CONDITION

Absent menstrual periods - secondary

Learn what secondary amenorrhea means, common causes of missed periods, how it is evaluated, treatment options, and when to seek urgent care.

WHAT IT IS
Stopping of menstrual periods after they previously occurred

BODY SYSTEM
Reproductive system

MAIN SYMPTOMS
Missing periods, lighter periods, hot flashes, acne

WHAT CAUSES IT
Pregnancy, hormonal changes, illness, medicines

HOW IT IS DIAGNOSED
Menstrual history, pregnancy testing, selected blood tests

MAIN TREATMENT
Treatment of the underlying cause

CAN IT BE CURED?
Sometimes - depends on the underlying cause

IS IT AN EMERGENCY?
Sometimes - missed period with severe one-sided pelvic pain

LONG-TERM OUTLOOK
Varies by cause, with possible bone, fertility, and uterine lining problems

Overview

Secondary amenorrhea means menstrual periods have stopped in someone who previously had them. It is usually defined as no period for more than three months in someone whose cycles were regular, or for six months in someone whose cycles were already irregular.

Secondary amenorrhea is not a disease by itself. It is a sign that pregnancy, hormones, the reproductive organs, general health, or certain medicines may be affecting the menstrual cycle. Pregnancy is the most common cause and is usually checked first.

The menstrual cycle depends on coordinated signals between the hypothalamus and pituitary gland in the brain, the ovaries, and the uterus. The hypothalamus and pituitary release hormones that help the ovaries produce estrogen and release an egg. The uterine lining then builds up and is shed as a period if pregnancy does not occur. A change anywhere in this

process can stop bleeding.

Periods may also stop because of hormonal contraception, breastfeeding, perimenopause, or menopause. These situations are not always abnormal, but pregnancy and other causes may still need to be considered.

Evaluation matters because some causes affect fertility, bone strength, the uterine lining, or long-term health. Most cases can be assessed through a medical history, examination, pregnancy testing, and selected blood tests.

Symptoms

The main symptom is missing menstrual periods. Some people first notice that periods become farther apart or lighter before stopping completely.

Other symptoms can offer clues about the cause. They may include:

Not everyone has additional symptoms. The absence of symptoms does not rule out pregnancy or a hormonal condition.

Hormonal birth control can make bleeding very light or stop it. This may be an expected effect of some pills, injections, implants, or hormonal intrauterine devices. However, a pregnancy test may still be appropriate if contraception was missed, delayed, or not used as directed.

- Nausea, breast tenderness, fatigue, or other possible pregnancy symptoms
- Hot flashes, night sweats, vaginal dryness, or reduced interest in sex
- New or increased facial hair, acne, or scalp hair thinning
- Milky nipple discharge when not breastfeeding
- Headaches or changes in vision
- Major weight loss or gain
- Restrictive eating, intense exercise, or increased emotional stress
- Pelvic pain or changes in vaginal bleeding
- Symptoms of thyroid disease, such as unusual sensitivity to heat or cold, changes in bowel habits, or a racing heartbeat

Causes and risk factors

Pregnancy is the first cause to consider in anyone who could become pregnant. This remains

true even when contraception is used or there are no typical pregnancy symptoms.

Polycystic ovary syndrome, often called PCOS, is another common cause. In PCOS, ovulation may happen infrequently or not at all. Periods can become irregular or stop. Some people also develop acne, increased facial or body hair, or difficulty becoming pregnant.

Functional hypothalamic amenorrhea occurs when the brain reduces the hormonal signals needed for ovulation. It can be associated with eating too little for the body's needs, substantial weight loss, intensive exercise, illness, or psychological stress. A person does not have to be underweight for low energy availability to affect periods.

A high prolactin level can interfere with reproductive hormones. Prolactin normally supports milk production. Levels may rise because of certain medicines, pregnancy, breastfeeding, an underactive thyroid, or a usually noncancerous pituitary growth called a prolactinoma.

Thyroid disorders can disrupt menstrual cycles. Both an underactive thyroid and an overactive thyroid may contribute.

Primary ovarian insufficiency means the ovaries stop working normally before age 40. Periods may become irregular or stop, and symptoms may resemble menopause. Possible causes include genetic conditions, autoimmune disease, chemotherapy, or radiation treatment, although a cause is not always found.

Scarring inside the uterus, sometimes called intrauterine adhesions or Asherman syndrome, can prevent the uterine lining from developing normally. It may occur after certain procedures involving the uterus, particularly when performed after pregnancy, or after a serious uterine infection.

Other possible causes include chronic illness, disorders of the adrenal glands, hormone-producing tumors, and medicines that affect prolactin or ovarian function. Antipsychotic medicines, some antidepressants like sertraline or fluoxetine , opioid medicines, chemotherapy, and certain hormonal treatments are examples. Medicines should not be stopped without speaking with the prescriber.

Age also matters. During perimenopause, ovulation becomes less predictable and periods may be skipped. Menopause is confirmed after 12 consecutive months without a period when there is no other cause.

Diagnosis

The evaluation usually begins with a detailed menstrual and health history. A clinician may ask when the last period occurred, whether cycles were previously regular, and whether pregnancy is possible. Information about contraception, sexual activity, recent weight changes, eating

patterns, exercise, stress, illnesses, surgeries, and medicines can help narrow the cause.

The clinician may also ask about hot flashes, headaches, vision changes, nipple discharge, acne, increased hair growth, pelvic pain, or symptoms of thyroid disease. A physical examination may include checking weight trends, blood pressure, thyroid changes, skin or hair findings, breast discharge, and signs of low estrogen. A pelvic examination is useful in some cases but is not always necessary.

A pregnancy test is generally the first test. If a home test is negative but pregnancy remains possible, a clinician may repeat urine testing or order a blood test.

Common blood tests include thyroid-stimulating hormone, known as TSH, and prolactin. Follicle-stimulating hormone, or FSH, and estradiol may help assess ovarian function and estrogen levels. Testosterone or other androgen tests may be ordered when there is increased facial hair, acne, or another reason to suspect excess androgen hormones.

A pelvic ultrasound can examine the uterus, uterine lining, and ovaries. It may support an assessment for PCOS or identify structural problems, but ultrasound findings alone do not diagnose PCOS.

A pituitary MRI may be considered when prolactin is persistently elevated or when symptoms suggest a pituitary problem. Other testing may include genetic studies, evaluation of adrenal hormones, or examination of the uterine cavity. Bone-density testing may be appropriate when low estrogen or functional hypothalamic amenorrhea has lasted for an extended time.

Treatment and management

Treatment depends on why periods stopped, the person's symptoms, pregnancy goals, age, and overall health. The goal is not always simply to trigger bleeding. Treatment may also protect bones or the uterine lining and address the underlying condition.

If pregnancy is confirmed, the next step is pregnancy care or a discussion of available options with a qualified clinician.

For functional hypothalamic amenorrhea, care focuses on restoring enough energy for normal body function. This may involve increasing food intake, adjusting intensive exercise, addressing stress, and treating an eating disorder when present. A dietitian or mental health professional may be part of the care team. Hormonal medication can cause bleeding, but it does not by itself correct an ongoing energy deficit.

For PCOS, management may include lifestyle support, hormonal contraception, or periodic progestin treatment to protect the uterine lining. Fertility treatment may be considered when pregnancy is desired. The best approach depends on symptoms, health risks, and personal

goals.

An underactive or overactive thyroid is treated according to the specific thyroid disorder. Periods often improve when thyroid hormone levels return to an appropriate range.

High prolactin is managed by addressing its cause. A medication may need to be changed when a suitable alternative exists. Prolactinomas are often treated with medicines that lower prolactin and shrink the growth. Surgery is needed less often.

People with primary ovarian insufficiency may be offered hormone therapy to replace estrogen that the ovaries are no longer making consistently. This can help symptoms and support bone and cardiovascular health. Treatment decisions should account for the person's medical history. Spontaneous ovulation can occasionally occur, so pregnancy and contraception goals still matter.

Scarring inside the uterus may be treated with a procedure called hysteroscopy. During hysteroscopy, a thin camera is passed through the cervix so the clinician can inspect and, when appropriate, treat the uterine cavity.

Calcium, vitamin D, weight-bearing activity, and avoidance of smoking support bone health, but they do not replace treatment of significant estrogen deficiency or low energy availability.

Complications

Possible complications depend on the cause and how long it continues. Some people have no lasting complications, especially when missed periods are an expected effect of contraception or a temporary response to illness.

Low estrogen over time can reduce bone density and increase the risk of stress fractures or osteoporosis. This is an important concern in functional hypothalamic amenorrhea and primary ovarian insufficiency.

When ovulation does not occur regularly but estrogen continues to stimulate the uterus, the uterine lining may become too thick. This can happen with PCOS and may raise the risk of endometrial hyperplasia, an abnormal overgrowth of the lining. Treatment that protects the uterine lining can reduce this concern.

Amenorrhea may make pregnancy difficult because ovulation is absent or unpredictable. Fertility depends on the underlying cause and cannot be determined from bleeding patterns alone.

Complications can also come from the condition causing amenorrhea, such as untreated thyroid disease, an eating disorder, or a pituitary disorder. Timely evaluation helps identify

which health effects are relevant.

Follow up

Arrange a routine medical appointment if periods have stopped for three months without a known explanation. Seek advice sooner if pregnancy is possible, symptoms are bothersome, or periods stopped after a uterine procedure.

Keep a record of bleeding, pregnancy test results, medicines, weight or exercise changes, and related symptoms. This information can make the evaluation more focused. Follow-up testing may be needed because hormone levels can change and one result does not always establish the cause.

Contact a clinician promptly for new nipple discharge, persistent headaches, vision changes, severe hot flashes at a young age, or rapid development of facial hair or a deeper voice.

Seek emergency care for a missed period or positive pregnancy test accompanied by severe or one-sided pelvic or abdominal pain, shoulder pain, heavy bleeding, fainting, marked weakness, or dizziness. These can be symptoms of an ectopic pregnancy or significant bleeding. A sudden severe headache, loss of vision, confusion, or new weakness also requires emergency assessment.

Sources

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