

perforation in the septum is often present, patients may still present with amenorrhea and hematocolpos. Additionally, other malformations of the urological tract or rectum may be associated.

THYROID DISORDERS

Hypothyroidism

Although hypermenorrhoea or oligomenorrhoea are the more prevalent menstrual disorders, amenorrhea can also be seen and is thought to be due to increased prolactin secondary to raised TSH.

Hyperthyroidism

Patients with hyperthyroidism have rates of menstrual irregularities ranging from 20% to 60%, with rates of amenorrhea reaching up to 20%.

ADRENAL CAUSES

Congenital Adrenal Hyperplasia

CAH refers to a group of autosomal recessive disorders of steroidogenesis.

A number of enzyme deficiencies have been found, but more than 90% of cases are caused by deficiency of 21-hydroxylase. The two other major enzyme deficiencies are deficiencies of 11-beta-hydroxylase and 3-beta-hydroxysteroid dehydrogenase.

There are two major clinical forms of congenital adrenal hyperplasia, depending on whether the enzyme deficiency is complete or partial—the classic form and the nonclassic form. The classic form usually presents in infancy with salt wasting or ambiguous genitalia. It occurs in approximately one in 16,000 births. The nonclassic form is one of the most frequently seen autosomal genetic disorders and occurs in approximately 0.2% of the general population. This nonclassic form of congenital adrenal hyperplasia usually presents in childhood and is characterized by premature pubarche and in adolescence by hirsutism or amenorrhoea.

Cushing Syndrome

Cushing syndrome is caused by high circulating levels of cortisol. In adolescents, Cushing syndrome is most frequently caused by iatrogenic exogenous administration of corticosteroids. Other causes include hypersecretion of corticotropin by a microadenoma of the anterior pituitary (Cushing Disease); secretion of corticotropin by an adrenal tumour, or occasionally ectopic production of corticotropin by a nonpituitary tumour such as carcinoma of the lung.

The clinical findings are usually self-evident. Oligomenorrhoea and amenorrhea may be part of the clinical picture. The pathophysiology is direct suppression of the HPO axis.

REFERENCE

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