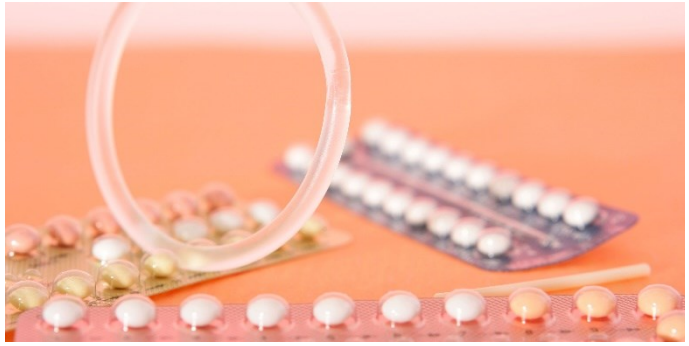
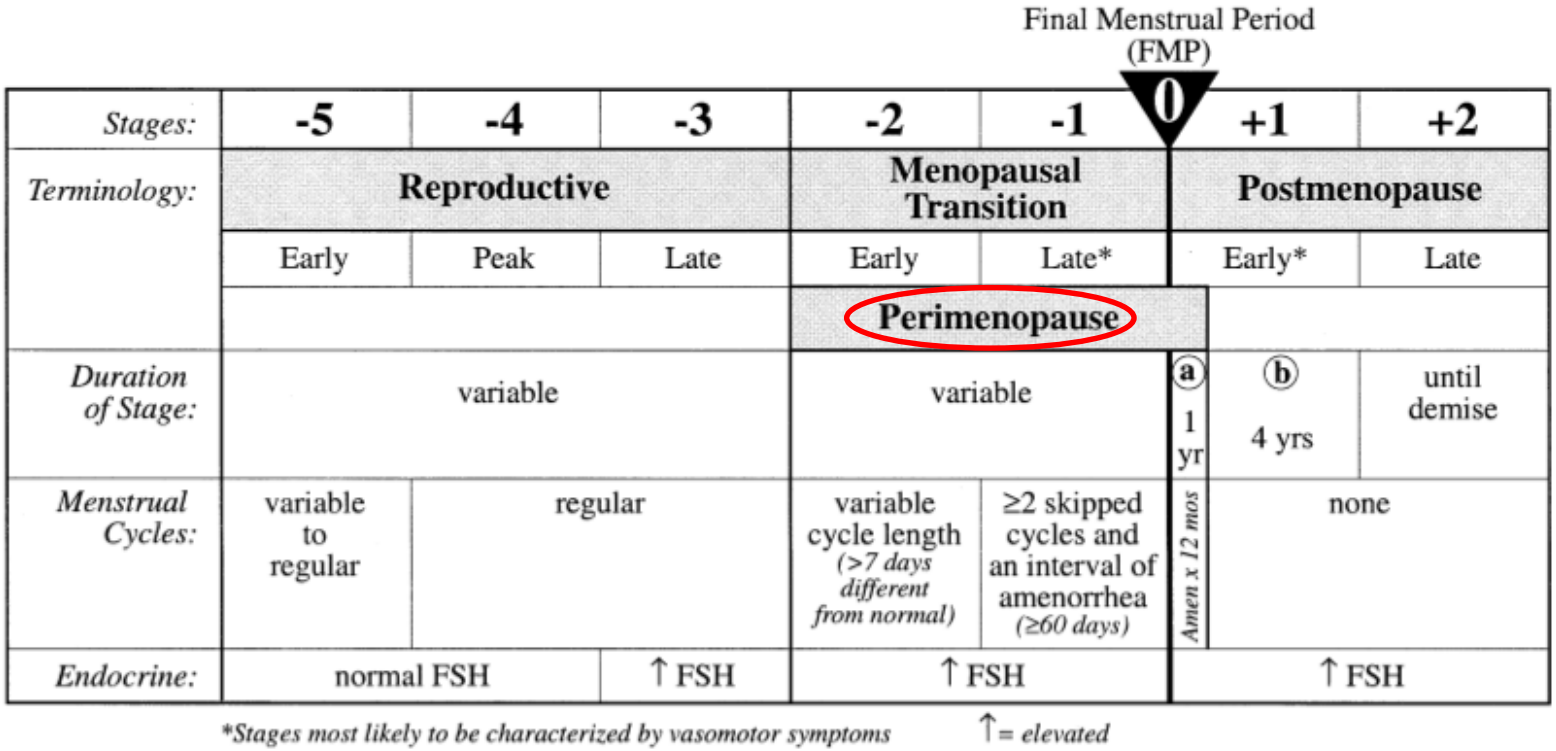
Perimenopozal Dönemde Kontrasepsiyon



Dr. Murat Ulukuş
Ege Ünviversitesi Tıp Fakültesi
Kadın Hst.ları ve Doğum AD
Bornova-İzmir

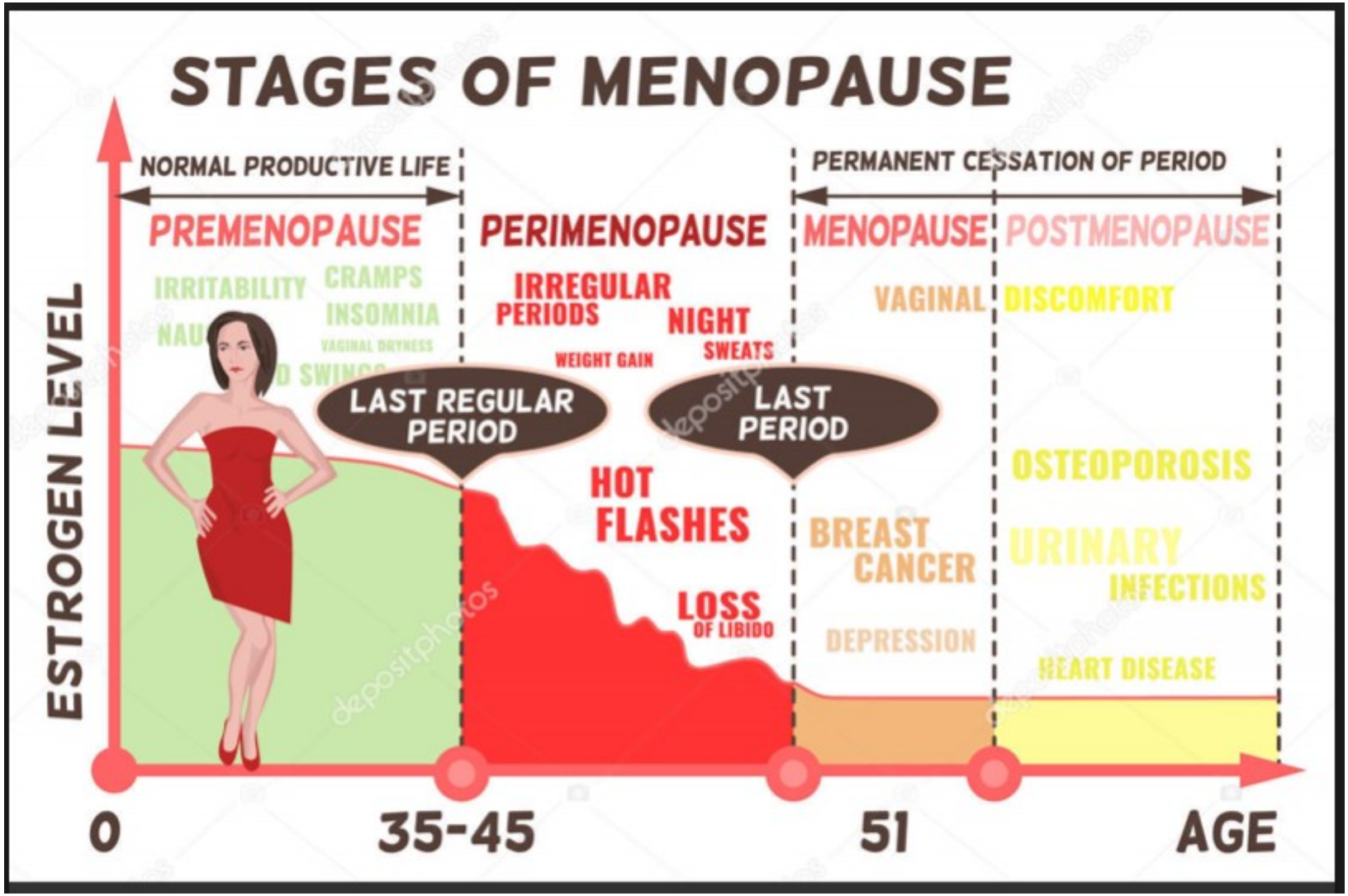
FIGURE 1

The STRAW staging system.

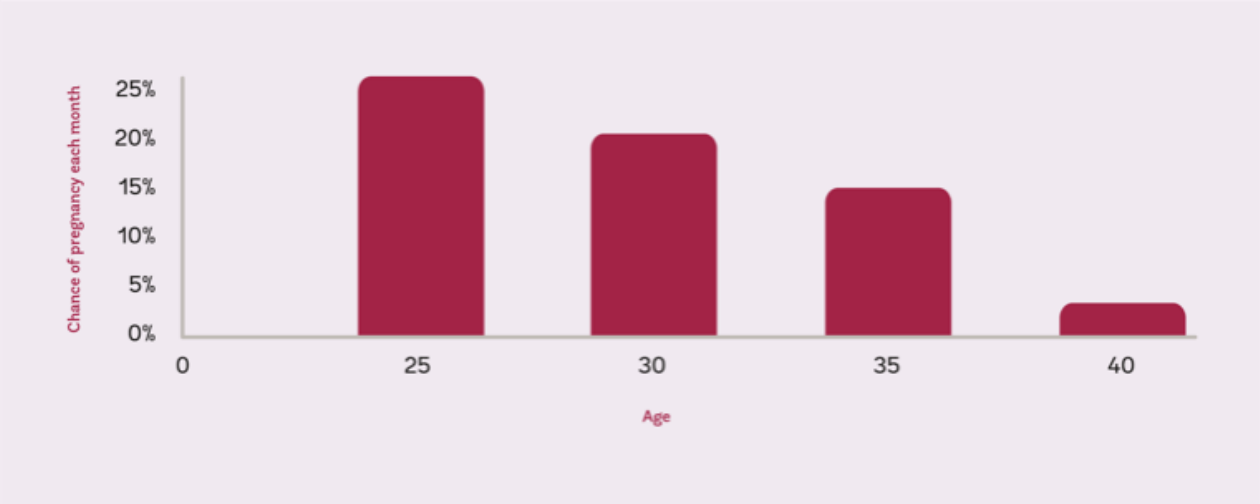


Soules. Executive Summary of STRAW. Fertil Steril 2001.

Menopozla ilişkili semptomların başlamasından menopoz sonrasındaki 1 yıla kadar geçen süreyi kapsayan dönem
Menstruel siklus uzunluğu ve endokrin değişiklikler


STAGES OF MENOPAUSE
NORMAL PRODUCTIVE LIFE
PERMANENT CESSATION OF PERIOD
PREMENOPAUSE
PERIMENOPAUSE
MENOPAUSE
POSTMENOPAUSE
ESTROGEN LEVEL
IRRITABILITY
CRAMPS
INSOMNIA
VAGINAL DRYNESS
IRREGULAR PERIODS
WEIGHT GAIN
NIGHT SWEATS
VAGINAL
DISCOMFORT
LAST REGULAR PERIOD
LAST PERIOD
HOT FLASHES
OSTEOPOROSIS
BREAST CANCER
URINARY INFECTIONS
LOSS OF LIBIDO
DEPRESSION
HEART DISEASE
0
35-45
51
AGE

Fertility statistics by age: monthly chance of natural pregnancy



Ages	Number of genetically abnormal embryos
25-30	25%
31-35	35%
35-37	45%
38-40	60%
41-43	80%
≥44	≥80-90%

Source: Fertility and Sterility, 2014

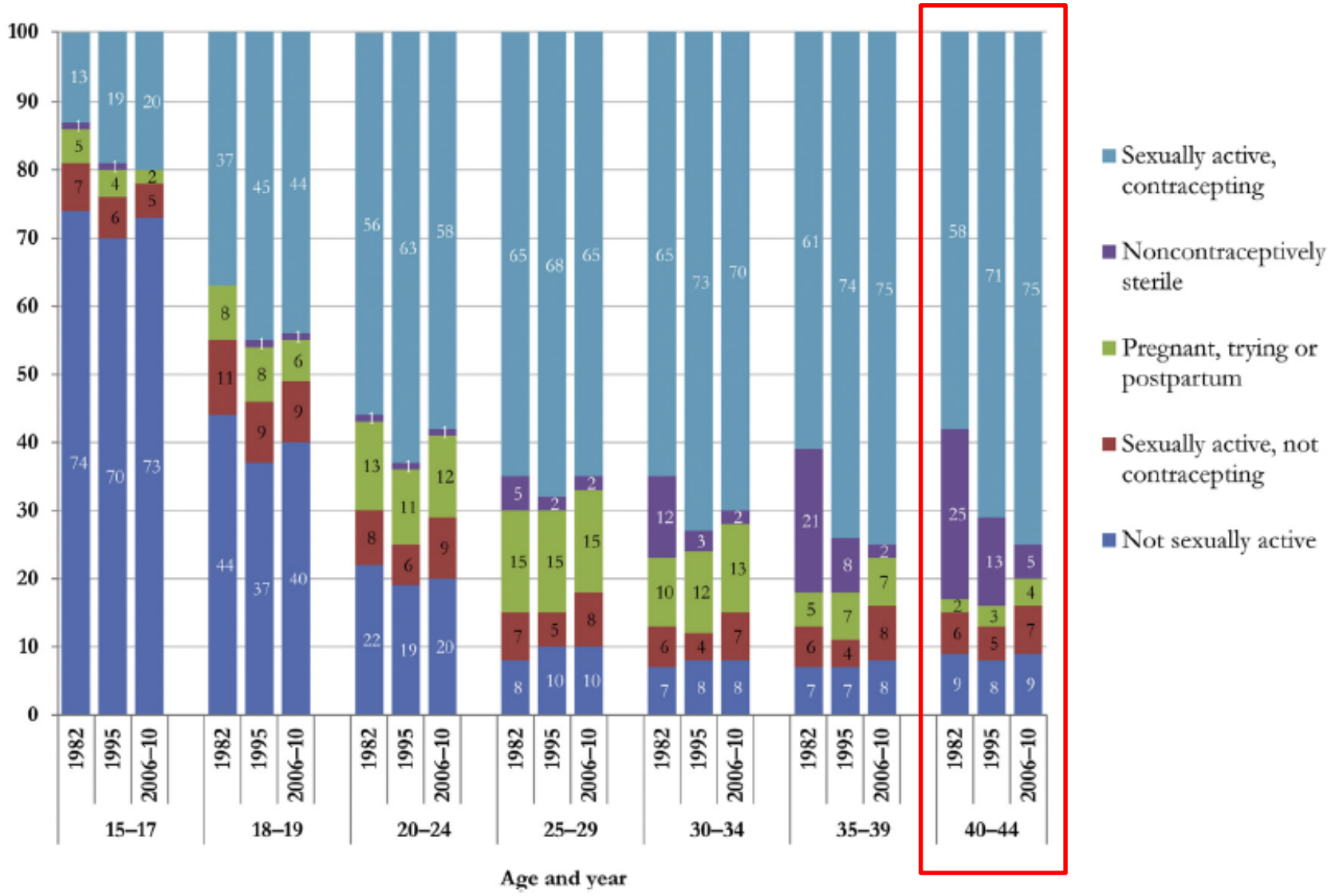


Figure 5. Percentage of women age 15 to 44 who were in various reproductive stages at each age.

TABLE 1—Number of Total and Unintended Pregnancies, Percentage of Pregnancies That Were Unintended, and Pregnancy Rate by Intention for All US Women, by Demographic Characteristics: 2001 and 2008

Characteristic	No. of Pregnancies (Thousands), 2008		% of Pregnancies Unintended		Pregnancy Rate[a]					
					Total		Intended		Unintended	
	Total	Unintended	2001	2008	2001	2008	2001	2008	2001	2008
All women	6583	3367	48	51	103	106	54	51	49	54
Age group,[b] y										
15–19	750	612	83	82	80	69	14	13	66	57
15–17	249	227	89	91	46	39	5	4	41	35
18–19	501	385	79	77	131	114	27	26	103	88
20–24	1683	1075	59	64	173	163	72	59	102	104
25–29	1748	788	40	45	170	168	101	92	68	76
30–34	1360	479	33	35	132	141	89	92	44	50
≥35	1025	397	33	39	42	48	28	30	14	19

Table 2. Percentage of Unintended Pregnancies That Ended in Abortion and Rate of Unintended Pregnancies That Ended in Birth for All U.S. Females, 2008 and 2011.

Characteristic	Percentage of Unintended Pregnancies That Ended in Abortion*		Rate of Unintended Pregnancies That Ended in Birth†	
	2008	2011	2008	2011
All females	40	42	27	22
Age group‡				
15–19 yr	37	38	30	21
15–17 yr	35	43	19	10
18–19 yr	38	37	47	37
20–24 yr	41	44	53	40
25–29 yr	42	42	38	33
30–34 yr	41	42	24	21
≥35 yr	45	46	8	7

2013
Türkiye
Nüfus ve Sağlık Araştırması

Tablo 5.4 Yaşa göre gebeliği önleyici yöntemlerin halen kullanım

Halen kullanılan gebeliği önleyici yönteme ve yaşa göre 15-49 yaşlarındaki tüm kadınların ve halen evli kadınların yüzde dağılımı, Türkiye 2013

			Modern yöntem										Geleneksel yöntem					
Yaş	Herhangi bir yöntem	Herhangi bir modern yöntem	Tüplerin bağlanması	Erkeğin kanallarının bağlanması	Hap	RİA	İğne	İmplant	Kondom	Diyafram	Emzirme	Herhangi bir geleneksel yöntem	Takvim	Geri çekme	Diğer	Yöntem kullanımı yok	Toplam	Kadın sayısı
TÜM KADINLAR																		
15-19	3.3	1.2	0.0	0.0	0.1	0.3	0.1	0.0	0.7	0.0	0.0	2.1	0.0	2.0	0.1	96.7	100.0	1,572
20-24	26.5	14.7	0.1	0.0	1.9	4.5	0.2	0.0	8.0	0.0	0.0	11.8	0.0	11.8	0.0	73.5	100.0	1,337
25-29	55.8	34.8	1.4	0.0	4.2	12.8	0.8	0.0	15.4	0.1	0.1	21.0	0.2	20.8	0.0	44.2	100.0	1,492
30-34	71.4	47.1	5.8	0.0	6.3	15.8	0.6	0.1	18.2	0.0	0.2	24.3	0.2	24.0	0.0	28.6	100.0	1,565
35-39	76.2	54.0	12.7	0.0	4.3	19.6	0.7	0.0	16.5	0.1	0.0	22.3	0.3	21.8	0.2	23.8	100.0	1,513
40-44	74.2	49.7	16.7	0.1	3.9	18.2	0.2	0.0	10.5	0.1	0.0	24.5	0.7	23.8	0.0	25.8	100.0	1,238
45-49	52.4	31.8	13.1	0.0	1.1	12.2	0.0	0.0	5.3	0.1	0.0	20.6	0.5	19.8	0.3	47.6	100.0	1,029
Toplam	51.0	33.2	6.6	0.0	3.2	11.8	0.4	0.0	10.9	0.1	0.1	17.8	0.3	17.5	0.1	49.0	100.0	9,746

Perimenopozda izlenen biyolojik ve psikososyal değişiklikler

- Fertilite ↓ ancak istenmeyen gebelik oranları nispeten ↑
- Abortus, kr. anomaliler, ektopik gebelikler, preeklampsi ve postpartum kanamalar
- Ağır menstrual kanamalar ve klimakterik semptomlar
- Yaşla ilişkili ↑ KVH riski (VTE, MI)
- Yaşla ilişkili ↑ Ca riski (meme, em, over)
- Yaş ve hormon düzeyi ile ilişkili osteoporoz riski
- Psikososyal sorunlar, mental sağlık riskleri ve cinsel disfonksiyon

Perimenopozal kontrasepsiyon

- İstenmeyen gebeliklere karşı etkili korunma sağlamalı
- Yaşla ilişkili spesifik sağlık sorunlarına karşı risk yaratmaması (KVH, metabolik, malignite)
- Sağlık açısından ek faydalar sağlamalı (yaşla ilişkili hastalıkların önlenmesi, semptom ve şikayetlerin tedavisi)
- Mental ve cinsel yönden de fayda sağlayarak yaşam kalitesini iyileştirmesi

Tıbben uygun, ulaşılabilir, ekonomik, yan etkileri az ve non-kontraseptif etkileri de olan

Categories for the WHO's Medical Eligibility Criteria for Contraceptive Use

Categories	Description	General implication of the recommendation for the contraceptive method	
		With good resources for clinical judgement	With limited resources for clinical judgement
Category 1	A condition for which there is no restriction for the use of the contraceptive method	Use method in any circumstances	Yes (Use the method)
Category 2	A condition where the advantages of using the method generally outweigh the theoretical or proven risks	Generally use the method	
Category 3	A condition where the theoretical or proven risks usually outweigh the advantages of using the method	Use of method not usually recommended unless other more appropriate methods are not available or not acceptable	No (Do not use the method)
Category 4	A condition which represents an unacceptable health risk if the contraceptive method is used	Method not to be used	

Source: World Health Organization. Medical eligibility criteria for contraceptive use, fifth edition. Geneva: World Health Organization, 2015.

Kontraseptif yöntemler

- Non-hormonal kontraseptif yöntemler
- Tek başına progestin içeren kontraseptifler
- Kombine hormonal kontraseptifler
- Sterilizasyon yöntemleri

Table 1. Non-hormonal contraceptives.

Method	*Failure rate (%: perfect/typical)*	*Drug delivery*	*Dosing regimen (label)*
Male condom	2/18	None	Condom placed on penis *prior* to vaginal insertion and left on until ejaculation *and* removal from vagina. May be used concomitantly with vaginal spermicidal agent
Female condom	5/21	None	Vaginal placement of condom and left *in situ* until ejaculation and removal of penis. May be used concomitantly with vaginal spermicidal agent
Cervical cap	6/12	None	Device inserted prior to penile insertion and left *in situ* until ejaculation *and* removal from vagina. May be used concomitantly with vaginal spermicidal agent
Diaphragm	6/12	None	Device inserted prior to penile insertion and left *in situ* until ejaculation *and* removal from vagina. May be used concomitantly with vaginal spermicidal agent
Vaginal spermicide	18/28	Foam, cream, gel, suppository, film	Gel inserted prior to vaginal insertion of penis
Intrauterine device (IUD)	0.6/0.8	Copper	Inserted at a time when pregnancy is not likely (e.g. menses) or within 120 h of unprotected intercourse (as emergency contraceptive). Left *in situ* for prescribed period of effectiveness. Removed and replaced if further contraception is desired

RIA (TCu-380 A)

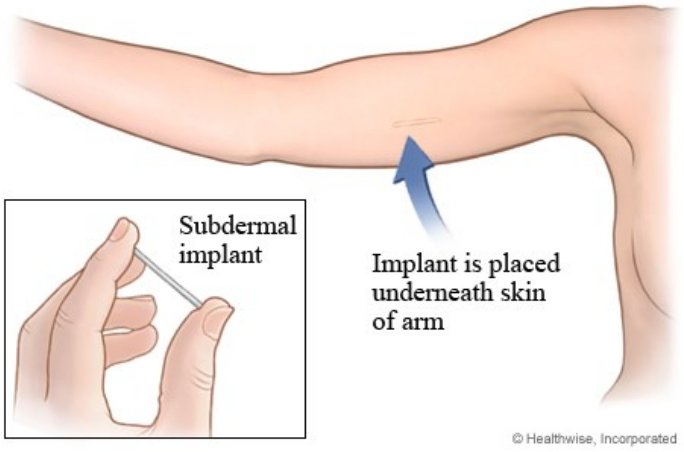
- En yüksek etkinliğe sahip non-hormonal yöntem
- 5 yıl
- Reversibl
- Acil kontrasepsiyon amacıyla uygulanabilir
- Tıbbi co-morbidite varlığında en etkin yöntemlerden biri

- Menopozal semptomları olanlara ek faydası yok
- Menstrual kanama miktarını ↑

Tek başına Progestin içeren yöntemler

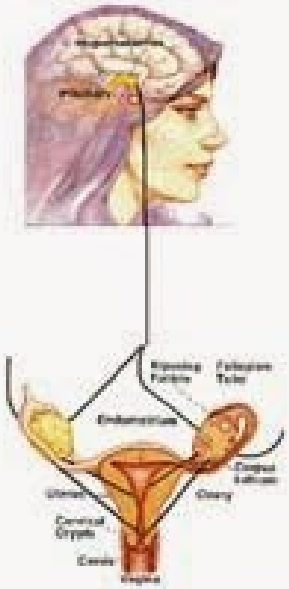
Table 2 Progestin-only hormonal contraceptives[a]

Method	Failure rate (%: perfect/typical)	Drug delivery	Dosing regimen (label)
Oral contraceptives	0.3/9	Oral	Daily ingestion of pill; most regimens are continuous in nature
Subdermal implant	0.05/0.05	Subdermal	Subdermal placement of implant system and left *in situ* for prescribed period of effectiveness. Removed at end of time period and replaced if continued contraception is desired
Injectables	0.3/6	Intramuscular/ subcutaneous	Intramuscular or subcutaneous initiation for prescribed time period. Reinjection at end of time period if continued contraception is desired
Intrauterine contraceptive LNG-IUS[b]	0.2/0.2	Levonorgestrel	Inserted at time when pregnancy is not likely (e.g. menses). Left *in situ* for prescribed period of effectiveness. Removed and replaced if further contraception is desired



Mode of Action of the Pill, Norplant, The Patch and Depo - Provera Injection

1. Inhibits Ovulation

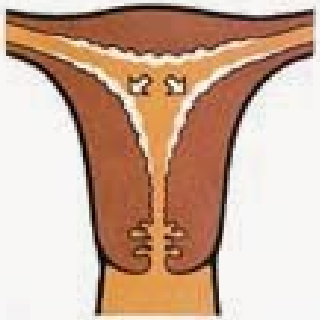


1. The high levels of estrogen and progesterone support the 2 hormones FSH and LH and prevent them from being released by the pituitary gland in the brain

2. Thickens the Cervical Mucus

2. The levels of progesterone thicken the cervical mucus making sperm migration difficult.

3. Prevents the normal build up of the endometrium



3. Doesn't allow the normal buildup of the endometrial lining of the woman's uterus. Thus, if conception occured the newly conceived baby tries to implant but does not find enough nourishment to remain in the uterus for the rest of the pregnancy. This is the abortification effect of these methods.

75 mcg Desogestrel

POPs

- Doğal fertilite kaybolan kadar güvenle kullanılabilir
- Kan basıncı, Lipid profili, ve DM üzerine etki minimal
- VTE, MI, İnme riskini arttırmaz
- BMD üzerine etki yok
- Norethisteron, LNG ve Desogestrel
- Ağır menstruel kanamalar ve dismenorede etkin
- Em.üzerine koruyucu etki

- Düzensiz kanama paternleri
- Baş ağrısı, bulantı, meme hassasiyeti, mood değişiklikleri
- Unutulan tabletlerde güvenlik aralığı dar
- Menopozal semptomlar üzerine etkisi yok
- Meme ca. riski çok hafif ↑

İmplantlar

- Etonogestrel (68 mg), 3 yıllık koruma
- En etkin LARC
- Menopoza kadar güvenle kullanılabilir
- VTE, MI, İnme riskini arttırmaz
- BMD üzerine olumsuz etkisi yok
- %20 kadında 1.yılda amenore

- %20 olguda persistan düzensiz kanamalar
- Takılma ve çıkarılma minör cerrahi gerektirir
- Vazomotor semptomlarda iyileşme sağlamaz
- Em üzerine koruyucu etki?
- Meme ca üzerine etki ?

Enjektable Progestinler

- LARC
- MPA 150 mg IM, 12 hf ara ile
- MPA 104 mg SC, 13 hf ara ile
- NET-EN 200 mg IM, 8 hf ara ile
- %50 ↑ 1.yıl sonunda
  %70 2.yıl sonunda amenore
- KVS ve Meme ca üzerine etkisi gösterilmemiş

- İlk 2 yılda %5 BMD ↓, kırık riski?
- 50 yaş sonrası kullanılması önerilmemekte (FSRH)
- Düzensiz kanama
- Bırakıldığında fertilite dönüşü uzayabilir

LNG-RİA

- Etkisi lokal ve suboptimal ovulasyon inhibisyonu
- Mirena → 52 mg LNG (5-7 yıl)
- Levosert → 52 mg LNG (3 yıl)
- Jaydess → 13.5 mg LNG (3 yıl)

- 45 yaş üstü kadınlarda 7 yıla kadar (FSRH)
- Amenoreik olanlarda menopoza kadar bırakılabilir (FSRH)
- Ağır menstruel kanamalarda etkin
- Em üzerine koruyucu etki olan tek lisanslı ürün
- Enz.le ilişkili ağrıda etkin
- VTE riskini arttırmıyor

Contemporary Hormonal Contraception and the Risk of Breast Cancer

Table 4. Relative Risk of Breast Cancer among Women Using Various Types of Hormonal Contraception Who Were Followed until December 31, 2012.*

Variable	No. of Person-Yr	No. of Breast-Cancer Events	Age-Adjusted Incidence Rate (*no. of events/100,000 person-yr*)	Adjusted Relative Risk (95% CI)†	Age-Adjusted Risk Difference (95% CI) (*no. of events/100,000 person-yr*)
Current or recent use of progestin-only products					
Oral contraceptive					
Norethisterone	128,848	78	58	1.00 (0.80 to 1.25)	3 (–10 to 16)
Levonorgestrel	10,547	16	102	1.93 (1.18 to 3.16)	47 (–4 to 99)
Desogestrel	77,847	42	69	1.18 (0.87 to 1.60)	14 (–8 to 36)
Nonoral contraceptive					
Implant	42,217	9	46	0.93 (0.48 to 1.79)	–9 (–42 to 25)
Levonorgestrel-releasing intrauterine system	503,441	571	70	1.21 (1.11 to 1.33)	16 (9 to 22)
Depot medroxyprogesterone acetate	19,308	5	51	0.95 (0.40 to 2.29)	–4 (–49 to 42)

FSRH, LNG-RİA
Mevcut/aktif meme ca için UKMEC kategori; 4
Geçmiş 5 yıldaki meme ca için UKMEC kategori; 3

State of emergency contraception in the U.S., 2018

Table 1 Comparison of methods of emergency contraception

	Copper IUD	UPA	LNG
Efficacy[a, b, c, d]	1 Most effective overall	2 Not as effective as copper IUD; most effective ECP	2 Less effective than copper IUD or UPA
Timing of use[b, c, d, e, f]	Typically 5 days after UPI (120 h), but may be effective at any point in the cycle	5 days after UPI (120 h)	3 days after UPI (72 h), although may have efficacy up to 120 h
Available OTC[c, g]	No	No	Yes
Timing of long-term birth control after use[b, c]	Leave in for continued use for up to 12 years	Wait 5 days	Immediately (quick-start)
Dosage[b, g]	N/A, insertion by medical provider	30 mg, one dose	1.5 mg, one dose
BMI[g, h]	1 No decrease in efficacy by BMI	2 Decrease in efficacy for BMI ≥ 30	2 Decrease in efficacy for BMI ≥ 25
Breastfeeding[e]	1	1	1
Hx of severe cardiovascular disease[e]	1	2	2
Migraine[e]	1	1	1
Severe liver disease[e]	1	2	2
CYP3A4 inducers[e]	1	2	2

Haeger *et al. Contraception and Reproductive Medicine* (2018) 3:20

Kombine hormonal kontraseptifler

Table 3. Combination hormonal contraceptives[a].

Method	*Failure rate (%: perfect/typical)*	*Drug delivery*	*Dosing regimen (label)*
Oral contraceptives	0.3/9	Oral	Daily ingestion of pill; most regimens still 21/7 though more with 24/4 and 26/2 and some continuous use regimens
Transdermal patch	0.3/9	Skin	Transdermal patch placement and left *in situ* for 1 week. Patch is then removed and replaced with new patch. Repeated for 3 weeks and then followed by a patch-free week before re-initiation
Vaginal ring	0.3/9	Vaginal	Vaginal placement of ring and left *in situ* for 3 weeks; removed for 1 week ring-free interval before replacing new ring

Kombine hormonal kontraseptifler

Tablo 5: Türkiye'de bulunan kombine oral kontraseptifler

Ürün adı	İçeriği, dozu ve formu	Piyasaya veriliş tarihi
Microgynon	Levonorgestrel 0.15 mg, Etinil östradiol 0.03 mg / 21 draje	Nisan 1979
Desolett	Desogestrel 0.15 mg, Etinil östradiol 0.03 mg / 21 tablet	Ağustos 1985
Diane 35*	Siproteron asetat 2 mg, Etinil östradiol 0.035 mg / 21 draje	Eylül 1989
Ginera	Gestoden 0.075 mg, Etinil östradiol 0.03 mg / 21 draje	Eylül 1993
Myralon	Desogestrel 0.15 mg, Etinil östradiol 0.02 mg / 21 tablet	Mayıs 1995
Miranova	Levonorgestrel 0.1 mg, Etinil östradiol 0.02 mg / 21 draje	Ocak 2001
Yasmin	Drospirenon 3 mg, Etinil östradiol 0.03 mg / 21 tablet	Şubat 2003
Gynelle	Siproteron asetat 2 mg, Etinil östradiol 0.035 mg / 21 draje	Şubat 2007
Belara	Klormadinon asetat 2 mg, Etinil östradiol 0.03 mg / 21 film tablet	Ocak 2008
Yazz	Drospirenon 3 mg, Etinil östradiol betadeks 0.02 mg / 28 tablet (24 tablet + 4 plasebo)	Nisan 2009
Elleacnelle*	Siproteron asetat 2 mg, Etinil östradiol 0.035 mg / 21 draje	Eylül 2010
Jerbera	Levonorgestrel 0.15 mg, Etinil östradiol 0.03 mg / 21 draje	Kasım 2010

Kombine hormonal kontraseptifler

- Menopozal semptomların tdv.si
- BMD ↑ (perimenopozal E ↓)
- Over, Em ve Kolo-rektal ca.lere karşı koruyucu
- Tüm E içeren rejimler; E tipi, dozu, veriliş şekli ve hangi P le kombine edilmiş olursa olsun hepsi benzer fayda ve güvenlik kaygıları taşımaktadır

- Kanama düzensizlikleri, baş ağrısı, meme hassasiyeti
- 35 yaş ↑ sigara (FSRH)
- (50 yaş üzerinde) ↑ VTE riski
- Meme ca. riskini ↑
- Serviks ca riskini ↑

Acil kontrasepsiyon (KHK)

	30-35 mcg EE 150 mcg LNG	50 mcg EE 250 mcg LNG
Step 1	İlk 72 h: 1x4	İlk 72 h: 1x2
Step 2	12 h sonra: 1x4	12 h sonra 1x2
Step 3	3 hf sonra β-hcg	3 hf sonra β-hcg

Table 1: Venous thromboembolism risk for all women by type of combined hormonal contraception used[1]

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/ Reproduced with permission

= EV + DNG

VTE riski en yüksek ilk 3 ayda mg
Bırakıp tekrar başlamak > Sürekli kullanım

Table 2. Relative Risk of Breast Cancer, According to Duration of Use of Hormonal Contraceptives and Time since Last Use, among Women Followed until December 31, 2012.

Variable	No. of Person-Yr	No. of Breast-Cancer Events	Age-Adjusted Incidence Rate	Adjusted Relative Risk (95% CI)*	P Value†	Age-Adjusted Risk Difference (95% CI)
			no. of events/ 100,000 person-yr			*no. of events/ 100,000 person-yr*
Never used hormonal contraception	7,815,180	5955	55	1.00 (Reference)		Reference
Used hormonal contraception >6 mo previously	4,348,722	2883	58	1.08 (1.03 to 1.13)		3 (1 to 6)
Duration of current or recent use of hormonal contraception‡						
Any hormonal contraception	7,308,437	2679	68	1.20 (1.14 to 1.26)	0.002	13 (10 to 16)
<1 yr	1,170,657	266	58	1.09 (0.96 to 1.23)		3 (–5 to 10)
1 to <5 yr	3,339,451	909	64	1.18 (1.10 to 1.27)		9 (4 to 13)
5 to 10 yr	2,118,912	899	69	1.24 (1.15 to 1.34)		14 (9 to 19)
>10 yr	679,417	605	74	1.38 (1.26 to 1.51)		19 (13 to 25)
Combined oral contraceptives	6,424,088	1935	68	1.19 (1.13 to 1.26)	<0.001	13 (10 to 17)
<1 yr	1,084,435	194	54	1.03 (0.89 to 1.19)		–1 (–8 to 8)
1 to <5 yr	2,980,688	603	64	1.17 (1.07 to 1.27)		9 (3 to 14)
5 to 10 yr	1,808,425	652	70	1.27 (1.16 to 1.38)		15 (8 to 21)
>10 yr	550,540	486	76	1.46 (1.32 to 1.61)		21 (14 to 28)
Time since most recent use of hormonal contraception						
Any hormonal contraception					0.73	
<1 yr	1,039,247	455	60	1.09 (0.99 to 1.29)		5 (–1 to 11)
1 to <5 yr	1,989,435	1152	57	1.03 (0.96 to 1.10)		2 (–2 to 5)
5 to 10 yr	983,689	859	58	1.04 (0.97 to 1.12)		3 (–1 to 7)
>10 yr	341,657	417	58	1.08 (0.97 to 1.20)		3 (–3 to 4)
Combined oral contraceptives§					0.55	
<1 yr	1,032,653	400	60	1.05 (0.95 to 1.17)		5 (–2 to 12)
1 to <5 yr	2,169,364	1166	56	1.00 (0.93 to 1.06)		1 (–3 to 4)
5 to 10 yr	1,174,457	1026	60	1.05 (0.98 to 1.13)		5 (1 to 9)
>10 yr	431,393	524	62	1.05 (0.96 to 1.16)		7 (–1 to 16)

Table 2: Recommendations regarding stopping contraception[1]

Contraceptive method	Age 40–50 years	Age >50 years
Non-hormonal	Stop contraception after 2 years of amenorrhoea	Stop contraception after 1 year of amenorrhoea.
Combined hormonal contraception	Can be continued	Stop at age 50 and switch to a non-hormonal method or IMP/POP/LNG-IUS, then follow appropriate advice.
Progestogen-only injectable	Can be continued	Women ≥50 should be counselled regarding switching to alternative methods, then follow appropriate advice.
Progestogen-only implant (IMP) **Progestogen-only pill (POP)** **Levonorgestrel intrauterine system (LNG-IUS)**	Can be continued to age 50 and beyond	Stop at age 55 when natural loss of fertility can be assumed for most women: • If a woman over 50 with amenorrhoea wishes to stop before age 55, FSH level can be checked • If FSH level is >30 IU/l the IMP/POP/LNG-IUS can be discontinued after 1 more year • If FSH level is in premenopausal range then method should be continued and FSH level checked again 1 year later.
		A Mirena® LNG-IUS inserted ≥45 can remain *in situ* until age 55 if used for contraception or heavy menstrual bleeding.

IMP=progestogen-only implant; POP=progestogen-only pill; LNG-IUS=levonorgestrel intrauterine system; FSH=follicle-stimulating hormone; IU=international unit

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/ Reproduced with permission

Table 3: Contraceptive options in conjunction with hormone replacement therapy[1]

Contraceptive method	Safety with hormone replacement therapy	Role in hormone replacement therapy	
		Women aged <50	Women aged ≥50
Levonorgestrel intrauterine system (LNG-IUS)	Safe to use as contraception alongside oestrogen of choice.	Mirena® is licensed for endometrial protection when combined with oestrogen. 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.	
Progestogen-only injectable	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 oestrogen as part of HRT but cannot be recommended as unlicensed for this indication.	
Progestogen-only implant (IMP)	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.	
Progestogen-only pill (POP)	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.	
Combined hormonal contraception (CHC)	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.

LNG-IUS=levonorgestrel intrauterine system; HRT=hormone replacement therapy; IMP=progestogen-only implant; POP=progestogen-only pill; CHC=combined hormonal contraception

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/ Reproduced with permission

Table 2. Selected UKMEC categories relevant for perimenopausal women

Eligibility criteria			CHC	ENG implant or POP	DMPA	Cu-IUD	LNG-IUD
Arterial vascular disease and risk factors							
Multiple risk factors for cardiovascular disease	For example older age, smoking, diabetes, hypertension and obesity		3	2	3	1	2
Smoking	Age ≥35 years	<15 cigarettes/day	3	1	1	1	1
		≥15 cigarettes/day	4	1	1	1	1
Obesity	BMI 30–34 kg/m²		2	1	1	1	1
	BMI ≥35 kg/m²		3	1	1	1	1
Hypertension	Adequately controlled		3	1	2	1	1
	Consistently elevated systolic 140–159 mmHg or diastolic 90–99 mmHg		3	1	1	1	1
	Consistently elevated systolic ≥160 mmHg or diastolic ≥100 mmHg		4	1	2	1	1
Current and history of IHD, stroke or TIA: To initiate			4	2	3	1	2
Current and history of IHD, stroke or TIA: To continue			4	3	3	1	3

Table 2. Selected UKMEC categories relevant for perimenopausal women

Eligibility criteria		CHC	ENG implant or POP	DMPA	Cu-IUD	LNG-IUD
VTE current (on anticoagulant) or history of		4	2	2	1	2
Family history VTE	First-degree relative aged <45 years	3	1	1	1	1
	First-degree relative aged ≥45 years	2	1	1	1	1
Major surgery	With prolonged immobilisation	4	2	2	1	2
Immobility, unrelated to surgery		3	1	1	1	1
Known thrombogenic mutation		4	2	2	1	2
Breast and reproductive tract conditions						
	Carriers of known gene mutations associated with breast cancer	3	2	2	1	2
	Current breast cancer	4	4	4	1	4
	Past breast cancer	3	3	3	1	3
Endocrine conditions						
Diabetes	Non-vascular disease, insulin or non-insulin-dependent	2	2	2	1	2
	Nephropathy/retinopathy/neuropathy or other vascular disease	3	2	2	1	2

Sonuçlar

- Perimenopozal dönemde azalan over rezervine rağmen istenmeyen gebelik oranları yüksektir
- Bu dönemde de hormonal ve non-hormonal yöntemler kullanılabilir
- Yaş tek başına hormonal kontrasepsiyon kullanımı açısından bir risk oluşturmamakta ancak ilerleyen yaşla birlikte sıklığı artan yandaş sağlık sorunları bazı kısıtlamalar getirmekte
- Hormonal kontrasepsiyonun menopoza geçiş döneminde meydana gelebilen vazomotor semptomları önlemesi de bu yaş grubu seçilmiş hastalarda avantaj sağlayabilmekte
- Her hasta için bireysel bazda risk ve kontrendikasyon profilini değerlendirmeyi sağlayabilecek Tıbbi uygunluk kriterleri kılavuzları kullanılabilir (www.who.int / www.fsrh.org)

1.

Ege Endometriozis - Adenomyozis Sempozyumu

7-8 Şubat 2019

EGE ÜNİVERSİTESİ MUHİDDİN EREL AMFİSİ