

events and mood disorders, but mood disorders are associated with certain somatic, particularly, pain disorders. Some patients with multiple pain complaints will have somatisation disorder, which occurs predominately in women and is characterised by multiple physical complaints not explained by medical findings. Approximately 30-80% of patients with mood disorders in primary care settings will have complaints of pain. There is a 6 fold increase of comorbid mood disorder if the patient has two pain complaints and an 8 fold increase with 3 pain complaints, the most common being chronic pelvic pain, chronic fatigue, migraine or other physical complaints. The pain syndromes of chronic pelvic pain and irritable bowel are of particular importance.

Up to 30% of women with complaints of pelvic pain will have no identifiable underlying disease. It is estimated that in as many as 25% of visits to general gynaecologists, a complaint of pelvic pain is made and as many as 12% of hysterectomies are performed for chronic pelvic pain. Although pain improves in approximately 78% of women who undergo hysterectomy for chronic pelvic pain, the remainder do not experience relief. Approximately 60% of patients with chronic pelvic pain who undergo laparoscopy for endometriosis or adhesions are not rendered pain free. Studies have shown that depression will occur in nearly 60% of patients who are being evaluated for pelvic pain, of which 50% will develop the pain and depression simultaneously, whereas 40% become depressed after they develop pelvic pain.

Although a disturbance in mood may not be the primary complaint in these illnesses, co-morbid mood disorders are commonly present if looked for. Low mood, thoughts of death, lack of interest, poor self esteem and guilt or pessimism about the future indicate the existence of a co-morbid mood disorder. An assessment of the patient's behaviour and level of functioning may also be helpful. Some women may complain that they find themselves short tempered with their children, others that their work performance has declined or that their housework goes undone. Antidepressant treatment has proved beneficial in controlling some pain syndromes and should be considered for the treatment of patients, with chronic pelvic pain. Not uncommonly, a majority of these patients will benefit from a psychiatric consultation and further psychological interventions.

### **Moods and the Oral Contraceptive Pill**

Mood disturbance is a side effect of great concern to many women who use hormonal contraceptive agents, not uncommonly resulting in OCP discontinuation. Putative risk factors for OCP-related premenstrual mood deterioration include a history of depression, premenstrual depression, dysmenorrhoea, higher estrogen

and progestogen doses, triphasic preparations, a family history of OCP-related mood changes and younger age at OCP use. Characteristics not associated with OCP-related premenstrual mood deterioration include age at menarche, menstrual cycle length, educational achievement and religion. Most studies suggest that most women do not have a change in premenstrual mood symptoms after starting the OCP.

The population in whom premenstrual mood is most likely to worsen with OCP use appears to be restricted to those with a history of depression. A subset of women with depression may be at risk for OCP-related premenstrual mood deterioration because they are particularly sensitive to the impact of cycling gonadal steroids on mood. This being possibly, the reason that the risk of lifetime depression in women is double that of men and that the peak prevalence of depression in women occurs between menarche and menopause. In contrast the women who are most likely to benefit from a positive influence of the OCP on premenstrual mood symptoms are those with early onset premenstrual mood disturbance or dysmenorrhoea. OCP-related premenstrual mood deterioration appears to occur in about 25% of women with depression before their first OCP use.

Given the many advantages of the OCP, women with a history of depression should be informed of the potential risk, but the OCP should not be withheld because 75% of these women are likely to tolerate the medication without mood deterioration. Likewise it is important to bear in mind that premenstrual mood symptoms are unlikely to improve with OCP use in women with a history of depression. This suggests that OCP should not be used specifically to treat premenstrual mood symptoms in women with a history of depression. However OCP's can certainly be used for other indications in women with depression and can be used in conjunction with antidepressants in this population.

In women without a history of defined depression, but who have premenstrual mood syndrome, approximately 20% will improve using the OCP, as opposed to approximately 15% who will deteriorate, whilst the rest probably are unaffected. Women with premenstrual mood symptoms who do not respond to an OCP, or deteriorate further on OCP, should be assessed carefully for the presence of clinical depression or PDD. Overwhelmingly women with PDD will have their symptoms worsened with OCP. Improvement of premenstrual moods appears to be most likely with monophasic OCP and more so if the patient has associated dysmenorrhoea. Hence information about previous depression, premenstrual mood disturbance and dysmenorrhoea can be used to inform clinical decisions about the potential and deleterious impact of OCP's on premenstrual mood. ◆

