RCHN Guideline
Irregular Menstrual Bleeding

Rady Children's Health Network

Concern for Irregular Menses

Cycle Length 21-45 days?

- Yes → Not irregular: Reassurance
- No
  - < 21 days → **Polymenorrhea** < 21 days apart → Refer to AUB Guideline
  - > 45 days

Oligomenorrhea
> 90 days apart at any age, or > 45 days apart if > 2 years post menarche

Amenorrhea
No menstruation for 3 cycles if previously regular or 6 cycles if previously irregular

Irregular Menses
≥ 2 years post menarche AND
> 45 days cycle length or
< 8 cycles per year or
> 90 days between any cycles

Labs (7-9am)

- Urine Pregnancy POCT
- FSH, LH, estradiol ultrasensitive
- Free & total testosterone
- DHEA-S
- Androstenedione
- 17-OHP
- TSH
- Prolactin
- CBC Diff
- HgbA1C
- Lipids
- ALT

Note: do NOT prescribe OCPs *before* labs.

Initial Clinic Evaluation

History:
- Period history
- Excessive hair growth
- Acne
- Sexual activity
- Nicotine use
- Family hx

Physical Exam:
- Growth Curve
- Change in wt/BMI
- Acne/hirsutism
- Acanthosis nigricans
- External genital exam (r/o clitoromegaly)

In-Office Labs:
- U Preg
- POC Hgb

LAB RESULTS

Most likely PMOS
(Poly Endocrine Metabolic Ovarian Syndrome)
1. Increased free testosterone (< 200) +/- inc total testosterone OR
2. Increased DHEA-S (< 500) AND
3. Lab otherwise normal AND
4. At least 2 years post menarche

Other Lab Abnormalities

Labs Normal
Immaturity of HPO axis up to 5 years post-menarchal
1. Asses functional impact
2. Offer cycle control for convenience
3. Reassess annually

1. Provide patient education
2. Assess for comorbidities: HbA1c, lipids and ALT q2years
3. Consider hormonal contraceptives for period regulation and to counteract manifestations of androgenicity

Endocrinology Referral
1. Suspected hypothalamic hypogonadism and not worried about decreased calories or exercise.
2. Significant cardiometabolic abnormalities (Lipids,HbA1c) NOTE: No need to refer to Endo for suspected PMOS if no cardiometabolic abnormalities
3. Non-classic congenital adrenal hyperplasia (CAH): 17-OH progesterone > 200
4. Suspected gonadal failure: elevated FSH/LH, low estradiol

DHEA-S > 500
Abdominal Pelvic ultrasound to evaluate for ovarian or adrenal mass
- Normal → Refer to Endocrinology
- Abnormal → Refer to Pediatric Surgery

Adolescent & Young Adult (AYA)
E Consult vs Referral
1. Suspected hypothalamic hypogonadism if decreased FSH/LH & low estradiol (< 40). May be due to decreased energy availability (Incl. exercise or dec caloric intake)
2. Refer for complex contraceptive needs

GI Referral vs. E-consult
Alt > 3x ULN