Hormonal Contraception in Older Reproductive Women and Transition to Menopausal Hormone Therapy

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Although fecundability declines in older reproductive age women, sporadic ovulation continues until menopause. In addition, older reproductive women are more likely than their younger counterparts to suffer adverse consequences should they conceive. Accordingly, contraception remains important in older reproductive age women. Furthermore, perimenopausal vasomotor symptoms (VMS) and irregular bleeding are prevalent. Fortunately, Centers for Disease Control, ACOG, and NAMS guidance regarding contraceptive selection for older reproductive age women are congruent. Healthy nonsmoking women can use combination hormonal contraceptives (CHCs: pills, patches, and rings) until menopause. In older reproductive age women smoking, obesity, hypertension, and migraines with aura place women at unacceptable risk for cardiovascular and cerebrovascular events when using CHCs. In this population, progestin-only contraceptives (pills, injection, implant, IUDs) are appropriate. Whether or not combination pills elevate breast cancer risk is controversial: if an increased risk is present, the magnitude of this risk is small and should be weighed against noncontraceptive benefits including reduced risks of ovarian and endometrial cancer and osteoporotic fractures as well as effective treatment of abnormal bleeding and VMS. Checking FSH levels in perimenopausal women is not useful and may be misleading. In healthy nonsmoking women, CHCs can be continued until women are in their mid-50s, at which time they can discontinue contraception and seamlessly transition to menopausal hormone therapy, if they wish. For some perimenopausal women, placing a progestin IUD and adding estrogen when VMS occur represents an appealing strategy.