When Aunt Flo Comes to Town: Typical Versus Atypical Menstruation and the Approach to Adolescents with Menstrual Concerns

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Q&A

Q: 15 y/o, menarche at 11y/o. She has several months of regular periods but has 1-2 months without a period. She is not sexually active—thoughts?

A: This is a patient that I would recommend a lab evaluation for irregular bleeding.

Q: If you know you have a patient with eating disorder, why repeat FSH/LH/estradiol?

A: That is true, I don't always repeat it when there is a known diagnosis of an eating disorder. I often repeat it when there is not a clear diagnosis or when the family or patients are resistant to the diagnosis. If I'm not certain that they're getting the treatment they need or the diagnosis is unclear, I repeat these labs in order to assess for an evolving process, particularly if I'm worried about estrogen deficiency.

Q: If they are in the first year or two post menarche and desire regulation, would you do a workup before initiating any treatment?

A: No, often I don't but if they desire regulation, then I'm more than happy to regulate their cycles.

Q: You typically recommend 30-35mcg estrogen?

A: I do typically recommend 30 to 35 micrograms of estrogen because a lower dose estrogen pill is more likely to cause breakthrough bleeding or irregular bleeding. Additionally, there is concern that lower dose estrogen pills may not provide sufficient support to bone growth and development, which is so important for adolescents. Risk of VTE and symptoms are not much different in 20-25mcg formulations versus 30-35mcg formations, so in my opinion, it is best to maximize the estrogen dose in adolescents because the risks of breakthrough bleeding and bone health are significant between the two doses.

Q: Do you have different recommendations for hormone medications for patients who smoke or have h/o migraine w/ aura or have a family h/o clotting disorder?

A: For these patients, progesterone-only options are safe. Unfortunately, progesterone options don't typically lead to a regular monthly cycle, which can feel like the goal for some patients, so I generally have a discussion about menstrual goals and the option for menstrual suppression instead of menstrual regularity.

Q: Parents often ask what is the minimum age a female can begin tampon use?

A: I say you can use a tampon when you are ready to use a tampon. So, if you are desiring tampon use, you have my full approval to start using tampons. There are no safety concerns for me or health concerns for me in terms of tampon use for any age.

Q: For those that elect to start treatment how long should they continue for before stopping to see if they have regular menses?

A: Often I have patients who want to start regulation or have heavy periods and want to see what's going to happen as they get out of this very early adolescent period. Typically, I recommend medication use for at least one year because it can take two to three months after starting medication to get into a menstrual pattern. After one year, if they want to see what their body is going to do, we can take them off the medication.

Q: Is it normal for clots to be present during menstruation? If so, is there an amount that is a cause of concern?

A: Yes, clots are normal. A lot of girls, particularly at night, or when they're sitting at school, will have blood leak into the vagina and then it will sit there, and it will coagulate and that is normal. Oftentimes I ask patients if they have history of blood clots and then I ask them to quantify their clots in terms of size: is it the size of a penny? nickel? quarter? golf ball? orange?

Typically, if they're reporting golf ball size or bigger, (even those reporting routine quarter size clots) I'll at least do a workup to make sure that their CBC is normal.

Q: So, is it more of a concern if a female doesn't have menses by age 16 or no menses 2 years after breast development? In other words, does one warrant a referral more than the other?

A: In a patient that is having primary amenorrhea because they haven't had periods at 15 or 16 or has had this prolonged lag between breast development and periods, those are equal to me and in terms of referral or needing further evaluation.

Q: What is best way to manage athletic amenorrhea?

A: This is really hard and it's really a long discussion about nutritional support. I often refer patients to a nutritionist who does an eating log and can make recommendations for nutritional needs in relation to caloric needs. A lot of times adolescent athletes don't know how to eat -- they think they're eating enough, but often they could optimize their intake to support the core requirements of their sport. Nutrition is the first place that I start.

Q: For patients with amenorrhea and normal labs (and do not have an eating disorder), do you recommend doing a provera challenge?

A: A provera challenge is another way to check on estrogen levels. Even if FSH/LH/estradiol is normal, it can be helpful to have a more long term look at what their estrogen support may be. If they've had estrogen support and they built up a lining and you give a provera challenge, they'll bleed, and if they have not had good long term estrogen support then when you give a provera challenge, they don't bleed because you need estrogen to build the endometrial lining. So, essentially, it's another assessment tool. I don't always do it if I feel like I have the answers I'm looking for, but if the picture is murky, or I need an additional way to show the family that it is the lack of estrogen that is causing the amenorrhea then I will recommend it.

Q: From a lab interpretation point of view, what reference values do you recommend as they often come back with ranges based on tanner stages as well as age? Additionally, since most of these girls have irregular periods and don't know where they are on their cycle, how can you accurately interpret FSH/LH/estradiol levels?

A: The traditional way, for example, when you talk a reproductive endocrinologist, is that you're going to want day three FSH/LH and estradiol. Tracking their period and getting them to come back for labs at that exact time is really difficult. So often I don't rely on that method so I'm looking more at FSH/LH and estradiol being in concert together; one is not super high and the other super low. Does that necessarily correlate with stages and tanner staging? It's not perfect, but I kind of take the overall, general picture of what's happening with the patient and how they're puberty is progressing as well as what their estradiol levels are. One general good rule of thumb for estradiol is typically that in someone who is menarchal 30 is the absolute lowest estradiol at any point in the cycle that should be considered "normal."

Q: Is it safe to use continuous OCPs in a healthy adolescent girl with normal periods?

A: There is no reason to have a period every month if you don't want a period every month. It is safe to not have periods if I'm giving you medications to make it so that you don't have periods. These medications make the endometrial lining relatively thin, so you don't have any reason to bleed. It is safe and healthy and I 100% advocate for no period if you don't want them.

Q: Is OCP the best way to treat Premenstrual dysphoric disorder (PMDD)?

A: OCP certainly can be used to help treat PMDD. I recommend some of the higher estrogen containing OCPs because what you're hoping to do is suppress the ovaries and suppress that fluctuation of estrogen and progesterone that may be related to mood changes throughout the cycle. You can also treat PMDD with a mental health specialist and SSRIs; some even advocate for alterations in dosing throughout the menstrual cycle to get the best control.

Q: If you have abnormal elevated free testosterone and borderline DHEAS - would you recommend a sono? or other eval before starting hormonal treatment?

A: No, I don't typically get sonos for free testosterone unless they're over about 150 (normal is between 20-30). I will let the testosterone go high before I do a sono. For DHEAS, it needs to be closer to 700-800 before really thinking about some type of androgen secreting tumor, so I do not often order additional imaging, particularly not for borderline values. In patients that I am concerned about with an elevated testosterone or DHEAS, I will consider metabolic screening and hemoglobin A1c just so I can monitor. Occasionally, if I'm really suspicious I will order an ACTH stimulation test to truly rule out late onset CAH.

Q: How long is it safe to be on OCPs?

A: Forever. If your period is bothersome or you don't like your periods, or it gets in the way of things, there is no reason to suffer or be in distress. So, if long term use of any of these medications makes your life better and that's what makes your periods better, I am all for that. Theses medications have been out for over 30 years, and there is a lot of long-term data to support that safety in long-term use.

Q: Is age of menarche decreasing over time? And why?

A: Yes, there has been data that over time, the age of puberty has been decreasing. A lot of things go into play about when puberty occurs, but we know that there are some relations to leptin and body mass. Interestingly, while the population age of puberty has decreased, there hasn't been as significant of an impact on the age of menarche. We still need a lot of research in this area to have a better understanding.

Q: Can you explain again how you use OCPs placebo discarding for heavy bleeding?

A: In the medication pack, there are four lines of pills. The first three lines are going to be one color and contain hormones while the last line is going to be a different color and that's typically your placebo pill. What I tell my patients is to just discard the placebo week pills in all their packs as soon as they get them. I tell them to take one of the same colored pill every single day. When they finish their pack, start the next pack immediately. I also alert them that at some point, they will have breakthrough bleeding. It can occur anywhere from four weeks after starting to maybe six months after starting. But when that breakthrough bleeding occurs, even if it's just a little bit of spotting, stop taking your pills--no medication for three days and then restart your pills again. That will allow and induce a period and then, when you start restart the medications the period should stop.

Q: How long can Depo-Provera be used without worrying about bone loss in adolescents?

A: The data has really changed over time. Several years ago, there was a black box warning about bone mineral density in adolescence and recently there's been some concern about the ages that we're starting this but what we found, is that in girls who were using Depo-Provera who had lost their bone mineral density, they were able to recover bone mineral density once they came off Depo. I believe it was within a year after stopping the Depo that they recovered bone mineral density. Ultimately, particularly when it comes to contraception, we know that unintended pregnancy is likely worse than a transient decrease in bone mineral density.

Q: What is the youngest age you would start the pill, assuming they have had irregular painful periods for 2-3 yr post menarche.

A: I will start the pill with the first period if that is what the patient desires or what they need because of a medical reason. They are safe to be used in any age patient.

Q: Do you have a minimum cutoff age for COCs? monophasic vs triphasic pills? which do you prefer?

A: Monophasic pills 100% all the time. Please get rid of all triphasic pills. If I could get the drug companies to outlaw them I would. Mostly because triphasic pills are just bad in helping to control irregular bleeding. You get a lot of irregular breakthrough bleeding with these medications. Monophasic pills with at least 30mcg of estradiol are my preferred OCP of choice.

Q: Any research being done regarding OCPs and future risk of fibroids?

A: I don't know of any ongoing research for this. Fibroids decrease when there is suppression of hormones, so I would be interested to see if there was a decrease in the amount of fibroids with these medications.

BOOKS FOR ADDITIONAL PERIOD/PUBERTY RESOURCES

- Girl's Guide to Becoming a Teen – published by the American Medical Association
- Hair in Funny Places by Babette Cole – good for young readers/puberty preparation
- The Every Body book by Rachel E Simon – LGBTQ+ inclusive
- Welcome to your period by Yumi Stynes

ONLINE RESOURCES

- Girlology.com – lots of great articles and videos on periods, period tracking, puberty; very much centered on cis females
- Bedsider.org – focuses on contraception, but is a great resource for patients to learn about hormonal medications
- Dr. Hina Talib (teenhealthdoc on Instagram) – adolescent medicine physician with lots of resources for parents of teens
- Dr. Charis Chambers (theperioddoctor on Instagram) – pediatric gynecologist with great resources for parents and teens (ex how to insert a tampon, how to clean the vulva); I recommend that all of my patients follow her!

APPS FOR PERIOD TRACKING

- Clue
- MagicGirl
- Pink Pad – has the option to set gender, so inclusive of all menstruators; has an option to join an online community for additional resources that I haven't validated