

# Postponing menstruation: choices and concerns

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## BACKGROUND

Since writing an editorial for this journal in 2014<sup>1</sup> I have been repeatedly asked about my views on postponing menstruation. Women in the 21st century want to avoid periods when on holiday yet have difficulty accepting highly effective, reversible forms of contraception which provide infrequent bleeding. Authors of a *BMJ* article published 16 years ago suggested that prescribing progestogens to delay periods was a lifestyle choice and should not be funded by the National Health Service.<sup>2</sup> I am not sure I feel that strongly but I do think women need to know all options and any potential risks or side effects associated with each treatment – they may think twice.

## NORETHISTERONE

Only one drug is licensed to postpone menstruation in the UK and that is norethisterone. The Summary of Product Characteristics (SPC) state that at low dose '5 mg three times a day' norethisterone may be used to treat "metropathia haemorrhagica, premenstrual syndrome, postponement of menstruation, dysmenorrhoea, endometriosis and menorrhagia".<sup>3</sup> There is limited evidence to support these indications<sup>1</sup> but it does delay the onset of menses. Why has norethisterone been our preferred choice for this indication? First, it works; second, it is cheap; and third, many women return to our clinics requesting a further supply year on year when they head off to the sun in the summer.

My reservations about the use of norethisterone in postponing menstruation are related to safety. There is evidence to suggest that taking norethisterone at doses of 10 mg or more a day may increase a person's risk of venous thromboembolism (VTE).<sup>1</sup> Norethisterone is one of a few progestogens that can be aromatised to ethinylestradiol (EE).<sup>1</sup> Therefore when women are taking between 10 and 15 mg

norethisterone a day it is equivalent to taking a 20–30 µg EE combined oral contraceptive (COC) pill.<sup>1</sup> As clinicians, we need to ask ourselves if we would be happy prescribing a COC to the women requesting a supply of norethisterone? If the answer is no, then we should offer a safer alternative.

The SPC for norethisterone tablets (5 mg) states that "previous idiopathic or current venous thromboembolism (deep vein thrombosis, pulmonary embolism), active or recent arterial thromboembolic disease (e.g. angina, myocardial infarction), the presence or a history of prodromi of a thrombosis (e.g. transient ischaemic attack, angina pectoris), a high risk of venous or arterial thrombosis or a history of migraine with focal neurological symptoms" are contraindications to its use.<sup>3</sup> It warns about the potential risk of VTE in users and advises immediate discontinuation if symptoms of a VTE occur.

## OTHER OPTIONS

In practice, clinicians have a number of alternatives for those women wishing to postpone menstruation. The first is to choose a contraceptive method that will provide high levels of amenorrhoea. Depot medroxyprogesterone acetate (DMPA), whether it is given intramuscularly or subcutaneously, will result in about 55% of women having no periods over a 90-day reference period by the end of the first year of use.<sup>4</sup> Levels of amenorrhoea are lower for other hormonal methods (Table 1) but rely on women starting these methods well in advance of their travels.

What other options are available to those wishing to delay their periods?

- 1 5 mg norethisterone taken three times a day, started before the onset of menstruation and continued until menstruation can be tolerated. Bleeding normally commences 2–3 days after discontinuing norethisterone.
- 2 10 mg DMPA taken three times a day, started before the onset of menstruation and



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**Table 1** Amenorrhoea achieved with different methods of hormonal contraception

Method of contraception	Amenorrhoea achieved over a 90-day reference period (unless otherwise specified)
Jaydess® IUS	11.6% over time <sup>5</sup>
Mirena® IUS	23.6% at 3 years <sup>6</sup>
Nexplanon®	20% over time <sup>7</sup>
Depo-Provera®	55% at 12 months <sup>4</sup>
Sayana Press®	56.5% at 12 months <sup>8</sup>
Standard combined hormonal contraception given in a 21/7 regimen	<1% <sup>9</sup>
Estradiol combined pills with shorter hormone-free intervals	19.4–31% absent withdrawal bleeds over time <sup>10 11</sup>
Desogestrel POP	20% at 12 months <sup>12</sup>
Traditional POPs	3% at 12 months <sup>12</sup>

IUS, intrauterine system; POP, progestogen-only pill.

continued until menstruation can be tolerated. Bleeding normally commences 2–3 days after discontinuing DMPA. It is not licensed for this indication and there is no published evidence to support its use for postponing menstruation, although it has been shown to reduce heavy menstrual bleeding at this dose.<sup>13</sup> Anecdotally, it may not be as effective as norethisterone in delaying menstrual bleeding.

- Starting a combined hormonal contraceptive (CHC) method such as a monophasic COC or vaginal ring before menstruation may delay the next period. Advising back-to-back administration can also be tried.<sup>14</sup> A CHC provides contraception as well as cycle control, although breakthrough bleeding is more common in the first few months. A number of preparations now have information concerning the missing of a withdrawal bleed in their SPCs.<sup>15 16</sup>
- If there is some forward planning the timing of the period can be altered by either taking 5 mg norethisterone twice daily or DMPA 10 mg twice daily for 10 days to induce a bleed. This should move the date of the subsequent period.

## CONCLUSIONS

So to conclude, when faced with a mother requesting medication to delay her daughter's period, or a woman wishing to avoid menstruating while on holiday or at a religious festival, we should discuss:

- The relevant treatment options.
- The potential VTE risks associated with CHCs and norethisterone, especially if long-haul flights or prolonged periods of immobility on coaches or in cars are planned.
- Contraceptive choices that may reduce menstrual blood loss.

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