Accurate Answers

to Questions About Birth Control Pills

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How do the pills work to prevent pregnancy?

The birth control pill works primarily by blocking ovulation (release of an egg). If there is no egg to meet the sperm, pregnancy cannot occur. The pill also works by making cervical mucous thick and unreceptive to sperm, slowing tubal function which has to move the egg down the tube to meet the sperm, and by making the lining of the endometrium unreceptive to implantation of a fertilized egg should one get as far as the uterus. In general, women do not ovulate until at least 10 days after stopping birth control pills.

Pills effect on cervical mucous

I am on birth control pills, and I'm curious about something. I know that they are supposed to stop you from ovulating, but do they stop all the normal monthly activity? Like the changes in cervical mucous and cervical position? I'd like to be more in tune with my body, and an answer to this question will help.

The progestin component in the pills changes cervical mucous to be very thick such as that found after ovulation, not thin and stretchy egg-white mucous. The progestin also keeps the cervix more closed if that is what you mean by position.

For women who can take the pills regularly without missing them, the pill is the most effective reversible contraceptive currently available.

When should I start a new prescription of birth control pills?

Traditional advice has been to start the pills on the nearest Sunday to when the menses starts. This results in the menses starting every month on a Monday, Tuesday or Wednesday because the last active pill is taken on a Saturday. Starting it after a menses helps assure there is no pregnancy. The problem with this advice is that the pills are more effective that first cycle if they are started on the first day of the menses. Also, pills can actually begin anytime in a cycle as long as a woman is not pregnant. Some women will get pregnant while waiting for their next menses to start the pill. The best advice for starting a new prescription of oral contraceptives is to start on the first day of a menses or start today if not pregnant.

Starting birth control pills the first time

Choose a backup method of birth control (such as condoms, diaphragm, or foam) to use with your first pack of pills because the pill may not fully protect you from pregnancy

during the first week that you start taking them. Keep this backup method handy and use it in case you:

Run out of pills
Forget to take your pill
Discontinue pill use
Need protection from transmission of sexually transmitted diseases, particularly the virus that causes AIDS (the condom is recommended)

There are several ways to start taking your pills. Use one of the following approaches:

First approach: Start your first pack of pills on the day your period begins.
Second approach: Start your first pack on the first Sunday after your period begins. This will result in your menses almost always beginning on a Tuesday or Wednesday every 4 weeks.
Third approach: Start your first pack on the fifth day after your period begins.
Fourth approach: Start your pill today if there is absolutely no chance that you could be pregnant. Use a backup method of contraception until your first period.

Take one pill a day until you finish the pack. Then:

If you are using a 28-day pack, begin a new pack immediately. Skip no days between packages. If you are using a 21-day pack, stop taking pills for 1 week and then start your new pack.

Try to associate taking your pill with something you do at about the same time every day, like brushing your teeth in the morning, eating a meal, or going to bed. Keep the pill near the place where you engage in the selected activity. Establishing a routine will make it easier for you to remember. The pills work best if you take one at about the same time every day. Check your pack of pills each morning to make sure you took your pill the day before.

Continuing on the Pills - What If...

- If you have bleeding between periods, try to take your pills at the same time every day. If you have spotting (light bleeding between periods) for several cycles, call the doctor's office for advice.
- If you forget your pills for a day or two, follow the instructions below:
  If you miss one pill, take the forgotten one (yesterday's pill) as soon as you remember it, and take today's pill at the regular time. Although you probably will not become pregnant, use your backup method until your next period to be safe. If you miss two pills in a row, take two pills as soon as you remember and two pills the next day. You may have some spotting. Use your backup method of birth control until your next period. If you miss three or more pills in a row, start your backup method of birth control immediately. Your ovaries may produce an egg (ovulation), and without a backup contraceptive you could become pregnant. Ask yourself, "Am I a good pill user?" Another method of contraception may be better for you. To continue your pills: Take two pills for 3 days and use your backup method of birth control until you have your next period, OR Stop taking pills from your old pack of pills. Start a new pack of pills the Sunday after you missed three or more pills, even if you are bleeding. Use your backup method of contraception for the first 2 weeks that you are on your new pack of pills.
- If you have severe diarrhea or vomiting lasting several days, begin using your backup method of birth control on your first day of diarrhea or vomiting and continue using it

until your next period. The pills may not absorb from your gastrointestinal tract when you are sick like this.

- Periods tend to be short and scanty on pills, and you may see no fresh blood at all. A drop of blood or a brown smudge on your tampon or underwear is considered a period. This is because combined estrogen and progestin birth control pills suppress the formation of uterine tissue. Therefore there is very little tissue to slough each month. The scant or absent period is not due to blockage or pregnancy. If you have not missed any pills and you miss one period without any signs of pregnancy, pregnancy is unlikely. Do a home pregnancy test or call the doctor if you are worried. If you forgot one or more pills and miss a period, run a home pregnancy test or contact your doctor about a pregnancy test. If you miss two periods in a row and feel pregnant or if you miss three periods in a row, contact the doctor for an examination, even if you took your pills every day and even if a home pregnancy test is negative.
- If your doctor has you on continuous pills (21 days of active pills followed by 21 days of active pills with no 7-day break of non-hormone pills) in order to suppress your menses because of endometriosis or premenstrual syndrome, you will very likely have breakthrough bleeding. If the spotting persists through more than 3 packs of pills, contact your doctor to confirm that you should stay on that brand of pills.
- Pills may cause pregnancy symptoms when you first start taking them. Breast soreness, upset stomach, mild headaches, mild edema of the legs and mood irritability are common. If you can bear these symptoms, try to continue taking the pills as best you can because most of these mild symptoms go away after the 2nd month of taking the pills. If you still have annoying symptoms in your 3rd month of taking birth control pills, contact your doctor to see if a change in formulation or brand of the pills is indicated.
- Breakthrough spotting or bleeding follows the same principles as above, i.e., try to stick with the pills you are taking but if it persists in the third cycle, contact your doctor to see if a change in pill is indicated.
- Some women with persistent mood or physical symptoms find that these symptoms are on the days when they are NOT taking the active hormone pills. Keep a diary of your symptoms and if this is the case with you, check with your doctor to see if you can take the non-hormonal, placebo pills for only 4 days instead of 7 or if you can be placed on a pill that has small amounts of estrogen during the 7 spacer days.
- If you see a physician or any health-care provider for any reason, be sure to mention that you are on birth control pills.
- Most antibiotics do not decrease the effectiveness of pills. There are some anti-tuberculosis drugs that do. Check with your doctor or pharmacist if a given medication is known to interfere with birth control pill effectiveness.
- The question always comes up could I get (or be) pregnant if:
  I missed one or two pills
  I was late in taking my pills
  I had breakthrough spotting after missing two pills
  I was sick and had the flu
  I took another prescription or nonprescription medicine, hormone or antibiotic, etc.
  I had sex during the days of the inactive pills

The answer is always, it is possible but very unlikely. You should always use back up protection if you are not sure and perform a home pregnancy test at the time of your first missed menses or light bleeding. Home pregnancy tests are positive approximately 12-15 days after ovulation or at the time of the first missed menses.

Complication Signs

Contact the doctor immediately if any one of these danger signs (or "aches") appears:
Abdominal pain (severe)
Chest pain (severe), cough, shortness of breath
Headaches (severe)
Eye problems -- blurred vision or vision loss
Severe leg pain--calf or thigh
Yellow jaundice
Learn the pill danger signs. If you smoke more than 14 cigarettes a day, you should be especially careful. You should STOP SMOKING. If you are over age 35 and still smoke, you have a significantly increased chance of serious vascular problems if you also take birth control pills.

What is the best regimen for taking oral contraceptives?

There are several principles that improve oral contraceptive compliance:

Women should develop a daily routine for taking pills so that each day, taking pills will be as regular as brushing their teeth. Women without a daily routine forget or miss pills 3 times more than those with a daily routine. Be familiar with the literature included with the pills. Know about how the pills work and what to expect when first starting the pills. Know what to do if a pill is missed. Take the missed pill or pills as soon as you remember and then continue on to finish the pack if full menstrual bleeding has not started. If bleeding the equivalent of menses has started, just wait as if you finished the pills and start a new pack of active pills after being off 5-7 days. Use back up contraception if you miss more than one pill. Plan a backup contraceptive method. Be prepared with condoms and foam or indulge in abstinence until being back on the active pills for one week.

Nausea when beginning the pills

I'm into my third pack of pills (7th pink pill tonight), and for the past few weeks in this cycle I have been experiencing some strange gassy-nausea pains in my stomach. This isn't classic nausea--a good belch or...uh..from the other end will alleviate it, as will eating something. When I wake up, it seems that instantly I have to burp to stop it. It's particularly aggravating if I don't eat a meal, especially breakfast. Plus, it is more of a queasy feeling in my stomach rather than fall-down sick. I do not feel as though I have to vomit.

Could the pills be causing some kind of GI irritation? I take them at 9:00 p.m. without food, could this night time schedule be involved? I have not missed any pills this cycle and use condoms with the pill every time.

Yes. Pills can cause this. It is thought to be a direct irritation of the stomach. Often we will have women switch to taking pills in the morning with food because for some reason the meals make them less irritating. Taking the pills in the evening can be sort of like having "morning sickness."

Starting the pills before a menses

I am 34 years old. I never used any oral contraceptive until recently. My physician gave me a prescription for Levora®. He told me to start it on Sunday, the 5th. My regular period was due on the 8th of this month. I started the medicine on the 5th, and I noticed from about the 5th until right now, that I have had slight cramping and very light spotting. I am very bloated and feel sluggish. Is the Levora® interfering with my period? Is this spotting going to continue until next month when I have my period? Or is the pill going to cause my period to start at a different time of the month altogether. I called the pharmacy and the pharmacist said that most women start taking the pill after the period begins.

In general, BC pills are started after the menses starts but not always. Your menses will start when you finish the active pills. Between now and then its difficult to say what will happen. You may have no bleeding, continuous spotting or some combination of the preceding. The bleeding usually will straighten out by the second or third pill cycle.

Lost a pill

I am taking Ortho Tri-Cyclen® as an oral contraceptive. I am on the Sunday start pack (white, light blue, dark blue and green reminder pills). I dropped a pill down the sink (light blue/second week) and I can't get it back. What do I do? Do I continue to take the pills normally and use back up? I mean should I just throw the pack away?

Just keep taking the next pill and finish the pack one day early. If you do not want to permanently have your menses one day earlier, then start the next pack back on a Sunday and do not take any pill on Saturday (because you will have run out on Friday). You can then use backup protection that Friday through Monday, which should be enough.

Is sex safe during the 7 days of placebo pills?

I want to know if it's completely safe to have sex during the seven-day break of the pill. During those days when you are supposed to wait for your period to come, is it safe to have sexual relationships even though you are not literally putting a pill inside your body? Does following the cycle make it safe enough?

Yes, you are safe from pregnancy during the 7-day pill withdrawal period for several reasons. 1) The process that starts egg development (follicles) takes about 10-14 days to kick in and you restart the suppression before then (don't start your next cycle late). 2) The lining of the uterus is getting ready to be sloughed so implantation could not effectively take place. 3) The lining of the uterus then has to regenerate for 10-14 days to be receptive for implantation but by restarting the pills in 7 days, the lining is actually unreceptive. 4) The cervix is less receptive to sperm at that time because of the "washout" taking place. Just be sure not to restart your next cycle late.

After several years of oral contraceptives, should I take a break to let my body recover?

Quite a few years ago, providers were uncertain of the long-term effects of oral contraceptives. There have been studies now over 20 years of taking pills with no long-term effects shown. This advice commonly leads to unwanted pregnancies and confusion about when to restart the pills if there is amenorrhea after stopping the pills. The best instructions are to continue taking the pills as long as you need contraception without any breaks.

What to expect

Oral contraceptives have many benefits for control of bleeding during the menstrual cycle. They also have side-effects and complications that make their use unsatisfactory. Almost a third of women who discontinue birth control pills do so because of bleeding problems. Then what kind of bleeding can you expect when using birth control pills? A recent supplement to the American Journal of Obstetrics and Gynecology, 1999;180:s275-306 had several articles about oral contraceptives and bleeding.

Does birth control pill use lessen abnormal menstrual bleeding?

Oral contraceptives reduce the overall incidence of bleeding problems by about 50% from what occurs in non-contraceptive users. The rate of heavy menses in the general population is about 2.4%. In women on birth control pills it drops to 1.2%. Irregular menses goes from 1.3% normally to 0.5% in oral contraceptive users. Intermenstrual bleeding (breakthrough bleeding as a recurrent problem) decreases from 0.5% to 0.3% in women who have been on oral contraceptives over time.

How much breakthrough bleeding can I expect when starting oral contraceptives?

Studies have shown differences in breakthrough bleeding rates in the first 3 months of women starting birth control pills ranging from 10%-55%. Even the same pill in different studies has widely varying rates. The rates are so high that routine advice upon starting the pills is to ignore the breakthrough bleeding for the first 3 months of use; then if it persists let the doctor know.

Does the bleeding get better the longer I take the pills?

Yes. The intermenstrual bleeding rate drops to about 10-15% in the 4th and subsequent cycles and in most studies does not seem to lessen after that. This is still a high percentage of bleeding so it causes many women to discontinue the pills.

Pill components and potencies

Different pills and their ingredients

Which Oral Contraceptive Pill is Best for Me?

I am 25 years old. I haven't had a period in about 6 months but I don't want to get pregnant now. I'm overweight and can't lose any, I am always tired, have acne that I can't clear up, and I have excess body hair. I have been put on birth control

pills but they haven't helped. What would be the best brand of pills for me to be on for my problem?

Be sure to give the pills you are currently taking a fair trial of at least 2-3 months. If your pills are switched, also give them 2-3 months trial because it often takes 2 months just for your body to adjust to the estrogen and progestin in an oral contraceptive. Also when we say a pill has certain characteristics because of its estrogen dose and its progestin dose and potency or androgenicity (male hormone effect), every woman responds differently to those components and sometimes the general principles just do not apply.

Many experts believe there are no consistent side-effect differences between different formulations of birth control pills because all pills have been reduced in dose so much from when older data on higher dose pills was examined. Others agree that those unique side-effects have been reduced but they are still manifest in some women. In my experience some women still have side-effects according to the different oral contraceptive components and their doses in a given pill formulation.

How do the doses of pill components vary by brand of pill?

Birth control pills now have only one (synthetic) estrogen type, ethinyl estradiol. Therefore the estrogen potency of a given pill is directly related to the number of micrograms of ethinyl estradiol with one exception. Sometimes the specific progestin also has some estrogen activity. For the most part, the estrogen potency of the progestins is small in comparison with ethinyl estradiol so it is not added in to potency tables.

Estrogen potencies

Estrogen and Progestin Hormone Doses in Combined Birth Control Pills

Estrogen level ethinyl estradiol (micrograms)	Pill Brand Name	Progestin	Dose (mg)

20 mcgm	Alesse®	levonorgestrel	0.10
	Levlite®	levonorgestrel	0.10
	Loestrin 1/20® Fe	norethindrone acetate	1.00
	Mircette®	desogestrel	0.15
phasic 20/30/35 mcgm	Estrostep® Fe	norethindrone acetate	1.0/1.0/1.0
30 mcgm	Levlen®	levonorgestrel	0.15
	Levora®	levonorgestrel	0.15
	Nordette®	levonorgestrel	0.15
	Lo/Ovral®	norgestrel	0.30
	Desogen®	desogestrel	0.15
	Ortho-Cept®	desogestrel	0.15
	Loestrin® 1.5/30	norethindrone acetate	1.50
phasic 30/40/30 mcgm	Triphasil®	levonorgestrel	0.05/0.075/0.125
	Tri-Levlen®	levonorgestrel	0.05/0.075/0.125
	Trivora®	levonorgestrel	0.05/0.075/0.125
35 mcgm	Ortho-Cyclen®	norgestimate	0.25
	Ovcon-35®	norethindrone	0.40
	Brevicon®	norethindrone	0.50
	Modicon®	norethindrone	0.50
	Necon®	norethindrone	1.00
	Norethin®	norethindrone	1.00
	Norinyl® 1/35	norethindrone	1.00
	Ortho-Novum® 1/35	norethindrone	1.00
	Demulen® 1/35	ethynodiol diacetate	1.00
	Zovia® 1/35E	ethynodiol diacetate	1.00
phasic 35/35 mcgm	Ortho-Novum® 10/11	norethindrone	0.50/1.00
	Jenest®	norethindrone	0.50/1.00
phasic 35/35/35 mcgm	Ortho-Tri-Cyclen®	norgestimate	0.15/0.215/0.25
	Ortho-Novum® 7/7/7	norethindrone	0.50/0.75/1.00
	Tri-Norinyl®	norethindrone	0.50/1.00/0.50
50 mcgm	Necon® 1/50	norethindrone	1.00
	Norinyl® 1/50	norethindrone	1.00
	Ortho-Novum® 1/50	norethindrone	1.00
	Ovcon-50®	norethindrone	1.00
	Ovral®	norgestrel	0.50
	Demulen® 1/50	ethynodiol diacetate	1.00
	Zovia® 1/50E	ethynodiol diacetate	1.00

Progesterone and androgen potencies of pill components

Which pills have higher progestin side-effects or cause more acne and hair growth?

Each progestin has a different potency, milligram per milligram, in terms of progesterone effect to stop menstrual bleeding or androgen effect to stimulate acne and hair growth. However you must remember that a higher potency progestin may be used in a much

smaller milligram dose and thus be equivalent to a larger milligram dose of a less potent progestin. For example, desogestrel is a very potent and androgenic progestin but its usual oral contraceptive dose is 0.15 mg instead of 1.00 mg for norethindrone. Its progestin potency compared to norethindrone would be 0.15 X 9.0 = 1.35 times. For androgenicity, it would be 0.15 X 3.4 = .51 or half as androgenic as a pill containing 1 mg of norethindrone.

Progestin Potency of Different Oral Contraceptive Progestins*

Progestin	Progestational Activity (relative to 1 mg of norethindrone)	Androgenic Activity (relative to 1 mg of norethindrone)
norethindrone 1 mg	1.0	1.0
norethrindrone acetate 1 mg	1.2	1.6
ethynodiol diacetate 1 mg	1.4	0.6
levonorgestrel 1 mg	5.3	8.3
dl-norgestrel 1 mg	2.6	4.2
norgestimate 1 mg	1.3	1.9
desogestrel 1 mg	9.0	3.4

* - From Table 2 in Dickey RP: Individualizing oral contraceptive therapy. OBG Management Supplement October 2000, p 5.

The pills that are likely to be worse for acne and hair growth are those pills high in androgenicity and low in estrogen content. Such pills might include:

- Loestrin® 1.5/30
- Loestrin® 1/20 Fe
- Estrostep® Fe
- Levlen®
- Alesse®
- Ovral®
- Norlestrin® 1/50

Keep in mind that MOST women on these above pills DO NOT have acne problems, just those that have a tendency toward androgenicity.

What pills would be better for...?

In order to classify an oral contraceptive as an estrogen dominant, progestin dominant or androgenic pill, you must multiply the actual dose of the components times the relative potency of that component. Keep in mind that these are relative classifications and do not always hold from one woman to another.

Current Pill Problems and Choice of Pill to Switch To

Problem or Concern	Principal	Pill Suggestions

Acne	higher estrogen, lower androgen potency	Demulen® 1/50, Othro-Tri Cyclen®, Ortho-Cyclen®, Brevicon®, Modicon®, Necon®, Mircette®
Breakthrough bleeding	higher estrogen, higher progestin potency, lower androgen potency	Demulen® 1/50, Zovia® 1/50E, Ovcon® 50, Desogen®, Ortho-Cept®, Estrostep® Fe, Loestrin® 1/20
Absent or too light menstrual flow	higher estrogen, lower progestin potency	Ortho-Cyclen®, Ovcon® 35, Brevicon®, Modicon®, Necon® 1/50, Norinyl® 1/50, Ortho-Novum® 1/50, Necon® 1/35, Norinyl® 1/35, Ortho-Novum® 1/35,
Depression	lower progestin potency	Ovcon® 35, Ortho-TriCyclen®, Othro-Cyclen®, Brevicon®, Modicon®, Necon® 1/35, Alesse®, Levlite®, Tri-Levlen®, Triphasil®, Trivora®
Moodiness or irritability	lower progestin potency	Ovcon® 35, Ortho Tri-Cyclen®, Othro-Cyclen®, Brevicon®, Modicon®, Necon® 1/35, Alesse®, Levlite®, Tri-Levlen®, Triphasil®, Trivora®
Headaches (not menstrual migraines)	lower estrogen, lower progestin potency	Alesse®, Levlite®,
Breast soreness	lower estrogen, lower progestin potency	Alesse®, Levlite®, Loestrin® 1/20 Fe, any lower estrogen pill than currently on
Weight gain	lower estrogen, lower progestin potency	Alesse®, Levlite®, Loestrin® 1/20 Fe, any lower estrogen pill than currently on
Severe menstrual cramps	higher progestin potency	Desogen®, Ortho-Cept®, Mircette®, Loestrin® 1.5/30, Demulen® 1/35, Zovia® 1/35E, Demulen® 1/50, Zovia® 1/50E
Endometriosis or endometriosis prevention	lower estrogen, higher progestin potency, higher androgen potency	Loestrin® 1.5/30, Loestrin® 1/20 Fe, LoOvral®, Levlen®, Levora®, Nordette®, Demulen® 1/35, Zovia® 1/35, (used either continuously with zero days of placebo pills or with only 4 days of placebo pills for prevention)

Mono phasic vs. triphasic pills

I started taking BC Pills a while back and thought that I was on the lower hormone level pills because I am not sexually active and am taking the pills to reduce the flow and the cramps, and also regulate when I get my periods because they would come every 30-50 days which was a pain. I recently found out that I am on a higher level pill---I am on the "mono phasic" (is that the right word?) rather than the triphasic pills and was wondering why I'd be put on such a strong pill. I know people that are married and are on the triphasics, so I guess I'm sort of confused. Does weight have anything to do with it, because I am overweight? But, the pill (Desogen®) really hasn't helped with the bleeding-- it's sort of heavier, so what kind of pill is better to help bleeding---mono phasic or triphasic? Most everyone I know is on the triphasic pill and they say they hardly bleed at all. Is it just a matter of getting the right combination of hormones and which hormone controls the bleeding and which one controls the regularity? And, is it a higher or lower dose of each that results in better regularity and less bleeding? I want the least bleeding with the most regularity! Is there anything out

there comparing pills and their effectiveness on different problems like bleeding or pain or regularity, etc? Just curious!

Mono phasic pills are not necessarily higher or lower in potency than triphasic pills. Triphasic pills tend to vary the estrogen and progestin dose by a small amount in the different phases of the cycle so many people think triphasics are lower but mono phasic pills such as Loestrin® 1/20 and Allesse® would be lower total amounts and potencies than most triphasic pills.

It's hard to say whether raising the progestin potency or the estrogen dose lessens bleeding. Sometimes both combinations need to be tried.

The Desogen® you are on is actually a "low" potency progestin so if you are having heavier bleeding, the next likely pill would be one with more progestin potency such as Demulen® 1/35 or Levlen®. It might be that you would respond with less bleeding to a triphasic. In these instances it can be a matter of trial and error to get you to the right formulation for how your body responds.

Why were Tri-phasic pills developed? What are the assumed benefits of a dosing schedule that varies week-by-week?

The original intent was to minimize breakthrough bleeding on the pills by altering the doses.

I've noticed that some tri-phasic pills have a static estrogen dose, but a varying progestin dose, usually increasing each week. For example, Ortho-Novum® 7/7/7 and Ortho Tri-Cyclen®.

Yes. Preventing breakthrough bleeding is both a progesterone problem and can be an estrogen level problem so companies have experimented with many different regimens.

Others, such as Tri-Levlin®, have a varying estrogen dose (up the second week, and then down again the third week) while progestin increases each week. And still others, like Ortho-Novum® 10/11 and Tri Norinyl®, have a static estrogen dose, with a progestin that goes doubles the second week, then goes back the third week. What is the logic behind this? My hunch is that during the second week the strongest doses are necessary because that's when ordinarily the body prepares the lining of the uterus for implantation and releasing of the egg. But then why are monophasics still around?

Because they seem to give the least bleeding problems in most women. Most doctors will use monophasics as their first line OCP and switch to triphasics in women having bleeding problems or other side-effects.

And why the increase of progestin the third week for so many?

Because the body has sometimes let ovulation take place and a higher progestin is needed to prevent bleeding early.

Pill – drug and disease interactions

Do weight-loss pills effect birth control pills, or cause breakthrough bleeding?

Drug-drug interactions with oral contraceptives that may reduce their efficacy have long been worrisome but not always well documented. It was felt on a mechanistic basis that any drug, which stimulated liver enzyme production, could theoretically lessen the effectiveness of birth control pills because they are mainly metabolized in the liver. While there were anecdotal reports of women becoming pregnant while on a specific drug, there were very few studies that looked critically at whether women taking oral contraceptives and on the drug had any more unintended pregnancies than women not taking the drug.

Anti-tuberculosis drugs such as rifampin®, anti-fungal drugs such as griesofulvin® and antibiotics such as tetracycline® and ampicillin® were the most strongly suspected for drug interactions causing an increased pregnancy rate. Dentists, dermatologists and any physician prescribing antibiotics is concerned with whether to advise patients to use extra contraception. Oral contraceptives have also been thought to increase the requirement for anti-epileptic drugs. Many of the anti-seizure medications, with barbituates being the classic drug, stimulate liver enzymes and thus are suspect to speed up the metabolism and degradation of birth control pills.

A large study of over 8058 women taking combined oral contraceptives and seeking elective termination of pregnancy showed 70 women (0.87%) who became pregnant while using oral contraceptives . This is about the expected failure rate of 1% for OCPs so it is very unlikely that there is a significant impact of many medicines on oral contraceptive efficacy considering all of the medications that are prescribed.

Is there an interaction between diet pills and oral contraceptive efficacy?

This seems a natural question because diet pills often speed up a woman's metabolism and you might think that it would speed up the metabolism and degradation of oral contraceptives. Unfortunately there is no data in the medical scientific literature one way or the other. It simply has not been studied in any clinical trials. As with most other drug interactions with OCPs it is unlikely that diet pills would decrease the effectiveness of birth control pills but this is just an educated guess.

Do antibiotics make birth control pills less effective?

Early data about 20 years ago seemed to indicate that when antibiotics were taken along with birth control pills, more women got pregnant than you would normally expect. Drugs like ampicillin® and tetracycline were suspected to interfere with OCPs . However, all of the recent studies that have looked at this, have shown that antibiotics do not increase the pregnancy rate at all and they point out that the old data was not reliable enough to draw conclusions about pregnancy rates on any of the antibiotics .

Some antibiotics have been studied and shown not to affect the metabolism of OCPs. Ciprofloxcin (Cipro®) is one that does not seem to alter metabolism . Fluconazole (Diflucan®) does not decrease estrogen levels in pill users; if anything, it raises estrogen levels .

Does erythromycin reduce the effectiveness birth of control pills?

I take Desogen, and have previously taken erythromycin 333mg 3 times a day for acne. My skin is acting up, and I'd like to take it again.

Erythromycin is safe to take with oral contraceptives. It does not decrease the efficacy as best we know. Older data suggested antibiotics of various types might reduce the effectiveness of oral contraceptives. This has now been shown not to have a significant effect.

Do birth control pills cause more seizures in women being treated for epilepsy?

There are some older studies showing a higher pregnancy rate among epileptic women on anti-seizure medications and taking oral contraceptives . Also, teens have a higher abnormal bleeding rate when on the combination of OCPs and anti-epileptic drugs and this goes away when the estrogen levels in the pills are increased . In general, it is felt that certain anti epileptic drugs stimulate or induce liver enzymes to metabolize birth control pills faster but there is not good clinical data to make recommendations for practice guidelines such as to increase the dose of pills to prevent pregnancy. In practice, however, most experts recommend using higher dose birth control pills for women who are on anti-epileptic drugs or at least avoiding the very low dose pills.

Folate levels also tend to be lower while on anti-epileptic drugs. Taking birth control pills adds to this lowering so that folate supplementation is recommended.

Are there other diseases or conditions that can decrease the effectiveness of birth control pills?

The most common question situation that comes up is with a flu, gastritis or diarrhea condition and whether that affects absorption of the contraceptive pill. There is very little data to support this concept at all. It may be because episodes of acute gastrointestinal illness do not last long. We know that missing up to 10 pills in a row (7 placebo pills and the 1st 3 pills of a pill pack) does not result in ovulation . Therefore acute illnesses are unlikely to result in a decreased efficacy of birth control pills. This is probably why most antibiotics don't actually cause unwanted pregnancies because they are given in regimens of usually 10 days or less. Long-term medications that are suspected of inducing liver enzymes to a large extent should be treated as if they may require higher oral contraceptive doses.

Using the pills to regulate your menses

Shortening and decreasing your flow

I am 24 and have been on the pill since I was 16. I started my period at 11, and from that time until starting the pill, my periods were extremely irregular, heavy, and lasted 7 days. After going on the pill, the situation improved greatly--I am now regular and have less heavy bleeding, but the length of my cycle is still 7 days--annoyingly long, frankly. Is there anything I can do to make my periods shorter or "speed up" the bleeding? I'd trade 3 days of heavy bleeding anytime for 7 days of moderate.

Here are some suggestions for you to try. Make sure you are not taking any aspirin containing products around that time. Add a multivitamin including vitamin C and vitamin K if possible. Ask your doctor to write you a prescription for Ponstel®, which is a nonsteroidal, used for cramps that can sometimes decrease your flow even further. Ask your doctor to switch you to a high progestin potency pill such as Demulen® 1/35 or even Lo-Ovral®.

Finally, and probably the most effective, just take the placebo pills of the pill pack for only 4 days, rather than 7. This will make you menses come every 25 days but will decrease the flow and cramps considerably. You could also use the 21 active pills of a supplemental pack to replace 3 days of the placebo pills so as to have your menses still every 28 days. This would consume an extra pill pack every 7 months.

My second question is this: Is there a similar pill where you stop taking it for a shorter period of time, such as maybe taking it for 25 days and off for 3? I had read a magazine article awhile back that suggested such a pill for women in their late childbearing years, now of course I cannot find the article. I am thinking that perhaps I might be a candidate for something like that. By the way my pain was more tolerable during my menses.

In the previous answer I mentioned being off for 4 days. Actually any birth control pill can be taken with only having 3 days off of the active pills instead of 7. Three days is enough to induce a withdrawal for many women. You would still have to cannibalize an extra pack to do this (take 25 active pills instead of 21) or have shorter cycles (25 days instead of 28).

Side-effects of pills for heavy flow

I have painful and heavy periods and want to go on the pill to treat these symptoms. What are the negative side-effects and do I need to stay on it long-term?

Negative side-effects of the pills are nausea, headaches, dizziness, spotting, weight gain, breast tenderness and increased facial pigmentation (chloasma) in some women. You will probably need to stay on the pills for the cramps until after a pregnancy. They often get better then.

Pill potency to decrease flow on pills even more

Two and a half years ago, I started using Desogen®. I used the Sunday start method and thought I would not spot or have any breakthrough bleeding during the month, when I did get my period during the week of taking the "reminder" pills, it would start anywhere from a Tuesday one month, to a Saturday the next or anywhere in between. My periods had always been irregular so this was one of the reasons I decided to try the pill. Also, I knew they usually lessened the bleeding which was fairly heavy and also helped with cramps. Besides not getting my period on at least approximately the same day each month, they kept getting heavier and heavier each month, and the PMS also increased from one

week in advance to having it the entire month. The pill did nothing to help with the cramps, either. I told my gyn and she switched me to LoEstrin® 1.5/30 the following year. I also switched the pills to a Friday start so I would get my periods on Sundays. At first, this pill worked great as far as the bleeding. It lessened it and also shortened the length of time it lasted. I also got it the exact same day (Sunday) each month, which I found very convenient. Unfortunately, it did nothing to help with the cramps and I usually had to take about 24 Advil® within a 24 hour time period for a day or two. Eventually, the Advil® wasn't helping and I switched to using Ultram®, which helped much more. But, I noticed a few months after switching pain killers, that the first day of my period became quite heavy---heavier than before I took any BC Pills---and also contained many more clots. For about 12-18 hours on the first day I will bleed very heavily, then it will lessen to average and then go to barely anything for the next 2-3 days and end. I have since read that using Ibuprofen can lessen the flow and I think that's what happened with me---I stopped taking the Advil® and that's when the periods became heavier. I have become fed up with how heavy it is the first day and have recently asked my doctor what to do.

She suggested using Levlen® instead because it is a stronger pill than both Desogen® and LoEstrin 1.5/30® were. I am just wondering if you think this will help lessen the bleeding or make things worse like the Desogen® did because my understanding is that Desogen® is a stronger pill than LoEstrin®, yet it caused heavier bleeding. From what my pharmacist said, according to her chart, LoEstrin® is considered a "lower level" pill and Desogen® is an "intermediate level" pill. So, I'm thinking that because Desogen® caused me to bleed heavier and it was a higher level pill than the LoEstrin® (which lessened the bleeding in comparison to the two), then is Levlen® (which is a higher level than both of them) what I need or will it, too, cause heavier bleeding as the Desogen® did? Should I be going to a pill that's even lower than LoEstrin®? I guess I don't understand how you figure which way to switch someone's pills. My gyn said that you couldn't really compare two pills like Desogen® and LoEstrin® 1.5/30 because the types of progestin in the two are completely different. I've read that if you have heavy periods that you want to increase the progestin level, but it seems like going from Desogen® to LoEstrin® was a decrease (at least according to the pharmacist's chart), but it did work in lessening the amount of bleeding compared to what I had on the Desogen®. So, now I'm completely confused whether to try this pill or not. I'm not as concerned with the cramps as I am with the bleeding and I'm hoping that my doctor is basing her choice of new pills on the bleeding factor more than the pain factor, which I tried to stress to her. She said she thinks this will help more with both, but I am still leery because, well, I have to worry about everything!

Is there more progestin in Levlen® than the other two pills, and do you think it sounds like the right choice---or at least a choice that shouldn't make things worse even if it doesn't make things better? I believe that the levels of progestin in each are: Desogen®---desogestrel 0.15mg LoEstrin®----1.5mg Norethindrone Acetate Levlen®-----0.15mg Levonorgestrel Is it true that you should increase the progestin level for heavy bleeding? And, according to you, which is the weakest and strongest of all these pills? They all have the same dose of 30mcg of estrogen (the estradiol kind). I've heard that you can use two tampons at once---

do you place them next to each other? Does this really work? Sorry this letter is so long, but I'm starting college in June and my period is, of course, due that week and I guess I'm looking for some reassurance that I won't be hemorrhaging at the time like with the Desogen®! Should I give this pill a try--do you agree with her choice and that a stronger pill is what I need in spite of the bleeding, etc. that the Desogen® caused? Also, will I notice any change the first month or will it take a few? If the bleeding gets heavier on this pill in the first month, then I would think that it's not the right choice and change back or try another new one. If it doesn't get less, but stays the same, then I should try it for a few months, anyway. Does this sound correct? I am hoping that this pill will work like the others in that I will get my period the same day each month---do most pills work like that? Besides my Desogen® experience! Again, sorry that this letter is so long, but for some reason, this is a big issue with me---what I'd really like is a hysterectomy so I won't have to deal with it anymore, but....

Keep in mind that what follows about pill potency is controversial. Some very prominent experts in the field feel that since there is so much individual variability in how any woman's specific tissue reacts to any specific hormone, you can't assign biologic potencies accurately enough to clinically prescribe different formulations according to different symptoms. That being said, pills are assigned biologic potencies as a combination of both the estrogen and the progestin. Since almost all pills have the same estrogen (ethinyl estradiol), the estrogen potency only varies from a few pills at the 20 ug level (Loestrin® 1/20 and Allesse®) to the majority at 30 and 35 ug. In this respect Loestrin® 1/20 would be considered -low- but actually Loestrin® 1.5/30 I wouldn't consider low. It is a high progestin pill. That is why your bleeding is less. Progestin potency has in the past been measured by a "delay of menses" index, i.e., how well a hormone keeps the endometrium from sloughing. The higher the progestin potency (and it doesn't go mg per mg across different formulations), the more likely to stop heavy bleeding. For example Levlen® (levonorgestrel) mg for mg is more potent than many other progestins such as the one in Desogen®, which is actually a very mild progestin. Higher progestin potency also tends to decrease cramps more. To complicate matters more, sometimes a higher estrogen potency (dose) is needed to "stabilize" the endometrium if the progestin makes the endometrium too atrophic. You went from Desogen®, a low potency progestin, to Loestrin® 1.5/30, an intermediate potency progestin but a high total dose and your doctor has now suggested a higher potency progestin in Levlen. It seems like it would be worth a try. Another slightly higher progestin potency pill would be Demulen® 1/35. You may also need to get a thyroid check and a bleeding time check to rule out other causes of heavy bleeding.

Is it true that taking the 7 days of the iron pills that are at the end of the LoEstrin® pack can cause you to bleed heavier? A pharmacist mentioned that to me. I never took them, but am just curious in case I go back to that pill. I thought it would be the opposite if anything, but what do I know?

I've never heard of this and it doesn't make any physiological sense that iron pills would either increase or decrease flow.

Are there things you can do to lessen your bleeding or things you shouldn't do because it will cause heavier bleeding?

Avoid aspirin products, which cause heavier bleeding. They may help cramps but they often increase amount or days of bleeding.

I've heard that lessening the cramps or prostaglandins (is that the right word for what causes pain?) can lessen it somewhat. I read that the spasms can "force" the blood out more than if the uterus was relaxed. True or false?

I don't think cramps cause flow to be heavy but rather heavy flow causes more cramps. The uterus cramps to empty itself completely.

Also, what about exercise during the month before your period-- would that have any effect on the amount of bleeding when you get your period?

Not that I know of.

How about exercise during your period---I've heard that lessens cramps, but could cause heavier bleeding. Can exercise make the bleeding heavier or is it better to be active?

Exercise lessens the pain of cramps by producing endorphins, which are natural painkillers. I don't think exercise increases or decreases flow.

Last question (phew!) is about DepoProvera®. I heard that it often causes amenorrhea because it stops you from ovulating so therefore, your uterus eventually gets used to no egg being released and stops building up the lining in preparation for fertilization. Makes sense, but you don't ovulate on BC Pills, either, so why don't they also cause amenorrhea?

With DepoProvera® (progestin) the blood level of progestin is always present. It counteracts any body estrogen stimulation of the endometrium and thus growth. Therefore endometrium doesn't grow and the level of progesterone never drops to allow a withdrawal bleed. (Actually it's not that perfect, only about 65% of women have no bleeding on DepoProvera®.) With birth control pills, you have a progestin withdrawal (the seven days of placebo/non hormonal pills) to allow sloughing of what endometrium is present as well as allowing 7 days of your body's natural estrogen to stimulate some uterine lining growth. If you were to take birth control pills continuously, as we sometimes prescribe for women with endometriosis, you would have little or no bleeding also.

You may want to discuss with your doctor a regimen in which you are only off the active pills for 4 days instead of 7 days. That might help decrease the flow and cramps you have on the first few days. Of course that will alter when your period comes each month unless you lengthen each cycle by three days, which you could do.

Delaying your menses

How to delay menses

Can you tell me how to use my birth control pills to prolong getting a period?

I have a vacation coming up and my menstrual is scheduled to occur right in the middle of it.

While birth control pills are normally taken with 21 active hormonal pills followed by 7 placebo or iron pills, there are other ways of taking the pills to control the timing of when you get your menses.

Menses usually starts after no active hormone pills for 3 or 4 days. That is why if you miss more than two birth control pills, a menstrual period often starts prematurely. Then it is best to let it proceed and just start a new pack 7 days after the first missed pill.

You could start your menses earlier than usual by discontinuing the active pills and starting a new pack 7 days later. Ovulation rarely takes place in less than 10 days after stopping a pill so this should not lead to pregnancy unless you forget to restart them at the correct time.

Rather than having your menses earlier and starting a new cycle, you could start a new pack right after the 21 days of active pills and then your menses would be delayed by 3 weeks.

We know from women who take pills continuously for endometriosis that eventually you may have breakthrough spotting or bleeding if you continue on active pills but that still should not affect getting pregnant.

How to postpone period for holiday weekend

I'm going to a nude beach over the holiday weekend! My period will start about 1 or 2 days into my vacation. I am not on the pill. Is there any safe way to postpone my start date with less than a month to go?

If you were on a BC pill this entire cycle it might be possible by extending the active pills (i.e., using the three week active pills then taking another week of active pills and then discontinuing).

Since you are not on pills now, if you are within 7 days of starting your menses, you could start on a cycle of birth control pills assuming you had a prescription and take the active pills continuously until after your holiday.

Avoiding any menstrual period

The only way to avoid menses is to take the 21 active pills each day and then start a new pack taking the 21 active pills. In this way there is no 7 day withdrawal from the pills that allows any accumulated endometrial lining to slough. This regimen is often used for women with endometriosis. We do not know of any adverse effect of this continuous regimen in the long run but most physicians will have a patient go for the 7 days without active pills every 6 or 12 months. There is no scientific reason for this and it probably makes more sense just to continue on the pills as long as necessary.

Breakthrough spotting on continuous pill therapy

I've been having spotting for a while. It happened for about 4 days and then stopped for a week. Now I've been having heavier spotting for the past two days. My doctor said that he wasn't worried about spotting before, does that mean I shouldn't worry about it happening again, only a week later than the last time? I'm on Ortho-Novum 1/35 with no break (constant with no placebos taken). Does this mean I should be on heavier birth control? The reason I'm on it is because of constant ovarian cysts that don't go away, even after a year. Should I be worried about some kind of endometrial abnormality?

Breakthrough spotting and bleeding on continuous pill therapy happens to almost everyone sooner or later. Rather than switch pills, I would discuss with your doctor whether or not you could come off of the pills for a week (to have a withdrawal bleed) or even one month (to have a natural cycle withdrawal bleed). Then resume the pills. This is more likely to prevent further breakthrough bleeding for awhile.

Using the pills as emergency contraception

Emergency contraception is a recent term for the morning-after pill. It's a dose of estrogen and progestin (birth control pills), or progestin only that, if taken within 72 hours of having sexual intercourse, helps to decrease the chance of getting pregnant from that one unplanned episode. Right now, in most countries, this is only available by prescription. Since medical consultation is not easily available on short notice and many women are embarrassed to ask their physicians for emergency contraception, this is a very underutilized method of birth control.

Many countries, including the U.S., have made emergency contraception available. It is not yet over-the-counter without a prescription but there are many trials of cooperative arrangements between pharmacists and physicians that are making the medication more readily available upon request. There are many arguments against making it an over-the counter, non prescription medication. Pharmacists are concerned about minors buying it, drug companies worry about liability, many of the public believe that its availability will discourage the use of more reliable contraception, and that it may encourage promiscuity and unsafe sex. One of the biggest medical concerns is how women will use it. Will there be side-effects? Will it really reduce unintended pregnancies?

An Edinburgh study, Glasier A, Baird D: The effects of self- administered emergency contraception. N Engl J Med 1998;339:1- 4, looked at how women (549) might respond if they had emergency contraception readily available at home to use as they saw fit. The control group of women (522) had to get the prescriptions from their doctors. Of the women who answered detailed questions at follow-up, 47% of the study group and 27% of the control group used emergency contraception at least once over a two-year period. There were no adverse effects of the medication, and 98% of the study group used the medication correctly.

As far as pregnancies, there were 18 unintended pregnancies in the study group and 25 in the control group. This was not a statistically significant difference, but it was consistent with the literature of pregnancy occurring in 3% of the cycles in which it was used.

Overall there are studies to show that up to 30% of all births are unintended and in women under 20, as many as 65% are unintended. The question becomes as to whether easier access to morning-after-pills is in the best interest of the health of women. What do you think?

Emergency contraception regimens

Emergency contraception using birth control pills involves at least 1.5 mg levonorgestrel taken within 72 hours of intercourse in divided doses 12 hours apart or its equivalent.

Different regimens include:
Plan B®, levonorgestrel, 0.75 mg tab immediately then 0.75 mg tab 12 hours later
Preven®, two blue tabs immediately then two more tablets 12 hours later
Levlite® five tabs immediately then five more tablets 12 hours later
Levora® four tabs immediately then four more tablets 12 hours later
Levlen® four tabs immediately then four more tablets 12 hours later
LoOvral® four tabs immediately then four more tablets 12 hours later
Nordette® four tabs immediately then four more tablets 12 hours later
Ovral® two tabs immediately then two more tablets 12 hours later
Trilevlen® four yellow tabs immediately then four more yellow tablets 12 hours later
Triphasil® four yellow tabs immediately then four more yellow tablets 12 hours later
Trivora® four pink tabs immediately then four more pink tablets 12 hours later
Conjugated estrogens (Premarin®) 10 mg each day for 5 days
Estrone® 5 mg twice a day for 5 days
Copper IUCD insert within 5 to 7 days of exposure

Do I need emergency contraception?

I'm 18 and I was just wondering, is it possible for semen to go through underwear, and up into the uterus? Do I need emergency contraception? I am a virgin but I think my boyfriend leaked semen on my underwear. My friend told me there is a possibility. Is it true?

Anything is possible but the circumstances you describe would be very unlikely. The underwear would block almost all sperm like a diaphragm does. I wouldn't suggest a morning-after-pill in this situation.

It seems as if this was a "close call" and maybe you should consider seeing about birth control. There is often a dilemma for young women in that they think if they get on contraception, that is the same as being willing to engage in sexual relations, which you may not desire to do at this stage of your life. As a result many young women may not seek out contraception but some of those have accidents that they were not intending and they end up with a pregnancy long before one is intended.

I look at it differently. I don't expect anyone to be perfect, others or myself. We all make mistakes even though we have the best intentions. I buy car liability insurance even though I'm a good driver and don't intend to cause any accidents. I have medical malpractice insurance in case anyone even thinks I've made a mistake because I can't

control the actions of others who may sue me, but it could end up hurting my family or me.

A pregnancy could end up hurting you or your family. You may not have control over your partner. That happens much more often than you think even though you may do everything possible to avoid sex or getting pregnant or even getting into a situation where that could happen. Contraception would be a form of insurance.

Bleeding from the morning after pill

I'm a 21-year-old with no GYN problems except perhaps single ovarian cysts giving a little pain and irregular periods for which I am about to start the pill. A week ago, following a condom breakage, I took the morning-after pill. I was told I might have bleeding about 5 days later. I'm not sure whether what I had would count as a "bleed" (it was very light and lasted less than one day). What I want to know is: does any bleeding count as a period?

Yes it counts. Actually it's not usually a period but rather just bleeding or spotting like you had.

The other night, the condom broke again (an old pack- I should know better!) - so am I likely to be day 3 or day 18 of my cycle, in which case I may need another MAP (especially since my abnormal period length)? and is it wise to take 2 in one month? Any advice would be gratefully received.

It's not wise, but it is necessary. Go ahead.

Broken condom – Do I need emergency contraception?

I just stopped taking the pill a week ago because I was getting signs of depression. Last night, while engaged in intercourse, the condom broke. A friend told me that if a person stops taking the pill after being on it for at least five months, pregnancy wouldn't occur for the first month off. Is this true? I was on the pill for 10 months. I was on one pill for 6 months and another for 4. I'm thinking about getting the morning after pill. Would this be the best thing to do?

You do need to take the morning after pill. I'm guessing but I would say you have a 5-10% chance of getting pregnant from intercourse on day 7 of your cycle. There is no truth to the assertion that it is more difficult to get pregnant when you first come off the pill.

Pills and possible pregnancy

Effectiveness of pills

Failure rate of birth control pills

When using the pill, everyone knows that there is a slight failure possibility even if used correctly, but I have heard conflicting info on the statistics (assume perfect use)

I have heard:
1) 1 in 100 women failure rate
2) 1 in 1,000 women failure rate
Which is correct? There's a pretty big difference between those numbers!

From scientific studies where individuals have been highly motivated to comply, the pregnancy rate for the pills is 0.1% or 1 per 1000. Overall, however, the pregnancy rate in actual use is 3% or 30 per 1000. You are correct that this is a large difference.

Source for these numbers is Speroff et al, Clinical Gynecologic Endocrinology and Infertility, 5th edition, 1994, p. 689.

Cumulative contraception failure over 5 years

While surfing tonight, I found this site on birth control, including the following paragraph:

"If your method of contraception has an average failure rate of 18%, over five years your likelihood of pregnancy is greater than fifty percent. During those five years, figure 63 out of 100 women using a diaphragm will have gotten pregnant at least once. The average woman using reversible contraception can expect two unintended pregnancies in her lifetime... Even a low annual risk of contraceptive failure implies a high risk of becoming pregnant during a lifetime of use."

Of course, there are contraceptive failures, but to me that's as though the person who manages this website is saying that a woman who uses even effective contraceptives (pill, Depo) WILL become pregnant in a few years or so time, even if using it correctly! This goes against what I have been taught about contraception...the whole point, after all, is to prevent pregnancy! I know that women can use the pill for 10 years or more and never have a pregnancy, or Depo for a year or two. In fact, I always thought that the longer a woman uses her method, especially if it's a hormonal method, will only decrease her chances of getting pregnant on her method.

Is this just some misleading info put on the net?

This seems to be a non-sequitur. The statement about an 18% failure rate applies to a birth control method such as withdrawal (which isn't a very good method). If the failure rate is as high as 18%, the author is right. The cumulative pregnancy rate over 5 years will be over 50% and by probability, actually 63%.

For all methods of birth control, there is a theoretical pregnancy rate (assumes perfect use) and an actual rate (imperfect use by humans who forget). Of the major contraceptives only diaphragms and cervical caps approach 18% failure rate in actual use. DepoProvera® runs 0.3% in actual use while birth control pills run 3%.

The longer a woman uses a method, presumably she gets more perfect in its use and therefore her pregnancy rate approximates that of "perfect use" which for pills would be 0.1% and for DepoProvera® is about the same. I agree that the statement is misleading.

Are low dose (20 mcg) pills less effective in preventing pregnancy?

I am taking the new BC pill, Alesse®--it is a 20 mcg low dose pill and I am using it for birth control. However, I have heard people say that these lower dose pills are more "accident prone" in terms of failure than the 35 mcg pills. Is this true, or do all BC pills have pretty much the same effectiveness? I'm 20 and don't want to get pregnant!

If you don't miss pills, the 20 mcg dose is as effective as the 35 mcg dose. The lower dose does give you more of a chance of breakthrough bleeding. You are still protected from pregnancy but more likely to spot. If you try them and don't have any breakthrough spotting, then you should do just fine and would not be more likely to get pregnant.

When you're on the pill (5 full months) and you have a period on time, should you worry if it is scanty and lighter than your others on the pill, or is this normal? I have not missed any pills and take them at the same time each and every day.

Scanty or light periods on the pill are common and shouldn't cause worry. Sometimes you skip periods altogether.

Effect of diarrhea on pill effectiveness

While on my last pack of BC pills (Alesse®) I had an instance of loose stools--not quite diarrhea. It was solid, but a lot coming out fairly fast. This was quick and happened only once, I wasn't sick, but I do think that this may have been due to the fact that my pill period was on its way--it came the next day.

So, my questions are:

1) I worry about my pills' effectiveness. It was at least a day after I had taken my last pink active pill, and I was on the placebo pills the night of this incident. My pill pack says if you have vomiting or diarrhea the pills may not work as well, but was this really diarrhea? Would my pills' effectiveness have been hampered by this incident, based on the info I've provided?

No, a single episode of loose stool would not have altered the pill's effectiveness.

I'm not sure if the pill makers mean severe, continuous "runs" (like you'd get with food poisoning or the flu) or if solid but loose stools are covered under that definition.

Continuous diarrhea for 1 -2 days

2) If this is covered under that definition, how long should one use backup? (If this happens again so close to my period, should I use it until the period, or through the first 7 days of the next pack?)

In this case you don't need backup. If you do develop continuous diarrhea for 2 days, continue your BCP's and use additional backup while the diarrhea persists and for 7 days after it has stopped.

Do antacids interfere with birth control pills?

I had heard somewhere from a source (which I'm not sure to believe or not) that antacids interact with the pill in some way, as in decreasing effectiveness. I have never heard this before, had only heard about antibiotics, epilepsy medications. There's also no mention of it in my pill pack info. Has anyone heard this, and if it is true, what happens and why aren't women told about it?

I have not heard that antacids affect the efficacy of oral contraceptives. I found one abstract (included below) that maintains that antacids do not affect pill effectiveness. I think that's why women are not told about this. Note that there are some inflammatory diseases of the bowel that could affect absorption. Also, antibiotics are not now considered to decrease contraceptive efficacy.

Am J Obstet Gynecol 1990 Dec;163(6 Pt 2):2204-2207
Gastrointestinal disease and oral contraception.
Hanker JP Zentrum fur Frauenheilkunde of the Westfalische Wilhelms-Universitat, Munster, West Germany.

Oral contraceptive steroids play a major role in modern family planning. With the present tendency to decrease the doses of both estrogens and progestogens, any factor that reduces the bioavailability of the lower-dose preparations may have an impact on contraceptive protection. Although ethinyl estradiol, the most commonly used oral estrogen, is liable to an enterohepatic circulation as unchanged drug, the commonly used progestogens are not. At present, no convincing evidence exists in the human subject that disruption of the enterohepatic circulation by antibiotics or antacids does reduce contraceptive efficacy of the pill. Oral contraceptive steroids are mainly absorbed from the small bowel, and contraceptive efficacy depends on its absorptive capacity. Enhanced passage of gastrointestinal contents or impaired absorption may thus contribute to contraceptive failures in patients who have chronic inflammatory disease, diarrhea, ileostomy, or jejunoileal bypass.

Basal body temperatures (BBTs) as backup to pills

Can you (reliably) take BBT temperatures while you're taking birth control pills? I'd like to do this as a back up method to my pills, but don't want to if it will alter the temps either way.

That's an interesting question I don't think I've ever had asked before. I'm not sure, but I suspect the progestin in the pill would alter the early temps to make them higher. On the other hand, if you had a breakthrough ovulation on the pill it could well show a biphasic curve. If you took BBTs for two months and they were flat, I would quit taking them.

The failure rate of BC pills is about 1-3% overall but if there is perfect use (no pills missed) the failure rate is only about 3/1000. It seems if you are compulsive enough to take BBT temps, it's unlikely you would miss a pill. It therefore seems to be a bit of overkill to take BBTs while taking the pill.

Are the pills safe?

I'm not sure what birth control method I should use. I hear warnings on all of the pills or shots, how they cause clots or something else serious. I am not a smoker. Can you give me some advice what could be the safest and effective birth control.

There is no "correct answer" for what form of birth control is the safest. There are tradeoffs of side-effects, complications and failure rate with the attendant complications of pregnancy, for every form of contraception. The most effective as far as lowest pregnancy rate goes is either DepoProvera® injections or birth control pills. In my experience the pills have a lower complication rate than DepoProvera®. IUCDs work well also for many women if they have had a pregnancy. The blood clots from the pills that you hear about are less than 5/10000 women taking them at ages less than 35 and nonsmokers.

Home pregnancy tests

Can I be pregnant if…?

I want to ask you a question concerning something. I am married, and have been for four weeks. I have been taking birth control (although not on time sometimes) but I have been having some suspicion that I am pregnant. I have stopped taking birth control in case this is true, but I was wondering how long I need to be off birth control before I can go get a pregnancy test at the doctor's office. I figure that since the tests tell if you are pregnant by the hormone levels, and since birth control raises the hormone estrogen in the body, I might need to wait a while before getting a test done so that I can get a truthful answer. I am aware that birth control can give me symptoms that make me think I'm pregnant, but I have a feeling it may not just be birth control. Please give me your opinion as to what I should do if you can .

Pregnancy tests do not measure estrogen and progesterone so if you became pregnant while taking the pills, the pregnancy test would still be positive even though you were on the pills or had recently stopped them. It is unlikely your are pregnant now unless by “not

on time" you mean missing several days of the pills. At this point, having stopped the birth control pills, you need to decide if you wish to get pregnant or not in the near future. If you do not wish to become pregnant now, you should resume taking the pills and use backup contraception for a week.

Can I have a period month after month and still be pregnant?

I heard something on the net the other day that said that a woman could have a period month after month and still be pregnant. I know that you can have implantation spotting that may be mistaken for a period the first month and still be pregnant but how about a normal period for months at the same, normal time? Assume that this is in a normal reproductive system (not a double or bicornuate uterus....how is this possible? Is this rare or common?

This is rare but some women swear they had cyclic bleeding while they were pregnant. This usually is not reported past the first 4 months. As best I can tell, these cases have never been documented well and are thought to represent bleeding rather than menses except in the instances you mentioned.

Will taking birth control pills make a pregnancy test inaccurate?

No. The hormones of oral contraceptives do NOT interfere with pregnancy tests. You are correct that estrogens are elevated in pregnancy and birth control pills contain estrogens, but that is not the hormone that is measured to determine pregnancy. All pregnancy tests measure the beta subunit of a placental hormone called human chorionic gonadotropin (HCG). You will often see it abbreviated as beta HCG. It can be measured in the urine or blood. While it depends upon the sensitivity of the specific test, most home urine pregnancy tests (sensitive to 25 mIU) will turn positive about 10-16 days after conception. If you were not on oral contraceptives, this would mean about the time of the first missed menses. When you are on oral contraceptives, ovulation could have occurred at more irregular times so that all you can say is if the pregnancy test is negative, you are either not pregnant or are less than about 14 days pregnant from ovulation.

How likely is it to get pregnant with missing pills or being late in taking them?

There are many reasons why women may not take their birth control pill on time or even miss them entirely. Such reasons for missing pills include disruptions in their daily routines, their husband's absence, spotting, and just trouble remembering to take them each day. If you are missing pills, you are not alone. One study shows 47% of women missing $\geq$1 pill per cycle and almost a quarter (22%) missing $\geq$2 pills per cycle. Even though this rate of missing pills commonly happens, it is still unlikely for pregnancy to occur. In women off pills for 10 days, only about one in ten will ovulate.

While it is normal to be concerned about possible pregnancy when missing pills, most women can be reassured that they will not get pregnant as long as they do not continue to stay off of the pills.

If I miss some pills in a cycle, should I take them or just stop and wait for my menses?

Ovulation does not usually occur within the first 4 days of missing pills. For many women, however, by the third day of missing pills a menses will usually have started. If you have just missed one pill, take that pill (yesterday's) and today's pill both together and just continue on as per your normal schedule. If you have missed 2-4 pills and just have spotting, you should go ahead and resume taking the pills you are supposed to be on and finish out the pack. Even though the odds are still in your favor not to get pregnant, most doctors would advise you to use back up contraception (condoms/foam) over the next seven days or abstain from further intercourse until that cycle is over.

If your menses has fully started, just stay off of the pills until you have been off for seven days and then start a new birth control pill pack.

Can you have a pill withdrawal period and be pregnant?

I know that when you're on the pill, the bleeding you have during your placebo week is in fact withdrawal bleeding and not a "true" period, of course, the blood is real, but there is some difference.

Since this is true, is it also correct that if one became pregnant while on the pill, they would not have withdrawal bleeding at all during their placebo week, or it would be very spotty/light? (assuming that no pills were missed) I have heard that this withdrawal bleeding each month, when it is on time, normal, etc. is "proof" that the woman is not pregnant and the pills are working correctly--is this correct?

If you were to become pregnant on birth control pills, a normal withdrawal period would not occur because progesterone production from the corpus luteum gland on the ovary overrides the drop in progesterone from finishing the active pills. Occasionally a woman could have some spotting while pregnant but usually it isn't a full period. On the other hand, an absent or light menses on OCPs almost never signifies a pregnancy.

The chances of being pregnant but having periods

I have been reading on the issue of having a period when pregnant. I have a couple of questions about it. It is making me paranoid. What are the chances of being pregnant with a period if:

1) You haven't had sex for 4, almost 5, months
2) Are on the BCP, not missed any pills
3) Had three on-time periods since last intercourse (middle one lighter, but ones before and after that one were normal--not time yet for 4th)

0.1% (1:1000), actually I wish I could be that exact but it is an extremely low chance you are pregnant.

I guess the core question is, how many normal bleeds on the pill would a woman need to have before she could reasonably be assured?

It depends upon the definition of reasonably. I would say one normal period if NO pills have been missed but as you know it can rarely happen. 3 menses after would be almost a certainty in my book.

I just wanted to know some info so I wouldn't have to waste money on a test if I didn't need to...I need information!

Well, the cost of a home pregnancy test seems like a small price to pay to put your mind at ease, rather than worry for months about whether you may or may not be pregnant. If you are in this situation now, are you having any symptoms of pregnancy? If so, you need to have a test to be sure, and also to ease your mind.

On BCPs but condom broke

I just started my 4th month on the Alesse® BCP, didn't miss any pills the previous month. In fact, the only pill missed since I've been on the pills altogether was in my first month, which was lost due to a bout of vomiting. Under doctor's advice the next day, I was advised to make up the pill (which I did) and change my starting date back one day for all following packs (i.e. began first month on a Sunday, now I start all packs on a Saturday).

My partner and I have always used spermicidally lubricated condoms in addition to the pill, but tonight some semen leaked out while he was pulling out, landing about a drop or two on the area between my vaginal opening and anus--closer to my anus. We immediately wiped it away, but this is the first time that semen has actually touched me there, and so I'm terrified! I've never had sex without using a condom, so technically semen has never even been on my vaginal area.

Should I panic, or should my pills be protecting me enough to keep me safe? I have heard of the "morning after pill," but I'm not sure if it can be used in those women who are already on the pill regularly. Any advice about what to do?

The pill should be enough to protect you from pregnancy. I wouldn't recommend taking a morning after pill, just continue with your pills. I assume it is pregnancy you are worried about and not sexually transmitted diseases. In the case of STDs, you probably are still ok if the semen was only on the outside of the vagina and you had no open sore areas.

What happens if I was taking oral contraceptives when I was already pregnant?

While no one would intentionally take oral contraceptives if they knew they were pregnant, many women each year inadvertently take pills unaware they are already pregnant. In the U.S. and Europe, in approximately 2-5% of all pregnancies mothers have a history of having taken birth control pills without realizing they were pregnant. Many years ago, with higher dose contraceptive pills, there were concerns that the hormones in pills could produce genital changes in both male and female babies. Subsequent studies have failed to confirm this. At the Hospital for Sick Children in Toronto, Canada, the Motherisk program that tracks various birth defects, there is a good article on oral

contraceptives and their effect on pregnancy. This article suggests that there is no need to be concerned about the pills causing birth defects any more than the background rate of birth defects that normally occurs.

Fertility after the pills

How long should I wait to get pregnant after stopping birth control pills?

Providers used to advise waiting 3 months after stopping pills before trying to get pregnant. This wait improved the ability to accurately date a pregnancy. Now with improved ultrasound dating of pregnancy it is no longer necessary to wait this long. Women may begin attempting conception right after the first normal menses.

Will long-term pill use cause infertility or pregnancy problems?

Can remaining on birth control pills for a long time affect your chances of becoming pregnant or carrying a pregnancy to term in cases where there are no other identified risk factors?

No. Basically pills cover up whatever your body would have done over the time you took them, but they don't alter what your natural history is. For example, if you take pills from age 20 to 35 and then stop, your chances of getting pregnant are the same as any 35-year-old who just started trying. At 35 it may be slightly more difficult to get pregnant but the pills don't cause it; age or other intervening disease or circumstances does.

How long is too long to take the pills?

I am just wondering how long is too long to be on birth control? I have been on it for about 8 or 9 years. I am 22, married, and would like to have children by the time I am 24. Can I still take it for another year, or should I get off of it now so I can conceive by then?

Actually there is no known "too long" time on being on oral contraceptives. Studies have been done with women on oral contraceptives over 20 years. As best is known, they revert back to whatever pattern of ovulation they would have normally done had they not been on pills. The current recommendation is to discontinue pills and try not to get pregnant the first cycle off of them but at any time after.

Average time to pregnancy after pills

Can you tell me if there's an average time it takes to get pregnant after going off the pill? I am 21, don't smoke or drink, am in good health and so is my husband. Also, what are the chances that we know we're having sex when I'm ovulating without trying to keep track of that?

At your age the average time for pregnancy is about 3 months. The classic fertility numbers are:

Months of exposure	%Pregnant

3 months	57%
6 months	72%
1 year	85%
2 years	93%

After age 35, however, all of the above numbers can be divided in half. As far as having sex when you are ovulating you need to time sexual relations. Even then you cannot know for sure if you "hit" the right time. If your menses are regular 28 days from start of one to start of another, having sexual relations from day 11 to day 17 from the start of your last menses about every other day if possible is the best way to assure timing to coincide with ovulation. If your menses are regular but longer than 28 days, for each day longer than 28 days, add that number of days to the 11-17. For example, at a regular 30-day cycle, time relations for days 13-19 after the start of a previous period.

Pill bleeding problems

Breakthrough bleeding

What causes bleeding while on the birth control pills?

The most common cause of bleeding on oral contraceptives is unknown. It is theorized to be due to atrophic bleeding due to low estrogen. In other words, the lining of the uterus (endometrium) is quite thin and subject to abrasion just from normal activity.

There are three other factors known to be associated with increasing the bleeding rate on pills: chlamydia infection, smoking and not taking pills. In one study, women with intermenstrual bleeding on birth control pills had a 29% incidence of chlamydia while oral contraceptive users without intermenstrual bleeding had an 11% incidence of infection versus 6% in non-pill users. Several studies have confirmed an increase in intermenstrual bleeding associated with chlamydial infection on pills.

Cigarette smoking has been known to be associated with anti-estrogen effects. While new users have less and less intermenstrual bleeding with each cycle of pill use, non-smokers decrease breakthrough bleeding at a much faster rate than smokers. By the 6th month of pill use, smokers still have about twice the rate of spotting as do non-smokers and heavy smokers (>15 cigarettes per day) have an even higher incidence of breakthrough bleeding.

Missing pills is an obvious cause of breakthrough bleeding. Missing one pill only slightly raises the incidence of bleeding but by the time 3 pills are missed, over 80% of women will have some bleeding if not a full menses. Many women who miss pills (noncompliance) fail to tell their doctors about that and as a result may undergo therapies and changes in pills that are not really needed when in fact the best therapy would be to do nothing but take the pills more regularly. From 25-33% of women miss more than one pill in a cycle.

How is intermenstrual bleeding on the contraceptive pill best treated?

The primary treatment in the first 3 cycles of pill use is just reassurance that the bleeding problems are very likely to decrease and disappear with continued use. If the bleeding is distressing or continues after 3 months, a preferred treatment is to take estrogen for 7-10 days during the first part of the cycle to build up the endometrium and make it more resistant to sloughing. Unfortunately most physicians do not try this treatment first but rather switch the brand of pills in hopes that that will decrease bleeding. There actually are no scientific studies that test different strategies to arrest breakthrough bleeding on the birth control pills so we do not really know the best treatment for this.

Breakthrough bleeding after a year on pills

I am 20 years old and have been on the pill - Desogen® for over a year. Recently I began bleeding between periods, sometimes light, sometimes heavy. I have been seeing my gynecologist annually and have had no other problems. Is this something to worry about, or something minor?

Probably minor. Breakthrough bleeding is not uncommon on pills. It can be from missing a pill or two or taking them at different times in the day, but it also occurs for no reason at all. My rule-of-thumb is to change the brand of the pill if it happens 3 cycles in a row and a woman has not already tried several different brands. In that case, low dose estrogen is added on a daily basis.

My daughter had been taking loestrol® and now started taking her 2nd pack last Sunday after her period. All the while she has been on it she has been spotting off and on. She just started spotting today again. I make sure she takes them every night at the same time. She is 15 years old. The gynecologist is trying to get her regulated. It is very frustrating to her to be spotting constantly. Is this normal? Also, she had been getting a lot of headaches since starting these. Is this also normal?

It may take up to 3 months for your daughter's system to adjust, and yes these are 2 of the noted side-effects. If after 3 cycles the problem persists, I would recommend that you talk with her doctor about changing to another pill. It may take some time to find one that works well for her.

Breakthrough bleeding is quite common the first 3 cycles and usually goes away. About 10% continue with breakthrough bleeding and need to have different therapy. If this is too aggravating right now, the doctor can just add some estrogen for about 7-10 days during the first part of the cycle.

Okay, let me explain this. I had my son on August 15th. My period came after I stopped breastfeeding, and I wasn't too worried. I've also been on the pill for 6 weeks (Micronor®). At the beginning of this month, I got what I thought was my period. I bled for about a week (usual) and stopped. Normal so far. Then, three days later, I started cramping and bleeding AGAIN. Okay, maybe the last time was a fluke, and this is my real period, right? Right. Or so I thought. Three days after that one stopped, I started AGAIN! I'm currently on the third "cycle" and am REALLY frustrated. None should have to go through so many tampons in a month) Please don't tell me to go to the doc, as that's not feasible right now. I don't have insurance.

Micronor® is a progestin only pill and is used sometimes for women who are breastfeeding. It is not a very good pill to regulate your menses, which can tend to be somewhat irregular after discontinuing breastfeeding. One suggestion would be to call your doctor's office nurse and tell her you stopped breastfeeding and could she call you in a prescription for a regular (combined estrogen/progestin pill) monophasic pill. Start on that new pill as soon as you can.

Decreased libido and breakthrough bleeding

For several years I took Loestrin®. When I complained to my GYN about a lack of libido, he said I should analyze my relationship. Eventually, I switched physicians and found one that thought it could be related to the oral contraceptive. I switched to Alesse®. I have had much better libido with the Alesse®, but find that I have so much spotting and breakthrough bleeding that I can't take advantage. Whenever I start a new pill, I have frequent breakthrough bleeding for about 6-9 months. Then it regulates, but only if I take the pill at exactly the same time every day. If I take it even a half-hour late, I have spotting for the rest of the month, followed by a normal period. If I take it an hour or more late, I have breakthrough bleeding for the rest of the month, followed by a normal period. So, I resist the idea of changing pills, but would like a more predictable and flexible lifestyle. I seem to be even more "sensitive" to the time schedule with the Alesse® than the Loestrin®. I have considered trying DepoProvera®, but I am concerned about a decrease in libido. Can you please comment and provide suggestions? I have a GYN appointment scheduled for April and want to have considered some options before the visit.

Both Alesse® and Loestrin® 1/20 are quite low dose estrogen pills and will tend to give more spotting. You may do much better with the spotting with a 30-35 microgram estrogen pill. Also, it seems you do better with your libido with the progestin in Alesse® (levonorgestrol) rather than the one in Loestrin® (norethindrone acetate). That would suggest that a pill such as Levlen®, Trilevlen®, or Triphasil® would be a better choice to prevent breakthrough bleeding for you and to improve libido.

Continuous Bleeding on Birth Control

I started taking Ortho-Tricyclen® about 2 years ago. I would have my normal period for 5-7 days, and then the following year I started continual bleeding for 2-4 weeks out of each month in addition to my normal week period. Last year, I had my period for five weeks straight, and was rushed to the hospital, where I was put on highest estrogen pill (beige w/ butterflies) and taken off Ortho-Tricyclen®, until about 8 months ago. I experienced the same irregular bleeding with this pill, so they put me on the lowest estrogen pill for the next several months. No results from this pill either, they next tried Depo.

I've been on Depo since then, and have experienced continual bleeding for 9 months, until recently I was put on another low dose pill (could be Ortho Novum®

777, not sure), while still on Depo. The bleeding stopped within a day after taking the pill. I don't know whether to get off Depo or the pill? My doctors can't tell me what's wrong, and I am getting no answers wherever I go. I have a history of cancer in my family, and am afraid that this might be a factor?

You can either discontinue the pill and take some periodic added estrogen along with your DepoProvera® or you can discontinue the DepoProvera® and switch to a pill regimen that raises the estrogen component or gives you added estrogen in the week you are off of active pills.

The bleeding you are experiencing is most likely atrophic bleeding due to low estrogen. The only question in the history you give is why the bleeding did not improve when they gave you a higher estrogen pill for several months. The progestin in that pill (Ovral®) is also a very potent one and probably counteracted the higher estrogen. When you were given estrogen again in the form of a low dose birth control pill while the DepoProvera® was "onboard," your bleeding stopped.

Have your doctor check you out for a bleeding or coagulation disorder and for fibroids or polyps. The amount of bleeding you describe is more than is usual for atrophic bleeding.

What causes the prolonged bleeding when a woman is on birth control pills or DepoProvera®?

Assuming a woman is not just missing her pills every couple of days, the most common cause of continuous bleeding is due to low estrogens which make the endometrium atrophic. A small amount of estrogen is needed to make the lining of the uterus repair the open blood vessels that result from a menstrual slough. After a menses, estrogen alone in a normally ovulating woman not taking birth control starts the tissue growing again and in effect seals off the bleeding blood vessels. This makes bleeding stop. With birth control pills that have both estrogen (very small doses) and progestin in each pill, the progestin component works opposite the estrogen and does not allow the endometrial tissue to grow and repair itself. If a woman is on a progestin only birth control pill, or using DepoProvera® which is pure progestin only, the same effect takes place, i.e., the endometrium may not totally repair its entire surface inside the uterus because of a lack of estrogen or the antagonism of the progestin working against any small amount of estrogen present in the woman's body.

If you are a smoker, that lowers your body's estrogen levels and may explain why you are having a problem with this low estrogen level when many others on the same contraceptives may not. If you are thinner and have less body fat than other women your age, that may also play a role in having less estrogens.

If I want to continue taking birth control pills, how do I get around all this bleeding?

If you have this continuous spotting on the pills, the estrogen level needs to be raised. This can be done in one of two ways. A very small dose of estrogen can be given during the week when you are not taking active hormone pills. One pill that comes packaged this way is Mircette®. It has 10 mcgm of ethinyl estradiol in each of the 7 days of pills in between the 21 days of estrogen with progestin pills. The cycle control of bleeding with Mircette especially in the first two months of use is better than other low estrogen dose

(20 mcgm) pills such as Alesse® . Instead of using Mircette®, a supplemental estrogen of 1 mg estradiol could be given during that week off active pills or even a transdermal patch such as those used for menopausal estrogen replacement therapy.

In addition to being given a supplemental estrogen in between active pills, another solution might be to change to a pill with higher estrogen levels of 30 or 35 mcgm but combined with a progestin that is not as strong as the one you were given in Ovral®. Ovcon® 1-35 or Ortho Novum® 1-35 or their generics are pills that come to mind and might eliminate the continuous spotting you are having.

If I want to stay on DepoProvera® but not have all the continuous spotting, what can I do?

The principle here is the same as that needed with oral contraceptive pills. Estrogen needs to be added to the DepoProvera® regimen. Added estradiol of 1 mg per day for about two weeks each 3 months may be enough to stop the bleeding pattern. There are not good studies on this right now so the doctor will need to work with you to try to stop the bleeding problem. It would probably be better to use the estradiol than one of the other estrogens such as conjugated estrogens (Premarin®), estrone or estriol, which do not stimulate the endometrium as well as estradiol. Again, using an estradiol transdermal skin patch for 1-2 weeks might also be enough to stop the continuous spotting.

Absent or too light menstrual flow

What causes a very light period on the pills?

I am 26, married, and have been on birth control pills for about 5 years. My periods have always been regular, almost to the hour every month. Last period was almost non-existent, a few spots on Day 1, then nothing. Had same amount of spotting afterwards, about 2 1/2 weeks into cycle. Did home pregnancy test immediately after non-existent period, before restarting b/c pills and it was negative. Next period is due this week, and I feel really weird. I have been exhausted all last week and my back aches from top to bottom. Any ideas what could be causing this? No particular stress right now. I am just confused!

A light period on pills can be due to pregnancy even though it is very unlikely in your case. It is possible the pregnancy test was just too early to pick it up; it would probably be positive now if you were pregnant.

A light period can also happen just because not much tissue forms when on oral contraceptives. Even though this hasn't happened before doesn't mean something is wrong. As long as you are not missing pills, you should just keep on them and enjoy the light or absent menstrual flow.

Shorter and shorter periods on the pill

I am on the pill and every month when I get my period, it seems to last a shorter time. Last month I had my period for less than one day! This month, I stopped taking my 7/7/7 pill on Saturday, I usually get my period on Wednesday, but I did

not get my period. I have had cramping like I was going to get my period, but I never had any bleeding. I am wondering if this is due to the pill or if I am possibly pregnant.

Birth control pills usually decrease the amount of endometrial tissue formed each month. That is the mechanism by which they decrease menstrual flow and usually decrease cramps. Sometimes the amount of tissue formed each month is so little that a day of spotting or no menses at all can be the case. There is no long-term problem with having scanty or no flow other than the worry that in any one cycle it could represent pregnancy.

Pregnancy can occur while taking birth control pills but it is usually in the range of less than 1% of women who don't miss any pills. Missing pills raises the rate.

Checking a home pregnancy test will reassure you that the "no flow" represents little tissue formation rather than unintended pregnancy. Even though "no flow" on the pills is not thought to be harmful, women and physicians alike sometimes get "nervous" about that. In that case, switching to a pill with slightly higher estrogen dose or lower progesterone dose/potency may help restore at least light flow.

No period and negative pregnancy test

Period was due today and didn't come at all, not even spotting. Took a pregnancy test tonight (because I'm paranoid) and it was negative! I'm going to call my doctor tomorrow, but what is going on?

The negative test probably means you did not get pregnant the previous cycle. It sounds as if (assuming your menses does not start in the next several days) you may have atrophic changes from the pills. This happens more often then people think. Many women don't mind not having periods as long as they know they are not pregnant. If you skip 3 cycles in a row, you doctor may want to switch your pills although you don't have to.

Is a light period on pills same as a missed one?

I've been taking low-dose BC pills for several months now, and while skimming over the little pamphlet that comes with each refill, I noticed the paragraph that discusses missed periods. Assuming that one takes all their pills correctly, it says to continue as normal, and to get checked out if you miss 2 periods in a row.

My question is: Do lighter-than-what-one-is-used-to-on-the- pill periods count as "missing a period"? I have heard that such is counted as a miss, and I have also heard that any bleeding you get providing that it is at the correct time and you haven't missed any pills or taken any late, or not had any other situations that would have hampered the effectiveness, can be considered a period. In other words, the only time a miss would "count" is if a period was COMPLETELY skipped. My pill packet insert isn't really clear on this. Which is correct?

It is only counted as a missed menses if you have NO bleeding at all. A light or very light period is still a period on the pills.

Rarely, a very light period can be associated with a pregnancy if you missed more than one or two pills in a month.

Coming off the pills

Late with menses after coming off the pill

I started on Tri-Levlen® on April 1. (I had been having breakthrough bleeding for three months in a row.) I was unable to continue the pill because of side-effects. I discontinued it, with doctor's consent, ten days later on April 10. I had a three-day-long period beginning on the 11th. My normal cycle length is about 31 days. I am now (May 18) about a week late. For the past four days I had been bloated (never a problem before) and I had lower abdominal and lower back cramping CONSTANTLY. Today the bloating is gone and I haven't had any cramping. My question is: Should I get a home pregnancy test because I'm late, or is this common when a person stops the pill ten days into it, as I did?

It is common to have a withdrawal bleed (menses) any time you discontinue the pills after taking more than 2 or 3 pills. You have now been off the pills for 38 days and you may be pregnant if you have had unprotected intercourse. The best way to check is the home pregnancy test. On the other hand, delayed ovulation (and thus delayed menses) coming off the pill is not uncommon for up to about 8 weeks. All you can do if the home pregnancy test is negative is wait for awhile. Be sure to use other protection because you have no idea when you might ovulate.

I'm a 21 year old female, off of the BC pill for about 2 months now. Since I've been off, my periods have been lighter than before I began taking the pill and crampy, similar to the ones I had while on the medication. Believe me, I'm not complaining about having lighter periods, but I just wanted to know if this is normal?

The usual case is for periods to be heavier off the pill than on and also with more cramps. You have the more cramps part but it isn't heavier. I can't tell you what might be doing this but it is not a sign of anything abnormal.

I'm 32 years old and I just went off the pill around 2 months ago after being on it for around 10 years. My first period off the pill came after 30 days. Now I'm expecting my 2nd period and it hasn't come and it's been almost 40 days. I've felt bloated and miserable for over a week. Do you know any herbs or vitamins to take to make you less bloated and crampy?

Not really. Perhaps a diuretic tea may help.

Also, are there any vitamins or such to help bring on a period?

No, not that I know of.

I have been off of birth control pills for almost 3 months now. My first month off, I had a normal period. Since then, I haven't had a period and I have never had a problem with abnormal period because they have always been regular. My next period is due in 2 days and I don't even feel the slight twinge of cramps that I usually do a couple days before my period. I took two home pregnancy tests and they came up negative, and I'm wondering if this is normal or should I be concerned that I'm pregnant.

Home pregnancy tests are pretty accurate if done correctly. They are not perfect, however. If at any time you feel pregnant (breast tenderness, nausea etc.) then perhaps you should have the test checked at a doctor's office if the home test is still negative. Assuming the test is correct, which is likely, then you are skipping ovulations. Why that would happen is complex but sometimes it just takes time for the ovary to get going. I would say that if you skip 3 periods and are not pregnant, then you should see your doctor to see if an exam and blood studies are needed to diagnose a cause. If your menses tended to be irregular before going on the pill, that same pattern can recur when you stop taking them.

I stopped taking the pill with my last period, which started 9 weeks ago and was normal. I have not had a period since, and have actually had pregnancy symptoms. I tested the week my period was due, and the week after my period was due, and they were all negative. I guess my question is, could I be pregnant? It's been like 9 weeks since my last period. Or does stopping the pill sometimes delay your period this long? Help!

You should try another pregnancy test to make sure but if it is negative, then it is extremely likely you are not pregnant. Sometimes it takes awhile for your ovulation to start after pills. If no menses within 3 months after stopping, see your doctor for some medicine to start your menses.

Stopped pills because spotting, now no withdrawal bleeding

I wrote a while ago about being on continuous Ortho Novum® 1/35 with no break, and having spotting. My doctor took me off the pills for a week for a withdrawal bleed. It's been four days with no pills and NO bleeding. Is this normal? (I have a history of ovarian cancer with one ovary remaining)

Most of the time you have some withdrawal spotting within 4 days of stopping pills, but not always. Since you have been on continuous pill therapy, the lining of the endometrium is probably very atrophic (thin with little tissue). There was enough thinness to spot but now that you are off the pills, there is not tissue left to slough and the lining is starting to get more stable under your own body's estrogen. You will probably need to be off the pills for a month or so to have a normal cycle.

Another alternative for the spotting on the pills is to resume the pills but take an estrogen supplement to "stabilize" the lining of the uterus. I'm assuming you are not pregnant. Check that out if you need to.

Pills and other conditions

Acne, Skin and Hair

Do some brands of birth control pills make acne worse?

At the current time there is only one brand of birth control pill that has FDA approval to be used to prevent acne (Ortho Tricyclen®). Truthfully all estrogen containing oral contraceptives decrease sebum production, which in turn usually decreases acne. Many studies have shown up to 70% reduction in acne counts on the face, chest, neck and back. Levonorgestrel containing pills tend to decrease acne less than other progestins in pills but overall there still is a reduction even with the more androgenic progestins. The decrease in acne is directly proportional to the decrease in serum testosterone. The pill does this by increasing sex hormone binding globulin, which inactivates some of the circulating testosterone.

Some women will develop or have their acne worsen on the pill. In fact acne is often listed as a side-effect of the pills. Studies consistently show about 5% of women develop acne when starting pills.

Skin rash and sores

I have been on OrthoTricyclen® for BC for over a year now, but just got off of them. While on them, my skin (especially my legs) became leathery, with big red patches and it itched terribly. At first it started with small patches, but continually got worse until my entire legs were covered. It was extremely painful. After discontinuing the pills, my skin returned to normal (more or less). After seeing a dermatologist, I was just told to stop shaving. But he completely ignored the fact that it was not limited to my legs and that using a loofah 2-3 times a day kept it under control. In fact the day after shaving was the best relief. I've tried all sorts of creams and lotions to no avail, thinking it was just dry skin. Another problem was that the skin got scaly and would fall off in chunks if I didn't exfoliate regularly. This left big sores. I had also tried applying a topical steroid (a prescription a friend had). That helped immensely and kept it less red and painful but the dermatologist wouldn't give me the same thing, so I resorted to using an over the counter cortisone cream. That worked a little bit but I had to use so much to cover my whole legs that it got too expensive. And now that I'm off the pill things have drastically improved. I guess my questions are since I want to go back on BCPs, should I use the same kind or switch? I heard that my particular one was endorsed by dermatologists to control acne. Also, is it truly the pill causing it or something else and if so, is there anything to do about it?

The pills are likely contributing to the skin rash. You certainly should try a different pill with a different progestin if you resume it. This may be a problem with any pill you take and if the rash occurs with another pill, then do not take any more BCPs. The next pill you might try should be Alesse®, Levlite®, or Mircette®.

Hives

I've been breaking out in hives almost every day for the past 7 months. We can't figure out what the problem is, because we've tried changing laundry detergents, watching what I eat, and anything else we can think of. I am on Nordette® for birth control. Could that be my problem? I've been on Nordette® for about a year and a half, and my problems began last summer. I break out on my lower torso, my hand and a little now on my face. My arms and upper torso usually don't break out. Help!

I do not know if Nordette® is causing that or not but you are at the point where you need to discontinue all possible suspects so Nordette® should be stopped for a month to see. If that does not improve things then you should see an allergist. If it does improve the breaking out, you will need to switch to a nonhormonal form of birth control.

Eczema

I am curious after reading about Sarah who has been experiencing skin problems. I started taking Alesse® about two months ago to stop my heavy periods. About a month later I started breaking out on my arms and hips. I was told it was eczema caused by excessive dry skin (something new to me). I was wondering if it could be a side-effect of the pill.

This is not a common side-effect of any pills but it can happen. It may also be due to something else. The only way to know is to discontinue the pills and see if it goes away. If it does, restart the pills and see if it comes back. That way there is not doubt as to whether it is coincidental or caused by the pill

Hair loss

I have been taking Alesse® since April 98. Prior to that I took Loestrin® for several years. In November, I began to notice my hair is falling out. The hair has a small root visible; it is not breaking. The loss is uniform, not located on one area of my head. I could run my fingers through my hair and get a handful. Likewise, when I brush my hair I note more than normal amounts in the brush. I do not color, treat, or even blow-dry my hair. I initially thought it was related to intense stress at work, which began in September and ended in December. Then I noticed that after several months, beginning in January, the amount of hair falling out had declined. I was relieved. Now, in February, it has increased again. I am really beginning to worry and although my friends don't notice, I can certainly tell a difference. I had thick, long hair that began to look stringy, so I had it cut short. Now, it looks thin again. I have also been taking a diuretic (one herbal supplement a day) to combat the 6-10 pounds of water weight I gain with each cycle. I take St. John's Wort to help with PMS (a few capsules a month). For ten years, I have taken a multi-vitamin, Vit E, Vit C, and Calcium supplements. I have also had several bouts with sinus infections this winter and have been taking Entex® or Duratuss®. I also took the Z-Pack® and then Biaxin®. When not dealing with sinus infections, I take Claritin D® for allergies. Because of my worries I have stopped taking all meds and herbal supplements, until I can identify the reason for hair loss. I've been doing a lot of research on

the web regarding telogen effluvium vs. androgenic alopecia. I wonder if my hair loss relates to the intense period of stress or if it relates to my BC or something else I've been taking. I have also experienced weight gain during this period of time (around 15 pounds). I attributed this to the stress and lack of time to exercise (which I normally do). Could this be related? Can you share your opinion? Should I make a Doctor's appt.? With what type of doctor, a dermatologist? I am going to see my OB/GYN in April. I am scared to keep waiting, especially if time is an enemy regarding staying on Alesse®.

Alesse® should not be causing an androgenic effluvium but I suppose it could be possible. If you did not have any problems with the Loestrin® it should not hurt to go back to it or to a slightly higher estrogen pill. Sometimes the estrogen lowering can affect the hair growth phases and cause a telogen effluvium. I also think you are smart to discontinue all other meds since those set the stage for multiple interactions, which we may not fully appreciate with respect to hair loss. If the hair loss is at all related to changing the pills, it will eventually stabilize by about 6 months. In general, the estrogens in pills improve the thickness of hair growth. I hope these things work for you. A dermatologist would be the person to see at this point.

Age

Does anyone know a safe method of birth control for woman over 40?

Low dose birth control pills are often used for women over 40 who are non-smokers. An IUCD is also quite safe.

What are the best contraceptive methods for a woman who may be going in to menopause, but still ovulating? I am a practice nurse and have been also faced with the dilemma of when to stop the OCPs to switch to HRT.

In the perimenopause low dose pills work very well if your are a nonsmoker. An IUCD is also good unless you are having problems with heavy flow or cramps. Most women opt for tubal ligation in the late forties if their partners refuse vasectomy.

As far as switching to HRT, do not switch until you are having hot flashes in the week of the placebo pills AND your physician confirms menopause with a blood test for FSH.

Can birth control pills cause night sweats?

Generally they do not do this but the only way to tell for sure is to stop them for a cycle. Progestins can raise the basal body temperature slightly so I don't want to say absolutely that they don't. You can get night sweats during the placebo pill week if you are perimenopausal, usually after age 40.

More likely culprits as causes of night sweats are: room temperature is warmer than you are used to, increased evening meal/calories, ingestion of substances that vasodilate (alcohol, medications, hot peppers, caffeine). Medical problems include low-grade fevers, hyperthyroidism.

I am on the pill but have been having night sweats. Now I want to go off of the pill but am afraid that my night sweats may get worse. I am only in my early 30's. This isn't premenopausal is it?

It is unlikely to be premature menopause since the pills would be functioning as estrogen replacement even if you were in premature menopause.

Breast soreness

Both estrogen and progestin are usually needed to produce breast tenderness, but in general, higher doses of estrogen aggravate breast soreness. Progestins that are more androgenic may lessen breast soreness. Therefore the best combinations are low estrogen pills with an androgenic progestin such as Alesse® and Levlite®.

I have breast pain (soreness and tenderness) almost all of the time. Sometimes are worse than others but it is almost always there. I know caffeine can be a cause so I totally quit all caffeine over three months ago, yet the breast pain is still there. It is not as bad as it was when I was taking in a lot of caffeine, but I was expecting much more relief than I have gotten. Sometimes they are so sore that it even hurts to have the water from the shower hit them. Would it have anything to do with my birth control pill? My doctor said it was OK for me to stay on the "active" pills for three months in a row so that I would only have four periods per year. So I have been doing that for the last six months. Could this be a factor in my breast tenderness? Also, there is one particular spot on my right breast that especially bothers me. Sometimes I can feel a knot there but my breasts are so lumpy anyway I don't know what I should and should not be concerned about. I can't run to my doctor every time I feel something in my breast because if I did I would be there all the time. It's not fair - if I have to be small-breasted, they should at least not be painful! Any suggestions or information?

You were correct in discontinuing all caffeine. Make sure there are not any other sources of caffeine in your diet or medications, i.e., chocolate, tea, cold medicines etc.

Sometimes birth control pills especially those higher in estrogen and those with potent progestins can cause tenderness.

What pill are you taking?

I am taking Ortho-Cyclen®. I am taking it 3 months in a row without taking a week off for my period until after 3 months of straight "active" pills.

Orthocyclen® is a 35 microgram birth control pill. Breast tenderness is an estrogen side-effect. You would probably due better on a lower estrogen pill such as Alesse®, Levlite® or Loestrin® 1/20.

It is hard to say if you will get more breakthrough spotting on the lower estrogen pill but I think it would be worth a try if the breast pain is bothersome.

Depression and mood

Bipolar disorder - what pill to use?

Are there any specific birth control pills that are recommended for women with bipolar disorder? I have tried Ortho-tricyclen® and Tri-Levelen®. With both of them, I have had depressions worse than before I ever started on Lithium. I could really use some help.

In general it is felt that the progestogen component of birth control pills has the most effect on aggravating depression. Estrogen has the opposite effect, it usually improves depression. The progestogen in Levlen® is stronger than the progestogen in Tricyclen® milligram per milligram. I would expect Levlen® to be slightly more depressive than Tricyclen® but there is a confounding factor. Both have varying doses of the hormones throughout the cycle. They could conceivably worsen a cyclic process like manic-depression. I would think it would be better to be on a mono phasic pill that had a low progestogen potency such as Orthocyclen®, Norinyl® 1/35 or Desogen® 1/35. It's possible, however, that any combination could worsen the symptoms. Basically this solution involves trying different pills and giving each one about 2-3 months before drawing a conclusion. There is almost no scientific investigation in this area, i.e. effect of OCPS on manic-depression that I know of.

Emotional on monophasic pill after menses

I have been on the Levlen® birth control pill for just over 2 months now. I find the week after my period I become negative and very emotional, feel useless and lack confidence, am grumpy and have a very short tolerance span and feel almost suicidal. I have been on the pill before but it was Triphasil® and didn't seem to have problems like this. I don't have any reason in my life to feel these above feelings and most of the other time I am fine and happy. I am wondering if it would be the pill effecting me this way and should I change brands?

It is possible you could be sensitive to the different rate of changes in hormones between Triphasil® and Levlen®. Whether you go back to a triphasic pill (e.g., Triphasil®, TriLevlen®, Ortho-Tricyclen®, Tri Norinyl®, Ortho Novum® 777, etc.) depends on why you switched in the first place. If you didn't switch because of any symptoms, then going back to the Triphasil® or some triphasic pill would be very reasonable just to see if your current symptoms go away.

Endometriosis or endometriosis prevention

Continuous pill therapy for endometriosis

I am 39 yrs old with endometriosis. The pain, bleeding, and mood swings were so intense. Currently, I am on Loestrin® 1.5/30. This is my second month taking

it continuously with no menstruation. After 21 days I begin the next pack as to keep the hormone levels the same. I am also anemic. Two questions:

1) What, if any, are your concerns about taking the pill continuously?

No long-term concerns, as long as you are not a smoker. As far as short-term, breakthrough bleeding and spotting are the main problems.

2) While the pill seems to help the pain of endometriosis somewhat, the lethargy, bloating, and depression almost negates the benefits. What other pills might you suggest? More estrogen? More progesterone? Any information would be appreciated.

Not more estrogen, just a different progestin. The bloating and depression are progestin side-effects. You might try the OrthoCyclen®, Alesse®, Levlite® or Levlen®. I think they have somewhat less progestin side-effects. It is not a guarantee, however, because some women will react the same to almost any progestin.

I was on the birth control pills for six months because of endometriosis. After one month off all pills, I realize that the excessive bleeding, pain and anemia, (due to endometriosis) are too much to live with. Do you have any recommendations on when the best time to restart the pill is and why? First day of cycle? Last day of cycle? First sign of spotting or flooding?

The best time usually is the first day of your menses to start a cycle if you have not been on the pills the month before. This makes them protective sooner (one week) and tends to have less breakthrough bleeding that first cycle.

Moodiness or irritability

During my work up with my RE, he tested my hormone levels (I think on day 1-3) and everything came back normal. Recently I have started to take the pill (Zovia® 1/35). The interesting thing is this, and bear with me as I have never been on the pill before...but. When I first started taking it, I did not feel well, and went through PMS moodiness, and nausea etc. That lasted only a few days, and at that point I noticed that I started to feel better than I had previously (more energy, and just a better sense of wellbeing, as well as increased sexual responsiveness. This feeling continued throughout the month, and when I stopped the pills after a few days I began to feel rather blah again. I started the pills again on Sunday and went through the moodiness yesterday although it seemed the adjustment was easier. My first question is If my hormones were all normal, then how come I feel so much better on the pill (even my husband commented on the effects).

Any steroids can have a positive, mood elevating effect or negative side-effects. If you take any corticosteroid like prednisone®, you will "feel great" even though you had normal levels of adrenal steroids to start out with. Do not make the mistaken assumption that because you feel better or feel worse on a steroid medication that this means the levels were wrong in the first place. Many people will also feel better taking thyroid supplement even though they do not need it. There are long-term adverse affects from

most steroids. Birth control pills seem to be an even trade off because the ovaries usually pick right up to secrete hormones after coming off the pills but they are naturally in a cyclical pattern rather than with pills that give a constant dose.

Headaches and menstrual migraines

Do oral contraceptives cause headaches?

Many women will admit to having headaches while taking birth control pills. Headaches are very common among women however and some studies show that about 20 percent of women complain about headaches while taking with OCPs or placebo pills. Thus the extent to which currently prescribed pills cause headaches is uncertain.

In the earlier days of pills when they contained higher estrogen doses, the incidence of headaches seemed to be directly related to how high the dose of estrogen was. Most doctors consider headaches on the pills to be estrogen related and the treatment is to lower the estrogen dose. Many times this is not successful presumably because the headaches can be from other causes.

What is a menstrual migraine?

Sometimes migraine headaches are triggered by falling estrogen levels such as that which happens right before the menses when there is a natural lowering of estrogen. With birth control pills, you are taking 21 active pills with estrogen and then all of a sudden 7 pills with no estrogen. In some women this can trigger migraine headaches. A good treatment for this is Mircette which has a very low dose (10 mcgm) of estrogen in each of the 7day off pills. This may help prevent triggering a migraine. If that does not work, the doctor sometimes tries a low dose, transdermal estrogen patch such as that used for menopausal estrogen replacement therapy.

Perimenopause

What is the difference between being on birth control pills and being on hormone replacement therapy for perimenopause symptoms?

There is so much controversy surrounding hormone replacement therapy, but birth control pills are never mentioned. Do the same risks apply? I am 49 and have been on low dose pills (Alesse®) for two years. They've cleared up all my symptoms, but are there risks I don't know about?

There is not much difference in the low dose oral contraceptives and menopausal hormone replacement therapy during the perimenopause but there is some.

Low dose pills are still slightly higher effective hormone levels as far as estrogen and progestin potency go so they function as a contraceptive whereas continuous HRT does not. Being slightly higher in hormone efficacy may increase the risk of thrombophlebitis

by 2-4 per 10,000 women compared to HRT. Most of the time the progestins in oral contraceptives are better tolerated than the ones traditionally used in HRT although that is changing.

I'm not aware of other changes in non smoking women and low dose pills are being used more and more in the perimenopause. My subjective impression is that they control abnormal bleeding better and heavy bleeding better than traditional HRT.

Seizures

Menstrual Seizures and Progestin Only Contraceptives

I am trying to find a birth control pill consisting of only natural progesterone, (not synthetic). Is there such a thing?

Also, would a natural progesterone pill (or the cremes for that matter), protect you against getting pregnant? “

I am 34 yrs old and suffer from endometriosis, and seizures. I was put on the pill to help with the painful cramps, but the estrogen in these pills causes me to have seizures. I have catamenial epilepsy, and am taking Neurontin® for it.

Catamenial epilepsy refers to a condition of seizures whose frequency increases during a woman's menstrual period. It is not a matter of any seizures until the period and then a bunch of them. It is usually a matter of having twice as many seizures (e.g., 2 a day instead of 1 a day) on the days of menses versus the other days in the menstrual cycle.

How do reproductive hormones affect epileptic seizures?

Estrogens lower the threshold for seizures in the nerve pathways of the brain. In other words they permit a smaller electrical impulse along the nerve to start a complex cascade of electrical impulses that results in an epileptic seizure then would be necessary in the absence of estrogen. Progesterone has the opposite effect. It raises the threshold for electrical nerve conduction. With progesterone aboard, it takes more electrical stimulation to cause the convulsion. If you lower estrogens to menopausal levels using gonadotropin releasing factor (e.g., Lupron®) there is a significant reduction of seizure frequency.

Taking estrogen medications may cause an increase in seizure activity in some women prone to this and taking progesterone may lessen seizures. It is interesting that at the time of menses there is a decrease in both estrogen AND progesterone. Therefore it is the lack of progesterone that was preventing some seizures that is the primary force leading to increased seizures in catamenial epilepsy. And since progesterone is only naturally secreted in the last two weeks of the menstrual cycle, there may be a decrease in seizures at that time but the "decrease" disappears at the time of menses just as progesterone also disappears.

How does the seizure frequency vary with a menstrual cycle?

There can be several different effects of the normally cycling reproductive hormones on seizure frequency in women with epilepsy. In women with ovulatory cycles, there can be an increase in seizures right around ovulation at midcycle when estrogen levels spike higher. There also can be an increase during menses when progesterone (and estrogen levels) decrease. Finally, in women who are anovulatory, there seems to be a lower seizure incidence in the first two weeks of the cycle and an increased incidence after the first two weeks when there should be progesterone around but it is not present because ovulation did not occur.

Is there a birth control pill consisting of only natural progesterone, not synthetic progestins?

No, not at the current time. It sounds enticing to take a progesterone only birth control pill, which should keep constant progesterone levels throughout the entire cycle. Thus seizure activity should be decreased all of the time and not vary in frequency throughout the days of a menstrual cycle. In fact progesterone supplements have been shown to reduce catamenial epileptic seizures on the average by about 55%. The main problem is that natural progesterone alone is not a contraceptive. Synthetic progestins like medroxyprogesterone acetate (Provera®, DepoProvera®) can also reduce seizure activity but not as effectively as natural progesterone.

Would a natural progesterone pill or cream protect you against getting pregnant?

There are no natural progesterone containing birth control pills that I know of at the present time. Historically when researchers first developed oral contraceptives, they were looking for a way to manufacture progesterone from Mexican yams and when they first discovered the contraceptive effects of their manufactured progestins, they were very excited. As they purified the compounds to contain only progestins and not the contaminant estrogen (specifically mestranol) they lost the contraceptive effect of the pills. Thus the discovery that you needed both progestin and estrogen to have an effective contraceptive pill by mouth.

Now we know that progestin only pills can function as contraceptives, not by inhibiting ovulation but by making the cervical mucous hostile to sperm penetration and the endometrium hostile to fertilized egg implantation. But they are not as effective as combined oral contraceptives in preventing pregnancy. The typical use failure rate of progestin only pills is about 5%.

What would be the best birth control for a woman with catamenial epilepsy?

There is no best answer for this. I could not find studies of DepoProvera® used for contraception in women with epilepsy, nor with just progestin only pills. It is not even clear that regular oral contraceptives containing estrogens worsen seizure activity; they may not. In the absence of clinical trials and data, we need to reason using the studies and physiology that we do know about.

I think in the next patient I see who describes catamenial epilepsy, I might suggest one of several approaches: if a woman has had one or more children, the use of a progesterone IUCD and continuous oral micronized progesterone at about 100mg or 200 mg twice a day should provide birth control as well as decrease the seizures as much as reproductive hormones can. The above is also an option for a woman who has not had any children but if tolerating the IUCD was a problem, then using a very low dose estrogen containing

oral contraceptive (20 mcg dose) with a supplement of oral micronized progesterone at about 100-200 mg twice a day could be tried.

The twice a day dose of oral progesterone should be better to lower neuron sensitivity since the blood level of progesterone from an oral dose peaks at about 3 hours with therapeutic levels for 6 hours and clearing by 24 hours . I do not know if the current non prescription progesterone creams (25 mg/tsp) would provide this level of progesterone unless you used at least 1-2 teaspoons a day. No woman should use the progesterone cream as a contraceptive.

Severe menstrual cramps

Cramps and BCPs with iron

My gynecologist recently switched my birth control pills from Ortho-Cyclen® to Loestrin® FE 1/20. Since the switch I have been experiencing strong to severe abdominal cramps. It is like I am on my period even though I am in the middle of my pill pack. I am a little concerned but I am not sure if I should call my doctor. I have also been having an increase in appetite and weight but I thought this is normal. I am not sure what to do, any suggestions?

In your pill switch you've gone from a less potent progestin to a more potent one and a lower estrogen dose. The net result is a moderate increase in the progestin/estrogen ratio. This may be giving you some of the symptoms you describe. Appetite increase is a known progestin effect. Abdominal bloating is also a progestin effect. However cramps are usually decreased by progestin. Skip the iron pills this next cycle (the 7 different colored pills) to see if the cramps are just a gastrointestinal upset due to iron. If the cramps still continue during another cycle, you may need to switch back to OrthoCyclen®.

A pertinent question is how long have you been on these pills and why did the doctor switch you. If it is because you were having some problems, could the current symptoms be a continuation or worsening of those problems rather than new problems possibly associated with the pill change?

Weight gain and fluid retention

I have been taking birth control pills for about six months now. I am thrilled at the idea of not becoming pregnant, however, my problem is tremendous weight gain as a result of water retention. I have experienced no increased appetite, however my breasts are a full cup size larger and I feel that I have an added layer onto my body that makes me very uncomfortable. Is there anything that can be done about this problem?

Before we know if there is any way we can treat weight gain associated with oral contraceptives, we need to know if birth control pills cause fluid retention and by what

mechanism, do they cause increased appetite and how, and do they cause temporary or long-term weight gain by those or any other mechanisms?

With studies of recent low dose oral contraceptives, the whole premise as to whether there is any change in weight at all with beginning oral contraceptives is in question. This and other studies indicate that, on the average, women do not gain weight because of the pills. Remember this means that if 5-10% of women report weight gain when starting oral contraceptives, there is an identical 5-10% of women who gain weight even though they did not get active birth control pills. In other words the weight gain with pills was coincidental but not a cause and effect.

We know from older birth control pill studies, however, that weight gain was a problem both from fluid retention and from more fat deposition so we need to look at what was learned from those studies because those factors may be active in some women who are sensitive to them even at today's low pill hormone doses.

Do most women gain weight when starting on oral contraceptives and if so how much?

For the most part, older studies using higher dose pills tend to show an average of about 5 lb weight gain using pills. One study looked at adolescents who were using DeproProvera® (DMPA) for contraception and compared them to other teens using birth control pills. They found that after one year of contraception, the average weight gain was 6.6 lbs (3.0 kg) in the adolescents using shots (DMPA) and 5.3 lbs (2.4 kg) when using oral contraceptives. More importantly, only 7% of pill users gained more than 10% of their body weight while 25% of the DepoProvera® users gained more than 10%. If you just look at the average weight gain of 6.6 lbs vs. 5.3 lbs, you would conclude that DMPA had only a slightly higher weight gain than pills. The fact that these averages include 18% more women who gained greater than 10% of body weight can be hidden by average weight changes. Thus DepoProvera® has a greater side-effect of weight gain than oral contraceptives.

In another study with a fairly high dose pill (50 mcgm) from 20 years ago, investigators found an 11.4% weight increase of over 4.4 lbs (2.0 kg) but also a 14.3% incidence of over a 4.4 lbs weight loss on the same pill. In other words there was just as much weight loss as weight gain. This finding could be interpreted as the pills cause no overall weight change in woman on the average, but an alternative explanation is that some women get nauseated from pills and have a net weight loss while the others who did not get nauseated gained a substantial amount of weight.

Do oral contraceptives cause water retention and how much?

Estrogen in high doses is known to cause weight gain especially that due to fluid retention. The more estrogen there is in a pill, the more tendency to gain weight such that a 50 mcgm pill will result in more weight gain than a 35 mcgm pill.

The mechanism of action is probably direct stimulation by the estrogen in pills of kidney substances called renin-angiotensin that cause water retention. The water retention then causes sodium (salt) retention. A lower estrogen level pill, e.g., 20 mcgm, will help reduce weight gain due to fluid retention. This was confirmed in a more recent study with 30 mcgm pills in which there was essentially no difference in weight gain or weight loss between the placebo group and the oral contraceptive group. Again, however, 30% of

these women had a weight gain of more than 1 lb but the net result was the same in the control group. Those who did have weight gain had increased fat but no difference in fluid retention amounts indicating that fluid weight gain may be less of a problem with the newer, lower estrogen pills.

Do birth control pills stimulate your appetite?

There have been reports through the years, especially with the older, higher dose pills, of adverse effects on insulin resistance. Even recent studies seem to indicate that current pills can raise insulin levels. Insulin resistance is a condition in which insulin levels rise in response to carbohydrates and drive all energy into the fat cells and essentially prevent weight loss even with dieting.

Not all women are susceptible to insulin resistance and thus not all women gain weight using oral contraceptives. Those that have a tendency to abnormal glucose metabolism, however, may be the ones who gain weight. If a woman gains weight upon starting oral contraceptives and there are not other explanations, she should be checked out for possible insulin resistance.

Are there other mechanisms by which pills cause weight gain?

In one study of pills, a formulation containing desogestrel as the progestin and slightly less estrogen had significantly less weight gain when compared to a pill containing norethindrone (Ortho Novum® 7/7/7). This may imply that the specific progestin has a role in weight gain, possibly through the degree of insulin resistance. Or it could be the combination of lower estrogen and the specific progestin but in any case, there was less weight gain. Currently marketed pills with desogestrel as the progestin are Desogen® and Ortho-Cept®.

What can you do if you have weight gain on the pills?

Using the lowest possible estrogen containing birth control pill should minimize weight gain and swelling from water retention. Current 20 mcgm pills, which are the lowest estrogen doses available, are:

Alesse®
Levlite®
Loestrin-Fe®
Mircette®

If you are not taking one of the lowest dose pills, ask your physician or health care provider to switch you to one of the lowest dose pills, especially if you are having any weight gain or fluid retention symptoms.

Any weight gain after starting pills of more than 5% of body weight may be a signal of a woman's tendency toward insulin resistance or abnormal glucose metabolism. With this amount of weight gain associated with an oral contraceptive, I would suggest the woman be evaluated for possible insulin resistance. If this condition is present, she will have to adopt a low carbohydrate diet. Simple sugars in any amount and high carbohydrate only snacks or meals will negate all other dieting efforts on a daily basis and frustrate any long-term ability at weight control.

Can a lower estrogen pill cause weight gain?

In the 80's my doctor changed my pills from 1/50 to 1/35, I gained over 25 pounds. A few years later a doctor told me it was a thyroid reaction to the pill and my body eventually (1 year) evened out and got back to normal. Now I'm having night sweats and irritability, so my doctor changed me from Orthocept® to Estrostep®. In three months I have gained 5 pounds and feel sluggish. She is now going to change me to Ortho Novum® 1/35. Is it possible that some women feel better and keep weight gain down with a higher estrogen pill? She told me most women lost weight when they went from 1/50 to 1/35. Could I possibly have some estrogen deficiency? I'm only 31. I've had my thyroid checked and it is normal.

Weight change on pills has different components. Estrogens cause salt retention which in turn causes fluid retention and up to about 3-5 pounds in weight as a one-time event. This is visible on the scale but shouldn't change clothes size. Estrogen also picks up metabolism somewhat and can keep weight gain from eating down.

Progestins in pills usually stimulate appetite and thus are most often responsible for continuing weight gain. For example DepoProvera®, which is pure progestin is notorious for stimulating appetite and causes weight gain in many women using it.

Finally, progestin blocks the effect estrogen so a pill with a weaker progestin (e.g. Orthocept®) in effect might be a stronger estrogen effect than Demulen® 1/35 which has a stronger progestin even though both pills have 1 mg of progestin and 35 mcgm of estrogen.

Your doctor is correct that many women will decrease weight going from 1/50 to 1/35 because they have less of the fluid retention due to salt retention. On the other hand, some women are more sensitive to the progestin component. Estrostep® has less estrogen but that makes a higher progestin/estrogen ratio and thus a stronger progestin effect.

Pills and cancer risk

Breast cancer

Breast cancer has been studied extensively. There is thought to be a **slight** increase in the risk of breast cancer associated with birth control pills and also probably with the injectable contraceptive, depo-medroxyprogesterone acetate (DepoProvera®). The increase is a risk ratio about 1.3 and the risk decreases to 1.0 after 10 years.

Ovarian cancer

Ovarian Cancer is Reduced by Oral Contraceptives

We've known since the early 1990's that use of birth control pills reduces a woman's risk for ovarian cancer by about 50%. The exact mechanism isn't known but it has been postulated that by keeping the ovary from ovulation each month, this reduces the exposure of the ovary to any cancer causing viruses or toxins. At ovulation, the inside of the ovary is opened in order to release an egg.

Hereditary Ovarian Cancer

About 5 to possibly 10% of ovarian cancer is associated with a genetic predisposition; it occurs in women with mutations in the BRCA1 or BRCA2 gene. If a woman has a BRCA1 mutation, her lifetime incidence of ovarian cancer is about 45% instead of the usual 1.4% in the general population. If there is a BRCA2 gene mutation, there is approximately a 25% lifetime incidence of ovarian cancer. For women who are known to have these gene mutations, the only suggested risk reduction therapies have been prophylactic oophorectomy and ultrasound screening, neither of which have been used enough to know the extent of the risk reduction.

In one article, Narod SA et al.: Oral contraceptives and the risk of ovarian cancer. N Engl J Med 1998; 339:424-8, the authors looked at whether or not oral contraceptives reduced the incidence of ovarian cancer in women who had a genetic risk by having either the BRCA1 or BRCA2 gene. They found that women who used oral contraceptives in the past were at lower risk for ovarian cancer even if they were positive for either BRCA gene. The magnitude of reduction was the same as it was for women overall, i.e., if women had used the pills 3 or fewer years, their risk was 80% of the risk for non-pill users. If a woman had used the pills for 3-6 years, her risk was 40%. Basically the risk dropped by 10% for each year the pill had been used although there did not seem to be a further reduction after 6 years of use.

There were some limitations of this study so we will hope that others also research this subject. For now, the data suggests that oral contraceptives should be part of a program of prevention for women with known BRCA1 or BRCA2 mutations.

Other cancer risks

Most women are unaware that birth control pills are one of the few medicines that actually prevent cancer. In fact, 30-40% think that pills increase the risk of cancer. It is important to know the numbers. These have been coalesced in a recent article by Kaunitz and Benrubi in Kaunitz, AM, Benrubi GI: The good news about hormonal contraception and gynecologic cancer. The Female Patient 1998; 23:43-51.

Last year approximately 256,000 women had the new diagnosis of breast, endometrial, ovarian and cervical cancer. About 69,000 women died. Let's put the different cancers in perspective:

U.S. Incidence of Cancer

Cancer	Yearly incidence	Annual deaths
Breast	180,000	44,000
Endometrial	35,000	6,000

Ovarian	27,000	14,200
Cervical	13,000	4,500
Total	255,000	68,700

Breast cancer has been studied extensively. There is thought to be a slight increase in the risk of breast cancer associated with birth control pills and also probably with the injectable contraceptive, depo-medroxyprogesterone acetate (DepoProvera®). The increase is a risk ratio about 1.3 and the risk decreases to 1.0 after 10 years. There are many medical experts who question whether breast cancer is increased at all on oral contraceptives.

Endometrial cancer has a large reduction (50%, risk ratio 0.5) when oral contraceptives are used and this effect may last up to 20 years after discontinuing the pills. DepoProvera® reduces endometrial cancer even more, up to 80% -- so much so that it is sometimes used as a treatment for endometrial cancer.

Ovarian cancer is the most lethal of the female reproductive malignancies. Oral contraceptives, however, significantly reduce the incidence by 40% and it may be as much as 80% in women who have used the pill 10 years or longer. It appears that the benefit has something to do with inhibiting ovulation of the ovary(s) each month because pregnancy and lactation, both of which reduce ovulations, are also factors that lower risk.

Cervical cancer is present more often in contraceptive pill users than nonusers. This results in an increased risk ratio of about 1.5-1.9. An uncommon form of cervical cancer, adenocarcinoma, also shows an increased risk ratio of about 2.0-2.5 with pill use. We must remember, however, that cervical cancer is a sexually transmitted disease that is increased by having multiple sexual partners and is decreased by using barrier contraceptives such as condoms. Many physicians think that the excess risk for cervical cancer due to pills merely represents its comparison to non-pill users who predominantly use barrier contraceptives. No scientific studies have yet confirmed or denied this.

The following table tries to sum these different findings, but remember this is an artificial summation just for thought.

Cancer and Oral Contraceptives (OC)

Cancer	Annual deaths	OC risk ratio	OCP death change*
Breast	44,000	1.3	+13,200
Endometrial	6,000	0.5	-3,000
Ovarian	14,200	0.6	-8,520
Cervical	4,500	2.0	+4,500
Total	68,700	NA	+6,180

*Possible OCP death change - actually its not as simple as multiplying the risk ratio times the number of deaths, so look at this as a very crude estimate.

You can see from the above table why many women may be justified in their belief that oral contraceptives increase the risk of cancer. Even if cervical cancer is excluded, they

may be right! Oral contraceptive decisions should take into account family history of cancer.

Switching to other brands of pills

Pill brand change - will I get starting side-effects again?

I just switched my brand of BC pills from Alesse® to Nordette®. Should I expect to experience side-effects similar to those I had on the Alesse® when I first started them (light nausea, breast tenderness, etc.) where I am starting a new brand, even though there were no breaks in between packs? (i.e., finished placebos on last Alesse® pack and then started new Nordette® pack as told.)

It's hard to say but I do not think so. The nausea and breast tenderness that you describe are usually general effects that women get in starting pills in general. If your body has already adjusted to those you probably won't get them again.

Alesse® and Nordette® have the same two components in them, levonorgestrel and ethinyl estradiol. The doses are slightly different, however with Nordette® having slightly more estrogen and less progestin. The net result is a more estrogenic pill (but not probably by much).

Switching pills and switching back - Will they work the same?

I am switching from Loestrin® 1.5/30 to Levlen® to try and lessen the amount of bleeding on the first day of my period, and also, to help some with the cramps. I will be starting these new pills this week. I am still a little leery about switching pills thinking I may end up worse off than I am now, but I am willing to give it a shot. My main concern is that if I take these new pills and I am not happy with the results the first month for some reason, will I be able to go back to taking the LoEstrin® and have it work exactly like it was working before I made the switch, or will it be like starting a whole new pill in that there may be breakthrough bleeding, spotting, and I may not get it on the exact same day as I used to (it was always 3 days after my last hormone pill). I am just asking this as I know that with other meds I've taken (like anti-depressants...I suffer from panic/anxiety disorder and depression) that you may take them once and have no side-effects and they may work fairly well, but then if you stop that med for whatever reason and try and re- start it maybe a month or several months later, your body chemicals have now changed and the med either no longer works on you or you experience side-effects this time around.

What do you think the chances are of me being able to re-start the LoEstrin® after being off of it for one month and having it work exactly like it used to?

80-90% - pure guess

I am sure there is always a risk that it will not work the same, but how large is that risk? I have taken LoEstrin® for about 2 years. Does the risk increase the longer I am off of it?

Not over the course of less than a year, but after that I would think the chance is more that there might be change. Again pure guess -- no scientific studies I know of.

Late menses changing pill brands

This past month I have changed my BC pill brand from Alesse® (20mcg estrogen, 1.0 mg progestin) to Nordette® (30 mcg estrogen, 1.5 mg progestin). Today was the day that my period was supposed to start, but is hasn't yet. I have not had sex for 5 months, and have not taken any other medications, nor have I missed any pills or taken them late. In fact, the only differences in the month have been the brand change and a new diet and exercise program I started.

Does anyone have any idea what could be delaying my period? Could it be the changing of brands?

Changing the pill can result in the period being different by a day or at most two. Also, sometimes a higher progestin pill can cause less bleeding during menses, almost to the extent of skipping bleeding altogether or just spotting.

Switching to another brand in mid pill pack

I'm on my second cycle of BCP and have taken it for 5 days so far this month, but wanted to switch brands due some serious insomnia I've been having since I started back on the pill. Can I just take the new BCP brand right away or do I have to stop and have a period and then switch?

You can do either. It is safe to just substitute the new pill. If the dose is slightly different you may still have some breakthrough bleeding but you will still be protected.

Obsession about switching pills and control of period

I guess basically, before I switch, I just want to make sure that if this new pill does not work out that I will not be stuck with nothing---that I will be able to go back to my LoEstrin® either after one month of taking the Levlen®, or three, and have it resume working just as if I'd never come off of it. I would, of course, continue on the same pill schedule as I have been on and not re-start the LoEstrin® in the middle of a pack or something like that! I am hoping that the Levlen® will work and all of this will be a moot point, but just in case, I like to cover all bases. If need be, I could live on LoEstrin® if I had to, I just prefer to try something new and see if it can help lessen the bleeding and cramps because I'd be much happier with less blood loss each month. But, I don't want to switch if there's a high risk that I can't go back to my old pill and have it work.

In your experience, when people have stopped taking their BC Pills for whatever reason (want to get pregnant or have to stop them because of surgery or some other medical reason) and then start them up again, do they usually work the same way they did before they stopped them?

Usually

And, if they do work the same way, do they work this way the very first month, or do you have to give it a few months to readjust?

one to two months

I know when I started on LoEstrin® I was switching from Desogen®, but it worked right away and there was no adjustment period needed (there was no spotting, etc and I got my period the same day each month from the very start of the new pill and the bleeding was less compared to the previous pill on the very first month), so I'm hoping that that would mean that if I did have to switch back that chances would be good that my old pill would resume working as normal in the very first month I went back on it. Any thoughts on this?

Your concerns remind us that if symptoms are tolerable it may be better not to change. Only you can determine the severity of the symptoms.

That statement is something I've been struggling with for the past week. As far as the severity of symptoms, the pain is bad, but I can take pain meds for that, so that's not so much of an issue as is the amount of bleeding I have on the first day of my period. I know that sounds like "big deal", but for me, it is because it is keeping me from doing anything on that day. But, if I had to live with it because another pill wouldn't provide all the benefits I am looking for, then I could, but I figure that if I can lessen the bleeding AND have all the benefits of my current pill then why not try it?

This seems reasonable to try it since adverse consequences are not very likely.

If you have not figured it out yet, I suffer from obsessive- compulsive disorder (OCD) ---more the O than the C---and that is why I have to obsess on this issue and make sure that I know everything about changing from one pill to another and how it will affect everything. This is why I ask a zillion questions. I apologize for that. I have tried to get my Dr. to answer things, but she does not have the time and when I have spoken to her nurses, they seem unsure about their answers. I guess I just want to be able to weigh all the pros and cons BEFORE I make a decision and then it's too late to correct it.

If you would please humor me and answer some more of my concerns I would appreciate it greatly. On my current pill, since day one back about 2.5 years ago, I have always been very regular--I always get my period exactly three days after stopping my pills. Do most people that take BC Pills get their periods on the same exact day each month?

Yes.

Since I always have with LoEstrin® 1.5/30, what are my chances of this being the same case with Levlen®?

Educated guess 92.5%

Also, I have always been able to adjust my pills when needed (for vacations, holidays, etc). I have been able to take anywhere from one to seven extra hormone pills or even take one day less per month and I will still ALWAYS get my period three days after stopping the hormone pills. I like this a lot because I am able to plan things around it--or I should say, it around things! Anyway, is this normal for most mono phasic BC pills---can most people adjust to them as exact and to the day as I am able to do with these?

Yes, especially with mono phasic pills.

(i.e.--if they always get their period 4 days after their last pill and they take 2 extra pills in that pack, will they get their period 4 days after they take the extra two just as they normally get it 4 days after the last pill?

Will it always be the same amount of time between taking the last pill in the pack and the day they start their period?

Yes, unless you start trying to alter it by taking the active pills for less than 2 weeks.

I would really like this feature to stay the same with my new pill. If my new pills are always regular to the day, what are the chances of me being able to adjust them and have me get my period on the exact day I plan it like I am able to do with my current pill?

92.5% with the two pills you describe.

If I take 4 extra days of hormone pills, then will I most likely get my period four days later than normal, or could it vary between say, three to five, etc?

Almost always 4 days later.

I really like the fact that if I were to take 4 extra days now, I would get my period exactly four days later than normal. What are the chances of that staying the same with this Pill?

Very good. It seems your questions are repeating.

Right now I have it set so that I get my periods on Saturday and that's how I would like to keep it, but I don't know how that will work once I start this new pill--I may get it anywhere from 3 to 5 days after I stop the pills, and therefore, need to do some adjusting to get it back to having it come on Saturdays. How soon after I start taking the new pills can I try and adjust them if I have to?

Give it two cycles.

I would like to make sure that this new pill is very regular (i.e.- -I get it the EXACT same day each month) before I decide to continue with it. I am not sure the best way to go about determining that. The most obvious way would be to take them for at least 2 months and see if I get my period the same day on each of those months. Three months would probably even be a better sign of their regularity.

But, I would like to get them "on track" as soon as I can if this new pill does not have me get my period on a Saturday. Would it be okay and just as accurate in determining their regularity if I took them the first month and got it, say, on a Sunday which would be four days after the last pill, and then for the next month just stopped the pills a day sooner (take one less) and if I DID get it again four days later--which should be a Saturday this time--then would that tell me that they will in all likelihood, always cause me to get my period four days after the last pill?

Yes that would be ok.

Which would be the best way to go about this?

As you indicated.

I still would like to do a test as far as trying to adjust them by a day or two just to see if it works and comes out to the exact day like it does now. If it doesn't, then I would prefer to go back to my previous pill. How soon can I do this test, or what is the best time to do it so that I make sure I get proper results---I don't want to do it too soon and then find out.

Would wait until after the 2nd cycle if the time of menses was different from the old pill, and wait until after the 1st cycle if the time to menses was the same as first pill.

I am concerned that if I wait too long to decide whether or not to stay on this pill that I will not be able to go back to my current pill and get the same results. How long do I have, if any time at all, to be able to switch back to my current pill and still get the exact same results out of them as I am getting now?

Guessing -- 6 months.

I want to be able to switch back to them and have things work as if I had never stopped them. Hopefully, though, I would not have to switch back, but just in case, I want to know what my chances of doing so are.

How long would it take for me to notice a difference in the bleeding once I start these new pills?

1st cycle should give an indication but wait to 2nd cycle to draw a more certain conclusion.

Right now, I get my period very heavy on day one (about 24 hours), and then after that I only have it very light for one or two more days. Do you think that this new pill could make it last longer or even make me bleed heavier?

I would expect the opposite (higher progestin potency) but anything is possible.

If so, are the chances very high of each of those things happening?

Low, less than 10%

Again, I am very sorry to ask so many questions, some of which may be redundant, but for me this is a very big issue and I just want everything to be exact, or at least to have as much knowledge as I can before I make this decision--and I have to decide by tomorrow night for the next am.

Basically, I want all the perks of my current pill to also come with my new pill, but also have the added bonus of less bleeding and even less cramps would be nice. I guess my overall question is how close do you think the two pills will be as far as all these benefits?

I think the new pills may work better, at least it's worth a try.

I really want this to work out. I don't want to switch pills and then the new ones not work, the old ones not work anymore and ultimately be left with nothing.

I was so sure that I was going to switch until this past month when I read an article saying that taking ibuprofen could lessen bleeding so I decided to give that a try. In fact, that is when I noticed that my bleeding on this pill became heavier--- I used to take Advil® for cramps, then switched to Rx pain killers and that's when I noticed a change, but didn't make the connection back then. Anyway, I took the Advil® this month (about 13 in 24 hours) to lessen the bleeding, and still had to take my Ultram® (8 in 24 hours--50mg each) for the pain, but it did lessen the bleeding. Though, it was a pain having to take a pill every hour or two. I talked to my gyn's nurse about this and she said that that wasn't a smart thing to do because Advil® can cause ulcers. Well, honestly, I am willing to take that chance at this point! But, then again, I did adjust my pills this month by taking one less and maybe that's why it was lighter, though it wasn't a whole lot lighter, but still, it was an improvement. What do you think about this idea?

Advil® usually would either not affect or it would increase bleeding. Its main use would be to decrease the cramps associated with the bleeding. Ultram® shouldn't affect bleeding.

Do you think taking all that medication is okay and safe or would it be preferable to try the new pill?

Would try new pill.

I am thinking that maybe I am being greedy as far as what I am asking for out of these pills. Maybe one heavy day isn't such a bad thing. Right now I use a super plus tampon and have to change it about every one to two hours because it will start to leak--- is that considered heavy?

Not too excessive for one day.

I even set my alarm to wake up during the night to change tampons so that I don't have a major leakage when I wake up! Kind of a pain.

I hear so many people on BC Pills saying that their periods are so light that I guess I'm comparing myself to them. I'm not sure exactly what they are considering light, I guess. I did tell my gyn how much I bleed on the first day and she pretty much agreed that it was heavy and that the Levlen should help with that. I just never thought about all the other perks that I get with my current pill and whether they are pretty much standard perks will all pills or I just lucked out.

One last thing---I always look at people like athletes, etc and wonder how do they manage with their periods?

I don't really know.

How come they don't seem to have to worry about leakage and stuff?

They do.

I mean, how often do you see a figure skater, swimmer or gymnast wearing a pad?

Don't know.

(Please, don't mention Cathy Rigby!) I know most pro athletes may not even get their periods because of the lack of body fat, etc, but what about the amateurs and college level athletes---or even just the person on the weekend softball league? Even police women and other jobs where you are "on call" and don't have time to keep going to the bathroom---what is their secret?

I think it is difficult for many.

Another woman responds: When I have a heavy day or know I won't be near a bathroom to soon I always double up with a super tampon. Insert end to end just make sure the first one is in deep enough or you'll be uncomfortable plus wear a thin ultra pad. This isn't something you'd want to do too often but could get you through a few hours maybe.

Anyway, I know this is VERY long, but if you could please take the time to answer each of my individual questions (yes, there are many), I would appreciate it greatly as I do not know where else to turn for advice and all of the things I asked--even the little stupid questions--are very important issues to me even though to the average person they are not. I realize that most women would just take the new pill no questions asked and just wait and see, but I cannot do that. So, if you could, please try not to skip over answering anything--I know that sounds demanding, but I do not mean it that way--I am just trying not to have a stroke over this stupid decision. Thank you so much for your time! --- Boy, do I feel like a dork after all of these posts! Well, please try and answer everything that's in each post if you can-- -I would really, really appreciate it if you would and I am sorry that I had to post it this way--I know it's a pain! Thanks again!

Let us know later how this works out for you.

Thank you so much for your help in answering all of my posts/follow-ups from the other day titled "HELP! Need help by .... I did take the Levlen after 24 straight agonizing hours of deliberation....now I'm thinking I should have just left well enough alone because there's too much anxiety with taking a new pill---will it work, won't it and how long will it take to know for sure! I may just switch back next month unless I see a HUGE improvement that makes it worth the anxiety this is causing. Do you think that would be a problem to do---would it be too soon to change pills again because it would be too "confusing" to my hormones or is it perfectly fine to change back after just one month if I feel I have to? If so, should I adjust back to the old pill right away in all likelihood?

Not saying for sure that's what I'll do--I may start to feel more comfortable and less anxious with my decision as the month goes by, but as it stand I am quite nervous about the change.

This anxiety is because of the "O" in the OCD. It will get better as month goes on and decision to switch back or not will be obvious by the improvement or lack of improvement of the symptoms. It will be ok to switch back if that is what you want to do. Are you on any medicine for the OCD?

Also, yes, I have thought of some more questions now that I have started on this pill (cringe). For the past two years on the LoEstrin® 1.5/3, I have had it set to get my periods on Sundays. This past month I adjusted it to get it on Saturdays, as I will be starting college in June and that would just be easier. So, now I am wondering if adjusting my pills last month will have any affect on how these new Levlen® pills will adjust because I "fiddled" with my pills and hormone level last month---do you think it will take any longer for them to adjust or would last month really have no affect on this month and these new pills??

No effect.

I've just heard that your body gets used to certain hormone levels and I didn't know if my messing with my previous pills by one day last month (I took one less) would have any bearing at all on these new pills and how long it will take them to adjust now that I sort of changed the hormone level last month. What is your opinion?

Shouldn't affect it. The body doesn't really change its inherent nature due to pills.

Pills and pricing

Sources for discounted pills

Where can I get free or discounted birth control pills?

Planned Parenthood organizations and your local county Public Health Department often provide birth control pills on an ability to pay discounted scale. If you qualify, they may even be free. Look up in the yellow pages phone directory for the Planned Parenthood or Public Health Department for the county you live in. Give them a call and ask about the costs of pills. If you are in college either full or part time, you may also be qualified to

use the student health facility and often they provide oral contraceptives at cost or a discount.

When your doctor prescribes a given oral contraceptive, most of the time they indicate it can be filled with a generic equivalent. If not, ask the doctor to please do that or ask the nurse to have a prescription rewritten for a generic equivalent. There are sources on the Internet that will except mailed-in prescriptions and the cost of a generic equivalent is often in the $12-15 range. I have not used them but you may want to check out Hocks Drugs (http://www.hocks.com/bcpills2.htm) or use a search engine to look for "discount birth control."

Are expired pills still effective?

I was wondering how soon after the expiration date my birth control pills would lose their effectiveness? Would there be any unusual side-effects to taking expired bills and does it matter the brand?

Only the pharmaceutical manufacturer knows for sure. They usually set expiration dates on all meds with quite a margin of safety so I expect they would at least have a margin of 6 months after expiration date but I honestly don't know and the manufacturers don't publish that info that I know of. While no one could officially recommend taking pills that are expired, if they were less than 6 months old I don't think I'd throw them away.

Would there be any unusual side-effects to taking expired bills and does it matter the brand?

I would guess the only serious side-effect would be less effectiveness of the pills and if anything, the lower dose pills would loose their effectiveness sooner.

Generic equivalents at less cost

I have recently had my annual Pap smear. I just changed insurance and therefore had to switch doctors. I was previously on Orthocyclen® and the doctor switched me to Recon®. I was on Orthocyclen® for 4 years and wasn't having any problems. When I asked what the difference was I was told they are the same but Recon® is a generic form. Is this true? When I purchased Recon® it is much more expensive than the other is. Is this common practice to switch patients from different pills when they were reporting no problems with the previous pills? I felt this was weird. I have switched doctors before and they always gave me the same type of pills because I was not having any problems on them.

I am not familiar with Recon®. You will have to look on the package and see what the progestin is and its dose and what estrogen dose is. If they are the same as the Orthocyclen®, then they are a generic. Usually doctors write the same prescription if a pill is working for you. Pharmacies are allowed to switch to a generic if the doctor indicates this is ok.

Alternatives to birth control pills

IUCD - A Forgotten Contraception Method

Many women of reproductive age are at risk for unintended pregnancy. When you couple that with the lack of a perfectly ideal, reversible contraceptive, dilemmas are created for women who have certain risk factors or concerns about possible complications. The IUCD, intrauterine contraceptive device, is only used by about 1% of the population in the U.S. because of women's concerns about possible increased infections of the genital tract. Internationally, the IUCD is one of the most common forms of contraception. In most instances it has been shown that infection rates are not increased with long-term use and there are definite benefits to using a contraceptive that does not have unwanted hormonal effects. Thus the IUCD has been given a bad but undeserved reputation and it is really worth looking at as a method of contraception for many women.

A recent clinical opinion paper, Dardano, KL, Burkman RT: The intrauterine contraceptive device: An often-forgotten and maligned method of contraception. Am J Obstet Gynecol 1999;181:1-5,outlines the pros and cons of IUCDs and reminds us that it is a very appropriate contraceptive for many women.

Do IUCDs cause infection?

In the 1970's, one specific IUCD, the Dalkon Shield, was shown to have a design flaw of a braided string which allowed vaginal bacteria to be harbored in the crevices of the string and sometimes cause an infection that went into the upper genital tract. Later studies in the 1980s showed that the risk of infection was limited to two situations:

- Right at the time of insertion of the IUCD into the uterus
- In women who have multiple sexual partners who themselves may carry sexually transmitted bacteria

Subsequent research has shown that if antibiotics are given at the time of IUCD insertion, there is no increased infection rate if, additionally, a woman is not exposed to multiple different sex partners.

Because of the infection history of the Dalkon Shield, their manufacturers withdrew most IUCDs in the U.S. even though their specific IUCD was not the cause of excessive infection. Only two types remain, the copper T IUD (Paragard®) and the progesterone-releasing IUCD (Progestasert®). The copper T IUD is approved for 10 years of use and the progesterone-releasing IUCD is approved for one year. Several studies using the copper T IUD demonstrate an infection rate approximately 1 per 1000 insertions. This rate is felt to be acceptable in view of the fact of the high pregnancy protection rate and low long-term cost for IUCDs.

How effective is the IUCD in preventing pregnancy?

The total cumulative pregnancy rate of the copper T IUD by 7 years of use is 1.6 pregnancies per 100 women or 0.16 pregnancies per 100 women years. The progesterone-releasing IUD has a higher pregnancy rate at 3/100 women years. The IUCD (copper T)

also reduces ectopic pregnancies by ten fold to 0.05 annually per 100 women. The only downside on the pregnancy rates is that there is about an 8% incidence of expulsion of the IUCD right after it is first inserted. Thus the low pregnancy rates are based only on the IUDs that stay in place. Also, over 7 years, 30% of the IUDs are removed because of increased cramps or bleeding problems.

Do IUCDs cause early abortions as their mechanism of providing contraception?

A popular idea about IUCDs that has limited their acceptance by many women is that the way in which they prevent pregnancies is by acting as an abortifacient. That is, they prevent fertilized eggs from implanting in the endometrial lining. More recent studies, however, suggest that the copper IUD prevents fertilization of the egg. It somehow blocks the sperm from getting to the fallopian tube and those that do are damaged and thought not capable of fertilization. Also supporting the concept of not being an abortifacient is that super sensitive pregnancy tests show that women without any contraception have much higher rates of slightly positive HCG levels and do not end up being clinically pregnant. Women with IUDs have very low rates of low level positive pregnancy tests. No one could ever say for certainty that IUDs do not cause early abortion but the best evidence suggests that is not the primary mechanism by which they work.

Which women are the best candidates to use an IUCD as a contraceptive?

Women who are not at increased risk of genital tract infection are the best candidates for IUD insertion. This usually means women in a monogamous relationship who have not previously had pelvic inflammatory disease or any chronic diseases such as leukemia, acquired immunodeficiency syndrome or any other immune compromising disease.

Women with certain medical problems that contraindicate other forms of contraception are actually ideal candidates for IUDs. A history of venous thromboembolism (blood clots), severe blood lipid problems, liver disease, estrogen dependent tumors, poorly controlled hypertension, and even smokers over age 35 would be well advised to strongly consider the IUCD as a form of contraception. This is also true for women without infectious risk factors who want a non-hormonal method that does not require constant decisions and preventative actions with each episode of intercourse.

What are the contraindications to using an IUCD?

The only absolute contraindications to having an IUCD inserted would include current or recent pelvic infection, unexplained abnormal uterine bleeding and possible current pregnancy. Diabetes, valvular heart disease and even bleeding disorders are not contraindications. Relative contraindications would include heavy menstrual bleeding, moderate to severe menstrual cramps or unexplained pelvic pain. Even not having had a previous pregnancy is not a contraindication although a woman who has not had children and has moderate or worse menstrual cramps would be better off to consider another form of contraception first.

Must the intrauterine contraceptive device be inserted during the menses?

This rule-of-thumb came about because the menses helped reassure that the woman was not pregnant. Also the cervical is open at the time of the menses making it easier and less painful to insert the IUCD. Providers now feel this is too restrictive a policy. Vaginal

bleeding does not definitely exclude pregnancy and there is a higher expulsion rate if the IUCD is inserted during a menses. Current advice is that the IUCD may be inserted any time during a cycle if there is reasonable assurance the woman is not pregnant.

Increased mucous discharge after 4 year IUCD use

I have an IUD (four years old) and have not had any problems with it. My last period was about 3 weeks ago, and now I'm having a mucous discharge unlike anything I've ever had, except when I was pregnant and beginning to lose my mucous plug - it's shot-through with blood. There hasn't been a whole lot of it, but I'm concerned. There's no pain, just a tiny bit of cramping or "heaviness". I have a strange feeling that something is wrong - could there be a problem with my IUD, or a failed pregnancy? Or is something going on with my cervix?

It's difficult to say. Be sure to check a pregnancy test because that could explain it. However, it is not that likely that you are pregnant. This may be a symptom that persists for only a short time and then goes away after the next menses or it could be more permanent. The bleeding can come from IUD irritation (even after 4 years), cervical inflammation, or even uterine bleeding secondary to hormonal fluctuation. It actually doesn't sound like a pregnancy. As long as the mucous is not yellowish in color and there is no pain associated, you might just wait to see the next cycle if this persists.

Injectable Contraception - DepoProvera® (depo medroxyprogesterone acetate)

Should DepoProvera® contraceptive injection be started first during a menses?

Starting during menses ensured the woman was not pregnant. Now, doctors feel that the shot can be started any time if there is a reasonable assurance that the woman is not pregnant. A backup method of contraception should be used if it is not started at the time of the menses.

How long should a breast feeding woman wait until having a DepoProvera® contraceptive shot?

"Wait 6 weeks until the first contraceptive shot." That is what most providers said. There were theoretical questions about the effect of DMPA on the baby and also on the quality and quantity of breast milk. This advice to delay the shot resulted in many women becoming pregnant. The current concept is that the DMPA contraceptive shot can be given before leaving the hospital.

What are the side-effects of DepoProvera® in teens

Many women are concerned about undesirable side-effects of any form of contraceptive. The perceived incidence of these effects keeps women from using any protection against pregnancy so it is important to know what the chance of symptoms such as weight gain and irregular menstrual bleeding actually is.

S. C. Matson and others in J Pediatr Adolesc Gynecol 1997 Feb;10(1):18-23 documented the main side-effects of the injectable contraceptive, depot medroxyprogesterone acetate (DMPA, DepoProvera®) over 30 months in 53 adolescent females.

Each teen received 150 mg DMPA intramuscularly in either the shoulder or buttocks muscle. The first two DMPA injections were given 6-8 weeks apart in an effort to decrease menstrual irregularity. Subsequent shots were given every 3 months. At 5, 11, and 17 months of DMPA use, only 75%, 40%, and 19% of the women subjects respectively, continued DMPA. The most commonly perceived side-effects were weight gain (27%), headache (25%), irregular periods (24%), fatigue (23%), abdominal pain (18%), and decreased sexual desire (15%). Significant weight gain was noted with an average increase of 12 pounds (6.0 kg) at 11 months of DMPA use and 19 pounds (9.0 kg) at 17 months. No menstrual bleeding was experienced by 30%-40% of adolescents in any 3-month injection period, and those who had any menstrual bleeding averaged 8-13 days of bleeding between injections. No pregnancies occurred.

The study shows DMPA is an effective, acceptable contraceptive for some adolescent females who are at high risk for pregnancy. The side-effects are substantial however, with weight gain being the most significant one.

Leg and arm pains on DepoProvera®

I had a baby about 3 months ago (my 3rd) and since have had 2 injections of Depoprovera®. I'm not sure if it's related or not but I have noticed increased pain in my legs, mostly inner knee area (both legs) and sometimes calves. It is not a joint or muscle pain. I also have unaccounted for bruises on my legs and an amazing increase in varicose veins. Regarding my arms, I occasionally have similar pains but have also noticed numbness and some weakness. It is almost like how your hand feels if you've had a rubber band on your wrist. Fortunately, my baby sleeps great and through the night but I am almost constantly tired to the point of having difficulty keeping my eyes open. Hopefully I'm just paranoid, but I just don't feel "right."

You can sometimes get symptoms from hormones like you describe but it can just as easily be low estrogen rather than increased progesterone. I would consider coming off the DepoProvera® as birth control and using some form of mechanical birth control (IUCD, diaphragm) for a while to see how you do off of hormones.

If you get any acute redness in the legs, you need to see the doctor about possible blood clots in the legs. It can happen with DepoProvera® although more commonly it is from estrogen. The DepoProvera® may be making the varicose veins worse and that can be the cause of some of the symptoms. Also, be sure to increase your dietary potassium.

Faintly positive pregnancy test 1 month after DepoProvera®

I use DepoProvera® injections for birth control. My last injection was last month. My doctor told me that I had no more chance of getting pregnant using this method than women who have had their tubes tied. Recently, I have felt sick, all of the time (vomiting, and ache in lower belly and upper groin area). I took a pregnancy test just to see what it said. It came back faintly positive. Is this possible or due to other factors?

Usually DepoProvera® is quite effective with an extremely low pregnancy rate if taken every 14 weeks or less. While the nausea goes along with pregnancy, you don't mention breast soreness. Pain does not go with pregnancy.

Some things can give a false pregnancy test. Urinary tract infection comes to mind with your symptoms, although viral illnesses can also cause interference. I would wait about 3 or 4 days to check the pregnancy test, but in the meantime if you are having any urinary symptoms or diarrhea, you should have that checked out by your doctor.

Nausea with first DepoProvera® injection

Yesterday afternoon I got a Depo shot for the first time, but by the night I was really sick. I was throwing up all night and today hasn't been much better. Is it possible for the shot to cause this or do I just have a virus and they are coincidental?

It is likely due to the shot and the initially high progestin levels. They can produce dizziness and nausea. This should lessen significantly over the next 1-3 days. Subsequent shots may give some of the same symptoms but lesser in amount and duration and less with each subsequent Depo injection.

Clearance of the depo shot

I stopped taking the depo shot, my periods had not been coming regularly at first but for the month on January and February they came on the same date which is the 17th does this me that my body is back on track? And if so, how would I figure out when I am most fertile? Is it 14 days before the next period or is it 14 days after your last period?

Probably the Depo is out of your system although sometimes an anovulation episode can creep back in after two normal menses. You are most fertile 14 days BEFORE your next menses.

Difficulty with sexual intercourse and using DepoProvera®

I am currently using DepoProvera® for birth control. I had my last shot in December and in January I began bleeding after every time I have intercourse. Also sometimes while having sex it feels like my hubby's penis is pushing on my rectum. Are any of these signs of fibroids or tumors?

This does not sound like a fibroid or tumor but your husband may be hitting the cervix if it has dropped down or changed position. Since you are having bleeding after relations, you should have the doctor take a look to see if the cervix is what is bleeding and if it is irritated or inflamed. The doctor can also check if the uterus has changed position and if that is the problem.

Resuming menses after depo

I have been off of the depo shot since August and my periods started back in October and I have gotten them in November, but none in December. But on January 2, I came on my period. Then I got another period almost two weeks after the first period in January. Now it is February 5 and I have not received my period does this mean that I could be pregnant? And does it sound like the depo shot has left my system.

You are probably not pregnant but you may need to do a pregnancy test to confirm that. I would guess that your next menses might come 4 weeks after the two week bleeding episode. It sounds as if you are not ovulating regularly which can be due to the Depo not being fully metabolized out of your system.

Depo and lower libido

I am almost 39 and have been on Depo shots for a little over a year. About 2 years ago I noticed that my sex drive was almost non-existent. I have tried my best to research and figure out the "why" on my own, but I've had no luck. I've had thyroid studies done for other problems and that is normal. Is this just something I'll have to live with? Frankly, I could live without it but it is an issue at home so any answers or guides would be appreciated.

You need to determine if any of the anxiety, stress, fatigue, partner anger, fear of vaginal pain, low self esteem due to unattractiveness feeling, misplaced desire, medications etc., apply to you before looking for physiological reasons of decreased estrogens, androgens or thyroid. If you think any of those former things may apply, you will have to make major lifestyle changes to see the response. This will take cooperation and good communication from your partner.

Tubal ligation

Will the doctor do a tubal even if I have no children?

I am a twenty-year-old manic-depressive. My fiancée and I will be marrying within the next two years and neither of us wants children. My reasons are partially because of the manic-depression, but mainly just a personal preference. My question is would a doctor have a moral/ethical issue with tying the tubes of a young, married woman with no children? I cannot take birth-control pills because they cause me to go into severe depressions and I would be terrified to try an injectable form of birth control because it is still hormonal, like the pill. It seems that the only option I have to make love spontaneously (i.e. without condoms) is by having my tubes tied. (Diaphragms are out of the question-I would rather use a condom.)

There are always some doctors who might have a moral objection to tying tubes so young, but for the most part, doctors will perform the procedure as long as they are convinced that this is a well thought out decision and that you are unlikely to change your mind about it and "regret" having it done. Most "regret" rates at having tubal ligation are in the 2-3% range for all women (circumstances change later in life, e.g. a new medicine comes along that totally keeps manic-depression under control with no worsening from

hormones). Women who have a higher "regret" rate approaching 5-10% are those less than 25 years of age and those women having marital/partner discord.

While you are under 25 years of age and might have a slightly higher regret rate, talk to your gynecologist about all the reasons you have to want this. It may take more than one visit, but most doctors understand this; you are not the first woman who has had these problems and made these decisions. They are tough decisions but you can get a tubal ligation done if that's what you think is best for you.

Does a tubal ligation change your hormones?

I had a tubal ligation a year ago, after one last try with various pills. Took one for a month and Micronor® for about 8 days. I did not handle these well at all. Well, since then my periods have been strange. I get spotting for up to a week prior. The bleeding starts, then stops, and then finally finishes up. The whole event takes 2 weeks - 1 of spotting and 1 of on and off bleeding. What could be the cause of this? I read that progesterone and estrogen levels could be effected by a tubal.

In general, tubal ligation is not felt to alter what your body would normally do with ovulation. Thus estrogen and progesterone levels are not directly related to the tubal. It is hard to say for sure though. The most common approach to your current bleeding problem would be to try several cycles of just taking progestin (e.g., Provera®) during the last 7-10 days of your cycle.

Additional Resources for Answers

Web sites

BackupMD.net

FAQs about birth control pills – Questions and Answers as well as an index to the latest articles from BackupMD.net (formerly Woman's Diagnostic Cyber).

ARHP.org

Oral Contraceptive Update – From the American Society of Reproductive Health Professionals.

epigee.org

FAQs about Birth Control Pill Drugs – From the Epigee Birth Control Guide

Ann Rose's

Ann Rose's Ultimate Birth Control Links – Links for all the different types of birth control methods

What if my question is not answered in this book?

Sometimes due to unique circumstances or perhaps just not a clear presentation of answers, your question does not get fully and accurately answered. Your first choice should be to discuss this problem with your own physician.

If you want an additional opinion or if you cannot seem to connect with your own physician, a paid medical educational consult is available from this author.

Feedback and comments about this book

We would appreciate your feedback about this book. Please tell us what parts are good (so we do not eliminate them) and what parts need to be improved. Any answers that are vague or misleading we want to know about because this is a dynamic ebook that can be frequently updated to provide the most accurate answers on the net about birth control pills.

Enter comments about this book.

Where can this book be purchased?

This ebook – **Accurate Answers to Questions About Birth Control Pills** – can be purchased at:

Woman's Diagnostic Cyber Store