

Prescribing...

- ✚ As well as being an effective method of preventing pregnancy, combined hormonal contraception or CHC can be used for dysmenorrhoea, cycle control and menopausal symptoms.
- ✚ The risk of developing and dying from ovarian & endometrial cancers is lower in women on CHC.
- ✚ Current breast cancer, but not a family history, is a contra-indication for its use.
- ✚ For women aged over 35 who smoke, the risks of CHC usually outweigh the benefits.
- ✚ The risk of cervical cancer is slightly increased in users.

Combined Hormonal Contraception

There are currently three forms of combined hormonal contraception (CHC) available in the UK: the combined oral contraceptive pill (COC), the combined transdermal patch, and the combined vaginal ring (CVR). A limited range of these products is available at public expense via the White List for the treatment of gynaecological conditions. In the last twelve months there were 6,431 prescriptions dispensed on the islands at a cost of £47,000 plus fees. Most of the available evidence regarding health benefits and risks is for COC. The risks and benefits are similar and therefore guidelines from the Faculty of Reproductive and Sexual Healthcare apply to all three methods. The remainder of this bulletin summarises the Faculty's advice.

Health benefits and risks associated with CHC use

1. Bone health

It is not possible to say from the evidence that currently exists, whether use of steroidal contraception influences fracture risk. Studies have often failed to include women from older age groups and do not generally include the low-dose formulation COCs or other CHC methods such as the CVR and transdermal patch.

A Cochrane review that examined findings for all women collectively has recently stated that CHC does not appear to affect bone health. Other systematic reviews suggest that there might be a positive effect of CHC use on bone mineral density (BMD) in perimenopausal women. But it is not clear how changes in BMD before the menopause will affect fracture risk following the menopause.

2. Dysmenorrhoea and cycle control

Whilst Cochrane reviews have stated that there is limited evidence from randomised controlled trials to suggest that COC use can improve primary dysmenorrhoea or reduce menstrual blood loss compared with other treatment, data from observational studies suggest that COC use does have a beneficial effect. NICE guidance indicates that COC can be used for the treatment of heavy menstrual bleeding. A placebo-controlled, double-blind, randomised trial has also suggested that low-dose COC could possibly be used to treat pain associated with endometriosis.

For premenopausal women over the age of 40 years, CHC methods can provide cycle regularity. Unscheduled bleeding is more common with a 20ug compared with a 30ug EE pill. The CVR has been shown to provide good cycle control; and following the initial two cycles, breakthrough bleeding with the transdermal patch is no more common than when using COC.

3. Menopausal symptoms

There is a small amount of data that suggests CHC may help to improve some of the symptoms associated with menopause. There may be some theoretical benefit from an extended regimen such as taking three pill packets continuously or tricycling, although such use is outside the product licence.

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4. Ovarian and endometrial cancer

The risk of developing or dying from ovarian or endometrial cancer is reduced with use of COC. The risk reduces with increasing duration of COC use; and whilst the protective effect reduces over time, it may last for 15 years or more after used. A case control study has suggested that this protective effect is more strongly associated with premenopausal than postmenopausal disease. Data also suggests a reduction in the incidence of ovarian cysts and benign ovarian tumours amongst women using COCs.

5. Benign breast disease

A decreased risk of benign breast disease and decreased risk of hospitalisation for fibroadenoma and chronic cystic disease have been noted with use of COC, although in all studies confounding and bias cannot be excluded.

6. Breast cancer

The annual risk of breast cancer increases with increasing age irrespective of hormone use. Overall there is no clear evidence as to the risk of breast cancer with use of CHC. A collaborative re-analysis of early case-control studies showed an increased risk of breast cancer while using COCs, with a subsequent meta-analysis showing an increased risk of premenopausal breast cancer. However, other well-conducted observational studies have found no increased risk or a very small increased incidence of breast cancer or breast cancer in situ. Any increased risk associated with use has been shown to decrease with time since stopping, reducing to no significant risk 10 years after cessation. However CHC methods represent an unacceptable health risk for women with current breast cancer.

A systematic review has concluded that, based on recent evidence, women who have a family history of breast cancer do not increase their risk of breast cancer by using COC. A family history of breast cancer is a condition for which the use of CHC methods is unrestricted.

7. Cervical cancer

There is a small increased risk of cervical cancer, both invasive and in situ, with increasing duration of COC use. Long-term users can be reassured that the benefits of use generally outweigh the risks. The risk of invasive cancer has been shown to decline after use ceases and by 10 years or more return to that of never users. Women should be informed about the link between human papillomavirus or HPV and cervical cancer, and be advised that the risk of cervical cancer can be reduced through condom use and regular cervical screening.

8. Cardiovascular and cerebrovascular disease

Amongst women of reproductive age, morbidity and mortality from venous thromboembolism (VTE), myocardial infarction (MI) or stroke are rare but the risk increases with increasing age. Whilst use of CHC methods may be associated with small increases in cardiovascular and cerebrovascular risk, overall the absolute risks are still small and current evidence suggests that women who have used oral contraceptives have no higher risk of mortality than those who have never used them.

Women who are aged 35 years or over and smoke should be advised that the risks of using CHC usually outweigh the benefits. Clinician should be aware that there may be a very small increased risk of ischaemic stroke with CHC use. Women with cardiovascular disease, stroke or migraine with aura should be advised against the use of CHC.

Practitioners who are prescribing CHC to women aged over 40 years may wish to consider a pill with <30ug EE as a suitable first choice. Hypertension may increase the risk of stroke and MI in those using CHC. Blood pressure should be checked before and at least 6 months after initiating a woman aged over 40 years on a CHC method and monitored at least annually thereafter.

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Reference: Contraception for Women aged Over 40 Years, Faculty of Sexual and Reproductive Healthcare July 2010