Contraception Issues Complex in Perimenopause

With many birth-control options available, women older than 40 tend to prefer long-term methods.

BY MELINDA TANZOLA
Contributing Writer

ATLANTA — Women in perimenopause have unique issues that should be considered when developing a contraceptive plan, Dr. Miriam Zieman said at a conference on contraceptive technology that was sponsored by Contemporary Forums.

Older women are generally less fertile and thus their bodies may be more forgiving in terms of contraceptive efficacy. However, perimenopausal women often still ovulate for several years and thus the potential for pregnancy exists. In fact, the abortion ratio (number of abortions per 1000 live births) is high in women over 40.

To more easily gauge progress through perimenopause, women should keep a menstrual diary of any bleeding or spotting that occurs. "Taking an accurate menstrual history is so important to our diagnosis during these ages," said Dr. Zieman of Emory University, Atlanta.

Comorbidities, including hypertension, heart disease, and obesity, are more common in older women. These conditions can affect the choice of contraception, because the risks associated with contraception generally increase with age. In general, though, "combination contraceptives can be safely used by lean, healthy, nonsmoking women until menopause," Dr. Zieman said.

Because women older than 40 are often finished with childbearing, they tend to prefer long-term contraceptive methods. Indeed, data from the Centers for Disease Control and Prevention show that tubal sterilization is the most common contraceptive method in women aged 35-39 and 40-44.

Dr. Zieman suggested that intrauterine devices should be considered more frequently, as they are reversible, less risky than sterilization, and safe for most women. IUDs can also be used in a broader range of women, including those with contraindications to estrogen-containing hormonal contraception. Women with venous thromboembolism, arterial vascular disease, and acute liver disease; women who smoke; and those with migraine are all candidates for the copper IUD, and most can use the levonorgestrel system. For specific information, see the World Health Organization medical eligibility criteria at http://www.who.int/reproductive-health/publications/mec/iuds.html.

For women without contraindications, combination oral contraceptives may be a good option, as they provide noncontraceptive benefits, such as improving menorrhagia, reducing vasomotor symptoms, and reducing the risk of endometrial and ovarian cancers.

Progesterone-only pills may be more appropriate choices for women with estrogen-contraindicating comorbidities such as hypertension.

Depot medroxyprogesterone acetate (DMPA) would be another good progestin-only option for perimenopausal women not planning to have more children. Women with hypertension can use DMPA as long as their blood pressure is controlled below 160/100, according to the World Health Organization guidelines.

When using methods that interfere with menstruation, the decision of when to stop contraception because of suspected menopause is arbitrary.

Follicle-stimulating hormone testing is not a reliable indicator of potential fertility in women older than 45 years. Moreover, in women using oral contraception, FSH testing cannot sensitively predict menopause on day 7 of the pill-free interval.

Dr. Zieman suggested that a woman may consider discontinuing oral contraceptives at age 50, while continuing to protect herself from pregnancy, in order to evaluate her menstrual status. Alternatively, she may want to continue them until age 55, at which point she has likely entered menopause.

The safety of continuing oral contraception through that age is not fully understood, and decisions should be made on an individual basis, taking into account how the woman feels about continuing with pills, she said.

Dr. Zieman has received honoraria from or consulted for Ortho, Barr, Berlex, Organon, and Wyeth. ■

Depression May Be Linked to Perimenopause in Some Women

BY JOHN R. BELL
Associate Editor

NASHVILLE, TENN. — Perimenopause does induce depression in a subgroup of women, as illustrated by results of several recent studies and by early findings from his own investigation, Dr. Peter J. Schmidt said at the annual meeting of the North American Menopause Society.

He and his colleagues conducted an observational study of 29 asymptomatic premenopausal women with regular menses and followed them with reproductive and behavioral measures for a mean of 5 years until they had gone through menopause.

Episodes of depression occurred sporadically, he reported, until the year before the last menstrual period, when the investigators observed four episodes of depression, followed by five episodes in the year after the last menstrual period. Overall, there were nine depressive episodes in eight women. Only two of the women had a prior history of depression, he noted.

"Overall, then, within the 24 months surrounding the last menstrual period, we identified approximately a 14-fold increased risk for an episode of depression to occur," said Dr. Schmidt, chief of behavioral endocrinology at the National Institutes of Health, Bethesda, Md.

He noted that these happened late in the menopausal transition—a period marked by estrogen withdrawal and hypogonadism.

Despite assertions by some studies in the literature that the onset of menopause is not directly associated with mood disorders in women, considerable laboratory evidence bears out the relationship between estrogen and depression, Dr. Schmidt said.

Anxious phenotype has been implicated in studies of estrogen-receptor–knockout mice, and compounds that selectively modulate the estrogen receptor β have been identified as anxiolytic and reduce stress response to a novel environment.

Depression frequently precedes a comorbid condition by several years, suggesting it is causative or that the two share a similar pathophysiology.

Dr. Schmidt emphasized that depression has measurable physiologic consequences for women and noted as an example that one observational study from the Women's Health Initiative found that in women who had no history of cardiovascular problems, depressive symptoms were linked to an increased risk of cardiac death over 5 years' follow-up (Arch. Intern. Med. 2004;164:289-98).

Other negative outcomes linked to depression are stroke, metabolic syndrome, and dementia. He cited recent community-based epidemiologic studies that followed women with no prior history of depression and found that onset of menopause was associated with a 2-2.5–fold risk of depression.

He noted that several studies have found that depression frequently precedes a comorbid condition by several years, "suggesting in fact that depression is causing the medical condition or that the two conditions share a similar pathophysiology." ■

Use of Fertility Drugs Called Safe After Ovarian Tumor Treatment

SANTA MONICA, CALIF. — Fertility drugs can be used safely in patients who experience infertility after conservative management of early-stage borderline ovarian tumors, according to a poster presentation by Dr. Anne Fortin at the biennial meeting of the International Gynecologic Cancer Society.

The use of fertility drugs is theoretically contraindicated in patients treated for ovarian malignancies, but only 4 of 30 patients (13%) developed a recurrence after fertility treatment.

Generally the recurrence rate is 15% for stage I borderline ovarian tumors and 20% for stage II-IV tumors, according to published sources (www.emedicine.com/med/topic3233.htm).

Thirteen of the patients (43%) became pregnant. Among those were one miscarriage, one premature delivery at 20 weeks of amenorrhea, and 11 normal pregnancies, including one set of twins and one set of triplets.

In the multicenter, retrospective study, the investigators, from Universitaire Bichat, Paris, and Institut Gustav Roussy, Villejuif, France, identified 30 women from 27 centers who had conservative surgery for borderline ovarian tumors that was aimed at preserving subsequent fertility.

To be included in the study, patients had either simple ovarian stimulation with clomiphene citrate or in vitro fertilization with hyperstimulation.

Eight of the patients underwent cystectomy, 17 underwent oophorectomy or salpingo-oophorectomy, and 5 underwent salpingo-oophorectomy and contralateral cystectomy. After histology it was found that 23 of the patients had a serous tumor and 7 had a mucinous tumor or a mixed tumor. Twenty of the patients had stage I disease, four had stage II disease, four had stage III disease, and two patients were not staged.

Twenty-five of the patients were treated for infertility; the other five were stimulated at relapse and were referred to as "emergency cases." Of the patients with infertility, the median period of infertility before treatment was 20 months.

Three of the five patients requiring emergency treatment and 10 of the 25 patients treated for infertility became pregnant.

The median follow-up after conservative treatment of the ovarian tumor was 93 months, and the median follow-up after infertility treatment was 42 months.

Of the four patients with recurrences, two were disease free for 12 months, one for 40 months, and one for 84 months.

The authors concluded that fertility drugs may be safely used in patients who were infertile after conservative management of an early-stage borderline ovarian tumor that has been carefully followed up. They wrote that the number of patients with advanced-stage disease was too small to draw conclusions regarding the effect of fertility drugs.

—Robert Finn