

SSRIs and the Spectrum of PMDD Care: Balancing Efficacy with Safety

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Dear Editor,

Premenstrual dysphoric disorder (PMDD) is observed as a severe variant of premenstrual syndrome (PMS), in which emotional instability and physical discomfort become intense enough to disrupt daily life.¹ The symptoms arise during the luteal phase of the menstrual cycle and may include severe depression, intense anxiety, mood swings, sleep difficulties, irritability, difficulty in making decisions or concentrating, fatigue, appetite changes (such as overeating or food cravings), physical discomfort (including joint pain, headaches, muscle pain, and bloating), and breast tenderness or swelling.²

A recent study published in the Journal of Central South University, Medical sciences in 2025 shows that irregular activity in the amygdala, a brain region that is vital for processing emotions and stress may contribute to the onset of both PMS and its more severe form, PMDD.³ Even though PMDD greatly affects daily functioning and overall wellbeing, it continues to be neglected and often misdiagnosed in medical practice.

The best treatment so far is selective serotonin reuptake inhibitors which are consistently supported to help improve mood and behavioral symptoms. However, excessive use of this medication may cause more harm than benefit. While the doses taken in limit enhance the serotonergic activity, overdosing can overstimulate hormone sensitive pathways, leading to agitation, insomnia, gastrointestinal disturbances and at its most severe, Serotonin Syndrome, with systemic complications affecting the liver, kidneys, and heart. Over medications of drugs may alter normal physiological conditions. This may promote drug dependence, overlook lifestyle and psychosocial

contributors. It may also expose women to unnecessary side effects. Management of severe PMDD typically includes pharmacological therapies such as SSRIs. Another line of research has examined combined oral contraceptives (COCs), containing both estrogen and progestin that helps to suppress ovulation also stabilize hormonal fluctuations.⁴

Clinical reports show that the most common SSRIs taken by women are sertraline, citalopram, or paroxetine, though medications like escitalopram and fluvoxamine may be associated with fewer sexual side effects. During SSRI therapy, these effects arise though it is not associated with overdose.⁵ The basic principle involves increased synaptic serotonin, inhibits dopaminergic and noradrenergic pathways that are critical for sexual arousal and orgasm. Symptoms like sexual desire, blunt genital sensitivity, and delay orgasmic response are reduced due to this serotonin modifications.

In summary, a balanced approach that unifies evidence based pharmacotherapy with nonpharmacological therapy including dietary modifications, regular exercise, cognitive, and behavioral therapy, micronutrient support, offers a safer and more comprehensive way in managing PMDD. This plan of action not only enhances therapeutic efficacy but also considerate the physiological complexity of menstruation and helps to minimize the risks of over medicalization also promote the long term wellbeing.

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