Contraceptive Counseling in the Perimenopausal Woman

Rachael R. Dirksen, MD1,2, Mitra Razzaghi, MD2,3, Amy Huebschmann, MD3

University of Colorado Denver School of Medicine, Primary Care Internal Medicine Residency Program1, Women’s Integrated Services in Health Clinic2, Division of General Internal Medicine3

Learning Objective

To recognize the importance of reviewing sexual histories and providing contraceptive counseling as part of the clinical management of perimenopausal women.

Clinical Case

A 52-year-old female with one year of irregular menses presents to clinic asking for a pregnancy test. She and her husband had unprotected intercourse three weeks ago. They do not use contraception as she believed she could not conceive given her age. Her last menstrual period was approximately three months ago. She describes symptoms similar to those that she experienced in her prior pregnancies, including bilateral breast swelling and food cravings. She confides that if she is pregnant, she would like to terminate the pregnancy.

Physical Exam: unremarkable except for a mildly enlarged uterus, which is firm & mobile.

Labs: Urine HCG Negative

After discussing contraceptive options with the patient, she elected to use barrier contraception.

Discussion

Over a third of all pregnancies are unintended in women aged 40 years and older, a higher percentage than that observed in women aged 30-39 years. One likely reason for this disparity in unintended pregnancy rates is the common misconception in perimenopausal women that they are no longer fertile once they develop irregular menses. In one study of women older than age 40 years with an unintended pregnancy, 56% terminated the pregnancy.

Graph 1: Unintended Pregnancy and Abortion Rates in 2001

Our patient had the misconception that her irregular menses would prevent her from becoming pregnant. As general internists, we need to counsel our perimenopausal patients regarding their fertility and contraceptive options. For optimal contraceptive counseling, we need to be knowledgeable of contraceptive options in women with and without medical comorbidities, as well as the benefits of various contraceptive agents for treating perimenopausal symptoms. In our clinical management of perimenopausal patients, we must address sexual histories & proactively provide appropriate contraceptive counseling in order to reduce the disparate rate of unwanted pregnancies in this population.

Contraceptive Agents: Risks & Benefits

**Combination oral contraceptive (OCP)**
- Benefits: Improves vasomotor symptoms & menorrhagia; Prevents bone loss, benign breast disease & ectopic pregnancy; Reduces ovarian & endometrial cancer
- Risks: Increases risk of venous thromboembolism (VTE) but less so than pregnancy; increases CV complications, of particular concern in smokers

**Progestin Only Oral Contraceptive (POP)**
- Benefits: Less thrombotic than estrogen containing; may increase lactation quality/duration postpartum
- Risks: Similar profile to combination OCP

**Vaginal Ring**
- Benefits: Less medication interaction because avoids first pass hepatic metabolism; Simple monthly dosing promotes adherence
- Risks: Similar profile to combination OCP

**Implanon: Implantable progestosterone rod**
- Benefits: No deleterious effects on bone health; may increase lactation quality/duration postpartum
- Risks: Increases risk of venous thromboembolism (VTE) but less so than pregnancy; increases CV complications, of particular concern in smokers

**IUD**
- Benefits: Adherence independent for both copper and Mirena; Copper-hormone free; Mirena-reduces menorrhagia, prevents endometrial hyperplasia
- Risks: Copper-menorrhagia

**Barrier: Male & Female Condom**
- Benefits: Hormone-free; protection against sexually transmitted infection
- Risks: High failure rates; adherence dependent

**Sterilization: Tubal ligation, vasectomy**
- Benefits: Effective; adherence independent
- Risks: Surgical risks; high relative cost

Contraception Counseling in the Perimenopausal Woman

Specific to perimenopausal women:
Avoid injectable medroxyprogesterone acetate given deleterious effect on bone mineral density; avoid hormonal patch given increased odds of VTE and MI as compared to OCP

Women >35 years: Individualize OCP use based on cardiovascular (CV) risk factors including obesity, hypertension, hyperlipidemia

Smokers: Avoid OCPs given increased risk of cardiovascular disease, particularly in women 35 years or older, POP may be appropriate

Hypertension: OCP may be used if blood pressure well controlled on medication, but expect ~7mmHg increase in systolic blood pressure

Diabetes: OCP do not impair metabolic control, theoretical risk spurs recommendation that OCP be avoided in diabetic women over age 35 years with diabetic complications (e.g. retinopathy)

History of VTE: avoid OCP but may use POP, acceptable to use OCP if patient therapeutically anticoagulated, particularly if treating complications of anticoagulation (e.g. menorrhagia)

History of coronary artery disease, heart failure, cerebrovascular disease: OCP contraindicated but POP may be appropriate

Recommendations

References: