



Designer Menses: Should Menstruation Be Optional?

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There are those who believe menstrual suppression is unnatural. However, studies have proven that suppression of ovulation and menses by hormones, either combined oral contraceptives (COC) or progesterone-only contraception, reduces the risk of ovarian and endometrial cancer by at least 40% after one year of use.¹

How does it work?

After the 21 days of active tablets, during the seven-day hormone-free interval (HFI) COC regimen, the hypothalamic-pituitary-ovarian (HPO) axis recovers, with ovarian follicle growth by the beginning of the next pill cycle. Pill omissions adjacent to the HFI are associated with escape ovulation and contraceptive failure.

Extending the number of days of active COC may increase contraceptive efficacy, as there would be less opportunity to omit pills adjacent to the HFI.

Decreasing the HFI to three or four days could also potentially increase contraceptive efficacy by reducing HPO recovery. The lower the COC dose, the faster the recovery of the HPO axis.

In Europe and the U.S., use of low-dose COCs—containing as low as 15 µg of ethinyl estradiol—has led to new contraceptive regimens. These regimens extend the number of active pills and reduce the number of hormone-free days to diminish hypothalamic recovery associated with the traditional seven-day HFI.

Though physicians have produced menstrual suppression in the past, most have not done so for social reasons. Using progesterone-only contraception, along with continuous COC, danazol and gonadotropin-releasing hormone antagonists/agonists, suppresses menses in women who have endometriosis, menorrhagia, menstrual migraines and other symptoms associated with the HFI.²

Zena's case



Zena, 23, has been taking the oral contraceptive pill since age 18 for dysmenorrhea and contraception.

Her menstrual cramps have decreased in intensity, but are still present and necessitate 24 hours of ibuprofen. In addition, she occasionally has menstrual headaches.

Zena just finished university and is planning to travel around Europe for the summer. She asks if it is possible to avoid menses while on her trip. She is informed about taking her oral contraceptive continuously.

For more on Zena, go to page 61.

Quick Point

In 2001, a study asked women their preferred frequency of menses and found that the majority of women of all ages preferred to have bleeding less than monthly, regardless of oral contraceptive use.³ Interestingly, approximately 36% of reproductive-aged women would choose never to menstruate, by far the most popular choice.³

Are there any side-effects?

To date, no additional risks, beyond those currently recognized for COCs, have been identified with the use of hormonal contraceptives to suppress menses. Although there is a paucity of systematic studies on the continuous use of COCs, there is also no evidence of any health benefit to the seven-day HFI.

One bothersome side-effect of extending the number of active tablets is breakthrough bleeding (BTB), but this tends to dissipate the longer active tablets are used; after one year of continuous use, only 20% of women have some form of BTB.⁴

Some final thoughts...

At a minimum, menses are considered a nuisance by most women; however, for some, menstruation is debilitating and associated with loss of productivity. No other medical condition requiring monthly analgesia and causing reduced functioning would be left untreated. Because menstruation is viewed as natural, women and physicians often accept the associated inconveniences as part of a "woman's lot."

Although there are many women who will choose not to alter their menstrual cycle, those who are taking COCs should be offered the option of decreasing the frequency of withdrawal bleeds.

Women not using the COC, but who wish to alter their menses, should begin the COC on the first day of the next menses and, if possible, have one withdrawal bleed prior to extending the use of active tablets. This will reduce the incidence of BTB once the pills are taken continuously.

Menstrual manipulation has been called the "best kept medical secret" because it has been used for years without public knowledge or evidence of ill effects. Perhaps it is time to allow our patients, once properly informed, to decide on their own bleeding patterns. **Dx**

References

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3. den Tonkelaar I, Oddens BJ: Preferred frequency and characteristics of menstrual bleeding in relation to reproductive status, oral contraceptive use and hormone replacement therapy use. *Contraception* 1999; 59(6):357-62.
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A followup on Zena

When Zena returns from her trip, she reports having successfully postponed her menses and has now induced a withdrawal bleed. She wonders if this technique could be done routinely to avoid menstrual symptoms.

After discussion, it is decided to try Zena on a 63-day-on/ four-day-off regimen.

Quick Point

According to the literature, it appears the frequency of withdrawal bleeding most acceptable to women and physicians is every 63 or 84 days.⁴

For those women with intolerable menstrual symptoms, the fewer the withdrawal bleeds, the better.

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