Menstrual Suppression

Guidance and Resources on Menstrual Suppression Care for Service Women

Disclaimer: Any mention of commercial services, applications or products is provided as a matter of common interest and is not intended as an endorsement.

Overview

- Background
- Menstrual Suppression Options
- Provider Resources
- Patient Resources
- Menstrual Product Options
- Management of Breakthrough Bleeding on Hormonal Contraceptives

Background

Disclaimer

- This information pertinent only when counseling patients with regular menses (every 21-35 days with bleeding lasting < 7 days), without amenorrhea or menorrhagia.
- Pertinent only to counseling patients without underlying bleeding, endocrine, pregnancy, or uterine disorders.

Background

Impact to Active Duty Females

- Active duty females encounter conditions which make management of menses challenging.
- Field conditions make carrying and management of menstrual products difficult.
- Therefore suppression or elimination of menses is often desirable for female service members.

Background

What is amenorrhea?

- Amenorrhea – Absence of menses.
- Complete amenorrhea may be difficult to achieve, and realistic expectations should be addressed with the patient and her caregivers.
- The goal in menstrual manipulation should be optimal suppression, which means a reduction in the amount and total days of menstrual flow.

Background

Remember

Conduct a pregnancy test for amenorrhea – especially in sexually active patient using pills with poor compliance or with signs/symptoms of pregnancy.

Pregnancy Test | *Source: Centers for Disease Control and Prevention (CDC)*

Background

How to be Reasonably Certain That a Woman is Not Pregnant

A health-care provider can be reasonably certain that a woman is not pregnant if she has no symptoms or signs of pregnancy and meets any one of the following criteria:

- Is ≤ 7 days after the start of normal menses
- Has not had sexual intercourse since the start of last normal menses
- Has been correctly and consistently using a reliable method of contraception
- Is ≤ 7 days after spontaneous or induced abortion
- Is within 4 weeks postpartum
- Is fully or nearly fully breastfeeding (exclusively breastfeeding or the vast majority [≥85%] of feeds are breastfeeds), amenorrheic, and ≤6 months postpartum

Guidance on Uncertain Pregnancy Situations

In situations in which the health-care provider is uncertain whether the woman might be pregnant, the benefits of starting the implant, depot medroxyprogesterone acetate (DMPA), combined hormonal contraceptives, and progestin-only pills likely exceed any risk. Therefore, starting the method should be considered at any time, with a follow up pregnancy test in 2-4 weeks. For intrauterine device (IUD) Insertion, in situations in which the healthcare provider is uncertain that the woman is not pregnant, the woman should be provided with another contraceptive method to use until the healthcare provider can be reasonably certain that she is not pregnant and can insert the IUD.

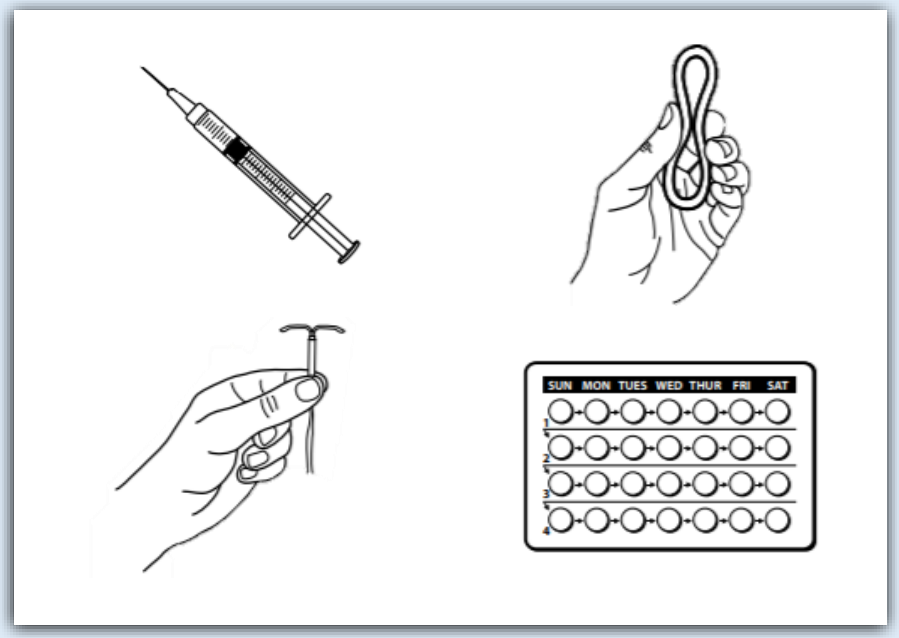
Centers for Disease Control and Prevention, "U.S. Selected Practice Recommendations for Contraceptive Use", 2013 *Adapted from the World Health Organization Selected Practice Recommendations for Contraceptive Use*, 2nd Edition).

Menstrual Suppression Options

Menstrual Suppression Options

Options

- Nonsteroidal anti-inflammatory drugs (NSAIDs)
- Progestin-Only Methods
- Combination Estrogen-Progesterone Methods
- NuvaRing®
- Intrauterine Device



Menstrual Suppression Options | *Source: Centers for Disease Control and Prevention (CDC)*

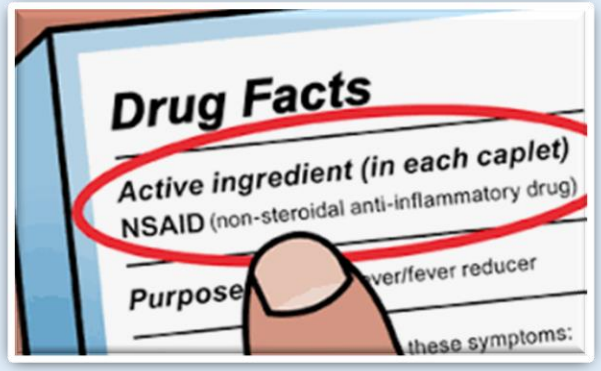
Nonsteroidal Anti-Inflammatory Drugs (NSAIDs)

Background

- Antiprostaglandin drugs, in adequate dosages based on the patient's weight, decrease ovulatory menstrual bleeding by approximately 30–40%.
- Although this treatment will not stop menses, it may help with pain and bleeding.

Types of NSAIDs

- Motrin® 800 mg every 8 hours orally during menses.
- Celecoxib 200 mg orally daily during menses.
- Mefenamic Acid 500 mg orally three times a day during menses.



NSAIDs | *Source: Food and Drug Administration (FDA)*

Progesterone Pills aka Micronor (Mini-Pill)

What are progesterone pills?

- Efficacy in achieving amenorrhea is dependent on dose and adherence to taking the hormone as close to the same time each day as possible.
- Mini-pill not a good option for contraception due to need for taking at nearly exact time each day.
- Most commonly used for breast feeding mothers postpartum.

Mini-Pill | *Source: Food and Drug Administration (FDA)*

Medroxyprogesterone Injection

Depo-Provera ("The Shot")

How to Use

- Administered by a provider every **3 MONTHS** or patient can self-administer a subcutaneous shot (104mg SC instead of IM).

Pros

- **94% effective** at preventing unplanned pregnancy.
- Easily reversible (you can stop injections to try for pregnancy).
- Makes periods **shorter and lighter.**

Cons

- Can cause **irregular menstrual bleeding.**
- Average **weight gain** of 5 lbs.
- Long term may cause **BONE LOSS.**
- **Does not prevent against sexually transmitted infections (STIs).**

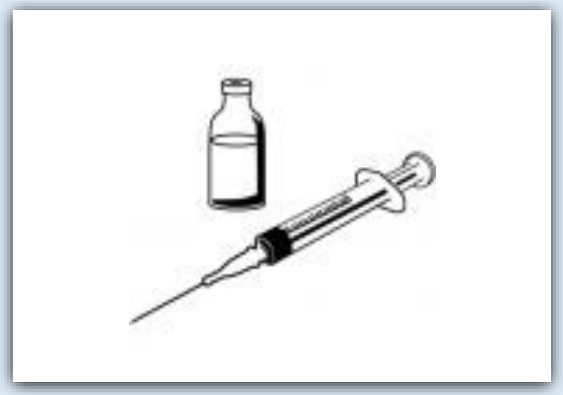
Implications for Military Service

- May be difficult to continue shots over time.
- Self-administered shots may encourage patients to continue regular use.

Intramuscular Depo Medroxyprogesterone Acetate

Background

- 150 mg (administered in 1 mL syringe).
- Given intramuscular (IM) injection (usually buttock or arm) every 3 months (13 weeks). If more than 13 weeks between injections, rule out pregnancy prior to administration.
- Suppresses ovulation, thickens cervical mucous to keep sperm from reaching egg.
- Thins endometrial lining which reduces flow and may result in amenorrhea.
- Once discontinued, may take 10+ months to resume ovulation (delay in fertility).
- 0.3% of women will have an accidental pregnancy in the first year of use.
- Ok for nursing mothers.

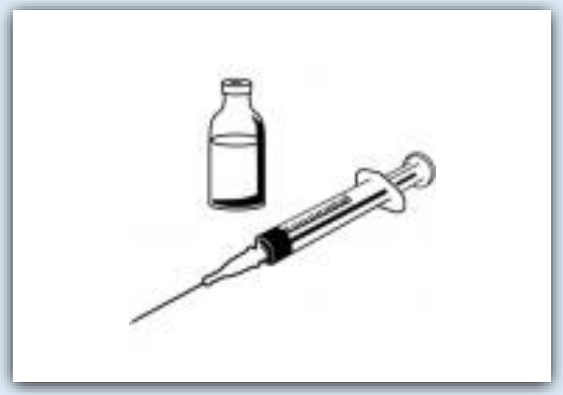


Depo-Provera Shot | *Source: Food and Drug Administration (FDA)*

Intramuscular Depo Medroxyprogesterone Acetate

Impact

- By 12 months: 55% of women have amenorrhea.
- By 24 months: 68% of women have amenorrhea.
- Fracture risk—Although a decrease in bone density has been described with DMPA use, there is evidence of adequate bone density recovery after DMPA is discontinued.
- Weight gain—The average weight gain is 5.4 pounds in the first year of use, and 8.1 pounds after 2 years of therapy.



Depo-Provera Shot | *Source: Food and Drug Administration (FDA)*

Estrogen-Progestin Oral Contraceptives

Impact of Use

- Continuous Use: Take hormonally active pills daily indefinitely, without an induced withdrawal bleed.
- Extended Use: Take hormonally active pills daily for intervals of several months, thus minimizing scheduled bleeds to only a few times per year.
- Anticipate unscheduled bleeding and spotting, particularly during the first three months of use - improves to 80 to 90 percent by months 10 to 12.
- Levonorgestrel (LNG), 30 rather than 20 mcg of ethinyl estradiol (EE), results in less unscheduled bleeding than other formulations.

Uptodate, "Levonorgestrel Systemic Drug Information"

Oral Contraceptives | *Source: Office on Women's Health (OWH)*

Estrogen-Progestin Oral Contraceptives

The Pill

How to Use

- Taken orally daily.
- Can skip the placebo week and start a new pack in order **to skip a period.**
- Can **help with acne** and **makes periods shorter and lighter** (or absent if you skip the placebo week).
- Combined Oral Contraceptive Pills (OCPs) can be used continuously for an extended period to obtain optimal suppression.

Pros

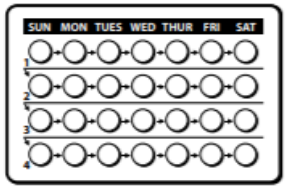
- **91% effective** at preventing unplanned pregnancy.
- Easily **reversible** (you can stop taking it to try for pregnancy).
- Can **help regulate** and **skip periods.**

Cons

- **Needs to be taken daily.**
- Requires refills (can only get 6 months worth of pills in advance).
- **Does not prevent against STIs.**

Implications for Military Service

- Challenging for long-term, deployed settings.
- Breakthrough bleeding can often occur during first few months of use.



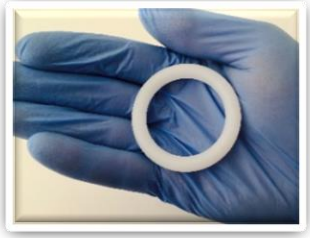
Oral Contraceptives | *Source: Centers for Disease Control and Prevention (CDC)*

NuvaRing®; not ideal for deployed settings

NuvaRing® ("The Ring")

How to Use

- Placed **inside the vagina** for **3 weeks.**
- Fourth week: leave it out and have a period
- Insert a new ring the following week.
- **May remove the ring for up to 3 hours.**

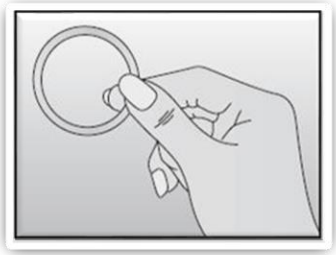


Pros

- **93% effective** at preventing unplanned pregnancy.
- Easily reversible (you can stop insertion it to try for pregnancy).
- Can **skip a period** by placing a new ring every 3 weeks
- Makes periods **shorter and lighter.**

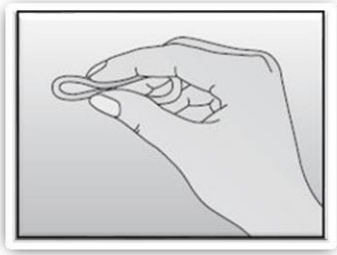
Cons

- Often needs to be stored in a refrigerator.
- Lack of privacy in communal space.
- **Does not prevent against STIs.**



Implications for Military Service

- **Not optimal if deploying to very hot environment** (needs to be stored around 77° F, no hotter than 86° F).
- **Not optimal in close quarters for privacy.**



The Ring Images | *Source: National Institutes of Health (NIH)*

IUDs

IUD Myths

- Abortifacients
- Large in size
- Cause ectopic pregnancies
- Cause pelvic infection
- Promotes infertility
- Need to be removed for pelvic inflammatory disease (PID)
- Need removal for inflammatory changes on a Pap Smear test
- Fetal abnormality if pregnancy occurs

IUD Truths

- ***Can*** be:
  - used by women who have had an ectopic pregnancy
  - inserted same day
  - started immediately postpartum or post-abortion
  - used by nulliparous women
- ***Have:***
  - high continuation rates (76 to 87% at 1 year)

Duenas JL. *Contraception*. 1996; Forrest JD. *Obstet Gynecol Surv*. 1996; Hubacher D. *N Engl J Med*. 2001; Lippes *J. Am J Obstet Gynecol*. 1999; Otero-Flores JB. *Contraception*. 2003; Penney G. *J Fam Plann Reprod Health* Care. 2004; Stanwood NL. *Obstet Gynecol*. 2002; *Medical Eligibility Criteria for Contraceptive Use. 4th ed.* 2009; Rosenstock JR. *Obstet Gynecol.* 2012.

IUDs Do Not Cause PID or Infertility

Risk Myth Busting

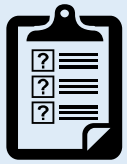
- PID incidence among IUD users is similar to that among the general population.
- Risk is increased only during the first month after insertion.
- Preexisting STI at time of insertion, not IUD itself, increases risk.
- Chlamydial infection, not use of IUD, is associated with increased risk of tubal occlusion (NOTE: test if indicated based on risk factors/treat through if positive).

IUD | *Source: Centers for Disease Prevention and Control (CDC)*

IUD and Implant Images | *Source: Centers for Disease Control and Prevention (CDC)*

Few Absolute Contraindications to IUD Use

Contraindications to Consider



- Known or suspected pregnancy
- Sepsis (Postpartum & Abortion)
- Unexplained vaginal bleeding at initiation
- Pelvic tuberculosis at initiation
- Uterine fibroids that interfere with placement
- Uterine distortion (congenital or acquired)
- Cervical cancer at initiation
- Endometrial cancer at initiation
- Active purulent cervicitis/PID
- Breast cancer <5 years (hormonal IUDs)

Centers for Disease Control, *MMWR;* 2016. WHO. *Medical Eligibility Criteria for Contraceptive Use. 4th ed.* 2009.

IUDs and Implants – various effects on menstrual cycle

Name	Type	Coverage	Additional Information
Kyleena® 	IUD	5 Years	• 99% effective at preventing pregnancy • Fewer hormones than Mirena, but more than Skyla • May have irregular periods or no period • Slightly smaller than Mirena
Liletta® 	IUD	5 Years	• 99% effective at preventing pregnancy • May have irregular periods or no period at all • Slightly smaller than Mirena
Mirena® 	IUD	5 Years	• 99% effective at preventing pregnancy • Highest dose of hormones and slightly larger • More likely to have irregular periods or no period at all
ParaGard® 	IUD	10 Years	• 99% effective at preventing pregnancy • Hormone free • Periods are usually regular or slightly heavier
Skyla® 	IUD	3 Years	• 99% effective at preventing pregnancy • Slightly smaller than Mirena, less hormone dose • May have irregular spotting or no period at all
NEXPLANON® 	Implant	3 Years	• 99% effective at preventing pregnancy • May have irregular spotting or no period at all

Provider Resources

Useful Tools & Patient Education Materials

US MEC
US SPR
CDC

There is an app for that!

- http://www.cdc.gov/reproductivehealth/contraception/usspr.htm
- http://www.bedsider.org
- Food and Drug Administration (FDA) Office of Women's Health: www.fda.gov/womens
- FDA Pt. Education Materials: www.fda.gov/womenshealthplus

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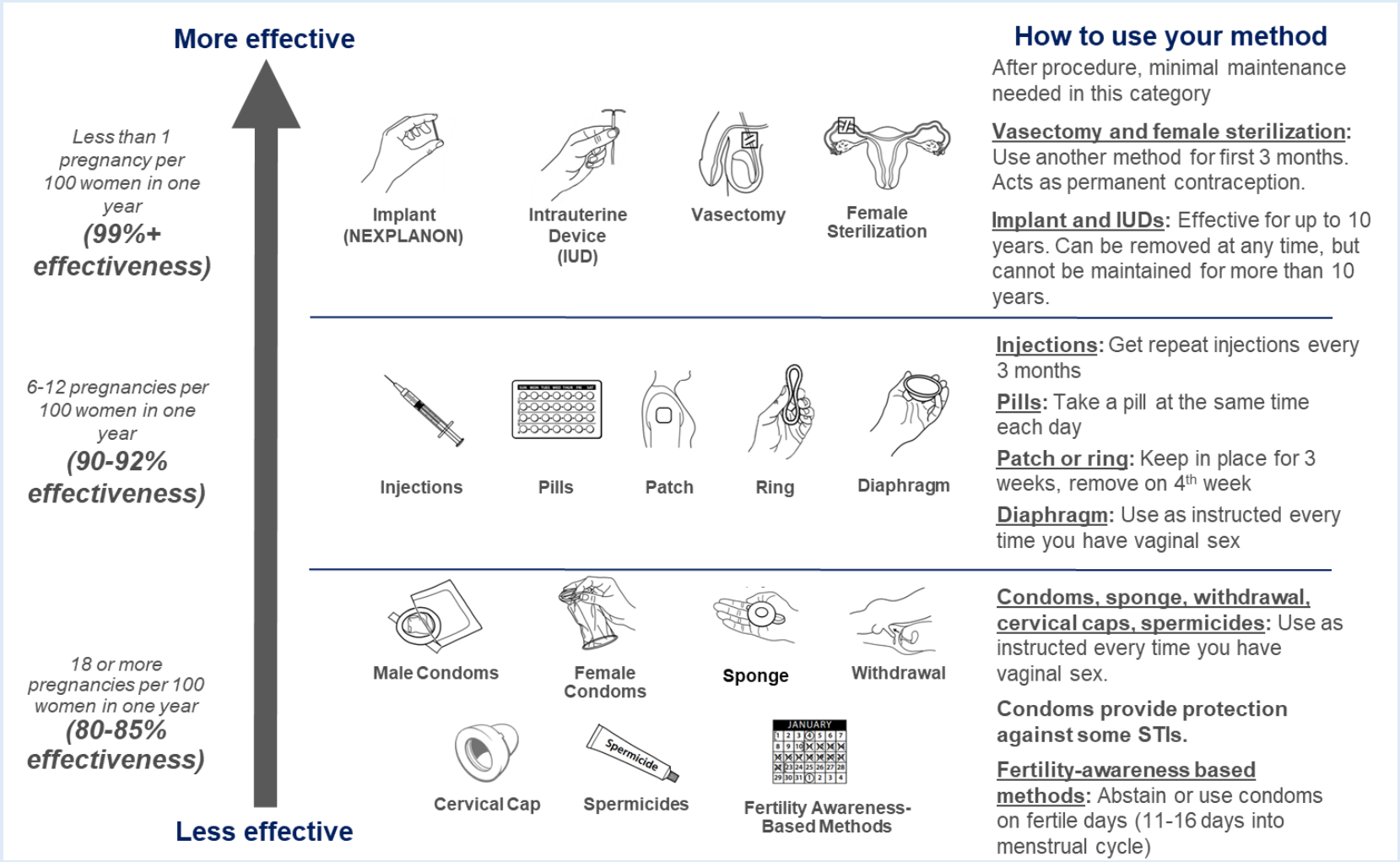
Effectiveness of Contraceptive Options



Contraception Option Images | *Source: Centers for Disease Control and Prevention (CDC) and Food and Drug Administration (FDA)*

Additional Resources

Association of Reproductive Health Professionals (ARHP)
- http://www.arhp.org

Centers for Disease Control and Prevention (CDC)
- https://www.cdc.gov/reproductivehealth/index.html

Navy Marine Corps Public Health Center (NMCPHC) Sexual Health and Responsibility Program (SHARP)
- http://www.med.navy.mil/sites/nmcphc/health-promotion/reproductive-sexual-health/pages/sharp.aspx

Planned Parenthood
- https://www.plannedparenthood.org/

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Free Resources for Providers and Free Handouts for Patients

ARHP

- http://www.arhp.org/Publications-and-Resources
- http://www.arhp.org/Professional-Education/Chalk-Talk-Is-Medication-Abortion-Right-for-Me (video on abortion)

FDA

- https://www.fda.gov/downloads/ForConsumers/ByAudience/ForWomen/TaketimetoCareProgram/UCM515773.pdf (FDA resource on contraception geared toward college age)
- https://www.fda.gov/ForConsumers/ByAudience/ForWomen/FreePublications/default.htm (FDA free publications for women that you can order online to have them mailed to you)
- https://orders.gpo.gov/fda-womens-health.aspx (link to order the various publications)

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Free Resources for Providers and Free Handouts for Patients

Milsuite

- https://www.milsuite.mil/book/groups/womens-health-family-planning-sub-community/ (Military women's health family planning sub-community with links to handouts on Contraceptive Walk-in clinic, etc)

SHARP

- http://www.med.navy.mil/sites/nmcphc/health-promotion/reproductive-sexual-health/Pages/reproductive-and-sexual-health.aspx (SHARP website for women's health)

Application (App)

- U.S. Medical Eligibility Criteria (MEC)/U.S. Selected Practice Recommendations (SPR) CDC app on how to choose contraception for a patient. Basically you can look up a patient's symptoms (migraines, obesity, HTN, etc) and it will tell you what you can give them (or not give them) based upon medical criteria. To find it in the app store search for "CDC Contraception".

- A 'paper' version of this is : https://www.cdc.gov/reproductivehealth/contraception/pdf/summary-chart-us-medical-eligibility-criteria_508tagged.pdf (also see attached PDF 'summary chart'; it's great to determine who can get what contraception). Also is the "FDA contraception chart" which shows efficacy.

Patient Resources

AHRP Resources

Patient Resources

Contraception Method Match Tool

- http://www.arhp.org/MethodMatch

Understanding Menstrual Suppression Factsheet

- http://www.arhp.org/Publications-and-Resources/Patient-Resources/fact-sheets/Understanding-Menstrual-Suppression/

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How to Skip Periods

Oral Contraceptives

- Skip the last week (placebo), start a new pack.
- Can do this continuously, or can take the placebo week every 3-4 months to have a period (this will reduce the amount of breakthrough bleeding).

NuvaRing®

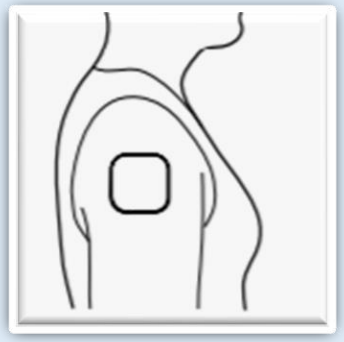
- Replace the ring every 3 weeks with no ‘week free’ interval.
- Can do this continuously, or have a ‘week free’ interval every 3-4 months to have a period (this will reduce the amount of breakthrough bleeding).

Depo Provera

- No daily maintenance required.
- If breakthrough bleeding occurs, try taking Motrin® 800 mg every 8 hours for 7 days, or, speak to your provider about options.

The Patch: Not Recommended to Skip Periods

Xulane (The Patch)
It is **not recommended** to advise patients to apply a new patch after the third week to avoid their period.



The Patch | *Source: Centers for Disease Control and Prevention (CDC)*

How to Skip Periods

Guidance for Hormonal IUDs and NEXPLANON ®

No daily maintenance required.

If breakthrough bleeding occurs, try taking Motrin® 800 mg every 8 hours for 7 days, or, speak to your provider about options.

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Menstrual Product Options

Menstrual Products

Menstrual Cups

- Folded and inserted in the vagina for up to 12 hours
- Reusable: patients wash the cup with soap and water and reinsert 2-3 times per day
- Durable: menstrual cups can be used up to 10 years
- Can be used with IUDs

Menstrual Discs

- Folded and inserted in the vagina for up to 12 hours
- Disposable: patients dispose of the product and insert a new one after up to 12 hours
- Average use of 8 discs per cycle
- Can be used with IUDs

Menstrual Underwear

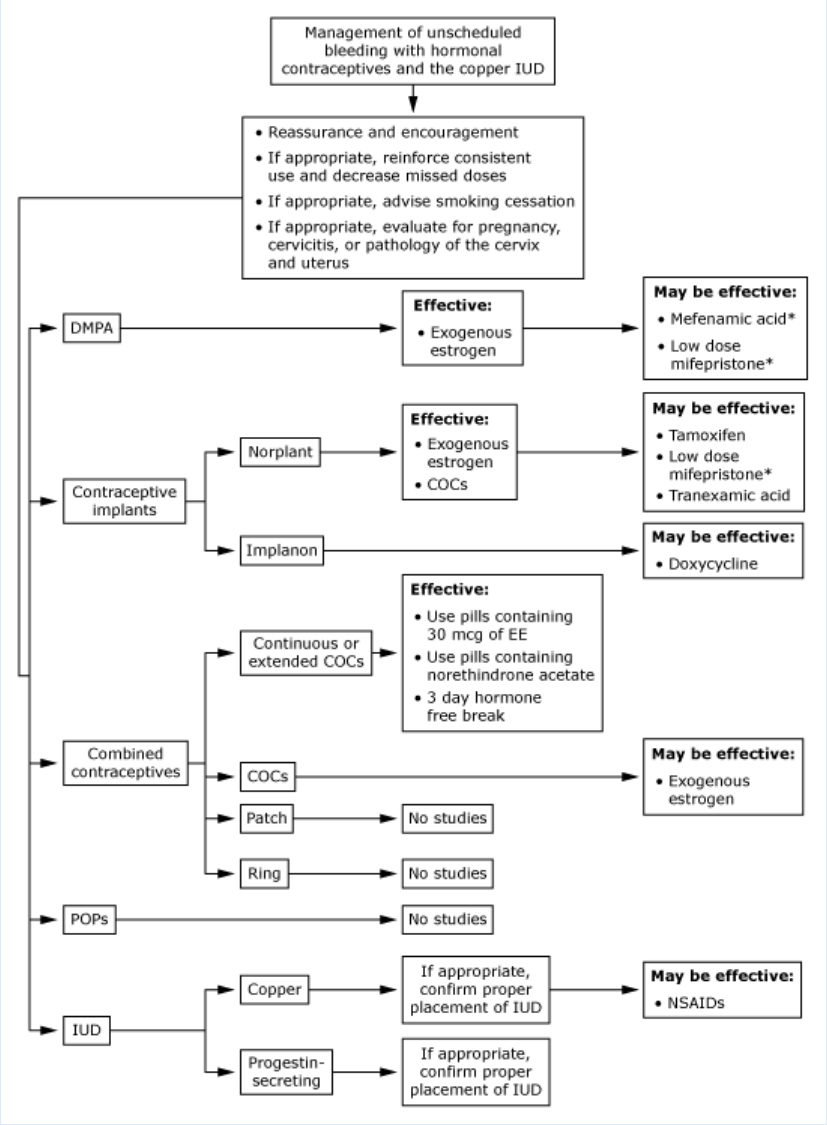
- Collects menstrual blood, keeping area dry and bacteria-free
- Can hold up to 2 tampons worth of menstrual blood.
- Can provide back-up protection for tampons and pads
- Can be used with IUDs

Management of Breakthrough Bleeding on Hormonal Contraceptives

Management of Unscheduled Bleeding in Women Using Contraception

Acronym Key

- **COCS:** Combined oral contraceptives
- **IUD:** intrauterine contraceptive device
- **POPs:** progestin-only pills
- **NSAIDS:** nonsteroidal anti-inflammatory drugs
- **EE:** ethinyl estradiol



Bleeding with Continuous Use Combined Hormonal Contraceptives

Consider Hormone-Free Interval

- United States Selected Practice Recommendations for Contraceptive Use (2016) recommend discontinuing the combined hormonal contraceptive for **3-4 consecutive days** (i.e. a hormone-free interval), as long as this is done **after the first 21 days of hormone use**.
- The intervention of scheduling a short hormone-free interval can be repeated whenever bothersome breakthrough bleeding occurs while on continuous hormonal contraception.
  - Most patients do well with a scheduled bleed for 3-4 days every 3 months.
  - Over time, breakthrough bleeding episodes will become spaced out and stop.
- **This technique should not be used more frequently than every three weeks in order to maintain contraceptive effectiveness.**
- Women using contraceptive ring continuously
  - For women using the vaginal ring continuously, a randomized trial found that when unscheduled bleeding persisted for five or more days, women who removed the ring for four days and then reinserted it generally had fewer subsequent days of bleeding than those who continued use of the ring.

Doxycycline

Doxycycline as Treatment for Breakthrough Bleeding

- The use of the antibiotic doxycycline was not effective in decreasing unscheduled bleeding in continuous combined oral contraceptive users when taken at the onset of unscheduled bleeding.
- Doxycycline was studied because it inhibits matrix metalloproteinases. Matrix metalloproteinases play a role in endometrial degradation and are thought to be upregulated by the progestin dominant effect of hormonal contraceptives.
- However, co-administration of doxycycline (40 mg daily) for the first 84 days after beginning continuous oral contraceptive pills resulted in a significant reduction in the length of time needed to achieve amenorrhea (62 versus 85 days).

Uptodate, “Doxycycline Drug Information”.

Tranexamic Acid

Tranexamic Acid as Treatment for Breakthrough Bleeding

- Tranexamic acid is an antifibrinolytic used primarily during operative procedures in patients with hemophilia.
- A randomized placebo-controlled trial of 100 DMPA users with unscheduled bleeding found that tranexamic acid 250 mg orally four times per day for five days was effective in halting bleeding . The tranexamic acid group had a significantly higher percentage of subjects in whom unscheduled bleeding stopped during the first week of treatment (88 versus 8.2 percent with placebo), and during the four-week follow-up period (68 versus 0 percent with placebo).
- The mean number of bleeding/spotting days was also significantly different between the groups (5.7 versus 17.5 days).

Uptodate, “Tranexamic Drug Information”.

NSAIDS

NSAIDS as Treatment for Breakthrough Bleeding

- May decrease overall bleeding
- Motrin® 800 mg every 8 hours orally for 5-7 days
- Celecoxib 200 mg orally for 5-7 days
- Mefenamic Acid 500 mg orally three times a day for 5-7 days

Protocol for Nexplanon® Related Irregular Bleeding

1

- OPTION 1: Start with combined oral contraceptive monophasic medication containing 30-35 mcg estrogen dose (Mononessa)
  - Double up on pills until bleeding stops (usually 3-5 days)
  - Discard that pack and restart new pack for one month, wait to see if bleeding recurs
  - If patient with spotting only, can start with 1 pill per day (QD) for 14-30 days

Protocol for Nexplanon® Related Irregular Bleeding

2

- OPTION 2: Use conjugated estrogens (Premarin) at 1.25 mg or Estradiol (Estrace) at 2 mg daily for 7 days, wait to see if bleeding recurs
  - If bleeding recurs: use conjugated estrogens (Premarin) at 1.25 or Estradiol (Estrace) at 2 mg daily for 7 days again PLUS Doxycycline 100 mg bid for 10 days, wait to see if bleeding recurs.
  - If bleeding recurs: start combined oral contraceptive, patch, or ring (based on patient preference), do this for 3 continuous months, patient should not take the placebo pills. Follow up with provider 2 weeks after completion of the 3 months.

Protocol for Nexplanon® Related Irregular Bleeding

3 • OPTION 3: Patch (Xulane) for one month, wait to see if bleeding recurs

4 • OPTION 4: NuvaRing® for one month, wait to see if bleeding recurs

GOAL: Stop the acute heavy or prolonged bleeding and reset the menstrual cycle. Remind patients only 30% of patients develop amenorrhea with NEXPLANON® and their bleeding can continue to be irregular, heavy, light, or with spotting

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