Managing perimenopause: the case for OCs

Perimenopausal patients—and their physicians—often view oral contraceptives with suspicion, believing the pills too risky for older women. But, the author argues, the evidence proves just the opposite.

By PATRICIA J. SULAK, MD

A 37-year-old patient who has been taking oral contraceptives (OCs) for several years announces during her annual exam that she wishes to discontinue them. Since she is nearing perimenopause—the 2 to 8 years leading up to the cessation of menses—she is concerned about adverse effects with long-term OC use. To prevent pregnancy, she plans to undergo tubal ligation.

When you point out that she is stopping OCs just when they have the potential to be most beneficial, the patient appears quite surprised. You explain that, as women approach perimenopause—which can begin as early as the late 30s—they tend to become hyperestrogenic, with reduced luteal-phase progesterone levels. These changes can lead to menorrhagia, anemia, hyperplasia, or growth of fibroids. Because oral contraceptives suppress ovarian hormone production, they help treat and prevent these conditions.

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With the new formulations available, women can safely take OCs until menopause occurs.

Positive effects

OCs have so many beneficial effects, I often recommend them as a patient's primary preventive strategy during the perimenopausal years. I encourage women who are doing well on OCs to stay on them, and I search for reasons to initiate them in women who are having any menstrual difficulties. As indicated in Table 1, they serve as effective contraception, help stabilize the menstrual cycle, protect against ovarian and endometrial cancers, ease vasomotor symptoms, and prevent bone loss.[1-3]

If a woman continues taking OCs until menopause, she need not resort to sterilization for birth control, as many perimenopausal women do. Further, since OCs do not increase the growth of fibroids, they can be used even by women with this pathology.[3-5]

With OCs, women's premenstrual symptoms generally ease.[1] Because they inhibit ovulation, the pills also reduce the incidence of functional ovarian cysts and ovarian cancer, as well as the rate of endometrial cancer and menstrual-related pelvic pain.[6-11] Indeed, with perimenopausal OC use, the need for further diagnostic and therapeutic interventions is greatly diminished, since the pills are so effective in preventing and treating a range of gynecologic problems involving the endometrium,

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Oral contraceptives and perimenopause: frequently asked questions

Q What is perimenopause and when does it start?

A Perimenopause is the 2- to 8-year interval before menstruation ceases completely. It usually begins around the age of 45, but may start as early as a woman's late 30s or as late as the age of 50.

In perimenopause, the length of the menstrual cycle begins to fluctuate, as does the production of estrogen by the ovaries. Hot flushes, night sweats, and other "vasomotor symptoms" often result. Many perimenopausal women go through a "hyperestrogen" phase that can lead to heavy periods and growth of fibroids.

Q My periods are already so infrequent, why should I worry about birth control?

A In some ways, perimenopausal women face a greater risk of unintended pregnancy than their younger counterparts, since menstrual cycles tend to become more erratic as menopause approaches, making it difficult to determine when ovulation occurs.

But the pill offers other benefits besides birth control. For example, it stabilizes the menstrual cycle and protects against ovarian and endometrial malignancies. It eases vasomotor symptoms and helps prevent bone loss, reducing a woman's risk of bone fractures after menopause. There is even evidence that it helps protect against arthritis and colorectal cancer.

Q Who should NOT take birth control pills?

A Women who are pregnant or seeking to become pregnant should not take oral contraceptives (OCs). Nor are estrogen-containing OCs recommended for breastfeeding women. In addition, they should be avoided by women with a history of heart attack, thromboembolism, stroke, breast cancer, or serious liver disease. Women over 35 who smoke or have other risk factors for cardiovascular disease, e.g., hypertension and/or morbid obesity, also should avoid OCs.

Q What if I have uterine fibroids? Are oral contraceptives safe?

A Yes, the pill is considered safe even in the presence of fibroids. However, your doctor should be advised of your condition at the time OCs are prescribed.

Q Don't OCs increase the risk of breast cancer?

A Although some recent research suggests a slightly elevated risk of breast cancer with the use of OCs, that increase may reflect the more intensive monitoring for cancer among women who are studied, or an increase in the diagnosis of local tumors (as opposed to systemic disease). Other research has found a decrease in the rate of metastatic breast disease with OC use. Further, the pill appears to reduce the incidence of fibrocystic breast masses and fibroadenomas.

Q What about side effects?

A Fortunately, the new OCs contain lower doses of estrogen, making major side effects less likely to occur. While a woman may experience any of a number of "nuisance" effects, these usually resolve on their own within 1 to 3 months of use. They include nausea, headache, breast tenderness, bloating, mood swings, and breakthrough bleeding. If these side effects persist, they often occur during the hormone-free interval and can be reduced or eliminated by increasing the active pill interval and decreasing the number of days off. Discuss this option with your health-care provider.

Q Don't OCs cause women to gain weight?

A The newer formulations do not appear to. A recent study found no difference in weight gain between women on the pill and those taking placebo.

Q Isn't it dangerous to take the pill for more than a couple of years?

A Not among healthy nonsmokers. In fact, some benefits such as prevention of bone loss and ovarian cancer occur with long-term use.

Q How will I know when I reach menopause if I'm taking the pill?

A With the new formulations available, women can safely take OCs until menopause occurs—usually around the ages of 52 to 55. One way to determine whether you have reached menopause is to have your levels of follicle-stimulating hormone (FSH) measured. If they exceed a certain level, menopause is likely to have occurred. Ask your doctor about this and other ways of assessing menopausal status.

myometrium, and ovary, including abnormal uterine bleeding and ectopic pregnancy.

In the breast, OCs reduce the incidence of fibrocystic lesions and fibroadenomas.[12] In bone, they increase bone mineral density (BMD) and lower the hip-fracture rate during menopause in women who use them after the age of 40.[13-19] There also is evidence that OC users have a lower incidence of arthritis and a diminished risk of colorectal cancer.[20-25]

Contraindications and other barriers to use

Contraindications to OC use—for women of all ages—include a history of myocardial infarction (MI), thromboembolism, stroke, breast cancer, or serious liver disease. Women over 35 who have risk factors for cardiovascular disease also should be discouraged from taking the pills. When in doubt, limit OC use among perimenopausal women to healthy nonsmokers.

There are a number of reasons perimenopausal women elect not to use OCs, and they need to be considered when counseling patients. For example, in some cases, cost may be an issue, while side effects discourage many other women. Fortunately, the low-dose formulations available today carry fewer side effects than in years past. They also may be administered in a number of different ways to further reduce the likelihood of adverse effects. For example, my colleagues and I found that some effects, e.g., headache, pelvic pain, breast tenderness, and bloating, occur more frequently during the 7 days when no pills are taken than during the 21 days when they are.[26] Many Ob/Gyns now extend the "active" phase of OC regimens while reducing the pill-free interval. In fact, a formulation is now available that includes only 2 pill-free days (Mircette; *Organon, Inc, West Orange, NJ*), and an OC with 12 weeks of active pills is currently under investigation (Seasonale; *Barr Labs, Pomona, NY*).

This strategy may be advisable for all perimenopausal women who take OCs, which can be extended for 12 active weeks or longer, if necessary. (In one investigation, older women preferred menstruating every 3 months to never.[27]) In this regard, triphasic pills have no advantages over monophasic formulations. If a patient taking a triphasic OC wants to try continuous dosing, I gener-

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TABLE 1

Beneficial effects of perimenopausal OC use

Contraceptive issues
- Reduction in unintended pregnancies
- Reduction in abortion rate
- Reduction in ectopic pregnancies
- Reduced need for sterilization

Benign gynecologic disorders
- Reduction in irregular menses secondary to erratic ovulation
- Lengthening of cycles with a shortened follicular phase
- Reduction in menstrual blood loss and associated anemia
- Reduction in ovarian cysts
- Reduction in premenstrual symptomatology
- Possible reduction in fibroid growth and endometriosis

Estrogen deficiency symptoms/sequelae
- Easing of vasomotor symptoms
- Prevention of bone loss
- Prevention of rheumatoid arthritis

Effects on the breast
- Reduction in fibrocystic masses
- Reduction in fibroadenomas

Cancer prevention
- Reduction in ovarian cancer
- Reduction in endometrial cancer
- Possible reduction in colorectal cancer

Diagnostic/therapeutic procedures
- Decreased need for endometrial biopsy, curettage, hysteroscopy, sonography, ablation, and hysterectomy for menstrual bleeding disorders
- Reduced need for diagnostic laparoscopy and hysterectomy for pelvic pain
- Reduced need for gynecologic oncology procedures secondary to malignancies

ally switch her to a monophasic equivalent. If breakthrough bleeding occurs on a 20-mcg OC, I prescribe a 30-mcg formulation. Hopefully, further research will elucidate the best way of extending OC dosing.

It is important to advise new OC users that, while they are likely to experience at least 1 side effect, most ease spontaneously within 1 to 3 cycles. It also is important to probe for any unsubstantiated fears the patient may have about OC use (see sidebar on page 55), as misconceptions are common.

Dispelling myths

Like their patients, some health-care providers have unfounded concerns about the use of OCs in women over 40. But the evidence indicates that complications are highly unlikely in healthy nonsmokers and that the benefits far outweigh the risks.[1,13,28] OCs do increase the risk of venous thrombosis from a baseline risk of less than 1 per 10,000 person-years in nonusers to 3 to 4 per 10,000 person-years in OC users.[29,30] Rarely are these venous thrombolic events fatal, however. In addition, the World Health Organization (WHO) recently found that nonsmoking, normotensive, nondiabetic women of any age who use OCs face no

Key points

- Among the many benefits oral contraceptives (OCs) offer perimenopausal women are effective contraception, a stable menstrual cycle, protection against ovarian and endometrial cancers, an easing of vasomotor symptoms, and prevention of bone loss.
- The World Health Organization (WHO) recently found that nonsmoking, normotensive, nondiabetic women who use OCs—at any age—face no increased risk of myocardial infarction compared with nonusers.
- OCs increase the risk of venous thrombosis from a baseline risk of less than 1 per 10,000 person-years in nonusers to 3 to 4 per 10,000 person-years in oral contraceptive users.
- If a perimenopausal patient is doing well on OCs, it is generally safe for her to continue taking them until the age of 55, by which time menopause has usually occurred.

Five myths about OC use

Misconceptions among women about oral contraceptive (OC) use persist, many of them associated with older formulations that contain higher doses of estrogen. The top 5 myths include:

- **The pill causes cancer.** Many women believe OCs can cause cancer when, in fact, they lower the risk of endometrial and ovarian cancer. Although some recent research suggests a slightly elevated risk of breast cancer with the use of OCs, that increase may reflect the more intensive monitoring for cancer among women who are studied, or an increase in the diagnosis of local tumors (as opposed to systemic disease). Other research has found a decrease in the rate of metastatic breast disease with OC use.[1,2]
- **I'll gain weight.** Another fear is significant weight gain. However, a recent analysis found similar weight gains among OC users and controls.[3] In fact, in the initial 6 to 9 months of use, a new 30-mcg ethinyl estradiol formulation that contains drospirenone was found to be associated with weight loss—rather than a gain.[4,5]
- **The pill is dangerous.** As long as the patient is a healthy nonsmoker, the benefits of OC use greatly outnumber the risks.
- **I'm too old to be on the pill.** Many patients think of the pill primarily as an option for younger women, i.e., those in their teens and 20s. However, OC use often is of greatest benefit to perimenopausal women, as it stabilizes the menstrual cycle and helps prevent a range of pathologies.
- **I've been on the pill too long.** Patients may be reluctant to take the pill for more than a few years, believing it increases their risk of cancer and other ills. However, as mentioned above, OCs actually reduce the incidence of endometrial and ovarian cancer. Other long-term benefits include enhanced bone density and fewer fibrocystic changes in the breast.

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increased risk of MI compared with nonusers.[30] In another study, the risk of MI increased among women using second-generation OCs (those containing levonorgestrel) but not third-generation formulations (those containing desogestrel).[31] Although the relative risk of ischemic or hemorrhagic stroke does not appear to rise in healthy nonsmoking OC users, it does increase in women who smoke, are hypertensive, or have a history of migraine headaches.[30,32-34]

Patients also may need to be reassured that long-term use is safe. As mentioned earlier, some of the benefits of long-term use are a reduction in the incidence of ovarian and endometrial cancers, stable or enhanced bone density, and a lower occurrence of menstrual disorders. By emphasizing these benefits, the health-care provider may improve compliance.

OCs to HRT

Women reach menopause at an average age of almost 52. However, if all patients

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Counseling patients about OC use

When any woman begins taking oral contraceptives (OCs), she should be counseled carefully. This is especially true for perimenopausal patients, since the public remains relatively unaware of the many benefits OCs offer this age group. When counseling patients, I typically do the following:

Rule out contraindications. Women with a history of myocardial infarction (MI), thromboembolism, stroke, breast cancer, or serious liver disease should not take OCs. Perimenopausal women with risk factors for cardiovascular disease, e.g., smoking, hypertension, diabetes, or morbid obesity, should be discouraged from taking OCs.

Emphasize noncontraceptive benefits. Not surprisingly, many women associate birth control pills with just that: birth control. But OCs offer other advantages as well, including fewer menstrual irregularities, a lower incidence of ovarian and endometrial cancer, and the protection and possible enhancement of bone density. These should be highlighted.

Dispel the myths. Explaining the reality behind the many misconceptions associated with OC use helps allay a patient's unsubstantiated fears and encourages her to try the regimen.

Detail side effects. The patient needs to be advised that "nuisance" side effects are common, occurring to some degree in almost all women during the first 1 to 3 months of OC use. These include nausea, headache, breakthrough bleeding, breast tenderness, bloating, and mood swings. I describe potential side effects clearly, since women generally are more tolerant of them when they aren't taken by surprise. I also reassure patients that any adverse effects often resolve spontaneously within the first 3 cycles.

Review rare complications. Although uncommon, venous thrombosis is increased in OC users and should be discussed with perimenopausal patients initiating OCs.

Encourage strict compliance. I ask patients to commit to a 3-month trial of therapy, as this tends to enhance compliance. If a woman is just starting OCs—or has not taken them for many years—I also review the packaging and instructions.

Discuss alternative regimens. I make it a point to inform my patients that deviations from the standard 21/7-day regimen may be beneficial to decrease hormone withdrawal symptoms and monthly menstruation.

Schedule the next visit. I encourage new OC users to schedule follow-up appointments after they finish the second cycle of pills or have begun the third. At that time, I ask about side effects and alter the regimen accordingly if they are occurring primarily during the 7-day hormone-free interval.

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were to stop taking OCs by the age of 52, half of them would still experience menses.[35] As long as the patient has remained a healthy nonsmoker and is doing well on OCs, it is safe for her to continue until the age of 55. Most women will have become menopausal by then, at which time hormone replacement therapy (HRT) can be initiated. If the patient continues to menstruate after discontinuing OCs at age 55, she can reinitiate them for an additional year. Another option is to measure follicle-stimulating hormone (FSH) levels at the end of the patient's last pill-free interval.[36-38] Levels exceeding 20 mIU/mL suggest—but do not confirm—that menopause has occurred.

Conclusion

As ovarian function becomes increasingly erratic during the perimenopausal years, a number of gynecologic disorders may occur that have both a physical and an emotional impact. These include menorrhagia or other abnormal uterine bleeding, fibroid growth,

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ovarian cysts, sleep disruption, depression, and vasomotor symptoms. For this reason, I recommend OC therapy for healthy nonsmokers as they enter this transition and look for any disorder that may be alleviated by oral contraceptives.

Before initiating OC therapy, it is important to ascertain what misconceptions—if any—the patient has about their use and to counsel her about their likely side effects. Scheduling a follow-up visit at the end of the second cycle of pills is a good way of ensuring compliance and tailoring the therapy to the patient's needs. Among the ways OC regimens can be adjusted is by extending the number of days that pills are taken—while reducing the pill-free interval to less than 7 days—to diminish side effects. ■

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