

12.9 SECONDARY AMENORRHEA

| TITLE | DESCRIPTION |
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| DEFINITION: | <p>Secondary amenorrhea is defined as the absence of any spotting or bleeding for a period of time that is 3 times the normal cycle length for that individual woman. For example, if a woman normally bleeds monthly, she would be considered having secondary amenorrhea only after not having a period for 3 months. If she has irregular periods, 6 months would be the threshold for secondary amenorrhea. Medical causes of secondary amenorrhea may include PCOS, hypothalamic dysfunction, pituitary disease, ovarian or uterine disorders, endocrinopathies, pregnancy, normal and expected effects of hormonal contraception (particularly hormonal injections, hormonal IUD, and hormonal implants), and side effects of various medications. If the underlying problem causes unopposed estrogen, the woman needs protection from endometrial cancer. If the woman's problem causes hypoestrogenism, the woman needs protection from osteoporosis and other menopause-related symptoms. If the problem causes unwanted infertility, that also must be addressed.</p> |
| SUBJECTIVE: | <p>May Include as Indicated:</p> <ol style="list-style-type: none"> 1. LMP/menstrual history. 2. History negative for symptoms of pregnancy. 3. History negative for natural or surgical menopause. 4. Documentation of current birth control method. 5. Prior hormonal contraceptive use. 6. Weight changes: significant weight loss or gain. 7. Recent life stressors. 8. Recent dilation & curettage (D&C), or uterine ablation. 9. Thyroid, adrenal, or ovarian disorders. 10. Current medication and/or drug use. 11. Strenuous physical activity. 12. Eating disorder. 13. Galactorrhea or recent breast feeding. 14. Vasomotor symptoms. |
| OBJECTIVE: | <p>May Include:</p> <ol style="list-style-type: none"> 1. Complete list of all classes of medications (prescription, over-the-counter, and street recreational drugs). 2. Physical and/or pelvic exam, with notation Tanner staging of pubic hair and acanthosis nigricans. 3. Breast exam; nipple discharge (galactorrhea). 4. Thyroid examination. 5. Signs of androgen excess (e.g. hirsutism, clitoromegaly, acne, oily skin). 6. Signs of estrogen deficiency, vaginal atrophy (e.g. dry and smooth vagina with lack of normal rugae, dry endocervix without mucous). 7. Cervical stenosis or cervical scarring. 8. Weight variances from IBW/BMI charts (see Body Mass Index Variances Protocol). 9. Signs of hypothalamic/pituitary disease: headaches, visual field defects, fatigue, polydyspia. |
| LABORATORY: | <p>May Include as Indicated:</p> <ol style="list-style-type: none"> 1. Negative sensitive urine pregnancy test. 2. Other lab tests (e.g. TSH, FSH, Prolactin, hemoglobin A1C) as indicated. |
| ASSESSMENT: | Client with secondary amenorrhea. |

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| PLAN: | <ol style="list-style-type: none"> 1. Treatment options will depend on medical history, contraceptive history, desire for pregnancy, peri-menopausal status, and BMI. 2. Offer contraception as desired to provide monthly bleeds or prevent bleeding if no pregnancy is desired. May consider combined contraception, continuous contraception or progestin only if client meets US Medical Eligibility Criteria for Contraceptive Use (See hormonal method protocols). 3. Consider hormone assays, Hormone Replacement therapy, or combined contraceptive method if client is having peri-menopausal symptoms. 4. Consider progestin challenge of MPA (Provera) 5-10mg oral for 10 days monthly OR as needed for cycles > 35 days, if no contraception is needed. Aygestin 5mg daily for 10 days may be used in place of MPA. 5. Evaluate for eating disorder and athletic triad as needed. 6. Advise adequate Calcium supplements 1200mg daily if at risk for osteoporosis. 7. For long established history of < 8 menses/year consider referral for pituitary axis testing as needed (TSH, Prolactin, DHEA-S, hormone levels, or diabetic testing). |
| EDUCATION: | <ol style="list-style-type: none"> 1. Review client treatment and discuss causes of amenorrhea, risks of endometrial hyperplasia, and osteoporosis. 2. Discuss future plans for contraception/conception and possible need for future medical intervention. 3. Encourage client to strive for a healthy balance between work, recreation, rest, and dietary intake. 4. Discuss further testing and/or follow up as per MD consult. 5. Recommend client RTC/PRN as appropriate per plan. |
| REFERRAL TO MEDICAL PROVIDER: | <ol style="list-style-type: none"> 1. Any client presenting with primary amenorrhea. 2. Any client who is pregnant, refer for appropriate care. 3. Any client needing further testing based on client's individual needs. 4. Any client with secondary amenorrhea greater than 1-year duration who is not on hormonal contraception. 5. Any client with diagnosed or suspected eating disorder. |
| REFERENCES: | <ol style="list-style-type: none"> 1. Hatcher RA, Trussell J, Nelson A, Cates W, Kowal D, Policar M. <i>Contraceptive Technology</i>. 20 edition. Atlanta GA: Ardent Media, Inc., 2015. Pp.537-541. 2. WHCC. Delayed Menses or Secondary Amenorrhea in Premenopausal Women. (http://whcc.labiomed.org/book/3.2.2%20Delayed%20Menses%20or%20Secondary%20Amenorrhea%20in%20Premenopausal%20Women.pdf) (Retrieved 2/8/2017). |