CONTRACEPTION IN THE PERIMENOPAUSE

Women are often tempted to give up contraception before their periods stop completely, but unintended pregnancy rates are similar to those in younger women. Louise Newson, a GP and specialist writer on women’s health reviews the contraceptive options available for the perimenopausal woman.

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### CLINICAL CASE STUDY

Mrs Smith is a 47-year-old lady who has been taking the progesterone-only pill, Cerazette for the past 6 years. Although it suits her well, she has occasional spotting which can be an inconvenience for her. She comes to see you to ask whether she can stop it now that she is older. Many of her friends are having menopausal symptoms and she is wondering if she really needs to take a contraceptive pill any more. What do you advise her to do?

Although the absolute risk of pregnancy is lower during the perimenopause due to decreased fertility and decreased coital frequency, unintended pregnancy occurs at ratios similar to those observed in young women.1 Women are often tempted to abandon contraception before their periods stop completely.

A woman is considered potentially fertile for 2 years after her last menstrual period if she is under 50 years and for 1 year if she is over 50 years. Some experts state that sterility cannot be assumed until at least the age of 60 because spontaneous pregnancies have been reported in women up to age 59.1

Contraception is therefore still required in women over the age of 40 years. This is especially important because of the increased risks of chromosomal abnormalities and miscarriage in women over 40. The risk of Down’s syndrome increases from around 1 in 1500 at 20 years of age to around 1 in 40 by the age of 45 years. Women should also be aware that they have an increased risk of both morbidity and mortality if they become pregnant after 40 years.

There is now a wide range of contraceptive choices for older women but the choice of contraception needs to be determined by individual risk factors and preferences. Some women may experience symptoms of the menopause, e.g. hot sweats and vaginal dryness, so ideally their choice of contraception should take any symptoms into account and improve these too. It is worth noting that no contraceptive method is contraindicated based on age alone.

**Combined hormonal contraception**

Combined hormonal contraception (CHC) is available in three forms: the combined oral contraceptive pill (COC), the combined transdermal patch, and the combined vaginal ring. Healthy, non-smoking women can actually take COC until they reach 50 years of age.

CHC has the added advantage of reducing any menstrual pain and bleeding. It also improves any menopausal symptoms as it contains oestrogen. It may also help to maintain bone mineral density. However, smokers need to stop taking CHC by the age of 35 years as the risks usually outweigh the benefits. CHC should be avoided if body mass index ≥33kg/m² unless there are no suitable alternatives. There may be a small increased risk of cervical cancer in women taking COC. Women should be advised that COC use for <10 years is associated with a negligible risk of cervical cancer, but this may increase with duration of use.2 Oestrogen-containing methods should generally be reserved for women without cardiovascular or thrombotic risk factors.

Although there are some risks associated with taking CHC, women should be informed that CHC can actually reduce a woman’s risk of both ovarian and endometrial cancers. The protective effect of oral contraceptives against ovarian cancer may be sufficiently explained by the duration of anovulation.3

There is a significant duration-response relationship of taking the COC and reduced risk of ovarian cancer. There has been shown to be a reduction in incidence of ovarian cancer of more than 50% among women taking the COC for 10 or more years.4 The risk of endometrial adenocarcinoma has been shown to be reduced by 56% after 4 years of use, 67% after 8 years and 72% after 12 years.5 Protection against these two cancers lasts for at least 15 years after discontinuing
use of the COC. In addition, compared with never-use, the ever-use of oral contraceptives is significantly associated with a reduction in colorectal cancer.6

There may be a small increased risk of breast cancer in women taking the COC.7 However, a cohort study, which was undertaken to examine the absolute risks or benefits on cancer associated with oral contraception, found that there is no increase in breast cancer risk for women without a family history.4 Any increased risk of breast cancer actually reduces to no risk 10 years after stopping the COC and women should be informed of this.

Although venous thromboembolism (VTE) risk rises with age, most women with genetic clotting disorders are usually identified before their mid-thirties, because of their high VTE risk within the first year of CHC use or in pregnancy.

If women experience menopausal symptoms while taking the COC then they should be advised to try the extended regimen (i.e. omitting the pill-free week).

Current recommendations are that women who start using CHC after the age of 40 years should have their blood pressure measured before and then at least 6 months after starting and then at least annually after that.9

The vaginal ring
This is a flexible, transparent vaginal ring, which contains 5µg ethinylestradiol and 120µg etonogestrel (NuvaRing®). Each ring is used for 3 weeks, followed by one ring-free week. It can be self-administered, as the woman can insert and remove it herself. It can be removed for up to 3 hours if desired, for example, for sexual intercourse.

The NuvaRing® has a similar efficacy to the COC and also results in good cycle control (comparable to that of a 30µg ethinylestradiol pill).2 However, like the oral CHC, the use of the contraceptive vaginal ring increases the risk of VTE.10

Progestogen-only pills
In women over 40 years, progestogen-only pills (POPs) are as effective as the COC pill. POPs may help alleviate dysmenorrhoea. However, they often result in altered bleeding patterns, which can lead to unnecessary investigations in some women. There is no increased risk of stroke or myocardial infarction in women taking POPs and there is little or no increased risk of VTE.9

Long-acting reversible contraception
This is a fairly popular choice for many women. It can be as effective as sterilisation.

Progestogen-only injectable contraception
Women need to be informed that the return of fertility can be delayed for up to 1 year after discontinuation of progestogen-only injectable contraception.9 The progestogen-only contraception is associated with a small loss of bone mineral density. However, this is usually recovered after discontinuation.

Subcutaneous depot medroxyprogesterone acetate (Sayana Press®) is an alternative progestogen-only injectable contraception that has recently been licensed. This is given subcutaneously, whereas the alternative, Depo-Provera® is given intramuscularly. This may be preferable for women at risk of haematoma due to bleeding disorders and also for women who are taking anti-coagulants.10 In the future, self-administration of subcutaneous depot medroxyprogesterone acetate (DMPA) may be an option for some women. It is not licensed for such use at the present time.

Current recommendations are that women who wish to continue using DMPA should be reviewed every 2 years to assess their benefits and potential risks. These women should be supported in their choice of whether or not to continue using DMPA up to a maximum recommended age of 50 years.9

Implants
Etonogestrel flexible rod implants (Implanon®) are another low-dose progestogen-only method and are useful for those women who do not want to take pills. Irregular bleeding may occur in these women using implants. Caution is required when prescribing DMPA to women with cardiovascular risk factors due to the negative effects of progestogens on lipids.

Mirena® coil
The levonorgestrel intrauterine system (LNG-IUS, Mirena®) has particular benefits during perimenopause and is safe for use in nearly all women.1 The LNG-IUS is approved for treatment of heavy menstrual bleeding, which can be a common problem during the perimenopause.

The LNG-IUS is licensed to provide the progestogen part of HRT, as well as contraception. It should be noted that the HRT licence is for 4 years, rather than the 5-year contraceptive licence. This is an extremely useful option for women approaching the menopause, because it reduces bleeding problems (once other pathology has been excluded), provides contraception and leaves open the option of adding HRT when required.

Copper-bearing intrauterine device
Women should be informed that spotting, heavier or prolonged bleeding and pain are common in the first 3–6 months of copper-bearing intrauterine device use. Women should be assessed for further investigations if the bleeding persists.

Non-hormonal methods of contraception
Male condoms and female condoms are, respectively, up to 98% and 95% effective at preventing pregnancy.
Diaphragm and caps are, respectively, estimated to be between 92% and 96% effective at preventing pregnancy. Spermicide should be used with diaphragms and caps.

Although many women may use natural family planning as their preferred method of contraception, it can be more difficult to work out correctly if they have irregular periods.

Although sterilisation is a very effective method of contraception, female sterilisation is not commonly undertaken in the UK. If sterilisation is requested, then a vasectomy is usually undertaken for the male partner.

Stopping contraception
Reliable contraception should be used until menopause is confirmed either by the cessation of menses for 2 years prior to age 50, for 1 year after age 50, or by two elevated follicle-stimulating hormone (FSH) values ≥20–30 IU/L, while the woman is off CHC for at least 2 weeks. FSH levels can still be assessed in those women who are taking progesterone-only contraception.

Women using non-hormonal methods of contraception can be advised to stop contraception after 1 year of amenorrhoea if aged over 50 years, and after 2 years if the woman is aged under 50 years.

Women who have an IUCD inserted at age 40 years or over may retain the device until they no longer require contraception (i.e. after 1 year of amenorrhoea if aged over 50 years, and 2 years if the woman is aged under 50 years).

However, women who have the IUS inserted at age 45 years or more for contraception or for the management of menorrhagia and are amenorrhoeic may retain the device until they are postmenopausal. If they are amenorrhoeic and their serum FSH levels are ≥30 IU/L on two occasions 6 weeks apart then the IUS can be removed after 1 year. Alternatively, the IUS can be removed at age 55 years when natural loss of fertility can be assumed for most women.

Women using CHC should be advised to switch, at the age of 50 years, to another suitable contraceptive method. FSH levels are not reliable indicators of ovarian failure in women using CHC, even if measured during the hormone-free or oestrogen-free interval.

The progestogen-only contraceptive pill or implant can be continued until the age of 55 years when natural loss of fertility can be assumed. Alternatively, the woman can continue with the progestogen-only pill or implant and have FSH levels checked on two occasions and, if both levels are greater than 30 IU/L, this is suggestive of ovarian failure. In this case, the woman may continue with the progestogen-only pill or implant or barrier contraception for another year (or 2 years if aged less than 50 years).

Women should be counselled about the risks and benefits of continuing with the progestogen-only injectable at the age of 50 years and be advised to switch to a suitable alternative.

For women using hormone replacement therapy
It is very important that women are informed that HRT is not contraception. Women on HRT should continue contraception until 55 years old, or can stop before if the woman stops HRT for 6 weeks to have her FSH measured on two occasions in order to confirm the menopause. A POP can be used with HRT to provide effective contraception.

Emergency contraception and STIs
It is important that when discussing contraception with perimenopausal women, emergency contraception and also sexually transmitted infections are discussed, so that women are aware of the types and availability of emergency contraception and also ways of reducing their risk of obtaining a sexually transmitted infection.

CASE HISTORY: WHAT DID MRS SMITH DO?
Mrs Smith has many options available to her. It is important that she does not just stop taking her Cerazette as she could still be fertile. She could have her FSH levels undertaken on two separate occasions and if they are greater than 30 IU/L, she should continue with Cerazette for another 2 years. If she is having menopausal symptoms, then she could consider taking HRT and could either continue with her POP or she could opt for a Mirena® coil. The Mirena® coil is likely to lead to amenorrhoea, which will be preferable to the spotting she is currently experiencing.

References
Full references available at www.bjfm.co.uk

KEY POINTS
1. Spontaneous pregnancies have occurred up to the age of 59 years
2. Combined hormonal contraception (CHC) can improve menopausal symptoms due to its oestrogen content and also help to maintain bone mineral density
3. CHC has been shown to reduce the risk of ovarian and endometrial cancers
4. Long-acting reversible contraception is a popular choice and can be as effective as sterilisation
5. The LNG-IUS is very useful when there is heavy menstrual bleeding, as it also provides contraception and leaves the door open to HRT
6. Reliable contraception should be used until the menopause is confirmed either by cessation of menses for 2 years prior to age 50 or for 1 year after age 50
7. A progestogen-only pill can be used with HRT