Perimenopausal contraception and sexual Health

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Definition of Sexual Health

World Health Organization

….." **a state of physical, emotional, mental and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity**.

Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as **the possibility of having pleasurable and safe sexual experiences**, free of coercion, discrimination and violence.

For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled."

WHO, 2006

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What should we consider?

- Fertility
- Contraception
- Sexually transmitted infection
- Sexual function
- Sexual desire
- Psychosexual issues

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Fertility

Starts to decline from mid 30s

- **Eggs**: Quality down. Numbers have reduced
- **Ovulation**: Ovulatory cycles less frequent
- **Frequency of coitus**: tends to decline with age. (unless in new relationship)
- **Age** Success rates for assisted conception falls if greater than age 35

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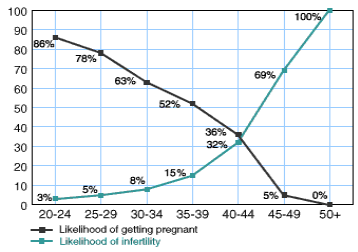
Fertility changes with age



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Changing Social Patterns theGuardian Wednesday 13th July 2016

Fertility rate higher among over-40s than under-20s for first time since 1947

Rate has more than trebled in over-40s since 1981 and average age of women giving birth is now 30.3, ONS figures show

The ONS statistician Elizabeth McLaren said: "The trend for women to have babies at older ages continued in 2015.

Over the last 40 years, the percentage of live births to women aged 35 and over has increased considerably. Women aged 40 and over now have a higher fertility rate than women aged under 20. This was last recorded in the 1940s."

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Changing social patterns

- 6% of UK births are to women over 40yr – this is increasing
- Fertility service mandatory after NICE CG11 (2004)
  - NHS provision varies, postcode lottery
  - 10% chance of success will exclude all >40
- Ethical considerations limit private service in UK: some will go abroad

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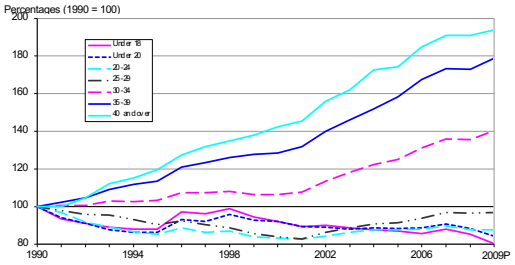
Change in conception rates/1000 women aged 40+

SOURCE: OFFICE FOR NATIONAL STATISTICS



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Risks of pregnancy to women in their 40s

Many have trouble-free pregnancies

- Need more vigilant antenatal care
- Increased risk of chromosomal abnormalities
- Increase in gestational diabetes and pregnancy-induced hypertension
- Fourfold increase in maternal mortality rates
- Doubling of perinatal mortality rates
- Increase in LSCS and PPH
- Spontaneous abortion rates doubled

Over 40% in UK will end in TOP

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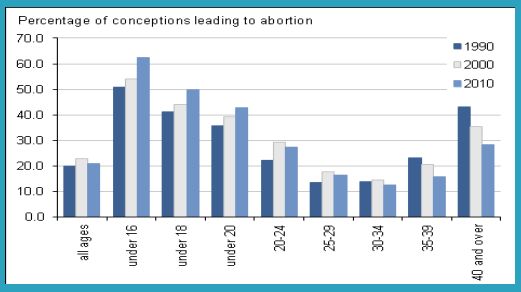
Conceptions: percentage leading to legal abortion by age of woman at conception, 2010

England and Wales

Source: Office for National Statistics 2010



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Contraceptive Choices

- **Often think 'they are too old' to get pregnant**
- **Frequently seek advice following a 'scare'**
- **Contraception is often a negative choice – the 'least worst' option, and not used correctly**
- **Older women may have preconceived ideas about certain methods**
- **Frequently unaware of the advances in contraceptive technology**
- **All methods are increasingly effective with age**
- **Contraceptive counselling and safe sex advice is just as important for the older woman as for the young adolescent**

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Contraception for Women Aged over 40 years

- Women over 40 have distinct set of needs with regard to contraception.
- Consideration of the onset of peri menopausal symptoms.
- Possible increased background risks for heart disease, obesity ,venous thrombosis.
- Women may be using treatments medical or complimentary for peri menopausal symptoms.
- All methods potentially available
- Risky women need to be identified and carefully counselled.

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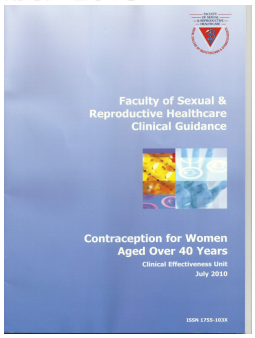
Guidance document up dated version November 2019



www.fsrh.org.uk

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Combined hormonal contraceptive

Suitable for low risk women

Consider risk factors for VTE, regular assessment BMI .VTE risks highest on initiation try to avoid stopping and starting.

women with no risk factors up to age 50 UKMEC category 2

COC for women over 40 first choice should be preparation with >30mcg ethinylestradiol

Reversible

Good contraception.

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FSHR Guidance document for Women aged 40 and over

- Suitability and safety of each method
- How it should be used
- When it should be stopped
- How it should be used with HRT

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Oral Combined hormonal contraception

Suitable for low risk women . Recommended to swap to safer methods at age 50yrs

Consider risk factors for VTE, regular assessment BMI .VTE risks highest on initiation try to avoid stopping and starting.

women with no risk factors up to age 50 UKMEC category 2

COC for women over 40 first choice should be preparation with >30mcg ethinylestradiol

Preparations containing Levonorgestrel or norethisterone confers lowest VTE risk

Continuous use may provide better control of peri or post menopausal symptoms.

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CHC-Advantages if over 35

- Reduction in ovarian and endometrial Ca. Which continues for up to 15 years after stopping.
- Reduction in colon Ca .
- Reduction in incidence of / treatment for fibroids.
- Reduction in incidence of / treatment for endometriosis.
- Control of menstrual cycle problems/pain/bleeding.
- Conceals climacteric symptoms / problems.
- Maintains bone density.

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COC-Disadvantages if > 35

- VTE risk ↑ with age
- Need to monitor carefully for other relative contraindications
- Breast cancer risk ↑ with age RR = 1.24 compared to non-users.

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Which CHC may be a suitable option?

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Table 1: Venous thromboembolism risk for all women by type of combined hormonal contraception used1

Type of CHC used	Risk of VTE per 10,000 healthy women over 1 year
No CHC, not pregnant	2
No CHC, pregnant	29
Ethinylestradiol with levonorgestrel, norgestimate, or norethisterone	5–7
Ethinylestradiol with etonogestrel (ring), or norelgestromin (patch)	6–12
Ethinylestradiol with gestodene, desogestrel, drospirenone, or cyproterone acetate	9–12
CHC containing dienogest, nomegestrol, or mestranol	Unknown

CHC=combined hormonal contraception; VTE=venous thromboembolism

Faculty of Sexual & Reproductive Healthcare. *Contraception for Women Aged Over 40 Years*. FSRH, 2017. Available at: www.fsrh.org/standards-and-guidance/documents/fsrh-guidance-contraception-for-women-aged-over-40-years-2017/

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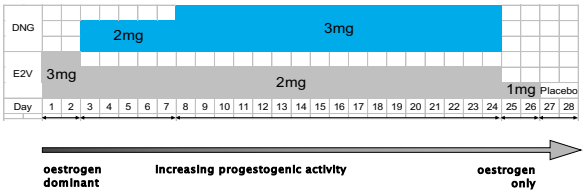
Qlaira Regimen Estradiol / Dienogest

- 26/2
  - Maintain stable E2 levels, optimise cycle control, inhibit ovulation



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Qlaira

- May be a good option
- The first COC to deliver estradiol valerate
- The first product in the UK to contain dienogest
- Potential for ↓ metabolic impact than COCs containing EE
- Good cycle control with high patient satisfaction
- Older women good at remembering
- Ideal if menorrhagia and not wanting an IUS
- Missed pill advice complicated

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Zoely

- Alternative COC containing Estradiol (1.5mg)
- First monophasic estradiol pill
- Combined with nomegestrol acetate
- Progestogen has mild anti androgenic activity
- No pill free intervals,but 4 inactive tablets
- Studies show comparable efficacy.
- Primary mode of action –Inhibits ovulation by suppression of gonadotrophins.

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Methods of combined hormonal contraception

♦**Patch**

- safety and efficacy trials only up to age 45

♦**Vaginal ring**

- studies between 18-40yrs
- releases 15mcg ethinylestradiol and 120mcg etonogestrel daily – lowest dose for a combined method
- can be removed for intercourse

Same benefits and risks as COC

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Progestogen only Pill

- May be used in older Women unable to take COC
  - High blood pressure,
  - Overweight,
  - Age over 35 and Smoker
  - Previous thrombosis.
  - Cardiovascular risk factors
- Suitable for older women as its effectiveness is comparable to that of COC in younger women.
- Fewer associated risks but does not provide additional non contraceptive benefits.
- Not licensed for endometrial protection and cannot be used as progestogen component of HRT

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First generation POP mode of action

Normal ovulatory cycles	Usual bleeding	40%
Follicular activity less luteal activity	Irregular bleeding	23%
Follicular activity No luteal activity	Irregular bleeding	21%
No follicular or luteal activity	Amenorrhoea	16%

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Second generation POP (Cerazette®)

- 75 µg desogestrel every day
- *Main* contraceptive effect: ovulation inhibition in 97% of cycles.
- Secondary effect: thickening of cervical mucus
- Efficacy similar to COC regardless of age
- 12 hour window if forgotten
- Bleeding pattern unpredictable & may be irregular

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Methods of progestogen only contraception

- Risks and benefits less studied than COC
- No apparent increase in MI, stroke or VTE
- Limited evidence but no significant increase in Breast cancer
- Irregular bleeding common
- Amenorrhoea not a reliable indicator of ovarian failure

- Highly effective in this age group
- Can use >50yrs – should stop at 55 yrs
- May give poor cycle control or amenorrhoea.
- May develop menopause symptoms.

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Progestogen only implants

- Highly effective contraception
- No specific age related concerns for women over 40
- Can alleviate menstrual and ovulatory pain
- Bleeding pattern unpredictable and not a useful indicator of menopausal status
- No age limit and can be used up
- until contraception is no longer required
- Not licensed for endometrial protection in HRT use

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Progestogen Only injectables

- Reduces menstrual pain and HMB.
- Bleeding may be Atrophic.
- DMPA is associated with BMD loss initially but this is not repeated or worsened at time of menopause.
- Women over 40 with risk factors for osteoporosis are recommended to consider alternative methods.
- DMPA aged 45 or over is considered to be category UKMEC 2
- Not licensed for endometrial protection in HRT use.

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Copper intrauterine device

Most licensed for 5–10yrs highly effective and convenient

- FSRH supports extended use if inserted at age 40 and over.
- Remove one year after LMP if over age 50yrs and 2 years if under age 50yrs
- May be unacceptable if dysfunctional bleeding or menorrhagia.
- Can cause longer heavier and more painful menses

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Levonorgestrel Intrauterine Systems

- Highly effective contraception.
- Ideal for HMB (80% reduction) if being used for HMB ONLY can be left in situ as long as required to control symptoms
- If inserted for contraception age 45yrs or over can be used until age 55yrs even if they are not amenorrhoeic provided it is not being used as endometrial protection for HRT .

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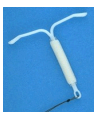
Levonorgestrel intrauterine systems

- May mask amenorrhoea of menopause
- Mirena is licensed for 4yrs for endometrial protection for HRT.
  FSRH and RCOG support its use for 5yrs
- only way to ensure 'period free' HRT for peri menopausal women.



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Levonorgestrel IUS

Only preparation suitable for oestrogen opposition in HRT

MIRENA 20mcg / 24 hours 5yrs
10mcg / 24 hours after five years

- Jaydess 6mcg / 24 hours 3yrs
- Levosert 15.6mcg / 24 hours 3yrs
- Kyleena 9mcg / 24 hours 5yrs

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Methods of contraception – barrier

Condoms

- Generally good at using them
- Rarely start using for the first time
- Some vaginal oestrogens are oil-based
- Protects against STIs

Diaphragm/cap

- Older women more reliable users and lower failure rates
- Spermicides give extra lubrication
- If prolapse / cystocele could try cervical cap

Spermicides

- could be used on own if >50 and no suitable alternative, also provides lubrication

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When to stop contraception

- Two years following the last spontaneous menstrual period if aged under 50
- One year following the last spontaneous menstrual period if aged 50 or over
- By age 54yrs – 80% are 1yr postmenopausal
- By age 55yrs – 96% are 1yr postmenopausal

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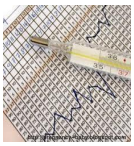
Methods of contraception – NFP



- Effectiveness depends on motivation
- More difficult to teach at this age due to
  - Irregular cycles
  - Difficult to interpret effect on cervical mucus as anovulatory cycles

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Stopping Contraception

If want to stop hormonal contraception before 50 yrs:-

- switch to non-hormonal method and
  - Stop once amenorrhoeic for 2 yrs
  - Potentially 3 yrs if on DEPO due to potential delay in ovulation

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When is contraception no longer needed

- Where timing of menopause is unclear due to use of contraception or HRT women can continue using contraception until age 55yrs and then stop.
- Spontaneous conception is rare at this stage even if a women continues to have menstrual bleeding.
- A women may wish to continue a method of contraception for non contraception benefits and this should be reviewed on an individual basis.
- Intrauterine contraception should not be left in situ indefinitely as it can become a focus of infection.

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Measuring FSH Levels

- Amenorrhoea not reliable indicator of menopause.
- FSH measurements ; More reliable in the over 50yrs
- If needed a women over 50 using progestogen only contraception including DMPA can have FSH levels undertaken to check menopausal status.
  FSHR guidelines 2017
- If level >30 IU/L – contraception can be stopped after one year
  FSHR guidelines 2017.
- FSH levels cannot be measured in women on HRT or CHC

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What about our young Ovarian Failure Women?

Points to consider:

- Is contraception needed or desired ? Is ovarian function ever likely to return?
- Time since Ovarian failure, age and causes are relevant.
- All methods of contraception are potentially available.
- CHC may be used as replacement therapy as well as contraception- free and in step with peers.
- Sexual health likely to be in step with own age group need to be advised accordingly.

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So – when to start HRT ?

- Symptoms (vaso-motor and psychological) are often at their worst in perimenopause
- Many women start for symptom relief even if regular periods
- Up to date and relevant information about menopause and treatment options should be given throughout 40s (at smear tests and contraceptive checks etc)

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When to Start HRT

- Non Hormonal contraception

  Can start HRT when clinically appropriate.

- Combined contraception.

  Oestrogen component should mask menopause and symptoms unlikely other than in pill free week .

Progestogen only contraception

HRT can be initiated when clinically appropriate. May consider sequential or continuous combined therapy.

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HRT + Contraception: Key Points

- No HRT is contraceptive – ovulation may still occur[1]
- If on HRT – impossible to assess if menopause has occurred (FSH unreliable)
- IUS Mirena provides contraception + progestogen element of HRT
- Barrier methods –consider use for *Safe sex*
- POP in conjunction with sequential or continuous combined HRT, is widely recommended, but no scientific data to confirm efficacy.

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When to stop contraception if on HRT ?

- 80% of women post menopausal at 54yrs
- Assume loss of fertility at 55yrs
- ? Break from HRT for 6wks – measure FSH
- If FSH >30pmols/ contraception for one more year. Reserve for women over 50yrs

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Sexually Transmitted Infections

- Older women often specifically excluded from surveys and prevention programmes
- Perceive themselves not to be at risk of an STI
- Vaginal pH increased – lactobacillus suppressed, vaginal infection more common
- Despite symptoms do not often consider they may have an STI.
- Many buy OTC preparations/treatments.

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Public Health England

Selected STI diagnoses & rates by age group, 2009 – 2013

	2009	2010	2011	2012	2013
Chlamydia Age 45–64yrs	588	637	731	1554	1522
Chlamydia Age 65+ yrs	10	18	16	49	55
Gonorrhoea Age 45–64yrs	147	143	211	215	251
Gonorrhoea Age 65+yrs	4	1	6	11	9
Anogenital Herpes Age 45–64yrs	1395	**1592**	1732	1808	1935
Anogenital Herpes Age 65+yrs	49	63	76	92	102
Syphilis Age 45–64yrs	30	23	32	27	34
Syphilis Age 65+yrs	1	2	2	2	6

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Vaginal Infections in older women

- Reduced Estrogen, vaginal secretions, reduced Lactobacillus.
- Changes in Vaginal PH more alkali
- Vaginal and Urinary tract infections more common.
- Candida BV TV and Chlamydia
- Adds to problems of vaginal soreness, painful sex, embarrassment and distress.

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Vaginal Infections; Solutions

- Full Sexual history
- Vaginal examination, swabs.
- Exclude abnormal pathology.
- Treatments for both the infections and vaginal atrophy.
- Advice for prevention of recurrence of infections.

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Sexual Function – the positives

- No further anxieties about contraception
- Freedom from fear of pregnancy
- Absence of periods
- No premenstrual syndrome
- More time for each other
- Time to reassess lifestyles

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Negative effects of mid life

- Loss of Libido, reduced sexual arousal
- Vaginal soreness, dryness
- Painful sexual intercourse
- 'Empty nest' syndrome
- Retirement
- Divorce
- Bereavement
- Elderly dependent parents
- Teenage children
- Financial problems
- Failed dreams
- Male 'mid-life crisis' Arousal difficulties

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Negative effects on sexual health in young menopausal women.

- Loss of fertility.
- Loss of femininity.
- Isolation from peer group
- Loss of status, Majority of societies elevate the status of parenthood.
- Rejection by partner

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Effect of Health on Sexual Function

- Less likely to have sex and more likely to have problems if health poor.
- Medications can effect sexual desire and performance.
- May be reluctance to talk about sexual health with health practitioners particularly if there are multiple health problems.

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Sexual function is complex

- Desire
- Arousal
- Penetration
- Orgasm
- Satisfaction
- Problems overlaid with psychological/relationship/ body image issues
- Estrogen deficiency can effect all of these components

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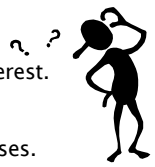
Couple relationship



- Lack of desirability of partner
- Fading of sexual intimacy and interest.
- Deteriorating physical health.
- Male problems (Viagra)
- Hard to break undesirable responses.
- Good communication is vital.

- *New partners – possible increase in libido, satisfaction and orgasm*

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Sexual function assessment

- An essential component of menopausal healthcare.
- Ask sensitively but openly: give permission to talk about the issues.
- Establish if it is a problem to the individual or couple.
- Consider social, medical, psychological (exclude depression) and relationship factors.
- Failure increases chance of further failure: discuss anxieties, and expectations

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Practical help

- Discuss emollients, lubricants
- Ensure adequate estrogen for vaginal comfort.
- Consider role of systemic estrogen therapy.
- Consider psychosexual counselling.
- Consider disabilities – discuss positions and practical issues.
- Consider Testosterone.

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Thank You

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