CONTRACEPTION IN PERIMENOPAUSE

Why it is important.

Combined Oral Contraceptive Pill (COCP)

The Combined Oral Contraceptive Pill (COCP), often called 'the pill', contains artificial versions of oestrogen and progesterone, which are hormones normally produced by your ovaries. The pill mainly works by inhibiting ovulation, thinning the endometrium (lining of the womb), and thickening the cervical mucus to make it harder for sperm to penetrate. When used correctly, it is a reliable method of contraception (99% effective). The COCP has other benefits, including menstrual regulation, a reduction of cyclical symptoms and reducing the risk of ovarian cancer. The protective effects of the COCP reducing ovarian cancer have been observed to increase with the duration of use and can persist for many years after stopping.

When you take the pill 'continuously' i.e., omitting the sugar pills, you can avoid a withdrawal bleed, although you may experience breakthrough bleeding. Additionally, because the pill delivers a constant amount of oestrogen and progesterone, unlike the natural cycle, it can mask perimenopausal symptoms such as hot flushes and night sweats. Women who are taking the COCP may not realise they are perimenopausal until they stop.

The COCP is considered 'safe' up until the age of natural menopause (typically around 51 years for most women), however, some guidelines suggest considering alternative methods around the age of 50 (the Royal Australian College of General Practitioners and the National Institute for Health and Care Excellence).

The use of COCP in women aged 35 or older who smoke are generally advised to stop using combined oral contraception due to significant risks of cardiovascular events, particularly venous thromboembolism (VTE), myocardial infarction, and stroke.

There are also certain contraindications to taking the COCP, such as raised blood pressure, migraines with aura, venous thromboembolism (clots), prolonged immobilisation, and poorly controlled diabetes mellitus.

Alternative Contraceptive Methods

Where oestrogen is contraindicated, the combined oral contraceptive pill cannot be used, and progesterone-only methods should be considered. The progesterone-only pill (POP) or a Long-Acting Reversible Contraceptive (LARC) such as Implanon, Depo or a progesterone-containing intrauterine system (IUS) is preferable. If the progesterone-containing IUS is being used for either contraception or to treat heavy periods, oestrogen replacement therapy can be added to manage perimenopausal symptoms, as the progesterone will protect the endometrium.

Newer progesterone-only pills function more like the combined oral contraceptive pill and inhibit ovulation, making them a more effective contraceptive option.

In addition, the copper IUD is generally well tolerated, although some patients notice that their periods become more painful and heavy. Barrier methods (e.g., condoms or diaphragm) are very suitable in the older age group as there are no contraindications to their use other than Latex allergy.

Permanent Contraception

Permanent methods of contraception include tubal ligation and removal of both fallopian tubes (bilateral salpingectomy), and vasectomy for men. These options are indicated for older women who have completed their families or women for whom hormonal contraception is contraindicated. Permanent methods of contraception are not first-line options for younger women, as the incidence of regret regarding loss of fertility is much greater in the under-35 age group. That said, it is a good option for younger women who are certain that their family is complete or that pregnancy would be detrimental to their health. Although tubal ligation is referred to as a 'permanent' method of contraception, the procedure can be reversed (tubal reanastomosis) with pregnancy rates of over 60%. A vasectomy is preferable to tubal ligation as it is more effective, quicker, safer, and cheaper, but there is a 5% risk of chronic testicular pain.

Age Related Fertility Decline and Contraceptive Needs

Fertility generally starts to decline in your 30s. This decline is more rapid over the age of 35. A woman in her early to mid-20s has a 25–30% chance of pregnancy per cycle, while at age 40, the possibility of getting pregnant in any monthly cycle is around 5%. Unintentional pregnancy is rare in women over the age of 50, but you still need to exercise caution. Women should use contraception for 2 years after their last menstrual period if they are 50 or under, and for 1 year after their last menstrual period if they are over 50.

Menopausal Hormone Therapy (MHT)

It is important to note that Menopausal Hormone Therapy (MHT) does not prevent pregnancy, as the dose of oestrogen and progesterone is too low to interfere with ovulation, unlike the COCP.

It is recommended that you see your doctor or gynaecologist to ensure the best treatment for you at this stage of your life.

ADDITIONAL INFORMATION

- **Perimenopause**