write this book. We are also grateful to Scion Publishing Limited for their advice and guidance along the way. A huge thank you goes to our families for their patience, care and constant support throughout this process. We would also like to thank all the women we have met and cared for throughout our careers. You have shown us the value of listening and the impact that can be made when we get it right; and you have inspired us to do what we can to help to change and improve women's healthcare in the future.

Thanks are also due to Dr Anne Connelly, Professor Vikram Talaulikar, Dr Toni Hazell, Dr Sarah Gray, Dr Rachael Chrystal, Dr Alison Macbeth, Dr Zoe Hodson, Dr Sarah Ball, Dr Claire Phipps, Dr Alice Duffy, Dr Jill Crowfoot, Dr Clare Grove, Dr Kayo Oshiga, Dr Louise Payne, Dr Georgia Weeks, Melinda McDougall, Fiona Clark and Diane Danzebrink for their teaching, proofreading and support.

About the authors

Carys Sonnenberg

Dr Carys Sonnenberg is an experienced NHS GP and a British Menopause Society (BMS) Registered Menopause Specialist. She has practised as a GP since 2002 and leads women's health services within her NHS practice, including contraception, LARC provision and complex menopause management.

She is a member of the Royal College of General Practitioners (MRCGP) and holds the Diploma in Child Health (DCH), the Diploma of the Royal College of Obstetricians & Gynaecologists (DRCOG) and the Diploma of the Faculty of Sexual & Reproductive Health (DFFP). She was awarded the BMS Advanced Certificate in the Principles and Practice of Menopause Care after completing training at University College London Hospital, and is trained in cognitive behavioural therapy (CBT) for menopause.

She is a member of the wider board of the Primary Care Women's Health Society (PCWHS), contributing to speaking at national educational events, teaching sessions and written articles. Alongside her broader educational work, she regularly delivers talks to local women and provides menopause and women's health training for corporate organisations.

Her clinical interests extend to metabolic health and to extend her knowledge, she undertook nutrigenomics training and completed the Nutrigenomics Practitioner Programme with LifeCodeGx. In 2026 she completed a Postgraduate Diploma in Obesity and Weight Management (PgDip) at the University of South Wales.

She founded and is a director of Rowena Health, a private online menopause clinic, extending her care to women across the UK. She provides personalised, holistic care, equipping women with clear, evidence-based knowledge about their hormonal health and supporting long-term wellbeing.

Angela Sharma

Dr Angela Sharma is a GP Partner, a British Menopause Society (BMS) registered menopause specialist and a clinical sexologist, as well as the co-founder of Spiced Pear Health, an online menopause and sexology clinic.

She has been a GP in Notting Hill, London, for 23 years. She has set up and leads a menopause service in her own NHS practice, and is also the women's health lead as well as leading in antenatal and postnatal care. She is passionate about changing the lives and health of women for the better.

She has a BSc in Immunology & Oncology, and is a member of the Royal College of General Practitioners (MRCGP) and has Diplomas in Child Health (DCH), the Royal College of Obstetricians & Gynaecologists (DRCOG) and the Faculty of Sexual & Reproductive Health (DFFP). She undertook her training in Advanced Menopause Care at King's College Hospital in London, where she acquired experience in managing complex menopause cases, and is also trained in cognitive behavioural therapy for menopause. She has trained further in clinical sexology by attending the European Society of Sexual Medicine (ESSM) School of Sexual Medicine, and has become a Fellow of the European Committee of Sexual Medicine (FECSM). She is qualified in both the psychosexual therapeutic techniques and the medical aspects of sexual dysfunction. She also volunteers at Maggie's in west London, running menopause and intimacy after cancer workshops.

She is currently a member of the Medical Advisory Council for the BMS, and is also a trustee and medical advisory board member for the Menstrual Health Project, a charity that educates and empowers women on all menstrual health conditions. She speaks regularly to women, corporates and her peers about women's health issues, menopause and sexology.

Angela Wright

Dr Angela Wright is a GP, Menopause Specialist and Clinical Sexologist. She is also qualified in Palliative Medicine and worked in hospice medicine for over a decade. She is particularly interested in improving sexual function and menopausal symptoms in women who have undergone cancer treatment.

Angela completed her Advanced Menopause Care training in Hull. She now has a permanent NHS clinic there, seeing patients with complex menopause issues, female sexual dysfunction and premenstrual disorders. She also consults as a Clinical Sexologist for the Portland Hospital in London and the Wilmslow Hospital in Cheshire, and online at Spiced Pear Health. Her 2-year Clinical Sexology training was with the Contemporary Institute of Clinical Sexology (CICS), and she went on to attend the European Society of Sexual Medicine's Advanced School of Sexual Medicine. She then passed the examination to become a Fellow of the European Committee of Sexual Medicine (FECSM). She is a Diplomate of the Institute of Psychosexual Medicine. She is also trained in CBT for menopause, and in EMDR and Somatic Trauma Therapy.

Angela is passionate about women's health and sexology and is frequently asked to teach or talk about this subject. She is a registered trainer for the BMS & CoSRH, involved in training future menopause specialists and is also part of the Faculty for the sexology course she trained on, teaching the biomedical part of the course. She is an active committee member of the British Society of Sexual Medicine, the education committee of the Primary Care Women's Health Society, and a trustee for The Wellness Gateway, a charity providing trauma therapy to those who need it.

Abbreviations

ACE	angiotensin-converting enzyme
ADHD	attention deficit hyperactivity disorder
AIDS	acquired immune deficiency syndrome
AN	anorexia nervosa
ARB	angiotensin II receptor blocker
ART	antiretroviral therapy
ASD	autism spectrum disorder
BASHH	British Association for Sexual Health and HIV
BDD	body dysmorphic disorder
BMD	bone mineral density
BMI	body mass index
BMS	British Menopause Society
BP	blood pressure
BPS	bladder pain syndrome
BSO	bilateral salpingo-oophorectomy
BV	bacterial vaginosis
CAM	complementary and alternative medicine
CAP	complementary and alternative practices
CBT	cognitive behavioural therapy
CBTi	CBT for insomnia
ccHRT	continuous combined HRT
CEE	conjugated equine oestrogen
CHC	combined hormonal contraception
CHD	coronary heart disease
CIN	cervical intraepithelial neoplasia
COC	combined oral contraceptive
COCP	combined oral contraceptive pill
CoSRH	College of Sexual & Reproductive Healthcare
COSRT	College of Sexual and Relationship Therapists
CTP	contraceptive transdermal patch
Cu-IUD	copper IUD
CUV	cliterourethrovaginal
CVD	cardiovascular disease
CVR	contraceptive vaginal ring
DCIS	ductal carcinoma *in situ*
DES	diethylstilboestrol
DEXA	dual-energy X-ray absorptiometry
DHEA	dehydroepiandrosterone
DHT	dihydrotestosterone
DMPA	depot medroxyprogesterone acetate
DRSP	drospirenone
DSG	desogestrel
DSM	*Diagnostic and Statistical Manual of Mental Disorders*
DYG	dydrogesterone
EC	emergency contraception
ECG	electrocardiogram
ED	everyday
EE	ethinylestradiol
EPAU	Early Pregnancy Assessment Unit
EPO	evening primrose oil
FAI	free androgen index
FGM	female genital mutilation
FRAX	fracture risk assessment tool
FSH	follicle-stimulating hormone
GAG	glycosaminoglycan
GBMSM	gay and bisexual and men who have sex with men
GMC	General Medical Council
GnRH	gonadotrophin-releasing hormone
GPD	genito-pelvic dysthesia
GSM	genitourinary syndrome of the menopause
GUM	genitourinary medicine
HDL	high-density lipoprotein
HER2	human epidermal growth receptor 2
HFI	hormone-free interval
HIV	human immunodeficiency virus
HMB	heavy menstrual bleeding
HPO	hypothalamic–pituitary–ovarian
HPV	human papillomavirus
HRT	hormone replacement therapy
HSV	herpes simplex virus
HVS	high vaginal swab
IC	interstitial cystitis
ICD	*International Classification of Diseases*
IDVA	independent domestic violence advisor
IGF	insulin-like growth factor
IMB	intermenstrual bleeding
IMP	implant
IMS	International Menopause Society
IPM	Institute of Psychosexual Medicine
ISPMD	International Society for Premenstrual Disorders

IUD	intrauterine device
IV	intravenous
IVF	*in vitro* fertilisation
LARC	long-acting reversible contraceptive
LCIS	lobular carcinoma *in situ*
LFT	liver function test
LH	luteinising hormone
LMP	last menstrual period
LNG	levonorgestrel
LNG-EC	levonorgestrel emergency contraception
LNG-IUD	levonorgestrel intrauterine device
MARAC	multi-agency risk assessment conference
MC&S	microscopy, culture and sensitivities
Mgen	*Mycoplasma genitalium*
MHRA	Medicines and Healthcare products Regulatory Agency
MHT	menopause hormone therapy
MI	myocardial infarction
MP	micronised progesterone
MPA	medroxyprogesterone acetate
MRI	magnetic resonance imaging
MS	multiple sclerosis
MSM	men who have sex with men
MSU	mid-stream urine
NAPS	National Association for Premenstrual Syndromes
NET	norethisterone NFS non-fatal strangulation
NFS	non-fatal strangulation
NOGG	National Osteoporosis Guidelines Group
NSAID	non-steroidal anti-inflammatory drug
OAB	overactive bladder
OCD	obsessive–compulsive disorder
OGTT	oral glucose tolerance test
OSA	obstructive sleep apnoea
OSFED	other specified feeding or eating disorder
OTC	over the counter
PCB	postcoital bleeding
PCOS	polycystic ovary syndrome
PCR	polymerase chain reaction
PCWHS	Primary Care Women's Health Society
PEP	post-exposure prophylaxis
PFMT	pelvic floor muscle training
PGAD	persistent genital arousal disorder
PID	pelvic inflammatory disease
PMB	postmenopausal bleeding
PMD	premenstrual disorder
PMDD	premenstrual dysphoric disorder
PMS	premenstrual syndrome
PN	pudendal neuralgia
PND	postnatal depression
POI	premature ovarian insufficiency
POP	progestogen-only pill
POP-Q	pelvic organ prolapse quantification
POTS	postural orthostatic tachycardia syndrome
PrEP	pre-exposure prophylaxis
RCOG	Royal College of Obstetricians & Gynaecologists
RCT	randomised controlled trial
RED-S	relative energy deficiency in sport
SARC	Sexual Assault Referral Centre
SCC	squamous cell carcinoma
SHBG	sex hormone-binding globulin
sHRT	sequential combined HRT
SNRI	serotonin–noradrenaline reuptake inhibitor
SPC	Summary of Product Characteristics
SSRI	selective serotonin reuptake inhibitor
STI	sexually transmitted infection
T2DM	type 2 diabetes mellitus
TCA	tricyclic antidepressant
TENS	transcutaneous nerve stimulation
TOP	termination of pregnancy
TV	trichomonas vaginalis
U&Es	urea and electrolytes
UCP	urgent care pathway
UFED	unspecified feeding or eating disorder
UK NSC	UK National Screening Committee
UKMEC	UK Medical Eligibility Criteria for Contraceptive Use
UPA	ulipristal acetate
USC	urgent suspected cancer
UTI	urinary tract infection
UUI	urge urinary incontinence
VIN	vulval intraepithelial neoplasia
VMS	vasomotor symptom
VTE	venous thromboembolism
WHI	Women's Health Initiative
WHO	World Health Organization

Chapter 8
Female mental health

8.1 Introduction to the premenstrual disorders

8.1.1 What are premenstrual disorders and who is affected?

- Premenstrual disorders (PMDs) is an umbrella term for several distinct conditions, including the widely-recognised premenstrual syndrome (PMS) and the most severe form of premenstrual dysphoric disorder, PMDD.
- Most women are aware of physical and/or psychological changes that occur during their menstrual cycle. The exact nature of the symptoms experienced physically and mentally varies.
- Despite the prevalence of the premenstrual disorders, they remain poorly recognised and undertreated.
- The impact of premenstrual disorders varies in severity.
  - Severe premenstrual disorders (including PMDD) have an enormous impact on women's physical, social, psychological and economic wellbeing.
  - In contrast, women who experience minor, transient premenstrual symptoms that do not impair their activities or affect their quality of life are described as having physiological premenstrual 'symptoms' rather than premenstrual 'syndrome'.
- A recent meta-analysis suggests that PMS affects approximately half of women of reproductive age worldwide.
- PMDD is thought to affect between 3.2 and 7.7% of women of reproductive age worldwide.
- Women with PMDD are almost seven times more likely to attempt suicide and almost four times as likely to exhibit suicidal ideation than women without the condition.
- Women with PMS are also at higher risk of suicidal ideation, but not suicide attempts.
- The key to effective management of the premenstrual conditions lies in symptom recognition and accurate diagnosis.
- **Many women who are susceptible to hormone-related mood change will have vulnerability across their reproductive lives.**
- Susceptibility to PMDs and other forms of reproductive depression seems more prevalent in women who are neurodivergent, e.g. with autistic spectrum disorders or ADHD. History of exposure to trauma is also more common in women with PMDs. There is also diagnostic overlap with joint hypermobility and autonomic dysfunction.

8.1.2 What causes the premenstrual disorders?

- Understanding the aetiology of the PMDs remains an ongoing area of research.
- It is clear that ovulation, and therefore the presence of luteal phase hormones, is a key factor in the premenstrual disorders, as symptoms of PMDs do not occur prior to menarche, during pregnancy or after menopause.
- The exact cause remains uncertain, however. **Research shows hormone levels are not distinguishable between women with and without PMDs –** showing it is not hormones per se that are responsible for the condition, rather that individuals with PMD have an atypical response to them.
- Overlapping genetic and environmental factors seem to feed into a state of neurobiological vulnerability to PMDs. Research is focused in four main areas:
  - **Genetic susceptibility**
    - Studies suggest some heritability in PMDD.
  - **Dysregulation in the serotonergic system**
    - Changing hormone levels may impact the serotonin system. Depletion of tryptophan, the main precursor of serotonin, has been shown to worsen premenstrual symptoms. The efficacy of SSRIs in treatment of the PMDs also supports this theory.
    - Oestrogen and progesterone levels also affect the dopamine system.
  - **The effect of progesterone and its metabolite, allopregnanolone, on the GABAergic system**

    - In people with PMDs there appears to be increased sensitivity to changes in allopregnanolone levels.
    - Allopregnanolone works as an agonist at the GABA-A receptor to enhance the neurotransmitter's calming effect on mood.
    - SSRIs may also alter allopregnanolone levels, which may explain how they can be effective treatment in PMD.
  - **Stress and inflammation**
    - Stress seems to have a role through amplifying sympathetic activity.
    - **There may also be an exaggerated immune–inflammatory response.**

8.1.3 Making the diagnosis

- **In order to diagnose a premenstrual disorder, we must demonstrate the following:**
  - Cyclicity with respect to luteal phase.
  - Relief of symptoms after onset of menses, with a symptom-free period.
  - Impact on daily functioning.
  - Presence of symptoms over at least two consecutive cycles (useful menstrual diaries for patients can be downloaded from www.IAPMD.org).
- Symptom persistence and severity can fluctuate: one study showed that only 36% of women who met the diagnostic criteria for PMS continued to meet the diagnostic criteria one year later.
- Postmenopausal women with previous PMDs may experience recurrence of psychological and physical symptoms when they receive progestogen therapy.
- Research indicates that reproductive steroids affect virtually every system implicated in the pathophysiology of depression. **Women who are susceptible to hormone-induced mood change may also show mood change with pregnancy, the postnatal period, infertility treatment, perimenopause and menopause, and when exogenous hormones are prescribed as contraception or HRT.**
- This susceptibility to sex-steroid-related mood change is widely recognised as creating a 'window of increased vulnerability' to mental health conditions during the reproductive years.

8.1.4 Classification of premenstrual disorders

- Historically, the nomenclature and definitions for the premenstrual disorders have been varied and confusing.
- The International Society for Premenstrual Disorders (ISPMD) produced the first consensus on definitions and diagnostic criteria. This now underpins the definitions in the *Diagnostic and Statistical Manual of Mental Disorders,* 5th edition (DSM-5) and the *International Classification of Diseases,* 11th revision (ICD-11). ISPMD also developed the clinical standards for managing PMDD which underpin the Treatment Guidelines released by the Royal College of Obstetricians & Gynaecologists (RCOG) in 2013.
- The ISPMD defined premenstrual disorders as core PMDs (associated with ovulatory cycles) or variant PMDs (see also *Table 8.1*).
  - **Core premenstrual disorders** (incorporating premenstrual syndrome and PMDD)
    - Symptoms occur regularly in ovulating women.
    - They are generally present during the luteal phase.
    - They generally resolve by the end of menstruation.
    - A key diagnostic point is that a symptom-free interval is present.
  - **Variant premenstrual disorders** include everything that does not meet the criteria for the core PMDs. There are four subtypes:
    - **Premenstrual exacerbation (PME):** where there is a physical condition (e.g. asthma, migraine, epilepsy) and/or a psychological condition (e.g. depression, anxiety, eating disorders or obsessive–compulsive disorder, OCD) which is present throughout the month but worsens cyclically (usually in the luteal phase).

Table 8.1: Differentiating between core and variant PMD

Core PMD	
Subclassified according to nature of symptoms: • Predominantly physical • Predominantly emotional • Mixed	Symptoms occur in ovulatory cycle Symptoms can be physical or psychological Symptoms absent after menstruation and before ovulation Symptoms must be prospectively rated for at least 2 cycles Symptoms must cause functional impairment
Variant PMD	
Premenstrual exacerbation	Exacerbation of an underlying somatic (e.g. asthma, migraine) or psychological disorder that is present throughout the month but worsens in the luteal phase
Non-ovulatory PMD	Poorly understood and rare; symptoms arise from follicular activity of the ovary
Progestogen-induced PMD	PMD symptoms arise from exogenous sources of progestogen in the COCP or HRT
PMD with absent menstruation	PMD arises from cyclical ovarian activity even though menstruation has been suppressed – e.g. in women who have had endometrial ablation, have a 52mg LNG-IUD or have had a hysterectomy

- **PMD with absent menstruation:** this may happen when amenorrhoea has been induced, e.g. following LNG-IUD insertion, endometrial ablation or hysterectomy with conservation of the ovaries. Symptoms are thought to arise from cyclical ovarian activity despite absence of ovulation.
- **Progestogen-induced PMD:** in susceptible women, the exogenous hormones in sequential HRT or hormonal contraceptives can induce symptoms. Progestogen-only contraceptives and continuous HRT can also cause PMD-like symptoms but as these are non-cyclical, they are not included in this definition and are considered as adverse effects of continuous hormonal therapies (colloquially this is often referred to as 'progestogen sensitivity').
- **Non-ovulatory PMD:** this disorder is poorly understood but it is thought that in some women, follicular activity can precipitate symptoms even if ovulation does not occur.

8.1.5 Premenstrual dysphoric disorder

- It was only in 2013 that PMDD was clearly defined and included as a distinct diagnosis in the DSM-5.
- In 2019 the ICD-11 also included PMDD as a distinct condition listed under genitourinary diseases but cross-listed in depressive disorders.
- This was considered a breakthrough for women's health, but also invited controversy regarding the purported pathologisation of 'normal hormonal changes' and risks of over-diagnosis.
- Since the inclusion of PMDD in the DSM and ICD there has been a significant increase in interest, funding and research into the condition.

How can we diagnose PMDD?

- The DSM-5 diagnostic criteria for PMDD require the following to be fulfilled:
  - **Cyclicity of symptoms**
    - Cyclicity is key, with definite temporal relationship to cycle.
    - Must be present in the final week before the onset of menses, start to improve within a few days after the onset of menses and become minimal or absent in the week post menses.

- **Presence of at least 5 of 11 symptoms as listed here:**
- **Core symptoms (of which at least one must be present):**
  - Marked affective lability (e.g. mood swings, feeling suddenly sad or tearful, increased sensitivity to rejection).
  - Marked irritability or anger and increased interpersonal conflicts.
  - Markedly depressed mood, feelings of hopelessness, or self-deprecating thoughts.
  - Marked anxiety, tension and/or feelings of being keyed-up or on edge.
- **Additional symptoms**
  - Decreased interest in usual activities.
  - Poor concentration.
  - Lethargy, reduced stamina.
  - Marked change in appetite, overeating or food cravings.
  - Sleep changes – hypersomnia or insomnia.
  - A sense of being overwhelmed or out of control.
  - Physical symptoms such as breast tenderness, joint pains, bloating or weight gain.
- **Severity of impact**
  - Clinically significant impact must be present (i.e. causing distress and interfering with work, school or usual social activities or relationships with others).
- **Exclusion of PME**
  - Often the hardest part of diagnosis.
  - Should not be an exacerbation of an underlying psychiatric disorder such as anxiety, depression or personality disorder.
  - PMDD can co-occur with these conditions.
- **Confirmation with prospective daily ratings**
  - Diagnosis requires cycle diaries for at least two consecutive cycles.
  - If one of these cycles is atypical, complete a third.
- **Symptoms are not attributable to drugs / other medical condition**
  - Take a careful drug history and medical history to exclude influences of medication, drug abuse or a medical condition such as hyperthyroidism.

Suicidality in PMDD

- Women with PMDD must be considered high-risk for suicidality. Loss of impulse control and impaired interpersonal functioning are likely to contribute to vulnerability to suicide in women with PMDD.
- Studies suggest that cycle diaries, though crucial to accurate diagnosis, are often not completed. Women are often desperate for help by the time they speak to a healthcare professional and if there is extreme distress or suicidal ideation, delaying treatment by 2 months may be unacceptable.

Differential diagnoses, variances and other associations in PMDD

- Distinguishing PMDD from premenstrual exacerbation or other mental health or physical conditions can be difficult. The presence of a symptom-free window for at least a few days after menstruation is crucial.
- Cycle diaries and a symptom-free interval are essential to separate PMDD from the premenstrual exacerbation of another condition.
- Particular care should be taken to distinguish PMDD from emotionally unstable personality disorder and understanding how it may relate to trauma-related conditions.
- A history of exposure to trauma is more likely in women with PMDD and there can be overlap between the diagnostic criteria for these conditions. Evidence also suggests women with trauma exposure may experience worsening of trauma-related symptoms during periods of reproductive shift, e.g. postpartum and in the perimenopause. Understanding the interrelated

nature of lived experience and physical/psychological symptoms allows us to take a holistic, biopsychosocial approach to management of these issues.
- PMDD is common in the neurodivergent population. Consider if 'missed' neurodivergence may be present when diagnosing PMDD. Look for the presence of cyclical exacerbation or symptoms in neurodivergent patients.
- Although the DSM-5 criteria focus on the classical late luteal pattern of symptoms, it is becoming increasingly evident that the PMDs encompass women with other patterns of cyclical symptoms, e.g. exacerbation during ovulation, or symptoms starting a few days after menses.
- Pragmatic questions should be asked, particularly whether this patient is likely to benefit from cycle control to manage her pattern of physical and psychological symptoms. The focus should be on identifying patterns that repeat from month to month, and on shared decision-making regarding treatments that may reduce the severity and impact of symptoms.
- Given the high risk of suicidal ideation and attempts in this population, patients with PMDD in primary care can be referred to secondary care for diagnosis and MDT management of symptoms, if the practitioner is not confident in management.

8.1.6 Management of the premenstrual disorders

Lifestyle and diet

- All women with premenstrual disorders should be advised that lifestyle modification has been shown to improve symptoms.
- General measures to improve symptoms include:
  - Eating regular balanced meals every 2–3 hours that are rich in complex carbohydrates (theorised to increase central serotonin availability via increased tryptophan, with some trial data to support this).
  - Regular moderate aerobic exercise.
  - Regular sleep.
  - Stress reduction.
  - Smoking cessation and alcohol restriction, where applicable.
  - Cognitive behavioural therapy (CBT) should be routinely offered and can be useful alongside pharmacological approaches as well as being an alternative to medication.

Supplements and complementary medicine

- Vitamin B6 has been extensively studied and 100mg has shown weak superiority to placebo in meta-analysis. Higher doses may lead to neurological side-effects.
- Calcium supplementation at 600mg twice daily has shown some benefit in RCTs. There is some additional evidence supporting vitamin D supplementation.
- Magnesium is recommended by the International Association for Premenstrual Disorders (IAPMD) at 500mg daily following evidence of benefit.
- Agnus castus is the best researched supplement for PMS with encouraging evidence of benefit. There is no consistent dose recommendation, although the National Association for Premenstrual Syndrome (NAPS) flow chart suggests 20–40mg daily. There is no standardised quality-controlled preparation available.
- Acupuncture, St John's wort, gingko, isoflavones and a number of other complementary and alternative medicines have a weak evidence base for efficacy but should currently not be recommended first-line.

Non-hormonal medications

- Menstrual cramping and joint pain can be managed with NSAIDs (unless contraindicated), e.g. ibuprofen, mefenamic acid or naproxen.
- SSRIs have a clear evidence base for efficacy and should be considered a first-line treatment.

- When used for PMDs, SSRIs seem to have a very rapid onset of action, with improvement seen within 24 hours and peaking at 48 hours. This suggests a different mode of action than when used in depression or anxiety.
- Starting doses are the same as for other indications and they appear equally effective when offered continually, or for the luteal phase only (i.e. given on days 15–28 of the cycle). Luteal phase dosing is off-licence.
- Adverse effects are present in around 50% of SSRI users, including sexual dysfunction, nausea, sleep disturbance and fatigue. Loss of libido can be particularly challenging for women with PMS/PMDD who may already be struggling in their relationships.
- Research is taking place into allopregnanolone modulators (blocking allopregnanolone at the GABA-A receptor). 5-alpha reductase inhibitors have also been studied, as they block the conversion of progesterone to allopregnanolone.
- Anecdotally, some women find antihistamines such as fexofenadine or H_2 antagonists such as famotidine helpful. There is currently no clear evidence to support their role in management. There are also potential overlaps between premenstrual disorders, hypermobility, mast-cell activation syndrome (MCAS) and autonomic nervous system dysfunction, e.g. POTS (postural orthostatic tachycardia syndrome), which may explain the efficacy of these medications in some patients.

Hormonal medications (including use of GnRH analogues)

- **Women with PMDs have usually experienced unwanted mood change with hormonal medications and are often nervous when a prescription is suggested.**
- It is important to reassure them that initial flare in symptoms is common with all options listed below but this usually settles within 6 weeks. **They should be reassured that they will be listened to if they wish to stop medication because they cannot tolerate it.**
- Patients may need to try several different options before finding one that suits them.
- Hormonal methods may be offered alongside, or as an alternative to, lifestyle and complementary therapies and SSRIs.
- Where hormonal medications fail to improve symptoms, patients should be referred to secondary care for consideration of GnRH analogues and/or surgery.

Combined oral contraceptives

- Ovarian suppression and modulation of hormonal fluctuations in the menstrual cycle are the main aims of hormonal therapies for PMDs.
- The combined oral contraceptive pill is an effective option when used in a tailored regimen. Evidence supports giving the COCP continuously (stopping only when breakthrough bleeding occurs) or bi-/tricycling (i.e. reducing the pill-free interval to every second or third pack).
- Breaks may need to be taken if persistent spotting occurs. When a break is taken, reducing this to 4 days rather than the typical 7 can minimise the risk of cycle-related symptoms.
- The best evidence base is for drospirenone-containing contraceptives, e.g. Yasmin / Lucette / Dretine / Yacella / Eloine.
- Evidence is increasing that Zoely, which contains estradiol and nomegestrol, is also well-tolerated in women with PMDs.

Estradiol

- **Inhibition of ovulation / cycle suppression can also be achieved with higher doses of transdermal oestrogen.**
- **This is particularly useful in women in whom the COCP is contraindicated, or in women at perimenopause who request HRT.**
- 100mcg patches of transdermal estradiol have been shown to be effective at suppressing ovulation and cycle-related symptoms.
- Contraception cannot be assumed.

- The endometrium requires protection. The following are all acceptable options to try – it is worth taking a detailed history of what previous synthetic and natural progestogens may have been tried and how they were tolerated. This may inform your choice of progestogen:
  - **A 52mg LNG-IUD** provides low-dose levonorgestrel. Around 10% of women with progesterone intolerance will not tolerate this device. Women should be advised that symptoms can flare initially but this generally settles within 6 weeks. They should be reassured the device can be removed if they remain intolerant, which should eliminate symptoms within 24 hours. Many women with history of mood change with contraception are fearful of a coil, as they cannot stop the treatment themselves – giving this clear reassurance often allows a woman to feel more comfortable in trying this method.
  - **Continuous Utrogestan** (micronised progesterone) is often better tolerated than synthetic progestins. 100mg nocte has historically been used – though the recent BMS Joint Guideline on Unscheduled Bleeding would now suggest that 200mg may be required to protect against endometrial hyperplasia with a dose of 100mcg of transdermal oestrogen.
  - **Sequential micronised progesterone** may be needed to ensure predictable bleeding in younger women. The NAPS and RCOG guidelines do not advise on dose, but usually this has been 200mg for 12 days. Again, recent BMS guidelines suggest 300mg may be required for adequate endometrial protection. Watch for flare of symptoms with progesterone initiation or withdrawal, which will make this pattern of prescribing unsuitable for many.
  - **Micronised progesterone** may be better tolerated vaginally as Cyclogest pessaries or 8% Crinone gel. Current evidence supports giving the same dose advised for the oral route. This route bypasses first-pass metabolism, avoiding conversion to allopregnanolone.
  - Some progestogen-intolerant women may struggle to take the higher doses of progesterone recommended by the most recent guidelines. **In these cases, consider referring to a specialist for further management**. The RCOG guidelines state: *"When using a short duration of progestogen therapy, or in cases where only low doses are tolerated, there should be a low threshold for investigating unscheduled bleeding."*
  - **Slynd** (drospirenone 4mg) is also now available and though off-licence, has been included by the BMS in acceptable options for endometrial protection (based on the fact that drospirenone-containing COCPs contain 3mg as adequate progestogenic opposition for up to 30mg of ethinylestradiol). This option has not been incorporated into PMD guidelines so far but has shown promising results in progestogen-sensitive women.

Danazol

- Danazol is an androgenic steroid which has been shown to be effective in cycle suppression but is rarely advised for use due to its potential for irreversible masculinising side-effects.

GnRH analogues

- **When simpler measures have failed, patients can be referred to secondary care for consideration of GnRH analogues.** These are not generally initiated by the non-specialist, but once commenced are often covered by shared care arrangements and administered in primary care.
- GnRH analogues produce profound ovarian suppression and effectively induce medical menopause.
- They induce hypo-oestrogenic side-effects which require treatment.
- GnRH analogues are usually reserved for severe PMDD where surgical management is being considered. If symptoms do not respond within 12 weeks, the diagnosis of PMDD may need reviewing.
- Significant bone loss begins within 6 months of use. GnRH analogues are therefore only licensed for 6 months of continuous use.
- Add-back hormones must be prescribed if use is to be extended beyond this. They are usually started much earlier to prevent bone loss and avoid troublesome vasomotor symptoms.

- Continuous combined HRT (the oestrogen dose does not need to be 100mcg in this situation as the ovaries are already suppressed by the GnRH analogue), usually with 100mg micronised progesterone orally or vaginally, is generally prescribed. An alternative is tibolone 2.5mg which is often well-tolerated.
- RCOG guidelines advise DEXA monitoring at least annually if on long-term GnRH analogues.
- Women may notice an initial flare in symptoms as the LH and FSH generally rise before being downregulated and therefore suppressing ovulation.

Surgical treatment of PMDD

- **When treating severe PMS or PMDD and other methods have failed, or long-term GnRH therapy is required, hysterectomy and bilateral oophorectomy has been shown to be of benefit.**
- Surgery is not usually considered without preoperative use of GnRH analogues to test cure and ensure that HRT will be tolerated.
- Occasionally oestrogen alone will be administered during this period if tibolone or progesterone are not tolerated. The RCOG guidelines state that this should be on an individual basis due to concerns regarding endometrial hyperplasia. This is usually only done with specialist initiation whilst considering surgical treatment.

8.1.7 Useful resources for professionals and patients

- www.PMS.org.uk – the National Association for Premenstrual Syndromes includes a PDF guideline for patients and professionals, cycle diaries and useful resources for managing the condition.
- www.IAPMD.org – the International Association for Premenstrual Disorders has information for professionals and patients, including webinars and cycle diaries, and online peer support for people with PMDD around the world.
- www.rcog.org.uk – the RCOG Green-top Guidelines for managing premenstrual syndrome.

8.2 Perinatal mental health

8.2.1 Definition and risk factors

- The DSM-5 criteria specify that peripartum depression onset is during pregnancy or within 4 weeks after delivery.
- It is generally agreed, however, that onset can occur at any time within the 12 months following childbirth. This contrasts with the 'baby blues', which affect between 3 and 8 out of 10 women and are usually mild and transient.
- Risk factors for perinatal depression include:
  - prior depression or anxiety, including during a previous pregnancy
  - life stress
  - prior history of premenstrual disorders or adverse mood reaction with hormonal contraceptives
  - lack of social support
  - relationship difficulties, e.g. poor partner support
  - domestic violence
  - unintended pregnancy
  - history of trauma, e.g. childhood abuse
  - complications at birth, e.g. preterm delivery, infant health problems or need for intensive care
  - antenatal thyroid dysfunction or pregestational/gestational diabetes
  - longer time to conception
  - having two or more children
  - history of substance misuse
  - discontinuation of psychotropic medication prior to / during pregnancy.

- Where there is a personal history of past or present severe mental illness, or a family history of severe perinatal illness, there is a higher chance of postpartum psychosis in the first 2 weeks after childbirth.

8.2.2 Prevalence and impact

- During pregnancy, 12% of women will be affected by depression and 13% of women will be affected by anxiety. In the first year after birth, 15–20% will be affected.
- First-time mothers, adolescent mothers and those who have had a traumatic delivery may benefit from proactive support. Studies have shown that home health visits, telephone peer support and psychotherapy can help prevent postpartum depression.
- Evidence suggests that perinatal depression is often missed or undertreated in general practice.
- Severe depression in pregnancy is associated with increased rates of obstetric complications, sudden infant death syndrome, low birthweight and preterm delivery, self-harm and suicide attempts.
- Suicide remains a leading cause of maternal death in the first postpartum year.
- There is an association between depression in pregnancy and depression in the adolescent and young adult offspring.
- There may also be impairment in cognitive, behavioural and emotional development of a minority of infants born to mothers with perinatal depression.
- There may be wider impacts within the family, including effects on the woman's partner and other children.
- Many women feel shame about these conditions and may benefit from psychological support to process their experience.

8.2.3 Prognosis

- If depression is untreated during pregnancy, women have a seven-fold increased risk of postpartum depression when compared to women without antenatal depression.
- Postpartum depression often improves spontaneously after 2–3 months. One-third of women remain unwell 12 months after childbirth, and 13% at 2 years.

8.2.4 Diagnosis

- **Mental health should be assessed during the pregnancy booking appointment, and in all contacts through the antenatal and postnatal period.**
- The postnatal check should include screening questions, such as the ones below, to elicit whether the baby blues resolved within 10–14 days of birth, or whether low mood has persisted:
  - *"During the past month, have you often been bothered by feeling down, depressed or hopeless?"*
  - *"During the past month, have you often been bothered by having little interest or pleasure in doing things?"*
- If there is a positive response to the depression screening questions, or the mother is at risk of a mental health problem, consider further evaluation using the Patient Health Questionnaire (PHQ-9) or the Edinburgh Postnatal Depression Scale (EPDS).
- Women should be assessed for level of risk. If there are severe symptoms, or you believe mother or infant to be at risk, refer to a mental health professional.
  - Consider whether there is adequate social support, and ensure the woman and her partner or other support know where to seek further help if things deteriorate.
  - You may need to follow local safeguarding protocols if you have any concerns about risk of child harm or maltreatment.
- Consider differential diagnoses, e.g. bipolar disorder and OCD.
- Ask about the presence of confusion, delusions or hallucinations, which may indicate the onset of postpartum psychosis.

8.2.5 Managing perinatal depression

Women on antidepressants prior to pregnancy

- **Where pregnancy is planned, advise women that antidepressants may be used at any stage of pregnancy where clinically indicated, including when trying to conceive.**
- The risk of destabilising the woman's condition should be weighed up against the wish to reduce, change or stop antidepressants.
- Aim for the lowest effective dose, and a single drug is preferable to polypharmacy. Where prescribing is complex, seek specialist advice.
- Antidepressants should not be stopped abruptly.
- No antidepressant has been proven to cause birth defects.
  - SSRIs:
    - SSRIs have the largest body of safety data and can be considered a first-line choice. There is no evidence one SSRI is safer than any other. Studies suggest a small risk of fetal heart defects (3 in 100 vs. 2 in 100 in the background population).
    - SSRI use in pregnancy may lead to transient neonatal withdrawal causing central nervous system, motor, respiratory and gastrointestinal symptoms. Hospital delivery is usually advised.
  - Tricyclic antidepressants (TCAs):
    - Although usually considered a second-line treatment in pregnancy, they are safe for use if clinically indicated (for example, where a patient is stable on them and may be at risk of relapse if treatment is withdrawn or changed).
    - Data is more limited than for SSRIs.
  - Serotonin–noradrenaline reuptake inhibitors (SNRIs):
    - Data is even more limited than for SSRIs and TCAs.
    - Where it is clinically indicated, they can be considered safe to use or continue, particularly where a woman is stable on treatment and at risk of relapse if treatment is stopped or changed.
- Consider her plans for breastfeeding, as there are some risks associated with psychotropic medications in this instance.
- Detailed information on risks of individual antidepressants is available from the UK Teratology Information Service (www.uktis.org). Prescribing should be a shared care decision, including the patient.
- Consider referring women with severe current or previous mental health issues, who are planning pregnancy, to secondary mental health service for preconception counselling. Pregnancy and the puerperium are vulnerable periods for relapse or destabilisation.

Managing new-onset antenatal depression

- Low-risk women with new onset of depression during pregnancy may be managed in primary care following the recommendations on treatment detailed at the start of *Section 8.2.5*.
- Consider urgent referral to secondary mental health services:
  - If there is evidence of risk of harm to the woman or other people.
  - If there is evidence (or history) of bipolar disorder.
  - If there is a history of severe mental illness, including previous perinatal depression or puerperal psychosis in the woman or a first-degree relative.

Managing postnatal depression

- Refer for immediate assessment by secondary mental health services (within 4 hours) if a woman has sudden onset of symptoms suggestive of postpartum psychosis or is at immediate risk of harm to herself or her baby.
- Refer urgently to secondary mental health services:
  - If she is severely depressed.

  - If she shows signs of self-neglect or being unable to look after her baby.
  - If there is a possible diagnosis of bipolar disorder.
  - If there is a history of severe mental illness, including perinatally.
- Where a woman is safe to be managed in primary care, take into account her preferences when prescribing.
- Information is available from the UK Drugs in Lactation Advisory Service (UKDILAS) on 0330 770 8564.
- An SSRI, TCA or SNRI can safely be used in the postnatal period.
- No psychotropic medication has a licence for use in breastfeeding mothers, so informed consent should be sought and documented.
- Paroxetine and sertraline are usually safer choices in breastfeeding mothers. The lowest effective dose should be used, and babies should be monitored for drowsiness, poor feeding and behavioural changes.

8.2.6 Postpartum psychosis

- Postpartum psychosis is rare, affecting 1–2 in 1000 women.
- It usually presents suddenly, within 2 weeks of delivery.
- Symptoms include severe mood swings, delusions, confusion and hallucinations. Distorted thoughts and behaviours may involve the baby and place it at risk.
- Recurrence in subsequent deliveries is common.

8.2.7 Bipolar postpartum depression

- Bipolar disorder may present postnatally, or an existing diagnosis may relapse in this period.
- 21.4–54% of women with postpartum depression have a diagnosis of bipolar disorder.
- These women are often younger in age, with earlier onset of symptoms after birth and some atypical depressive features.
- There may be a history of bipolar disease in first-degree relatives.
- It is important to identify bipolar symptoms, as treatment with antidepressants may trigger manic symptoms.
- These patients are usually managed by specialist mental health teams. Treatment often includes use of mood stabilisers, e.g. lithium, quetiapine and lamotrigine.

8.2.8 Perinatal obsessive–compulsive disorder

- Prevalence of obsessive–compulsive disorder (OCD) is higher in the perinatal population than in the general population.
- Clinical features in the perinatal period are likely to include concerns about harm to the infant, with contamination and cleaning/checking compulsions particularly common.
- Research suggests CBT with exposure and response prevention is particularly effective.
- There is also limited evidence for efficacy of SSRIs.
- Patients should be referred to specialist mental health services for assessment and treatment.

8.3 Hormonal contraception and mood disorders

- **Hormone-containing medications can often induce mood change in susceptible women.** Where cyclical, this falls under 'Variant PMDs – progestogen-induced' as detailed in *Section 8.1.4*.
- Where continuous administration of hormonal medication leads to mood change, this is usually considered an adverse effect rather than a form of premenstrual disorder. Colloquially, we often refer to this as progestogen intolerance or sensitivity.

- Management follows the NAPS and RCOG guidelines for PMS and PMDD. Many women will find they tolerate drospirenone- or nomegestrol-containing COCPs better or will improve when offered high-dose (100mcg) transdermal oestrogen alongside an LNG-IUD coil or anovulatory progestogen such as Slynd (drospirenone). Desogestrel is less often tolerated by progestogen-sensitive women, but may also be given. It can be used off-licence, in a double dose of 150mg, alongside transdermal oestrogen to provide both contraception and endometrial protection (though off-licence, this option is included in the BMS Joint Guidelines on Unscheduled Bleeding).
- Micronised progesterone is not contraceptive so is unsuitable for use for this indication.

8.4 Neurodiversity in women and girls

8.4.1 What is neurodiversity and who is affected?

- Neurodivergence is a term that describes the natural variation in human brain functioning and cognitive processing.
- Autism prevalence is estimated at 1–2% but is growing, likely due to improved recognition – especially amongst those with normal range IQ, and due to broadening of diagnostic criteria over time.
- Variations from the majority or 'neurotypical' population include:
  - autism spectrum disorder (ASD)
  - attention deficit hyperactivity disorder (ADHD)
  - dyslexia
  - dyspraxia (developmental coordination disorder)
  - Tourette syndrome
  - sensory processing differences.
- Diagnosis of neurodivergence is often missed or delayed in women and those assigned female at birth. Common symptom profiles were focused on male presentation, and biological and social factors can mean that the conditions present differently in females.
- A predictive model based on population data has suggested that 39% more women should be diagnosed with ASD than currently are.
- Diagnosis in adulthood is often more challenging, as there may be a lack of developmental history and individuals have learnt strategies to camouflage (mask) difficulties.
- Neurodivergent women and girls often mask more successfully than their male counterparts, but may struggle to continue to do so at reproductive milestones such as menopause.
- The considerable cognitive effort required to mask difficulties relating to neurodivergence leads to increased rates of stress, anxiety and depression.
- Individuals with 'milder' presentation may be more prone to late or missed diagnosis and have developed more coping strategies which 'hide' the diagnosis. For example, women with ADHD often become prone to work-related burnout, as challenges with executive function such as planning, prioritising, scheduling and multitasking can lead to overload and overwhelm. This may present clinically as anxiety, insomnia or depression, but deeper questioning may reveal relevant detail pointing to the need to consider neurodivergence.
- Consideration of the wider clinical picture can help in identifying possible 'missed' neurodivergence.
- Neurodivergent women and girls are more likely to also have:
  - Eating disorders (multiple studies reveal an overrepresentation of autism or autistic traits in the eating disorder population).
  - Premenstrual disorders such as PMS or PMDD (some research suggests that autistic individuals may be 2–3 times more likely to report cyclical mood change consistent with PMDD).

  - Heightened sensory sensitivity, emotional dysregulation and executive function challenges at certain points in their menstrual cycle or at reproductive milestones such as menopause.
  - Family members with existing ASD or ADHD diagnoses (heritability is estimated between 64% and 91%).
- Neurodivergence is not a mental health condition, but neurodivergent individuals are at a high risk of developing mental health problems, with depression and anxiety problems predominating, and suicide rates substantially increased.

8.5 Eating disorders and body dysmorphic disorder

8.5.1 Introduction

- Although eating disorders can present at any age, risk is highest between 13 and 17 years of age.
- It is estimated that over 725 000 people in the UK have an eating disorder. This is based on hospital admissions, so is likely to be a significant underestimate.
- The types of eating disorders as defined in the DSM-5 include the following:

Anorexia nervosa

- The lifetime prevalence of anorexia nervosa (AN) in females is between 2 and 4%.
- AN has a higher mortality rate than any other mental health disorder. 20% of deaths are due to suicide. The crude mortality rate is 5.1 deaths per 1000 person years.
- Clinical features of AN include:
  - Restricted energy intake or persistent behaviour which prevents weight gain and leads to a significantly low body weight.
  - Body image is disturbed, with denial of the seriousness of the current low body weight, or undue influence of body weight or shape on self-evaluation.
  - There is an intense fear of gaining weight, despite being underweight.
  - BMI specifiers were added in 2013:
    - Mild: BMI 17–18.5kg/m^2
    - Moderate: BMI 16–16.9kg/m^2
    - Severe: BMI 15–15.9kg/m^2
    - Extreme: BMI <15kg/m^2
    - The available evidence has questioned the reliability and clinical validity of these definitions.
- Although females with AN may present with hormonal disturbance and amenorrhoea, it is no longer included in the diagnostic criteria. However, periods and growth/puberty are often disturbed. Where amenorrhoea persists beyond 6 months there is risk of reduced bone density.
- Physical signs may include dry skin and hair loss, bradycardia, orthostatic hypotension, hypothermia, loss of muscle strength, constipation, fainting and fatigue.

Bulimia nervosa

- Recurrent (at least once weekly for 3 months) episodes of uncontrolled eating of an abnormally large amount of food.
- Binges are followed by inappropriate compensatory behaviours (induced vomiting, diet pill or laxative abuse) or excessive exercise.
- Self-evaluation is unduly influenced by body shape / weight, and often there is an intense fear of gaining weight.
- There may be persistent preoccupation with and cravings for food, then guilt and shame about bingeing and purging.

- Bulimia may go undiagnosed for years, as individuals may maintain a normal body weight and appear to eat normally in social situations.
- Physical signs may include knuckle calluses from recurrent induced vomiting (Russell's sign), salivary gland enlargement and dental enamel erosion.

Binge eating disorder

- Recurrent episodes of binge eating without any compensatory behaviours.
- Episodes associated with distress, guilt and marked loss of control.
- Individuals are often overweight or obese.

Avoidant/restrictive food intake disorder (ARFID)

- This is also referenced as 'selective eating disorder' in the DSM.
- Avoidance of food or restrictive pattern of eating based on certain food characteristics or aversive consequences.
- Leads to significant weight loss, nutritional deficiency, or dependence on supplements.

Pica

- Persistent eating of non-nutritive, non-food substances (for at least 1 month).
- Inappropriate to the developmental level.

Rumination

- Repeated regurgitation of food which may be re-chewed, re-swallowed, or spat out.
- Not due to a medical condition or better explained by another disorder.

Other specified feeding or eating disorder (OSFED)

- This is where there is clinically significant distress, but the full criteria for feeding and eating disorders are not met. Includes the following:
  - Atypical AN refers to restrictive disordered eating in people not at an extremely low body weight
  - Subthreshold bulimia or binge eating disorder
  - Purging disorder
  - Night eating syndrome.

Unspecified feeding or eating disorder (UFED)

- This covers disordered eating not more accurately captured by OSFED.

8.5.2 How can we diagnose eating disorders?

- **Eating disorders can be difficult to diagnose, especially in primary care.**
- Patients are often slow to present and may hide or fail to disclose symptoms. They may not think they have an eating disorder.
- The SCOFF questionnaire is a short, focused screening tool to identify anorexia nervosa or bulimia nervosa:
  - *"Do you ever make yourself feel **S**ick because you feel uncomfortably full?"*
  - *"Do you worry that you have lost **C**ontrol over how much you eat?"*
  - *"Have you recently lost more than **O**ne stone in a 3-month period?"*
  - *"Do you believe yourself to be **F**at when others say you are too thin?"*
  - *"Would you say that **F**ood dominates your life?"*
- Severe malnutrition and purging behaviours can cause cardiovascular instability or severe electrolyte disturbance – have a low index for assessing clinical signs. Emergency admission may be required; for example, where there is syncope, pre-syncope or severe abdominal pain. Check for risk of self-harm and suicide.

- Examination should ideally include calculation of BMI, temperature (hypothermia), BP (including lying/standing), hydration status, peripheral circulation. Look for muscle wasting (consider the Sit up-Squat-Stand (SUSS) test).
- Consider checking FBC, erythrocyte sedimentation rate (ESR), U&Es, LFT, blood glucose, creatinine and urinalysis and ECG if there is significant malnutrition or purgative behaviour. Calcium, magnesium, phosphate, thyroid function test (TFT), B12, folate and ferritin are sometimes also requested.
- Consider risk of insulin misuse in diabetic patients: often missing or reducing doses to induce weight loss. A high HbA1c, or history of recurrent diabetic ketoacidosis may raise suspicion of this.
- Differential diagnoses include inflammatory bowel disease, coeliac disease, mood disorders, drug misuse, thyroid disorders and malignancy.

How can we manage eating disorders?

- **Assess the need for emergency admission if there is serious medical or psychiatric risk.**
- Refer immediately to an eating disorder service for specialist assessment and management. Shared care agreements may be in place, particularly in chronic eating disorders.
- Whilst awaiting specialist assessment arrange regular review as appropriate.
- Have a low threshold for concern – people with eating disorders can appear deceptively well despite being medically unwell.
- Consider emergency admission if:
  - BMI or body weight rapidly falling (e.g. >1kg per week)
  - cardiovascular instability, e.g. bradycardia <40 bpm, tachycardia on standing, prolonged QT on ECG, or hypotension
  - hypothermia
  - reduced muscle power
  - concurrent infection
  - rapid deterioration
  - abnormal bloods
  - acute mental health risk, e.g. suicide attempt or serious self-harm.
- Compulsory admission may be required – seek specialist advice if you have serious concerns about a patient's safety but they do not consent to admission.
- The Royal College of Psychiatrists has released guidelines on assessing the impending risk to life in feeding and eating disorders. This document provides a red/amber/green rating to help us assess when urgent help may be needed. This is adapted from the previous MARSIPAN and JUNIOR MARSIPAN framework. The framework combines assessment of clinical risk factors with consideration of patient motivation, engagement with healthcare, and the presence of support around them.
- It is important to note that it is not only patients with AN who may present with immediate risk to life – for example, bulimic patients risk life-threatening electrolyte disturbances and gastrointestinal complications.

Bone health in eating disorders

- **Women with AN are 150–300% more likely to have fractures due to significantly lower bone mineral density than healthy control women.**
- Weight restoration is of key importance in the underweight to protect bone health.
- The long-term effects of bisphosphonates in this population are still unknown. The decision to start hormonal treatment for low bone density in a patient with an eating disorder should be taken with specialist advice.

Body image in women

- Body image is a frequent concern for women, with evidence that pregnancy, cancer and gynaecological conditions such as PCOS and reproductive milestones such as menopause are correlated with increasing body image concerns.
- Clinicians should be sensitive to the wider psychosocial pressures on women and consider referral for psychological support where women experience distress related to body image.

Body dysmorphic disorder in women

- Body dysmorphic disorder (BDD) is common but under-recognised. It affects women more than men. There is up to 49% heritability.
- BDD and OCD share genetic vulnerability. BDD may co-exist with OCD. There is also association with substance misuse and social anxiety disorder.
- Patients may not spontaneously disclose their concerns for fear of shame and negative judgement. Clinicians therefore may need to ask direct questions to identify the condition.
- It is defined in the DSM-5 as a preoccupation with perceived defects in one's physical appearance that to other people appear non-existent or only slight.
- The appearance preoccupation can trigger excessive repetitive behaviours (such as mirror checking, excess grooming, skin picking) or repetitive mental acts. To be diagnosed, the behaviours must cause impairment or distress.
- It is associated with marked functional impairment, poor quality of life and high rates of suicidality.
- Most women with BDD will seek cosmetic surgery treatment for their BDD concerns, but such treatment virtually never improves BDD symptoms and often makes them worse.
- Patients with suspected BDD should be referred to specialist mental health services for diagnosis and management. Treatment relies on psychotherapeutic approaches and pharmacotherapy, e.g. SSRIs.

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