FRI, 11:15 - 11:35

Contraception in women with migraine and endometriosis

The presence of migraine with aura is a contraindication (category 4) to combined hormonal contraceptives (CHCs) use at any age for an increased risk of stroke, according to the main international Medical Eligibility Criteria for Contraceptive Use. Migraine must be easily diagnosed: PIN and VARS scores can be considered good screening tools for gynecologists and general practitioners to identify those patients who require specific neurological examinations before the prescription of a CHC. In subjects with migraine, the use of progestin-only contraceptives [desogestrel progestin-only pill (POP) and etonogestrel implant] and intrauterine devices (IUD) must be preferred. POP use is associated with a modest reduction of migraine frequency. Treatments that can inhibit ovulation, such as CHCs or progestin-only contraceptives are effective in the long-treatment of endometriosis, giving in addition an important contraceptive efficacy in sexually-active women. In this disease setting, the most important point is to achieve the woman's compliance by all necessary means, in order to avoid repeated surgical procedures during her reproductive years. To this end, long-acting reversible contraceptives (levonrogestrel-IUD or implant) that last for some years should be preferred to short-acting reversible contraceptives (CHCs, POPs), due to higher long-term adherence. It is still unknown if the administration of estrogens should be completely avoided or it could be permitted in low dosages in subjects with symptomatic endometriosis: indeed the presence of the low dose estrogen component could represent an advantage in terms of bleeding control and therapy adherence. The use of levonorgestrel-intrauterine systems should be limited by the fact that they do not always inhibit ovulation and should be focused to subjects with symptomatic deep infiltrating endometriosis and/or adenomyosis, using the higher doses devices available on the market (levonorgestrel total content: 52 mg for 5 years). In general, CHCs and POCs are all effective for the relief of endometriosis-related dysmenorrhoea, pelvic pain and dyspareunia, and they improve quality of life. Some CHCs decreased the risk of disease recurrence after conservative surgery. There is insufficient evidence, however, to reach definitive conclusions about the overall superiority of any particular hormonal contraceptive. The use of emergency contraception is permitted without limits in both subjects with migraine and endometriosis.

Note

Speaker

G. Grandi
Italy