



# Contraception for women over 40

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- ▶ 'Contraception for Women Aged Over 40 Years' Guideline and Summary of Recommendations

- ▶ UKMEC and UKMEC Summary Table



## Key Points

- ▶ Up to age 50, no contraceptive method is contraindicated by age alone
- ▶ Contraception is generally not required after age 55
- ▶ Importance of contraception in the prerimenopause
- ▶ Many non-contraceptive benefits of using contraception
- ▶ HRT should not be used as contraception
- ▶ Progestogen only contraceptives can be used alongside HRT

## Considerations for women over 40....

- ▶ Women >40 have different background risks than younger women
  - ▶ increased background risk of VTE, CVD, breast cancer and most gynae cancers
  - ▶ this may affect choice of contraception.
- ▶ Women in the perimenopause often experience symptoms relating to fluctuating hormone levels
  - ▶ e.g. hot flushes, night sweats, mood changes, irregular/heavy menstrual cycles
- ▶ Contraception does not affect the onset or duration of menopausal symptoms but may mask the signs and symptoms of menopause

## Contraceptive Options

- ▶ IUS
- ▶ IUD
- ▶ Implant
- ▶ POP
- ▶ Depo
- ▶ CHC
- ▶ Sterilisation

All options are possible but some may be more suitable than others ...

## What does the UKMEC say about age?

**Table 3: UK Medical Eligibility Criteria for Contraceptive Use (UKMEC) summary table for hormonal and intrauterine contraception methods<sup>79</sup>**

Condition	Cu-IUD	LNG-IUS	IMP	DMPA	POP	CHC
Age (years)	Menarche to <20 = 2 ≥20 = 1	Menarche to <20 = 2 ≥20 = 1	After menarche = 1	Menarche to <18 = 2 18–45 = 1 >45 = 2	After menarche = 1	Menarche to <40 = 1 ≥40 = 2

CHC, combined hormonal contraception; Cu-IUD, copper intrauterine device; DMPA, depot medroxyprogesterone acetate; IMP, progestogen-only implant; LNG-IUS, levonorgestrel intrauterine system; POP, progestogen-only pill.

**Note- stop CHC at age 50**



## IUS

- ▶ 52mg LNG-IUS (Mirena/Levosert) offers very significant non-contraceptive benefits
- ▶ Very effective in reducing menstrual blood loss
- ▶ Reduces menstrual pain and pain associated with endometriosis
- ▶ 1<sup>st</sup> line treatment for HMB in the NICE HMB guideline
- ▶ There is limited evidence that the LNG-IUS protects against endometrial cancer
- ▶ The evidence is conflicting regarding the potential link between LNG-IUS use and breast cancer risk.



## Extended use of 52mg IUS

### ▶ **Contraception**

- ▶ if  $\geq 45$  at time of insertion of a 52mg LNG-IUS (Mirena or Levosert) it can be retained until 55 for contraception (even if not amenorrhoeic)

### ▶ **Endometrial protection as part of HRT**

- ▶ Mirena licensed for 4 years. FSRH supports 5 years.

### ▶ **Management of HMB**

- ▶ A 52mg LNG-IUS (Mirena or Levosert) can remain in-situ for as long as it controls symptoms (regardless of age at insertion.)

## A note of caution



- ▶ Mirena **must** be changed after 5 years if used for endometrial protection/HRT
- ▶ Jaydess/Kyleena/Levosert are **not** licensed for endometrial protection

## Case Study

- ▶ Erica aged 52 years
  - ▶ Mirena IUS inserted at age 48 for HMB and contraception
  - ▶ Amenorrhoeic
- 
- ▶ Does she still need contraception?
    - ▶ Yes- without knowing if Erica is now menopausal (past the stage of her final natural period) -she needs to continue contraception
  - ▶ When does the IUS need changed?
    - ▶ It was inserted after the age of 45, so Erica can continue using this Mirena for contraception and HMB until the age of 55
  - ▶ What if she tells you that she is now using the Mirena as part of HRT?
    - ▶ The Mirena would need changed after 5 years- when she is 53

## Copper IUD



- ▶ Can be used until aged 55
- ▶ When inserted at age 40 or over, a copper IUD can remain insitu until the menopause or age 55 (5 and 10 years devices)
- ▶ Associated with heavier, more painful or prolonged bleeding
- ▶ Offers no additional non-contraceptive benefits

## Implant



- ▶ Can be used until aged 55
- ▶ No significant increase in risk of venous or arterial thromboembolic events or breast cancer
  - ▶ ..... However evidence is limited
- ▶ Irregular unpredictable bleeding is common
- ▶ The available evidence is too limited to confirm or exclude an associated reduction in bone mineral density. No additional monitoring of bone density required

## POP



- ▶ Can be used until aged 55
- ▶ DRSP POP is likely to be available in the UK from 2022 and may have different contraindications and upper age limit
- ▶ There are no associated increased risks of VTE, stroke or MI
- ▶ The limited available evidence suggests no association between POP and reduction in BMD.
- ▶ The available evidence does not support an association between breast cancer and POP use
- ▶ Possible irregular bleeding pattern

## Depo/Sayana



- ▶ Depo/Sayana can be used until aged 50, then consider alternative methods
- ▶ Discussion of other methods should start when users are in their 40's.
- ▶ Majority of users become amenorrhoeic over time
- ▶ Caution with users with CVD risk
- ▶ Review regularly to assess benefits and risk of use



## Depo/Sayana

Bone health:

- ▶ Small loss in bone mineral density
- ▶ Usually recovers after discontinuation
- ▶ BMD does not appear to reduce further when a recent Depo/Sayana user becomes menopausal
- ▶ Does not appear to be associated with increased fracture risk
- ▶ Consider other risk factors for decreased BMD
- ▶ Review every 2 years to reassess risk/benefit ratio

## CHC



- ▶ Same contraindications as for someone aged <40
- ▶ Can continue until aged 50 (if no contraindications)
- ▶ However.....
  - ▶ Background VTE risk >40 increases significantly
  - ▶ Prescribing CHC to someone >40 is very different to someone in their 20's
  - ▶ There are safer options available

## CHC- risks

- ▶ Increased risk of VTE
- ▶ Potential increased risk of stroke and MI
- ▶ Some evidence of increased risk of breast cancer among COC users, but no increased risk by 10 years after stopping
  
- ▶ Consider carefully the risk factors for CVD and VTE
  - ▶ obesity, smoking, hypertension, diabetes, hyperlipidaemia

## CHC -consider....

- ▶ COC containing levonorgestrel or norethisterone should be considered 1<sup>st</sup> line preparations for women >40.
  - ▶ Potentially lower VTE risk compared to other formulations containing other progestogens
- ▶ Consider COC with lower oestrogen content
  - ▶ potentially lower risk of VTE, CVD and stroke
- ▶ Users aged 50 and over should be advised to stop taking CHC and safer alternatives discussed

## CHC- benefits

- ▶ Can reduce menstrual pain and bleeding and give cycle control
- ▶ Can reduce menopausal symptoms (can use extended/continuous regimen)
- ▶ COC is associated with a very significantly reduced risk of ovarian and endometrial cancer that lasts for several decades after stopping
- ▶ CHC can be used by eligible people <50 as an alternative to HRT for relief of menopausal symptoms and prevention of BMD loss

## Sterilisation

- ▶ Sterilisation does not alter or eliminate periods
- ▶ No added benefits that users of hormonal contraception often have
- ▶ LARC methods are as effective
- ▶ If stopping a hormonal method at time of sterilisation-bleeding pattern might change/become problematic after procedure

# Stopping contraception

- ▶ Contraception can be stopped when we know that someone is past their final ovulation
- ▶ Everyone can stop contraception at age 55

In general women can stop contraception at the age of 55 as spontaneous conception at this age is very rare, even in women still having periods



# Stopping contraception

## **Under age 55:-**

- ▶ Menopausal symptoms do not confirm loss of fertility
- ▶ Gonadotrophin levels fluctuate widely
- ▶ Could continue contraception to age 55
- ▶ But some people want to stop contraception before that, so....

## Stopping **non-hormonal** contraception

If using a non-hormonal method:-

- ▶ If last natural period was after aged 50, continue contraception for 1 year
- ▶ If last natural period was before age 50, continue contraception for 2 years (*be cautious with this*)

## Stopping **non-hormonal** contraception

- ▶ Aged **over 50**, can stop non-hormonal contraception after 1 year of amenorrhoea
  
- ▶ Aged **under 50** and amenorrhoeic on non-hormonal contraception:-
  - ▶ Consider other causes of amenorrhoea
  - ▶ FSH >30 indicates perimenopause
  - ▶ Can't exclude future ovulation
  - ▶ Continue contraception to age 50, then as above

## Stopping **hormonal** contraception

- ▶ Can't use amenorrhoea as indicator of menopause
- ▶ Think about checking FSH level
- ▶ CHC suppresses FSH
- ▶ Elevated FSH on progestogen-only contraception indicates perimenopause
- ▶ Aged 50 to 54, if FSH >30 on POC, continue contraception for one year, then stop

## Stopping **hormonal** contraception: age 45-50

- ▶ FSH on CHC is not useful
- ▶ Aged 45 to 50 and wanting to stop PO contraception because they think they are menopausal:-
  - ▶ FSH >30 indicates perimenopause  
(FSH <30 does not exclude perimenopause)
  - ▶ Can't exclude future ovulation
  - ▶ Continue contraception to age 50, then as previous advice
  - ▶ Can also use HRT alongside PO contraception

## Stopping contraception before age 45

Aged <45 years with menopausal symptoms

- ▶ Consider other causes of symptoms
- ▶ Check FSH
- ▶ If FSH >30, continue contraception
- ▶ Consider HRT

- ▶ Most women do not require measurement of hormone levels to diagnose menopause
- ▶ More helpful to focus on symptoms and needs rather than FSH levels unless there are concerns about premature menopause.

## Using FSH to guide stopping contraception

- ▶ As a general guide, an FSH level  $>30$  IU/L indicates a degree of ovarian insufficiency, *but not necessarily sterility*
- ▶ During perimenopause, isolated estradiol, FSH and LH levels can be misleading and should not be used as a basis for stopping contraception- ovulation may still occur
- ▶ Usually more appropriate to continue contraception (often with non-contraceptive benefits) and treat any menopausal symptoms
- ▶ Restrict measurement of serum FSH for advice about stopping contraception to women over 50 using POC who are amenorrhoeic.

## Can HRT be used alongside or in place of contraception?

- ▶ Sequential HRT is not contraceptive
- ▶ Continuous combined HRT should not be relied upon for contraception....**certainly in younger users**
- ▶ Currently POP, implant and depo are not licensed for (and cannot be recommended for) endometrial protection as part of HRT
- ▶ Mirena 52mg IUS offers an excellent and highly convenient option for both contraception and endometrial protection **as part of an HRT regimen**
- ▶ It is accepted practice to use progestogen only contraceptives alongside HRT



# Can HRT be used alongside or in place of contraception?

**Table 9: Contraceptive options in conjunction with hormone replacement therapy (HRT)**

Contraceptive method	Safety with HRT	Role in HRT	
		Women aged <50	Women aged ≥50
<b>Mirena 52 mg Levonorgestrel intrauterine system (LNG-IUS)</b>	Safe to use as contraception alongside estrogen of choice.	Mirena is licensed for endometrial protection when combined with estrogen. It is currently the only LNG-IUS approved for this purpose.  It may be used up to 5 years for endometrial protection and needs to be replaced regularly when used for this purpose, regardless of age at insertion.	
<b>Progestogen-only injectable (DMPA)</b>	Safe to use as contraception alongside sequential HRT but consider change to lower-dose progestogen-only method.	Highly likely to be effective for endometrial protection with estrogen as part of HRT but cannot be recommended as unlicensed for this indication.	
<b>Progestogen-only implant (IMP)</b>	Safe to use as contraception alongside sequential HRT.	Cannot be recommended at the present time for endometrial protection as part of HRT as no evidence to support efficacy.	
<b>Progestogen-only pill (POP)</b>	Safe to use as contraception alongside sequential HRT.	Cannot be recommended at the present time for endometrial protection as part of HRT as no evidence to support efficacy.	
<b>Combined hormonal contraception (CHC)</b>	Do not use in combination with HRT.	Can be used in eligible women <50 as an alternative to HRT.	Women should be advised to switch to a progestogen-only method of contraception at age 50; see above for alternative options as they relate to HRT.



Thank You