Hormonal Contraception—What Kind, When, and for Whom?
by Prof. Dr. med. Inka Wiegratz, Prof. Dr. med. Christian Thaler
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Side Effects
I read the article on hormonal contraception with great interest. The summary is easy to understand and has clarified some issues for me while serving as a refresher regarding others. However, I had been hoping that the authors would have also written about the following questions that are of major importance in routine general medical practice: depression triggered by the pill, increased appetite owing to the pill, edema resulting from the pill, increase in breast size because of the pill, sometimes including stretchmark formation prompted by the pill, and pill-induced changes to a woman’s libido. It is worth mentioning that every packet of contraceptive pills includes information about the consequences of missing a pill, and what to do in such a scenario.

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Risk of Venous Thromboembolism
Wiegratz and Thaler provide a comprehensive overview of hormonal contraception using the combined oral contraceptive (COC) pill, while also discussing side effects and risks (1). Unfortunately the risks are not comprehensively discussed, and the current state of knowledge is not reflected. With regard to the risk of venous thromboembolism, this may be because of the timing of the article submission.

The authors explain that there are indications of a modified risk for venous thromboembolism as a result of the gestagen component, and that combined preparations including desogestrel, gestodene, and cyproterone acetate entail a higher risk than COCs that include levonorgestrel. This statement is correct, but the authors make no mention at all of the more recent data concerning the risk of venous thromboembolism when using COCs containing drospirenone (2, 3). This is inexplicable since drospirenone-containing COCs are among the most commonly prescribed hormonal contraceptives in Germany (4) and the European Medicines Agency (EMA) has looked into assessing the risk for venous thromboembolism in association with several COCs on the basis of more recent study results as early as in March 2010 and, most recently, in May 2011 (see www.ema.europa.eu, plenary meeting, March 2010 and May 2010).

The EMA classes the risk for COCs containing drospirenone as higher than for COCs containing levonorgestrel, and it assumes that it corresponds to the risk associated with COCs containing desogestrel and gestodene.

In a notice in this issue of Deutsches Ärzteblatt (in German), the risk of venous thromboembolism is the subject of further discussion, as in our opinion the EMA’s assessment should be considered in the individual prescription of any COC.

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The authors declare that no conflict of interest exists.

Alternatives
The authors deserve thanks for their accomplished summary of such a complex topic (1); however, we wish to make some additional comments from a specialist perspective.

Although the title of the article promises a comprehensive overview of all hormonal contraceptive methods, it actually discusses merely combined preparations, and the main emphasis is on the contraceptive pill. The reason given—that all other methods were of lesser importance in Germany—may well be correct, but is a disappointment for readers expecting a comprehensive overview and thus satisfactory comparability. What was not mentioned at all was the trend found among many women, not to want to ingest any more
hormones and to look for genuine alternatives—which are actually available, and even as high-quality products.

At least the gestagen methods, which are effective in the long term, are clearly superior to the pill in terms of the Pearl index, in particular because of the reduced potential for missing a dose. Breakthrough bleeding—a common side effect in the initial phase—can be corrected by selecting suitable patients and providing careful explanations; the success is ultimately measured on the basis of the amenorrhea that is achieved in the long term, usually without problems. When discussing the risks, the main issue is the fact that such preparations are estrogen-free (which is naturally the case for all gestagen methods) or that estrogen is reduced: In women who wish to maintain a regular monthly cycle, the dates at which they are exposed to hormones need to be borne in mind, which as the “area under the curve” (AUC) for ethinylestradiol show notable differences when the complete cycle is considered (2). It is not least on this background that parenteral and primarily vaginal access via the contraceptive ring deserves far more attention.

Newer methods, which furthermore are superior to the established ones, are essential to any discussion; individualized treatment and risk minimization are the crucial steps towards greater satisfaction and health on the women’s part.

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In Reply:

Spontaneous occurrence of thrombosis is rare in young individuals. The risk increases with age and in women not taking hormone preparations is 2 per 10 000 per year in the 15–19 year age group and 7/10 000/y among those aged 45–49 years (1). Taking ethinylestradiol (EE)-containing combined oral contraceptives (COCs) of all generations undoubtedly increases the baseline risk. The risk increase depends primarily on the dosage of the EE component, but also that of the progestogen component. With regard to the influence of the combination of estradiol valerate and dienogest on the risk of thrombosis, data are so far lacking; for this reason this preparation was omitted from the following discussion.

Important desired and undesired effects of any COC depend on the estrogen dosage. Compared with preparations containing 30–35 µg EE, the thrombosis risk is 40% lower for a dosage of 20 µg and 60% higher for a dosage of 50 µg (2). In spite of this, combinations containing 30 µg EE remain the medication of choice for many women, including very young women, because of the poorer cycle control with 20 µg EE preparations. In view of the dose-dependent procoagulatory effects of EE, patients with a raised risk of thrombosis should be prescribed a gestagen mono-preparation.

According to what is currently known, progestogen only therapy probably does not affect the risk of thrombosis (1). However, progestogens may modify the EE-induced increase in the thrombosis risk. Many studies have shown that differences exist for the different