Medical Madness Making Menstruation Obsolete

Angela Frieswyk, BSc (Human Nutrition), Dipl Herb Med, NZAMH

By Angela Frieswyk,
Medical Herbalist & Clinical Nutritionist

Like it or not, the combined oral contraceptive pill has a long established foot hold on the mass medication of women. Along the way lessons were learnt, the side-effects and health risks of the early high dose oral contraceptives were improved upon, but they were never eradicated. Now it appears we are about to embark on yet another uncontrolled hormonal experiment, making menstruation obsolete.

Skipping your period using the combined oral contraceptive pill is nothing new. For those not educated in the practice, by skipping the seven days of inactive sugar pills and continuing straight onto the next 21 days of active pills, bleeding is effectively prevented. For some women this may be an occasional godsend, allowing for a welcomed menstruation-free wedding or holiday. Doctors have also prescribed hormone methods such as Depo-provera to suppress menstruation for medical reasons, such as severe endometriosis, uncontrolled menstrual bleeding, pain or migraines. In general, however, it has always been accepted that the pill cycle should mimic the natural menstrual cycle.

That is all changing, with a growing number of women being advised (or opting) to skip periods for nothing more than lifestyle choice. I believe this trend is a result of hard-sell marketing and doctor education strategies by those who stand to profit from the practice, pharmaceutical companies. There are already several extended cycle contraceptives (eg, 84 days of active pill) designed to reduce or even eliminate menstruation, approved for sale in the U.S. by the Food and Drug Administration. Whilst these are not yet available in New Zealand, it will only be a matter of time as some doctors pave the way by instructing women, often young and naïve, how to skip periods with current combined oral contraceptives. Thankfully not all doctors have been quick to endorse the practice.

In my somewhat futile search for studies indicating long-term safety of menstrual suppression, not only was I confronted with a lack of good research, but also by the number of articles coercing women and practitioners to accept that there is no need to menstruate when using oral contraceptives. Let me elaborate on their arguments:

Proponents of suppressing menstruation with extended cycle oral contraceptives argue that strictly speaking those on 'the pill' are not actually having a true 'period', rather a withdrawal bleed due to stopping the active hormone pills. This is true. On 'the pill' ovulation is suppressed and the endometrial lining does not thicken in preparation for pregnancy, hence there is little to shed (which is why periods are lighter on the pill). However, continuously taking the active tablets means that women are exposed to 25-30% more synthetic hormones than they would be if they were to taking the inactive pills and having regular monthly periods while on the pill. Another common argument is that women of yesteryear had fewer periods as they spent more time pregnant and breastfeeding; therefore if we suppress menstruation we are mimicking the 'good ole healthy days'. Of course that argument defies all logic, particularly as suppressing menstruation with synthetic hormones is entirely different from the natural state of pregnancy and lactation.

Joining the hard-sell ABC News printed a story about a study published in the *Journal of Obstetrics and Gynecology,* which highlighted the obvious savings on sanitary products between monthly and extended oral contraceptive users.

It's a pity research funds weren't better spent on investigating the real question at hand: what are the long term effects of taking proportionally more synthetic hormone and suppressing menstruation?

The fact is there are no large controlled studies of the long term effects of extended combined oral contraceptives. Proponents may argue that the modern combined oral contraceptives are much weaker than those prescribed forty years ago. But we must remember that even in low dose pills, ethinyl estradiol (synthetic estrogen) is still four times stronger than the estrogen naturally produced by menstruating women. And now some women are increasing the

amount of their synthetic hormone exposure by 25-30% or more, without understanding the long-term implications.

A Reminder

We already know that women on the oral contraceptive pill, particularly those who smoke, are at greater risk of blood clots, stroke and heart attacks. We also know that the higher the dose of estradiol, the higher the risk. What becomes of this risk when a woman extends 21 days of synthetic hormone medication to 84 days without a break? While the pill has been found to reduce risk of ovarian and endometrial cancer, the risk of breast, cervical and other cancers is still unclear.

Consider also the known nutrient depletions of folic acid, magnesium, zinc and vitamins B2, B6, B12 and vitamin C caused by oral contraceptives. Will these nutrient depletions become even greater on extended cycles? Should the trend catch on in a big way, there will of course be a greater environmental dump of hormone residue in the waste-water works. And what of the risk of delaying future fertility, which is already a problem for some long-term oral contraceptive users?

Making menstruation obsolete is no doubt proving to be profitable business for pharmaceutical companies. One can only hope that women remain mindful of the lessons learnt from Thalidomide, DES, early high-dose oral contraceptives and hormone replacement therapy. It is likely, however, that many adolescent and young women are unaware of this legacy and will continue to fall easy prey for yet another uncontrolled experiment on women's health.

Problems with "skipping periods"

To highlight some of the problems I see with 'skipping periods' using the combined oral contraceptive, I share three client cases (permission given and names changed). These cases also highlight how 'the pill' often masks an underlying hormonal problem, particularly when prescribed at an early age before the reproductive cycle has matured and been observed. Please note a lot of diagnostic detail has been left out and the following treatments are specific only to the individual to whom they were prescribed, but not for the intention of self-diagnosis and self-medication. If you require help please consult with a registered medical herbalist or naturopath so a full treatment can be prescribed that is specific to your needs. As a medical herbalist and nutritionist I frequently see how a well prescribed natural treatment plan can effectively address many of the hormonal problems for which the pill is often prescribed ... contraception, of course, being a whole other topic.

Sarah

Sarah first consulted me at age 18 years for help with severe period pain. Her period pain would last for the first four days of her cycle; so severe she was unable to leave the house. For period pain relief Sarah was using Panadol and Ponstan together, up to six times daily, with only minor relief.

Sarah's periods had started at 13 years of age. At 15 years Sarah's periods were still very irregular and she had bad acne, so her GP prescribed Monofem.

At 16 years Sarah had started skipping her period by continuously taking the active pills. This was common practice in Sarah's circle of friends, from whom she had got the idea. Sarah's mother was concerned about this and insisted Sarah consult with her GP. The GP advised Sarah to have a break every three cycles, just to prevent breakthrough bleeding, but could otherwise see no problem with this. By the time she came to see me, Sarah had been doing this for the past two years. The onset of the severe period pain started one year ago.

While an irregular menstrual cycle in adolescent years is quite normal, in Sarah's case I found there was a potential family history of polycystic ovarian syndrome (PCOS). Sarah's mother was diagnosed with PCOS in her early thirties after coming off the pill, which had previously masked her cycle irregularity and acne, typical of PCOS. Her grandmother and great-grandmother had also had fertility issues, also typical of PCOS.

Treatment plan

Sarah was now in a sexual relationship and did not want to come off the pill, but agreed to stop skipping her 'period'. Meanwhile I wrote a letter to Sarah's GP requesting medical investigation for potential PCOS.

Our initial focus was to reduce the period pain and the amount of pharmaceutical pain relief Sarah was relying on. It was also important to help clear the body of synthetic hormone metabolites via liver activation. I would typically prescribe an individualised liquid herbal formula, however Sarah was not keen on liquid tonics, so for the sake of compliance the following was the 'best fit' treatment for her case.

• High strength fish oil to help reduce the inflammatory pain-causing prostaglandins.

• Herbal/nutritional formulation designed to support liver detox pathways, containing broccoli sprout extract, turmeric and key amino acids. Sarah used this for eight weeks.

• Herbal tablet formulation (MediHerb Cramplex) that relieves menstrual cramping pain – used two days before and throughout the period for natural pain relief.

While we do not as yet have a clear diagnosis of PCOS, it was evident that Sarah had an increasing weight problem and significant carbohydrate cravings, typical of insulin resistance that occurs with PCOS. To help control this I gave Sarah a dietary plan, including regular quality protein snacks and meals to help maintain stable blood sugar levels, plus plenty of vegetable fibre and a decreased intake of refined carbohydrates (such as breads, pasta, soft-drinks, juice, etc). Sarah also joined a gym, working out three times a week.

Results:

Over the first four months Sarah's painful periods improved significantly and she no longer required either pharmaceutical pain relief or the herbal pain relieving tablets. Sarah is now on a maintenance treatment of fish oil and evening primrose oil, plus essential nutrients for assisting with blood sugar balance and to counter the nutrient depletions caused by oral contraceptives. With exercise and diet education, Sarah is now better able to manage her hormonal and metabolic health, particularly important should PCOS be confirmed. Sarah also actively discourages her girlfriends from skipping periods, in her words "Nature rulz".

Tania

39 year old Tania consulted with me regarding prolonged menstrual spotting. Through lifestyle choice, Tania had been using the oral contraceptive (Levolin) continuously to skip periods for over a year. During this time Tania would have

some breakthrough bleeding, but this was not initially of concern until the breakthrough bleeding became slightly heavier and persistent.

Tania initially consulted with her GP who checked her iron status (low iron will worsen bleeding, and vice versa). The GP also did a pelvic exam, pap smear test, STI check and arranged an ultra-sound; no problems were found. The GP changed her pill from Levolin to Gonet, but this had no effect on stopping the spotting. Six weeks later the GP prescribed Cyklokapron, a drug used to shut down bleeding. This effectively reduced bleeding within two days, however her side-effects included nausea, headache and loss of appetite, so Tania discontinued it. The GP next suggested Tania get a Jadelle implant, a contraceptive silicone device that is inserted into the upper arm, releasing synthetic progesterone. At this stage Tania decided to seek alternatives and ended up in my clinic, rather fed up after the second episode of continuous eight weeks of spotting.

Any unexplained bleeding outside of menstruation (or after sex) needs thorough medical investigation, as cervical, endometrial or ovarian cancers need to be first ruled out as a possible cause. It was reassuring that the doctor had undertaken this investigation (without this my client would have been referred back to her GP first before I progressed with her treatment). However, I was surprised that the GP had not suggested Tania stop continuous use of the oral contraceptive. It seemed as if this was not considered to be a potential part of the problem. I was also concerned to find that Tania's blood pressure was elevated (130/90) and that she smoked, both of these greatly increasing her risk of blood clots, stroke and heart attacks associated with the oral contraceptive.

Tania had started using the pill at the young age of 14 years, with only one break for pregnancy, approximately 23 years of synthetic hormone use. Tania decided to give her body a break from her oral contraceptive and our immediate priority was to stop the ongoing bleeding and clear the hormone metabolites.

Treatment plan:

• Anti-haemorrhagic herbal formula – to reduce / stop bleeding.

• Herbal/nutritional formulation designed to support liver detox pathways and help clear hormone metabolites from continued contraceptive pill use.

• Quality multi-vitamin/mineral/anti-oxidant – to compensate for nutrient loss known to be caused by contraceptive pill and smoking.

• MediHerb Chaste tree tablets - to help re-establish and regulate a natural menstrual cycle.

Results:

The herbal formula reduced the spotting within two days, then the spotting stopped altogether by day five (she was still using the oral contraceptive at this time). Unlike Tania's experience with Cyklokapron, the herbal formula had no unwanted side-effects (other than a foul taste!). At this stage Tania stopped her oral contraceptive and after two days Tania got another 'period' (withdrawal bleed) and I instructed her to allow this bleed to occur. We started Chaste tree tablets at this stage, as Chaste is best started at the beginning of the cycle.

Tania did not have another proper period for two months, but has now had three regular 28-31 day cycles with moderate five day bleeding and no ongoing spotting. Tania has returned to her GP for a follow-up and was offered a Mirena (Hormone-bearing IUD); Tania has refused, happy to use alternative contraceptive methods. Tania has also seen a hypnotherapist and successfully given up smoking and joined the gym. Her blood pressure is now 125/85. She is happy to report that her libido, previously non-existent, has improved.

Lisa

Lisa consulted with me at age 32, wanting help for breast tenderness. Lisa had been on the pill since she was 18 years old, regularly changing brands due to problems with mood swings. Two years ago Lisa spoke with her GP about wanting to skip a period for her wedding. Her GP suggested she extend taking her active pills from 21 to 63 days continuous use, giving Lisa just five 'periods' a year.

Lisa found she would get some breakthrough bleeding after the second month (spotting outside of the planned menstrual time). During the second year of skipping periods Lisa started feeling generally unwell with headaches and moodiness around each period. Lisa also noticed her breasts were becoming more lumpy and tender. Lisa consulted with her GP regarding this and was prescribed a different oral contraceptive, which improved her headaches but the breast tenderness and moodiness persisted.

Treatment plan:

I discussed with Lisa the problems I was observing with women skipping 'periods' on extended cycles. Lisa was happy to return to a monthly cycle, but not to stop using the OC at that time. Lisa had limited funds for treatment so the focus was on appropriate lifestyle changes to assist with her wellness, including a diet of reduced dairy and saturated fats, increased fish, nuts, seeds and vegetables. I recommended she include more raw foods, particularly bitter salad greens for liver and digestive health and cruciferous vegetables (broccoli sprouts, steamed broccoli/cabbage, etc) for estrogen clearance. Lisa started drinking two cups of nettle infusion daily, an affordable way to boost nutrient intake. Lisa also started using Nordic Naturals Omega 3 fish oil.

Results:

Within two months Lisa noticed significant improvement in breast tenderness, though the lumpiness remained. To monitor this I referred her for a Thermogram, a safe technique using infrared thermal imaging.

At subsequent consults Lisa expressed interest in starting a family within the next year, so we discussed coming off the oral contraceptive to allow plenty of time for a normal ovulatory cycle to re-establish. Lisa continues to use omega 3 supplementation and drinks nettle and raspberry leaf infusions, both organically home-grown. This is a good low cost lead-up to her preconception care, nettles providing a good source of many nutrients (including folic acid) and raspberry leaf improving uterine circulation and tone. Lisa's moodiness improved significantly once she was off the oral contraceptive, which she jokes has been very beneficial for their family planning.

About the author

Angela Frieswyk is a Medical Herbalist and Clinical Nutritionist based in Tauranga, NZ. She has been in private practice for over 10 years, practicing within an integrated Herbal Clinic and Dispensary. Angela also teaches 'HerbWiseNZ' traditional herbal medicine-making workshops.