OLIGOMENORRHOEA AND SECONDARY AMENORRHOEA

Kingston Hospital NHS Foundation Trust

- Prevalence 3-4% of women in reproductive age
- Suspect oligomenorrhoea if menses >35 days apart for 4 months or more
- Suspect secondary amenorrhoea
- Cessation of menstruation for 3 months in women with previously normal and regular menses
- Cessation of menstruation for 6 months in women with previous oligomenorrhoea

Initial investigations:

1. Detailed history of menses, diet and exercise, symptoms or signs of androgen excess, risk factors for premature ovarian insufficiency (radiotherapy, chemotherapy, autoimmune disease), chronic medical conditions, gynaecology surgical history and drug history
2. Examination: BMI, abdominal and pelvic examination, signs of androgen excess/virilisation or thyroid dysfunction
3. Pelvic ultrasound scan
4. Blood serology: thyroid function tests, prolactin, FSH, LH, total testosterone, serum estradiol
5. Pregnancy test (if appropriate). If positive manage as per early pregnancy.

Suspected diagnosis:
Hypothalmic Hypogonadotrophism

Low FSH and LH / low E2

Often caused by stress, diet, excess exercise

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Lifestyle advice and refer to Gynaecology at Kingston Hospital

Suspected diagnosis:
Polycystic Ovarian Syndrome

Normal FSH, normal raised LH, raised Testosterone

Diagnosis requires 2 of the 3 Rotterdam criteria: 1) Oligo/amenorrhoea, 2) Clinical or biochemical evidence of androgen excess, (Testosterone 2.5-5 nmol/L) 3) Polycystic ovaries on USS

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Please refer to PCOS primary care management pathway

Suspected diagnosis:
Premature Ovarian Insufficiency (POI)

Raised FSH
Raised FSH >20 or 25 IU/ 4-6 w apart in women below the age of 40 years
https://www.eshre.eu/Guidelines-and-Legal/Guidelines/Management-of-premature-ovarian-insufficiency.aspx

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Refer to Gynaecology or Fertility at Kingston (depending on patient primary concern).

Suspected diagnosis:
Ashermanns Syndrome or IU Adhesions

Normal FSH, LH, Normal E2
History of recent/repeated uterine surgery (e.g. ERPC) or pelvic infection / endometritis

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Refer to Gynaecology at Kingston Hospital

Suspected diagnosis:
Thyroid cause – manage in primary care first as per local guidance
Abnormal prolactin-serum prolactin level greater than 1000 mIU/L, or 500–1000 mIU/L on two occasions
Testosterone > 5 nmol; or signs of Cushing's syndrome

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Refer to Endocrinology at Kingston Hospital

References:
https://cks.nice.org.uk/topics/amenorrhoea/diagnosis/when-to-suspect-secondary-amenorrhoea/

Patient resources:
https://www.stgeorges.nhs.uk/wp-content/uploads/2013/11/Amenorrhoea.pdf

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Primary Amenorrhoea Management Pathway From Primary To Secondary Care
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