Congenital hypogonadotropic hypogonadism in females: Clinical spectrum, evaluation and genetics


Abstract

Congenital hypogonadotropic hypogonadism (CHH) are a well-known cause of pubertal development failure in women. In a majority of patients, the clinical spectrum results from an insufficient and concomitant secretion of both pituitary gonadotropins LH and FSH that impedes a normal
Congenital hypogonadotropic hypogonadism (CHH) results from abnormal gonadotropin secretion and is characterized by a complete or partial lack of pubertal development that is caused mainly by defective GnRH production or release by the hypothalamus, or by a primary gonadotropic cell dysfunction in the pituitary. The prevalence of CHH, evaluated from 1/10,000 to 1/4000 in males, was reported to be between two and five times less frequent in females [1,2]. These values mainly established by specialized teams belonging to teaching hospitals (Fig. 1) are probably underestimated compared to the real frequency of CHH in the general population of women as a consequence of recruitment biases. CHH is revealed in the majority of female teenagers and women by primary amenorrhea [1–6]. The classical hormonal signature of CHH is a low level of circulating sex steroids, together with low or “normal” levels of FSH and LH [1–6].

1. Clinical presentation

In women, CHH is revealed in by primary amenorrhea in more than 90% of cases [3]. Breast development is highly variable but it is absent in a minority of cases (Fig. 2). Indeed, it is often present and sometimes almost normal. Similarly, pubic hair may be absent (Fig. 2), sparse or even normal. These partial forms, in majority not referred to hospital contribute to explaining the underestimated prevalence of this condition in women [1,3]. In a very mild form, CHH can be restricted to isolated chronic anovulation, whereas estradiol secretion is adequate for...
endometrial development and therefore associated with the existence of a single menstruation (primosecondary amenorrhea) or even chronic oligomenorrhea or a positive progestin withdrawal test [3]. These attenuated forms have also been described in women having conceived spontaneously [7].

One challenge in women with sporadic CHH, normal olfaction and hypothalamic MRI and no identified mutation is the differential diagnosis of functional hypothalamic amenorrhea [1,8,9]. In women referred for primary amenorrhea and with an hormonal profile suggesting HH but without anosmia or hyposmia or identified genetic anomalies, the diagnosis of CHH must therefore only be considered with care, after ruling out underweight, eating disorders, excessive physical activity, and chronic underlying conditions (Fig. 3) [1,8,9]. When body weight or BMI are at the lower limit of normal, body fat measurement can also be useful to screen for functional hypothalamic amenorrhea in this context.

Finally, the presence of non-reproductive non-olfactory additional disorders, including mirror movements, palate anomalies, renal agenesis (ultrasoundography), hearing impairment (audiometric testing), and tooth agenesis, should be carefully searched in these female patients and, whenever possible, their first-degree relatives, because such anomalies can direct the clinicians and geneticist towards particular genetic forms of the disease [10] (Kallmann syndrome or more complex syndromic causes) in which genetic counseling is mandatory.

2. Evaluation

Serum estradiol concentrations are often low in women with CHH [1–6], sometimes below the detection limit. They seem to correlate with breast development: indeed, in the absence of breast development, circulating estradiol concentrations are undetectable while estradiol is detectable with a sensitive assay when breast development exceeds stage B2. A similar relationship exists between pubertal development and pituitary gonadotropin concentrations: the latter are often very low or undetectable in the absence of breast development, while in patients with stage B3 or B4 breast development, they can reach values close to those observed in the early follicular phase of women with normal cycles (Fig. 3). As in males with CHH, the GnRH test have a poor diagnosis value to make a positive diagnosis in females and serves more to confirm the severity of congenital gonadotropin deficiency [11], which in fact is often already clinically perceptible (reflected by the degree of breast development). Thus, the GnRH test provides no extra diagnostic information relative to baseline gonadotropin levels evaluated with modern assays [1]. In addition, it cannot show whether the gonadotropin deficiency is hypothalamic or pituitary in origin: for instance, the results of GnRH test can be negative in profound hypothalamic gonadodropin deficiency and positive in partial pituitary deficiency [1–6,11].

Before making a firm diagnosis of isolated congenital gonadotropin deficiency, all antepituitary functions must be investigated in order not to miss hyperprolactinemia, global anterior pituitary insufficiency, or an associated endocrine disorder that may be part of a syndromic form of CHH (Fig. 3).

On the same way, in the absence of anosmia or other associated signs suggesting a syndromic cause, primary juvenile hemochromatosis may mimic CHH and be a real differential diagnosis [12]. It is therefore useful to rule out iron overload, given the therapeutic implications in this disorder. Primary juvenile hemochromatosis can be ruled out by measuring serum iron and the transferrin saturation coefficient.

3. Imaging

Pelvic sonography is useful for determining the size of the uterus [13–15], which reflects estrogen impregnation, as well as endometrial thickness, ovary size and the number and size of ovarian follicles [13–15], that may correlate with the severity of gonadotropin deficiency [3].

MRI of the brain and olfactory bulbs is useful in CHH. Although the findings are nearly always normal in isolated normosmic CHH, MRI can rule out an expansive, infiltrative or malformative disorder of the hypothalamopituitary region. MRI can also be used to analyze the olfactory bulbs and furrows in a search for signs of Kallmann syndrome.

4. Genetics

Identification of genetic abnormalities related to CHH over the last 2 decades has provided important insights into the pathways involved in the development, maturation and function of
In women, mutations of **FGFR1**, **PROK2**, **PROKR2** and **FGF8** have been found specifically in Kallmann syndrome, a disorder in which CHH is related to abnormal GnRH neuron ontogenesis and is associated with anosmia or hyposmia [6,10–18] (Fig. 4).

In fact, in females as in males, the CHH phenotype is usually tightly linked to an isolated deficiency of gonadotrophin secretion. These patients, who have no clinical abnormalities, associated signs or hormone deficiencies independent of the deficiency in gonadotrophin and sex steroids, have isolated CHH [1]. Such cases are occasionally due to genetic alterations affecting GnRH secretion: mutations in **GNRH1** [5], **GPR54/KISS1R** [19,20] and **TAC3** and **TACR3** [21–23] or the GnRH sensitivity of gonadotropic cells: GNRHR [1,4,24,25] (Fig. 4).

Since more than 20 years, we have learned a great deal from a number of genotype-phenotype published studies: so, we know now the clinical features of patients with **GnRHR** gene mutations where both genders are highly variable, even in the same kindred [1]. On the same way, whatever the mutations, it has been clearly established that the spectrum of the reproductive phenotype in women with CHH, is much broader than originally anticipated (Fig. 5). There is no doubt that, these findings have changed our old oversimplified view of the disease.

Finally, we must be aware that a minority of female patients with Kallmann syndrome or a syndromic form of CHH may also initially appear to have isolated CHH. Close clinical, familial and genetic studies can correct the diagnosis, which is particularly important for genetic counselling [1,26].

**Conflicts of interest**

Aucun.

**References**


