Guidelines on Perimenopausal Contraception

A Clinical Guideline

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By:	Clinical staff
For:	Gynaecological patients.
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Guidelines on Perimenopausal Contraception

1. General points

- Although a natural decline in women's fertility occurs from their mid-30s, effective contraception is required to prevent an unintended pregnancy. Furthermore, mistakenly relaxed contraceptive vigilance after the age of 40 is a common phenomenon and around 27% of conceptions in women in this age group end in termination Women should be advised that effective contraception is required until menopause to prevent an unintended pregnancy.
- Women aged over 40 can be advised that no contraceptive method is contraindicated by age alone. Health professionals prescribing or advising on contraception should be guided by the UK Medical Eligibility Criteria for Contraceptive Use (UKMEC) 2016. Clinical judgement is also required, particularly when prescribing for women with multiple medical and social factors.
- Women over 40 with a significant change in their bleeding pattern should have appropriate gynaecological assessment and investigation, whether they are using a contraceptive method.
- Women over 40 should be asked about any urogenital symptoms or sexual issues they may be experiencing.
- Women over 40 should be informed of the age-related increased background risk of cardiovascular disease, obesity and of breast and most gynaecological cancers as this may affect choice of contraceptive method.
- Women should be informed that contraception does not affect the onset or duration of menopausal symptoms but may mask the symptoms and signs of menopause.
- Healthcare practitioners should discuss sexually transmitted infections (STIs) and sexual health with women over 40. This population should be advised about condom use and protection from STIs even after contraception is no longer required.

2. Intrauterine methods

- The Faculty of Sexual and Reproductive Healthcare (FSRH) supports extended use of the copper intrauterine device (IUD) until menopause when inserted at age 40 or over
- The FSRH supports extended use of a Mirena 52 mg levonorgestrel releasing intrauterine system (LNG-IUS) for contraception until the age of 55 if inserted at age 45 or over, provided it is not being used as the progestogen component of hormone replacement therapy (HRT) for endometrial protection.
- Women who have undergone endometrial ablation should be advised about the potential risk of complications if intrauterine contraception is used.

3. Progestogen-only Contraception (oral, subdermal, injectable, IUS)

There are currently four methods of progestogen only contraception (POC) available in the UK: the progestogen only pill (POP), injectable depomedroxyprogesterone acetate (DMPA), the etonorgestrel releasing subdermal implant (SDI) and the levonorgestrel-releasing intrauterine system (IUS). POC may help to alleviate dysmenorrhoea and, once pathological causes have been excluded, the IUS can be used for treatment of heavy menstrual bleeding. Women should be advised that altered bleeding patterns are common with use of

POC and women over the age of 45 years with excessive bleeding should undergo endometrial assessment.

- **VTE, MI and stroke:** the limited data available from observational studies suggest that the use of POC is not associated with an increase in stroke or MI and that there is little or no increase in the risk of VTE. However, because of the adverse effect of progestogens on lipid metabolism, there is a theoretical risk of vascular disease in women with additional risk factors. DMPA has a greater effect on lipids than other POC methods and therefore caution is required when prescribing this method. Women without additional cardiovascular risk factors may use DMPA until age 50 years. Women over 50 should be counselled on alternative methods of contraception. In some circumstances, consideration may be given to continuation, providing the benefits and risks have been assessed and the woman informed of the potential risks.Women can be informed that the POP and SDI are not associated with increased cardiovascular risk.
- **Breast cancer**: the evidence of an association between breast cancer and POC is inconclusive, with only small sample sizes. Some studies suggest a risk broadly similar to that of Combined Hormonal Contraception (CHC) whilst others have suggested no increased risk or a very small increased risk. Overall most evidence is reassuring with regard to breast cancer and POC.
- **Bone health**: most of the concern surrounding bone mineral density (BMD) relates to long term use of injectable DMPA. POP and SDI have not been shown to affect bone mineral density. It is recognised that DMPA does affect BMD but that it recovers upon cessation of use. Data on fracture risk associated with DMPA use are limited. A cohort study of women aged 40-49 years reported no significant differences in BMD between users of injectables, CHC and non-user controls. The initial loss in BMD due to hypoestrogenic effects is not worsened by the onset of menopause. Women with significant lifestyle or medical risk factors for osteoporosis should consider other methods. Women over 40 using DMPA should be reviewed regularly to assess the benefits and risks of use.

4. Combined Hormonal Contraception (CHC) (oral, transdermal, transvaginal)

- In women *who do not smoke and who do not have risk factors for cardiovascular disease*, use ofCHC up to age 50 is acceptable. Women can be advised that the use of CHC may help to maintain bone mineral density, reduce menstrual pain and bleeding and reduce menopausal symptoms. Use of CHC provides a protective effect against ovarian and endometrial cancer that continues for 15 years after stopping CHC. Women can be advised that there is a reduction in benign breast disease and colorectal cancer with CHC use.
- **Venous thromboembolism (VTE):** the relative risk of VTE is increased with use of CHC. The risk of VTE increases from a baseline of 2/10,000 to 5-12/10,000 woman years although the absolute risk in both groups is small. Combined oral contraception (COC) with levonorgestrel or norethisterone should be considered first line preparations for women over 40 due to the potentially lower VTE risk compared to formulations containing other progestogens.
- **Myocardial infarction (MI) and stroke:** the data are somewhat conflicting regarding CHC with some studies showing a small increased risk of ischaemic stroke and others showing no association. Risk may be influenced by factors such as smoking,

hypertension and migraine with aura. For women over 40 without cardiovascular risk factors, a COC with ≤ 30µg ethinylestradiol should be considered first line due to the potentially lower risks of VTE, cardiovascular disease and stroke compared to the formulations containing higher doses of estrogen. As both smoking and age are independent risk factors for cardiovascular disease, UKMEC places greater restrictions on the use of CHC in women aged over 35 years who smoke. These women should be advised that the risks of using CHC outweigh the benefits. Women aged 50 and over should be advised to stop taking CHC for contraception and use an alternative, safer method.

- **Breast cancer**: meta-analyses have found a slight increased risk of breast cancer among women using COC, but with no significant risk of breast cancer by 10 years after stopping

5. Sterilisation

- Clinicians should advise women that sterilisation does not alter or eliminate menstrual periods. Women who have been using another method of contraception should be made aware that bleeding patterns may well change after sterilisation because they have stopped a contraceptive method.

6. Emergency Contraception

- Women over 40 who still require contraception should be offered emergency contraception after unprotected sexual intercourse if they do not wish to become pregnant.

7. Stopping Contraception

- Menopause is usually a clinical diagnosis made retrospectively after 1 year of amenorrhoea. Most women do not require measurement of their serum hormone levels to make this diagnosis.
- If needed, women over 50 using progestogen only contraception, including DMPA, can have serum follicle stimulating hormone (FSH) measurements undertaken to check menopausal status. Women using CHC or HRT have suppressed levels of estradiol and gonadotrophins; measuring these hormones does not give accurate information on which to base advice regarding menopausal status and when to stop contraception.
- In general, all women can cease contraception at age 55 as spontaneous contraception after this age is exceptionally rare even in women still experiencing menstrual bleeding. If a woman aged 55 or over does not wish to stop a particular method, consideration can be given to continuation providing the benefits and risks for her as an individual have been assessed and discussed with her.
- Intrauterine devices and systems should not be left in situ indefinitely when no longer required as they can become a focus of infection.

Table 1- Advice for women on stopping contraception

Contraceptive method	Age < 50 years	Age > 50 years
Non-hormonal	Stop contraception after 2 years of amenorrhoea	Stop contraception after 1 year of amenorrhoea
Combined hormonal contraception (CHC)	Can be continued up to age 50 years[a]	Stop CHC at age 50 years and switch to a non-hormonal or progestogen-only method, then follow advice as below.
DMPA	Can be continued up to age 50 years[a] (may be continued beyond 50 years on an individual basis after appropriate discussion of risks and benefits)	Stop DMPA at age 50 years and chose from options below: Switch to a non-hormonal method and stop after 2 years of amenorrhoea **OR** Switch to POP, implant or IUS and follow advice below Continue method
Implant, POP, LNG-IUS	Can be continued to age 50 years or longer[a]	If amenorrhoeic either check FSH levels and stop method after 1 year if serum FSH is ≥ 30 IU/L on two occasions 6 weeks apart **OR** Stop at age 55 years when natural cessation of fertility can be assumed for most women. If not amenorrhoeic consider investigating any abnormal bleeding or changes in bleeding pattern and continue contraception beyond age 55 years until amenorrhoeic for 1 year.
[a] If a woman wishes to stop hormonal contraception before age 50 years she should be advised to switch to a non hormonal method and to stop once she has been amenorrhoeic for 2 years (3 years if switched from DMPA due to the potential delay in return of ovulation)		

8. Hormone Replacement Therapy (HRT) and Contraception

- HRT does NOT provide contraception. The summaries of Product Characteristics (SPC) for HRT regimens do not support their use as contraception and a separate contraceptive method must be recommended for sexually active women who are not yet postmenopausal. In a small study of sequential HRT users, ovulation was inhibited in only 40% of women with regular cycles and some women who had been anovulatory or had irregular cycles prior to HRT did subsequently ovulate on HRT. Measurement of FSH is largely unreliable whilst taking HRT.
- The Mirena IUS is effective and licensed to provide endometrial protection from the stimulatory effects of oestrogen replacement therapy for 4 years but may be used off licence for up to 5 years. When used in this way, the IUS should be changed no later than 5 years after insertion, irrespective of the age at which it was inserted. POP, implants and DMPA are not licensed for and cannot be recommended as endometrial protection with estrogen only HRT.
- All progestogen-only methods of contraception are safe to use as contraception alongside sequential HRT.
- CHC can be used in eligible women under 50 as an alternative to HRT for relief of menopausal symptoms and prevention of loss of BMD.

9. References

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