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The Risk of Breakthrough Bleeding Justifies the Use of Combined Hormonal Contraception Over Progesterone-Only Pills While Breastfeeding

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Abstract

Breakthrough bleeding is a side effect of progesterone-only pills (POPs) in 40% of women, and is reduced to 10% with combined hormonal contraceptives (CHCs). In addition, breakthrough bleeding is reduced if POP is supplemented with norethisterone. As breakthrough bleeding is responsible for a quarter of women stopping the pill, it is vital to realize that CHC is an alternative to POP—even during lactation. CHCs are considered safe during lactation, do not reduce milk production, nor impede infant development. Nevertheless, CHCs are often not prescribed for lactating mothers due to this misconception that they reduce milk production. Among Orthodox Jews, breakthrough bleeding frequently results in stopping POP, as Jewish religious law prohibits any physical contact of the mother with her partner during active bleeding, and for 7 days after bleeding. When such bleeding occurs, not choosing a CHC alternative, results in couples risking discontinuation of POP, and in conceiving within a year of the previous birth, with its increased risk of preterm labor and birth defects. To measure how physicians respond to the presumed dilemma of balancing the risk of breakthrough bleeding versus the concern of reduction of milk production, we conducted a preliminary online survey. Physicians were asked if they would prescribe CHC instead of POP to breastfeeding mothers, 3 months postpartum with breakthrough bleeding. Half of the physicians responded they would prescribe CHC, whereas close to half of the physicians responded that they would not. The main reasons given by the respondents for avoiding CHC was a concern regarding possible milk reduction. These results confirm a significant degree of a lack of updated pharmacological information regarding the options of oral contraceptive use for lactating mothers, particularly for those where breakthrough bleeding has major behavioral and religious consequences. Thus, we contend that the risk of breakthrough bleeding justifies the more routine use of CHC in lieu of POP in lactating mothers.

Keywords: progesterone-only pill, combined hormonal contraception, combined pill, lactation, breastfeeding, breakthrough bleeding

BREAKTHROUGH BLEEDING IS A side effect of progesterone-only pills (POPs) in 40% of women, and is reduced to 10% with combined hormonal contraceptives (CHCs).¹ In addition, breakthrough bleeding is reduced if POP is supplemented with another progestin, such as norethisterone.²

As breakthrough bleeding is responsible for a quarter of women stopping the pill,³ it is vital to realize that CHC is an alternative to POP—even during lactation. Not only are CHCs considered safe during lactation⁴ (category L2, >42 days postpartum), but also in randomized controlled study it did not reduce milk production,⁵ nor impede infant

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development.⁶ In reality, however, CHCs are often not prescribed for lactating mothers due to this misconception that they reduce milk production.

Among Orthodox Jews, breakthrough bleeding frequently results in stopping POP, as Jewish religious law prohibits any physical contact of the mother with her partner during active bleeding, and for 7 days after the bleeding stops. When such bleeding occurs, not choosing a CHC alternative results in couples running the risk of stopping all oral contraceptive, and in conceiving within a year of the previous birth, with its attendant increased risk of preterm labor and birth defects.⁷

To measure how physicians respond to the presumed dilemma of balancing the risk of breakthrough bleeding versus the concern of reduction of milk production, we conducted a preliminary online survey. Physicians ($n=112$) were asked if they would prescribe CHC instead of POP to a breastfeeding mother, 3 months postpartum with breakthrough bleeding.

Half of the physicians ($n=56$) responded that they would prescribe CHC. Of these, some would prescribe CHC only if breastfeeding was fully established. Close to half of the physicians ($n=45$) responded that they would not prescribe CHC at all, or only if 6 months had passed since the birth. A minority of physicians ($n=11$) did not respond. The main reasons given by the respondents for avoiding CHC was a concern regarding possible milk reduction, and to a lesser extent infant gynecomastia. These results confirmed that in certain physician circles there remains a significant degree of a lack of updated pharmacological information regarding the options of oral contraceptive use for the lactating mothers, particularly for those where breakthrough bleeding has major behavioral and religious consequences.

Thus, we contend that the risk of breakthrough bleeding justifies the more routine use of CHC in lieu of POP in lactating mothers.

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