**Secondary Amenorrhoea**

Please refer to NICE CKS for up to date guidelines

Up to 6 months- reassure & advise. Signpost to NHS choices:

Why your periods might stop

There are a number of reasons why your periods can stop. The most common reasons are:

* pregnancy
* stress
* [sudden weight loss](http://www.nhs.uk/conditions/unexpected-weight-loss/Pages/Introduction.aspx)
* being overweight or [obese](http://www.nhs.uk/conditions/Obesity/Pages/Introduction.aspx)
* extreme over exercising
* taking the [contraceptive pill](http://www.nhs.uk/Conditions/contraception-guide/Pages/combined-contraceptive-pill.aspx)
* reaching the [menopause](http://www.nhs.uk/Conditions/Menopause/Pages/Introduction.aspx)
* [polycystic ovary syndrome (PCOS)](http://www.nhs.uk/Conditions/polycystic-ovarian-syndrome/Pages/Introduction.aspx)
* Medication eg Antipsychotics, Antidepressants, Blood pressure medication,
Allergy medication

After 6 months- do full hormonal screen including prolactin, LH, FSH, testosterone, oestrogen, TFTs

* Manage girls and women with the following causes for secondary amenorrhoea in primary care:
	+ Polycystic ovary syndrome when appropriate
	+ Hypothyroidism — menses may take several months to resume with treatment
	+ Menopause (women 40 years of age or older, see the CKS topic on [Menopause](https://cks.nice.org.uk/menopause)).
	+ Pregnancy
	+ Anorexia
	+ Stress
* **Refer all other girls and women for specialist investigation and, where appropriate, management of the cause:**
	+ **Refer to a gynaecologist** if she has any of the following:
		- Persistently elevated follicle-stimulating hormone (FSH) and luteinizing hormone (LH) levels — which suggests premature ovarian failure in women younger than 40 years of age. If you are uncertain of the diagnosis or treatment. Otherwise, they can be managed with HRT.
		- Recent history of uterine or cervical surgery (such as endometrial curettage, Caesarean section, or myomectomy) or severe pelvic infection (endometritis) — which suggests Asherman's syndrome or cervical stenosis.
		- Infertility — see the CKS topic on [Infertility](https://cks.nice.org.uk/infertility).
		- Suspected polycystic ovary syndrome, if diagnosis and management are not feasible in primary care
	+ **Refer to an endocrinologist** if she has any of the following:
		- Hyperprolactinaemia: serum prolactin level greater than 1000 mIU/L, or 500–1000 mIU/L on two occasions. This includes girls and women on [drugs that are known to increase prolactin levels](https://cks.nice.org.uk/amenorrhoea#!backgroundsub:4).
		- Low FSH and LH levels (to exclude hypopituitarism or a pituitary tumour, although stress, excessive exercise, or weight loss are more likely causes).
		- An increased testosterone level that is not explained by polycystic ovary syndrome (suggesting an androgen-secreting tumour, late-onset congenital adrenal hyperplasia, or Cushing's syndrome).
		- Other features of Cushing's syndrome or late-onset congenital adrenal hyperplasia (besides an increased testosterone level).
* **Manage amenorrhoea caused by weight loss, excessive exercise, stress, or chronic illness after an endocrinologist has assessed and excluded a hypothalamic or pituitary tumour.** For:
	+ Weight related amenorrhoea — encourage weight gain and refer to a dietician if necessary. If an eating disorder is suspected, consider referral to a psychiatrist. For further information see the CKS topic on [Eating disorders](https://cks.nice.org.uk/eating-disorders).
	+ Exercise related amenorrhoea — advise reducing exercise, increasing calorie intake, and weight gain. Consider referral to, or liaison with a sports physician, if available.
	+ Stress-related amenorrhoea — consider measures to manage stress and improve coping strategies, such as cognitive behavioural therapy.
* **Offer contraceptive advice** to women who do not wish to become pregnant, as a small number of women with secondary amenorrhoea will become pregnant —
* **If amenorrhoea persists for more than 12 months, consider whether osteoporosis prophylaxis is required.**