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Women's health

Premenstrual syndrome

Professional dietetics sheet

A cyclic disorder where dietetics has real evidence: calcium, magnesium, complex carbohydrates and glycaemic stability are part of the first level of care, before any supplement.

UNDERSTANDING THE CONDITION

Premenstrual syndrome

Premenstrual syndrome (PMS) groups recurrent somatic and psychic symptoms of the second half of the cycle, which disappear when the period arrives: irritability, cravings, mastodynia, bloating, fatigue. Its severe form, premenstrual dysphoric disorder (PMDD), belongs to the psychiatrist as much as to dietetics. Three dominant profiles guide the intervention.

SUGGESTIVE SIGNS

- Irritability, anxiety, cyclic low mood, relieved when the period arrives
- Sugar cravings and hyperphagia in the second part of the cycle
- Mastodynia (painful breast tension), bloating, water retention
- Cramps, fatigue, premenstrual sleep disorders
- Symptoms present in most cycles, over at least two consecutive cycles
- Impact on daily life: work, couple, social life

THE FAVOURABLE TERRAIN

The typical terrain combines sensitivity to neurosteroid fluctuations (allopregnanolone), unstable glycaemia that amplifies cravings, insufficient calcium and magnesium intake (the best-documented deficiencies in this population), sedentary living and chaotic sleep. Tobacco, excess coffee and chronic restriction worsen the picture.

THE PROFILES

One plan per subtype

PMS is not a single disease but a constellation: the dominant profile in a given patient determines which dietary targets are worth working on first. The symptom diary over two cycles remains the sorting instrument.

SUBTYPE	DISTINCTIVE SIGNS	QUICK SIGNAL
Psychic profile: mood, irritability, cravings	Irritability, anxiety, violent sugar cravings, easy tears, all cyclic	***the evening craving that returns every month on the same day***
Somatic profile: mastodynia, bloating, cramps	Painful breast tension, swelling belly, retention, cramps at period onset	***the bra that becomes unbearable ten days before***
Severe form: PMDD and major impact	Marked dysphoria, anger, transient depression, strong impact on life, total disappearance at the period	***a week of life lost every month, then the woman becomes herself again***

The three profiles frequently blend in the same patient: work on the dominant profile, then broaden. Polycystic ovary syndrome, thyroiditis and anaemia are the differential diagnoses to evoke before an atypical or new 'PMS'. The symptom diary over 2 cycles conditions everything else.

1 Psychic profile: mood, irritability, cravings · *the most frequent*

The tryptophan and serotonin profile: the fall in neurosteroids and glycaemic instability combine into cravings then guilt. The goal is to stabilise glycaemia, ensure serotonin precursors and cover the documented deficiencies.

FOOD	WHY	PRACTICAL ADVICE
Chicken egg	Tryptophan + choline + complete protein: the breakfast that holds glycaemia	*2 eggs in the morning during PMS week*
Beef	Haem iron + zinc + B12: the deficiencies of the woman who bleeds	*1 to 2 lean portions a week*
Spinach	Magnesium + folates + non-haem iron	*Pan-fried or in soup, 3 times a week*
Black Sesame	The most calcium-dense plant of the base: ~1000 mg per 100 g	*1 tbsp ground a day, yoghurt or porridge*
Yogurt	Bioavailable calcium + protein: the base of PMS's first level of evidence	*Plain, 1 a day*
Peach	Sweet fruit with moderate GI: calms the craving without the spike	*1 as a snack with nuts*
Walnut	Omega-3 ALA + magnesium + tryptophan: the anti-irritability trio	*4 to 6 kernels as a snack*
Sardine	Omega-3 EPA/DHA + calcium (bones) + vitamin D	*In oil or pan-fried, twice a week*
Oats	Complex carbohydrate with low glycaemic index: the anti-craving answer	*Porridge at breakfast, no sugared flakes*
Banana	Vitamin B6 + controlled fast carbohydrate: the crisis snack	*1 in case of violent craving*

TO LIMIT	REASON
Sweets and pastries during PMS week	The glycaemic spike amplifies the mood crash that follows: the craving is fed by its own satisfaction
Excess coffee (beyond 2/day)	Anxiety and mastodynia are dose-dependent on caffeine in several studies
Alcohol	Double aggravator: mood and sleep quality of the premenstrual week
Skipped meals	Reactive hypoglycaemia is the direct trigger of late-afternoon cravings
Excess salt	Worsens retention and swelling in mixed profiles

GOLDEN RULE

A protein snack at the end of the afternoon of PMS week is worth more than any willpower against the evening craving.

WHAT THE RESEARCH SAYS

Calcium is the best-documented supplementation: 1200 mg/day halved symptoms in the Thys-Jacobs randomised trial (Am J Obstet Gynecol, 1998); the goal is dietary first. Vitamin B6 has a modest but real effect in Wyatt's meta-analysis (BMJ, 1999). Saffron showed superiority over placebo (Agha-Hosseini, BJOG, 2008), vitex agnus-castus a signal in Schellenberg's trial (BMJ, 2001).

2 Somatic profile: mastodynia, bloating, cramps · *the most visible*

The prostaglandin and retention profile: low-grade inflammation and a salted terrain amplify pain and swelling. The goal is to steer fatty-acid balance towards anti-inflammatory, ensure relaxing magnesium and limit salt.

FOOD	WHY	PRACTICAL ADVICE
Mussel	Omega-3 + iron + B12: the sea's anti-inflammatory concentrate	*Marinière or pan-fried, twice a week*
Oyster	The first zinc provider: zinc and PMS are linked in the literature	*4 to 6 a week in season*
Sardine	Anti-inflammatory EPA/DHA: prostaglandins are made with the meal's fats	*Twice a week*
Mackerel	The oiliest fish richest in accessible omega-3	*In white wine or pan-fried*
Spinach	Muscle magnesium: the release of cramps	*200 g cooked, regular*
Chestnut	Potassium + magnesium: the starch anti-retention	*As purée or soup*
Pumpkin	Potassium without salt, soft anti-bloating fibres	*Soup or roasted*
Chicken	Lean protein with low residue, vitamin B6	*Braised, without salt excess*
Fresh Ginger	Documented anti-inflammatory, effect on menstrual cramps in trials	*Infusion or grated in dishes*
Turmeric	Anti-inflammatory curcumin: favourable trials on cycle pains	*1 tsp with black pepper in dishes*

TO LIMIT	REASON
Excess salt and cured meats	First amplifier of retention and mastodynia
Ultra-processed foods	Hidden salt + pro-inflammatory fatty acids: the double aggravation
Excess omega-6 fatty acids	Excess sunflower/maize oils: substrate of pro-inflammatory prostaglandins
Alcohol	Worsens retention, pain and sleep quality of the week concerned
Raw vegetables in too large a quantity	Fermentation + gas: the premenstrual belly is already sensitive

GOLDEN RULE

It is the whole week that plays out, not the big day: anti-inflammatory measures must be daily before symptoms arrive.

WHAT THE RESEARCH SAYS

Omega-3 have a favourable signal on the somatic symptoms of PMS in controlled trials (Sohrabi et al., 2013, Complement Ther Med). Magnesium is plausibly deficient in this population and is among the tested supplements; calcium also covers this profile (Thys-Jacobs, 1998). Salt, alcohol and pro-inflammatory fatty acids are the best-documented aggravators.

3 Severe form: PMDD and major impact · *screening before anything*

When the impact is major, loss of function, dysphoria, dark thoughts, PMDD must be evoked and confirmed by the doctor: dietetics accompanies, does not replace. Alongside the medical pathway, the most useful dietary work is covering deficiencies, glycaemic stability and eliminating aggravators.

FOOD	WHY	PRACTICAL ADVICE
Chicken liver	Iron + folates + B12: covering the deficiency is the first gesture of the severe form	*Once a week*
Black pudding, pork blood	The most concentrated source of haem iron that exists	*Once a week if accepted*
Chicken egg	Tryptophan + complete protein + choline for the brain	*Possible daily*
Oats	The stable carbohydrate base of the day	*Daily porridge*
Millet	Complex carbohydrate + tryptophan + plant iron	*As cooked grain or porridge*
Yogurt	Daily calcium: the only reference supplementation of PMS	*Plain, daily*
Black Sesame	Plant calcium + zinc + magnesium	*1 tbsp ground a day*
Sardine	Omega-3 + vitamin D: mood is also a matter of intake	*Twice a week*
Saffron	Favourable randomised trials on PMS and mood	*Infusion or in a dish, twice a week*
Walnut	Omega-3 + magnesium + tryptophan	*Daily snack*

TO LIMIT	REASON
Alcohol, completely	In the severe form, alcohol is the first aggravator of the mood crash: complete elimination to propose
Coffee and stimulants	Anxiety and insomnia: test complete withdrawal over one cycle
Excess fast sugars	Glycaemic roller coasters amplify the mood crash
Chronic calorie restriction	Chronic calorie restriction backfires into binges and guilt during PMS week
Food isolation	Shared meals have real regulatory value in this profile

GOLDEN RULE

When PMS week costs a piece of whole life, dietetics accompanies the doctor, it never substitutes for him.

WHAT THE RESEARCH SAYS

PMDD is a medical diagnosis: diet plays the documented adjuvant role (calcium, Thys-Jacobs 1998; B6, Wyatt 1999; saffron, Agha-Hosseini 2008). SSRIs like sertraline have higher-level evidence in this form: the nutrition professional's role is screening, covering deficiencies and supporting the terrain, in liaison with the doctor.

CROSS-CUTTING

What applies to all profiles

Whatever the profile, five gestures form the base: they need no supplement and cover most of the documented benefit.

• Three complete meals + a protein snack at the end of the afternoon of PMS week: glycaemic stability is the first lever

• Cover calcium through food first (fermented dairy, sesame, sardine with bones): aim for the equivalent of 1200 mg/day in food, supplement on failure

• Stock up on green magnesium and nuts as routine, not only during PMS week

• Reduce salt over the whole premenstrual week, not just the day of symptoms

• Walk or move 30 minutes a day: exercise has its own favourable trials on PMS

• Eliminate alcohol completely during PMS week: the benefit is immediate and measurable at the next cycle

• Keep the symptom-meal diary over 2 cycles: it is what tells whether the intervention works

IN THE KITCHEN

Recipes that fit

Covering the deficiencies

Meals that provide iron, calcium and omega-3 of PMS week.

• Moules Marinières

• Sardines à la Plancha, Salade de Tomates et Basilic

• Caille Farcie aux Noix et Épinards

• Salade de Wakamé Goma-ae

• Soupe Miso aux Wakamé et Tofu

• Porridge Écossais Traditionnel

Stabilising the day

Dishes with stable glycaemia to cut the roller coasters of cravings.

• Maquereau au Vin Blanc

• Fenouil Braisé au Safran

• Congee de Larme de Job au Poulet et Gingembre

• Blettes à la Grecque (Spanakopita sans pâte)

• Orzotto aux Asperges et Citron

• Salade Niçoise

NOTES FOR THE PRACTITIONER

• A thinking aid intended for nutrition professionals: it replaces neither medical diagnosis nor clinical judgement. The PMS/PMDD diagnosis is clinical and confirmed over 2 cycles of diary.

• Signs requiring medical advice: severe dysphoria, suicidal thoughts even transient, PMS appearing or worsening after age 35, persistent symptoms outside the second half of the cycle, suspicion of PCOS or thyroid disorder.

• Key references: Thys-Jacobs calcium (Am J Obstet Gynecol, 1998); Wyatt vitamin B6 (BMJ, 1999); Schellenberg vitex (BMJ, 2001); Agha-Hosseini saffron (BJOG, 2008); Sohrabi omega-3 (Complement Ther Med, 2013).

• Strategy: diary first, glycaemic stability and calcium-magnesium coverage next, elimination of aggravators in parallel, supplementation as last documented resort.

• Documented second-line options, to discuss with the treating doctor: vitex agnus-castus (Schellenberg trial, BMJ, 2001) and saffron (Agha-Hosseini, BJOG, 2008); watch for interactions and hormonal contraindications.