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Easing the Perimenopause Transition with IUDs: Key Clinical Considerations

Announcer:
You're listening to *Advances in Women's Health* on ReachMD, and this episode is sponsored by Bayer. Here's your host, Dr. Brian McDonough.

Dr. McDonough:
This is *Advances in Women's Health* on ReachMD, and I'm Dr. Brian McDonough. Here with me today to discuss how IUDs can help manage perimenopausal symptoms is Dr. Monica Christmas. She's an Associate Professor of Obstetrics and Gynecology at the University of Chicago Medicine. She's also the Director of the Center for Women's Integrated Health and the Menopause Program, as well as Associate Director for the Menopause Society. Dr. Christmas, welcome to the program.

Dr. Christmas:
Thanks for having me.

Dr. McDonough:
So let's start with some background. Dr. Christmas, can you tell us what's driving the growing interest in using IUDs to help manage the perimenopausal transition, especially for patients in their 40s?

Dr. Christmas:
The perimenopause transition can be associated with some pretty extreme menstrual changes at times. There are some people that are lucky—their periods just get shorter, they get lighter, they space out, and then they politely go away. But many people will experience changes where their cycles become heavier, they may be longer, and they may be closer together. And then sometimes people get these loop cycles.

Our brain is sending signals to our ovaries to make those reproductive hormones—the estrogen and progesterone—and the ovaries are trying so hard to keep up with that demand. But as the ovaries get older, they start to malfunction a little bit, and sometimes they can overproduce. And that's where we get actually a much higher level of estrogen, which is why labs are not helpful during perimenopause—you can check them and they'll be either normal or you'll have a ton of estrogen. And so people will say, "Oh, you're not menopausal yet." But it's during those times that the menstrual cycles, as I said, could be heavier, longer, and closer together. Some people will say, "I bled for an entire month."

And so the beauty of using a progestin IUD is that it can thin out that lining. And the vast majority of people, after it's been in for a couple of months, won't have a period at all. And if they start to experience other symptoms, like pesky hot flashes or night sweats, you can add some transdermal estrogen to that progesterone coming from the IUD, and many people will do rather well.

Dr. McDonough:
And when it comes to managing abnormal uterine bleeding in perimenopause, how do hormonal IUDs compare to non-hormonal options, both in terms of mechanism and practical considerations for patients?

Dr. Christmas:

Great question. The non-hormone-containing IUD is great for contraception. It can provide contraception for up to 10 years. However, it does lack that progestogen, which keeps the endometrial lining nice and thin, and that's what prevents bleeding or having the menstrual cycle. So for women who are already experiencing irregular or abnormally heavy menstrual cycles during this perimenopause timeframe, using that non-hormonal IUD can increase bleeding as well as pain.

Dr. McDonough:
Given those different options, patient selection and upfront evaluation seem critical. So how do you assess who's a good candidate for an IUD during perimenopause?

Dr. Christmas:
There are very few contraindications, unlike estrogen, which confers higher risk of stroke—especially in older populations—and blood clots, including pulmonary embolism. Those risks are significantly less with a progestogen, especially one that's just having intrauterine absorption.

So the bigger risks for a progestin IUD are usually more anatomic ones. People have fibroids, especially if they're submucosal or intramural, so they're impacting the endometrial lining.

Additionally, any known structural anomalies, like a bicornuate uterus or a septum, may make it more difficult for accurate placement of an IUD and increase the risk of perforation.

Lastly, people who have undergone endometrial ablation where that lining of the uterus has been burned—it creates scarring, making it more difficult for placement of an IUD as well.

Dr. McDonough:
For those just tuning in, you're listening to *Advances in Women's Health* on ReachMD. I'm Dr. Brian McDonough, and I'm speaking with Dr. Monica Christmas about using IUDs to address perimenopausal symptoms in women aged 40 and older.

Now, Dr. Christmas, when counseling perimenopausal patients on IUDs, fertility and menopause timing often comes up. So how do you address concerns about masking menopause or interfering with future reproductive options?

Dr. Christmas:
Well, for anyone perimenopausal that desires fertility, I wouldn't advocate for having the IUD put in. It's certainly more difficult during that perimenopausal timeframe to get pregnant—not impossible, though. So for somebody who desires fertility, that wouldn't be a great option for them. However, for patients that don't want to get pregnant, that's not a consideration. Putting an IUD in is an excellent option because it provides contraception as well as minimizing the abnormal bleeding pattern that they might be experiencing.

Regarding the question you asked, though, and I get asked that a lot in the clinical setting—"Well, if I'm not getting a period, how will I know when it stops?" Because that's usually our demarcation for menopause—not having a period for a full year. And I tell people, "It doesn't matter. You're at the right age range for when this transition happens."

So the median age of menopause is about 52 in the United States. The normal or average range that people fall into is between the ages of 45 and 55. We start to experience symptoms related to hormonal fluctuations, though, up to seven to 10 years before the menstrual cycle actually stops.

So it is quite normal in the early, especially mid-40s, to be experiencing symptoms related to these hormonal fluctuations. And so putting an IUD in early on when patients initially start to experience those symptoms can be very helpful.

Let's say, for example, the IUD is put in around in the early 40s, and we take it out mid-40s. And you could say, "Well, we could wait to see if you actually are in menopause, or just put another one in," which is what I like doing, and riding it out until we know that they're over 55. And more than 90 percent of people at that point will have reached the definition of menopause.

Dr. McDonough:
Interesting. So once you've counseled patients and placed an IUD, what does follow-up typically look like as patients continue through

perimenopause and eventually reach menopause?

Dr. Christmas:
Pretty easy. Usually, we'll see patients back at about four weeks after the IUD was placed just to see how they're doing. I always tell people, “If you don't think it's as nifty as I think it is, then we'll remove it.” So that four-week time frame is a good time point to just do a check in.

I always warn people or let them know that irregular spotting or some nuisance bleeding can persist. For most people, it's initially in that first three months of use, and then that gets better, just to prepare them that they may experience that. Usually, a panty liner is sufficient.

Anybody that's experiencing any heavier bleeding or persistent pain needs to be evaluated. Ultrasound is usually needed to make sure the IUD is sitting in the correct position. And even if it is in the correct position, and it's a particular person that's really having a lot of side effects, they may not be a great candidate for it, and having it removed and discussing alternative options is more appropriate at that time.

Dr. McDonough:
Finally, Dr. Christmas, when you look at the broader picture of lifespan gynecologic care, how do you see IUDs fitting into the conversation around managing midlife health?

Dr. Christmas:
I love the fact that when you put the IUD in, it’s in. So for many people, they have fewer side effects. Often, with oral hormones, it gets metabolized through the liver. And especially when we're discussing more estrogen options, that can increase the body's clotting factors. But from a progestogen perspective, often, the side effects like bloating, breast tenderness—and even with many progestins, there can be a sleepy or somnolence side effect to it as well—you don't get when you're using that IUD.

Additionally, with the IUD, once you put it in, it's in; there's nothing else that someone has to do. And it makes it nice, so if we end up needing to add some estrogen for hot flashes or night sweats, we can do that as a transdermal form—so either a patch that the person changes once or twice a week or a daily gel that they rub into their thigh. So it eliminates the need for people that still have a uterus to take an oral progestogen, which, as I said, oftentimes confers higher side effects. So people tolerate that IUD really well. It minimizes any breakthrough bleeding. Often, hormone therapy dosing, even in the post-menopause timeframe, can create some irregular bleeding at times, and most patients or people don't have that with the IUD option.

Dr. McDonough:
Well, with those big-picture comments in mind, I want to thank my guest, Dr. Monica Christmas, for joining me to discuss how we can address perimenopausal symptoms with IUDs. Dr. Christmas, it was great having you on the program.

Dr. Christmas:
Thank you for the invitation.

Announcer:
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