

Amenorrhea

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The 30-year old female is suffering from secondary menorrhoea because she has previously experienced menstruation only that they were irregular. Secondary amenorrhoea is diagnosed when a woman fails to experience menstruation for six consecutive months or more in the absence of pregnancy. Besides pregnancy, breastfeeding and menopause do not cause secondary amenorrhoea. Secondary amenorrhoea is not harmful and is treatable in most cases. The conditions underlying secondary amenorrhoea have to be treated to ensure patient's overall health.

Pathophysiology and causes of amenorrhoea

Hormonal imbalances are cited as a common cause for secondary amenorrhoea. Tumors on the pituitary gland, low estrogen levels, high testosterone levels, and overactive thyroid glands cause hormonal imbalances. Testosterone contributes in the growth and development of reproductive tissues in women and excessive supply of it has been associated with irregular or absence of menstrual periods. Hormonal birth control can contribute to secondary amenorrhoea. Drugs and medical treatments such as chemotherapy and antipsychotic drugs can also induce secondary amenorrhoea (Santoro & Neal-Perry, 2010).

Polycystic ovary syndrome is associated with weight changes that are an important lifestyle factor in secondary amenorrhoea. Overweight and body fat that is less than fifteen percent are some of the things that can stop menstrual periods. The National Institute of Health (NIH) records that extreme diet has causal links with secondary amenorrhoea. Emotional stress is a non-physical element that can cause secondary amenorrhoea. Derailed menstrual cycle is one of the ways that the body uses to respond to extreme

stress (Heffner & Schust, 2010).

Possible pathophysiology associated with the patient's prior history of dysmenorrhea and irregular menstrual cycles

Mild hypothyroidism is one of the conditions that could precede presentation of dysmenorrhea and irregular menstrual cycles. However, mild hypothyroidism is associated with hypermenorrhea and oligomenorrhea more than with amenorrhea. Treating hypothyroidism restores menses but it may take months. Cushing's disease is the hyperactivity of adrenal glands and can combine with hypothyroidism to cause amenorrhea. Outflow tract obstruction, hyperandrogenic chronic, anovulation are some of the conditions in a patient's history that can be helpful in the diagnosis and treatment of dysmenorrhea (Ehrenthal et. al., 2005).

Asherman's syndrome is a common cause of outflow obstruction in secondary dysmenorrhea. This syndrome is a scarring and an intrauterine synechiae that results from curettage or infection. A history of uterine surgery including cesarean section, myomectomy and metroplasty is a predisposing factor of amenorrhea. Obstructive fibroids and cervical stenosis are other causes of outflow tract obstruction. Chronic anovulation and hyperandrogenism are the causes of polycystic ovary syndrome. Patients with a history of resistance to insulin are susceptible to this syndrome that further predisposes them to dysmenorrhea (Santoro & Neal-Perry, 2010).

A history of galactorrhea underscores the need for prolactin hormone level that helps rule out hyperprolactinemia. Some medications used in the treatment of psychiatric disorders and narcotics have causal links with amenorrhea. However, association with high prolactin levels and

galactorrhea complements their causal strength. A patient's history with severe postpartum hemorrhage points to pituitary insufficiency from infraction. Discontinuation of oral contraception is another cause of amenorrhea. However, evidence shows that amenorrhea of more than six months after a patient's last use of oral contraception is not caused by the contraception (Heffner & Schust, 2010).

References

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