Contraception and cardiovascular disease


1Department of Cardiology, Erasmus Medical Center, Office Ba 308, Postbus 2040, Rotterdam 3000 CA, The Netherlands; 2Department of Obstetrics and Gynaecology, Erasmus Medical Center, Rotterdam, The Netherlands; 3Department of Cardiology, Hatter Institute for Cardiovascular Research in Africa, MRC Cape Heart Group & IDM, Faculty of Health Sciences, University of Cape Town, Cape Town, South Africa; 4Department of Cardiology, University Medical Centre Groningen, University of Groningen, Groningen, The Netherlands; 5Department of Cardiology, Heart Institute Cincinnati Children’s Hospital Medical Centre, 3333 Burnet Avenue, Cincinnati 45229, USA; and 6Academic Department of Obstetrics and Gynaecology, Imperial College School of Medicine, Chelsea and Westminster Hospital, 369 Fulham Road, London SW10 9NH, UK

Received 31 January 2015; revised 7 April 2015; accepted 8 April 2015; online publish-ahead-of-print 29 April 2015

Contraceptive counselling should begin early in females with heart disease, preferably directly after the start of menstruation. In coming to a decision about the method of contraception, the following issues should be considered: (i) the risk of pregnancy for the mother and the consequences of an unplanned pregnancy; (ii) the risks of the contraceptive method; (iii) failure rates; (iv) the non-contraceptive benefits; (v) the availability; (vi) the individual’s preferences; (vii) protection against infection; and (viii) costs. In some women with heart disease, the issues may be complex and require the input of both a cardiologist and an obstetrician (or other feto-maternal expert) to identify the optimal approach. No studies have been performed in women with heart disease to investigate the relative risks and benefits of different contraceptive methods.

Keywords Contraception • Pregnancy • Cardiovascular • Heart disease

Introduction

The success of cardiac surgery and the medical management of women with congenital and acquired heart disease means that most will reach puberty and could become pregnant, as most become sexually active even with severe heart disease.1,2 However, pregnancy is high-risk in at least some of these women and needs careful planning.1–3 In the large international prospective registry of pregnant patients with cardiac disease (ROPAC), 38% of 1321 women was defined to be high risk and 4% had a contraindication for pregnancy.2 Effective contraception is essential especially in those with a contraindication for pregnancy. In other women, effective contraception is crucial to allow counselling and optimal timing of pregnancy, improving the chances of an uncomplicated pregnancy. In addition, women with cardiac disease may use medication that is teratogenic (i.e. ACE-inhibitors), consequently, effective contraception is essential. However, the provision of contraceptive advice to these women is sporadic. One study reported that nearly 35% of 49 women had not been advised on the use of contraceptives, while counselling in another 30% had been inappropriate.4 Another study reported the widespread use of oestrogen-containing formulations (33%), despite their association with an increased risk of thrombo-embolic disease, even in women with a contraindication for oestrogen-use, while the safer progesterone-only alternatives were used relatively infrequently (1.3%).5

Large population-based sexual health studies have all reported a decrease in median age at first intercourse over the past 50–60 years. In the western world, the median age of menarche is around 12–13 and the age at first sexual intercourse for women around 17 years, with 2–30% having sexual intercourse before the age of 15.6 The mean age at first intercourse of women with heart disease is similar to that of the general population.7 Clearly general practitioners, (paediatric) cardiologists, obstetricians, and other doctors caring for these women should offer appropriate contraceptive advice early, preferably soon after menstruation starts.

Medically, the key issues relate to reliability and the thrombosis- and infection risk of each possible method. The most reliable methods are those that are the most straightforward to use, the implant and the intrauterine device (IUD). The thrombotic risk is greatest with oestrogen-containing compounds and the copper IUD has the greatest risk of pelvic infection, while all non-barrier contraceptives at best have a limited benefit through thickening of the cervical mucous or not protective benefit at all in preventing infection. A good approach is the use of a long-acting reversible form of contraception combined with a male condom for prevention of sexually transmitted diseases.

---

* Corresponding author. Tel: + 31 10 7033989, Fax: + 31 10 7035498, Email: J.roos@erasusmc.nl

Published on behalf of the European Society of Cardiology. All rights reserved. © The Author 2015. For permissions please email: journals.permissions@oup.com.
From a health economic perspective, contraception is cost saving to society by preventing the costs and emotional distress associated with unintended pregnancies and terminations. This is even more pronounced in women with medical conditions like heart disease. Subdermal implants, IUDs, and sterilization are more cost effective than other methods. This is related to their contraceptive efficacy, high continuation rate, additional medical benefits (e.g., decreased menstrual blood loss, low thrombotic risk), and long duration of action.

However, the discussion on contraception should not be limited to the safest and most efficient way to avoid pregnancy, but should encompass other issues like menstrual regulation, reduction of uterine blood loss and menstrual discomfort, as well as the possibility of treatment for endometriosis, PCOS, acne, ovarian cysts, and other conditions. While these issues might be considered less important, they affect the daily comfort and wellbeing of women. The chances of a woman continuing to use contraception are much greater if the method used also makes her feel well. Given the complexity of each request, we prefer an individualized approach where the contraceptive and non-contraceptive benefits and the risks of each method are matched with the patient’s desire, after appropriate counselling.

In this article, we will discuss the relative risks and benefits of different contraceptive methods in the context of a woman with heart disease.

**Type of contraception**

To find the best type of contraception, issues such as risks, failure rates, non-contraceptive benefits, individual preferences, and protection against infection should be considered (Figure 1).

In some women with heart disease, the issues may be complex and require the input of both a cardiologist and an obstetrician to identify the optimal approach.

![Figure 1](https://academic.oup.com/eurheartj/article-abstract/36/27/1728/2398138)
The risks and consequences of pregnancy, planned as well as unplanned, can be estimated based upon the Modified WHO classification of maternal cardiovascular risk. For the risks of each contraceptive method, the detailed WHO medical eligibility criteria (WHO-MEC) for contraceptive use offer guidance in women with specific medical conditions. The WHO developed this practical system of recommendations with four categories for each contraceptive method and each medical condition including heart disease (Table 1). The guidelines are developed and regularly updated by a panel of international experts, primarily based on scientific evidence where available and expert opinion where it is not. As no studies on contraception have been performed in women with heart disease most recommendations are based on extrapolation of data from studies in women without heart disease. Several national guidelines are based on this system, adapted to the local situation.

The efficacy of a contraceptive method is based on its intrinsic mechanism of action, but is also highly dependent on its correct use. It is therefore often expressed as an optimal efficacy, reflecting its theoretical efficacy and a typical efficacy, based on what is observed in real life. Table 2 shows these efficacies along with the most important risks and benefits.

**Barrier methods, calendar methods, and withdrawal**

Barrier forms of contraception (including condoms, diaphragms, and cervical caps), calendar methods, or withdrawal before ejaculation are usually considered insufficient due to their substantial failure rate. It consistently seems that humans are not invariably rational or practical when passionate. Nevertheless, a male condom protects against sexually transmitted diseases in non-monogamous relationships and might prove valuable as an additional contraceptive method.

**Combined oestrogen and progesterone contraceptives**

Combined oestrogen and progesterone contraceptives combine either ethinylestradiol or estradiol valerate with various progestins (progestogens). They are mostly used as tablets with regular stop periods, but they can be delivered by a vaginal ring, injection, or transdermal patch. Combined oral contraceptives are divided in four generations depending on the progestin used and the type and dose of the oestrogen component.

The oestrogen component in combined oral contraceptives significantly increases the risk of venous thrombosis (2–7-fold) irrespective of the type of progestin used although the risk is small in absolute numbers (8–10/10 000 women-years exposure). This risk of an unplanned pregnancy must be weighed against the risks of the combined contraceptives. Besides venous thrombosis, combined oral contraceptives increase the risk of arterial thrombosis and hypertension. Therefore, combined oral contraceptives are not recommended (WHO-MEC 3) or even contraindicated (WHO-MEC 4) in women with cardiac disease (especially those with an increased thrombotic risk, either venous or arterial), ischaemic heart disease or hypertension.

Combined oral contraceptives inhibit ovulation, thicken the cervical mucus, preventing sperm penetration, and prevent implantation by altering endometrial receptivity. Theoretically, contraceptive efficacy is high, but this is completely dependent on its correct usage. Some medication may influence their efficacy. For instance, Bosentan, taken in the management of pulmonary hypertension, increases the metabolism of contraceptive steroids, decreasing their efficacy and in this circumstance, a supplementary method, like a condom, should be used. Combined oral contraceptives usually improve cycle control by making periods regular, less painful, and lighter. Women often reduce the frequency of withdrawal bleeds, by continuous intake for 2 or 3 months. Combined oral contraceptives can also be used for the treatment of ovarian cysts, polycystic ovary syndrome, and features of mild hyperandrogenism like acne or hirsutism.

**Progesterone-only contraceptives**

Progesterone-only methods of contraception come in a variety of formulations. Depending on the method used, the contraceptive mechanism of action is a combination of cervical mucus thickening, preventing sperm penetration, and reduction of endometrial receptivity, preventing implantation. The higher dose formulations also inhibit ovulation. Most importantly, progestins probably do not increase the risk of thrombosis, although discussion exists, as some papers have reported an increased risk of thrombosis in patients using Depo-provera, while others have not. Progesterone-only pills, commonly known as ‘mini-pills’ contain various types of progestogens and are used daily without a break. Most have a limited efficacy as contraceptive but were traditionally used as a contraceptive supplement to lactation.

Desogestrel (Cerazette) containing progesterone-only pill is the only one to effectively inhibit ovulation and has a similar safety window (12 h) and contraceptive effectiveness as the combined oral contraceptives. It is therefore the only progesterone-only pill recommended in women with (severe) cardiac disease. Depot-medroxyprogesterone acetate (DMPA) can be used for intramuscular or subcutaneous injection and offers contraceptive protection for at least 13 weeks. While its effect usually last much longer, adherence to the 13-weekly interval (with a 4-week grace period) is recommended in order to be able to rely on its contraceptive efficacy.

Subdermal implants containing etonogestrel or Levonogestrel keep their contraceptive efficacy for 3–5 years and are easily inserted after simple local infiltration in the medial groove between the biceps and the triceps.
<table>
<thead>
<tr>
<th>Group</th>
<th>Contraceptive type</th>
<th>Failure (typical, %)</th>
<th>Failure (optimal, %)</th>
<th>Continued use at 1 year (%)</th>
<th>Thrombosis risk</th>
<th>Infection risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>Highly effective (&lt;1%)</td>
<td>Implant</td>
<td>0.05</td>
<td>0.05</td>
<td>84</td>
<td>May be slightly increased risk</td>
<td>Minimal</td>
</tr>
<tr>
<td>Reversible</td>
<td>IUCD</td>
<td>0.2 (LNG)</td>
<td>0.2</td>
<td>80</td>
<td>No increased risk</td>
<td>Transient bacteraemia at insertion, increased PID</td>
</tr>
<tr>
<td></td>
<td></td>
<td>0.8 (Copper)</td>
<td>0.6</td>
<td>78</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Highly effective (&lt;1%)</td>
<td>Vasectomy</td>
<td>0.15</td>
<td>0.1</td>
<td>100</td>
<td>No increased risk</td>
<td>Post-operative</td>
</tr>
<tr>
<td>Irreversible</td>
<td>Tubal Occlusion</td>
<td>0.5 (abdominal, laparoscopic, or hysteroscopic)</td>
<td>0.5</td>
<td>100</td>
<td>No increased risk</td>
<td>Post-operative</td>
</tr>
<tr>
<td>Moderately effective (3–12%)</td>
<td>Injectable</td>
<td>Depo-Provera 3%</td>
<td>Depo-Provera 0.3%</td>
<td>56</td>
<td>Increased risk</td>
<td>Minimal, but no protection from PID</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Combined injectable 3%</td>
<td>Combined injectable 0.05%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>8</td>
<td>0.3</td>
<td>68</td>
<td></td>
<td>Increased risk</td>
</tr>
<tr>
<td></td>
<td>Combined oral contraceptive</td>
<td>8</td>
<td>0.3</td>
<td>68</td>
<td></td>
<td>Increased risk</td>
</tr>
<tr>
<td></td>
<td>Desogestrel containing progesterone-only pill</td>
<td>8</td>
<td>0.3</td>
<td>68</td>
<td></td>
<td>Increased risk</td>
</tr>
<tr>
<td></td>
<td>Patch</td>
<td>8</td>
<td>0.3</td>
<td>68</td>
<td></td>
<td>Increased risk</td>
</tr>
<tr>
<td></td>
<td>Ring</td>
<td>8</td>
<td>0.3</td>
<td>68</td>
<td></td>
<td>Increased risk</td>
</tr>
<tr>
<td>Poorly effective (18–28%)</td>
<td>Male Condom</td>
<td>15</td>
<td>2</td>
<td>53</td>
<td>No increased risk</td>
<td>Reduced PID</td>
</tr>
<tr>
<td></td>
<td>Diaphragm</td>
<td>16</td>
<td>6</td>
<td>57</td>
<td>No increased risk</td>
<td>Reduced PID</td>
</tr>
<tr>
<td></td>
<td>Female Condom</td>
<td>21</td>
<td>5</td>
<td>49</td>
<td>No increased risk</td>
<td>Reduced PID</td>
</tr>
<tr>
<td></td>
<td>Sponge</td>
<td>16–32 (nulliparous vs. parous)</td>
<td>9–20 (nulliparous vs. parous)</td>
<td>46–57 (parous vs. nulliparous)</td>
<td>No increased risk</td>
<td>No protection from PID</td>
</tr>
<tr>
<td></td>
<td>Safe Period</td>
<td>25</td>
<td>3–5</td>
<td>51</td>
<td>No increased risk</td>
<td>No protection from PID</td>
</tr>
<tr>
<td></td>
<td>Withdrawal</td>
<td>27</td>
<td>4</td>
<td>43</td>
<td>No increased risk</td>
<td>No protection from PID</td>
</tr>
<tr>
<td></td>
<td>Spermicide</td>
<td>29</td>
<td>18</td>
<td>42</td>
<td>No increased risk</td>
<td>No protection from PID</td>
</tr>
<tr>
<td>No contraception</td>
<td></td>
<td>85</td>
<td>85</td>
<td>85</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
triceps. The rare failures due to unnoticed loss of the implant at inser-
tion and problems of implant retrieval at removal with the etonoges-
trel containing implants have largely been overcome by a new
inserting device and incorporation of a radioactive filament.26,36 A
large Danish population study including 1,626,158 women, suggested
a potential slightly increased thrombotic risk with subdermal
implants (relative risk 1.4).32 However, the study failed to reach stat-
istical significance (95% CI 0.6–3.4). and with other studies assessing
the influence on haemostatic parameters being reassuring, there is
little evidence of increased thrombosis risk with their use.32,37–39

Prolonged exposure to progestagens induces endometrial atro-
phic changes. This results in an irregular and unpredictable bleeding
pattern, often with reduced blood loss, duration, and menstrual
frequency (occasionally amenorrhea).40–43 However, it is also
sometimes characterized by continuous spotting.26,44 The exact
mechanism responsible for this remains to be understood but may
be related to vascular fragility of the atrophic endometrium.

While most women welcome the reduction in vaginal blood loss,
the unpredictable nature or continuous spotting can be bothersome
in others. Creating realistic expectations during counselling often
greatly contributes to patient satisfaction and acceptance of undesir-
able side effects.29,30,45

Intrauterine contraceptive device and intrauterine system

The two most common forms of reversible intrauterine con-
traceptives are the banded copper containing intrauterine device
(copper-IUD) and Levonogestrel-releasing intrauterine system
(IUS) (Levonogestrel-IUS = Mirena). Copper is toxic to the ova
and sperm and the device induces an endometrial inflammation pre-
venting implantation, thereby offering safe contraception for 10
years. For the Levonogestrel-IUS, the gradual, local release of proges-
terone induces endometrial atrophy and the formation of a cervical
mucus plug, which impedes sperm penetration offering safe contra-
ception for 5 years. It suppresses ovulation for the 1st two cycles
thereafter the cycle returns to normal.46

Progestrone containing subdermal implants and Levonogestrel-
IUS and copper-IUD are considered long-acting reversible contra-
ceptives. By eliminating the dependency on patient adherence,
their efficacy is excellent even exceeding sterilization and fertility
rapidly returns upon removal.13,26,47

While menstrual blood loss and discomfort might be increased
after insertion of a copper-IUD, the Levonogestrel-IUS, after a 3–
4-month period of irregular light loss, usually reduces blood loss
and, in the majority, results in complete amenorrhea.

An IUD can be used in both nulli- and parous women and have no
effect on thrombogenic risk.48 Insertion is facilitated during menstru-
ation, offering immediate contraception, but can be performed at any
point in the cycle and even postpartum.49 Uterine perforation occurs
but is rare.

The risk of pelvic infection is increased for the 3 months after inser-
tion of IUD and women should be warned to report fever or other
worrying symptoms promptly. Transient bacteraemia has been docu-
mented at replacement but is rare during simple insertion or
removal.50,51 Guidelines for infective endocarditis prophylaxis
during placement of these devices has changed considerably over
the past decade across Europe and Northern America. The most
recent recommendations from the American Heart Association
(2008) and the National Institute for Clinical Excellence (2008) no
longer advise routine use of antibiotic prophylaxis for genito-urinary
instrumentation in women with cardiac disease (including valvular
heart disease, congenital heart disease, and cyanotic congenital
heart disease) irrespective of their underlying risk of endocarditis,
or those with a high risk of adverse outcomes associated with endo-
carditis.52,53 These guidelines have been driven by four large ran-
mized trials, which were reviewed in a Cochrane collaboration
meta-analysis by Grimes et al.54–58 These randomized controlled
trials were designed to explore the peri-procedural infective risk to
the upper genito-urinary tract associated with instrumentation
during IUD implantation. Pelvic inflammatory disease within 90
days was the primary outcomes in all four trials. Other secondary
outcomes included removal of the IUD (in two of the trials) for
reasons apart from ‘spontaneous’ expulsion of the device. Unsched-
uled visits were another secondary outcome measure. Overall these
trials demonstrated that prophylactic doxycycline or azithromycin
compared with placebo or no treatment conferred additional
benefit (OR 0.89 (95% CI 0.53–1.51).54 Sineil et al.,56 using doxycy-
cline prophylaxis, showed a significant reduction in non-scheduled
visits following IUD insertion in those having received antibiotic
prophylaxis, but failed to show a significant reduction in rates of
pelvic inflammatory disease following IUD insertion. Ladipo et al.,55
replicating this methodology in a Nigerian population, were unable
to demonstrate any difference in unscheduled visits or infection fol-
lowing IUD insertion. Walsh et al.,57 and Zorlu et al.,58 also failed to
demonstrate any significant benefit for prophylactic antibiotics on
pelvic inflammatory disease.

However, a recent retrospective study evaluated the effect on
endocarditis prevalence associated with the introduction of the new
guidelines over the period 2004–13 (i.e. before and after intro-
duction of the new guidelines). By March 2013, 35 more cases per
month of endocarditis were reported than would have been
expected.59 These results do not establish a causal relationship, but
call for further systematic evaluation of the specific benefit of anti-
biotic prophylaxis in high-risk women. Currently, the guidelines
states that antibiotic prophylaxis for the placement of an IUD or
IUS is not recommended, however, the administration of prophylac-
tic antibiotics (ampicillin 2 g and gentamicin 80 mg given intravenous-
ously 1 h before IUCD insertion) prevents bacteraemia and may be wise
in high-risk women (e.g. with a prosthetic valve) given the increasing
incidence of endocarditis since introduction of the new guidelines,
while endocarditis is associated with high morbidity and mortality
and the incidence or serious side-effects of prophylactic antibiotics
is relatively low.60

Sterilization
Sterilization in a patient with a contraindication for pregnancy or after
a couple has completed their family is not unreasonable.11,27,61 Vas-
ectomy, is a highly effective approach to contraception and poses no
risk to a woman with heart disease, but may not be ideal in the context
of a woman with a high chance of early demise as it compromises the
fertility of the man in eventual future relationships. Laparoscopic or
open tubal ligation and hysteroscopic insertion of intratubal stents
may be the best sterilization option as long as the woman understands
that such procedures should be considered irreversible. If a pregnant woman is to be delivered by caesarean section and has completed her family, then the option of a sterilization at the same time should be discussed mentioning that the regret and failure rate might be slightly higher and the possibility of reversal lower than for the standard laparoscopic approach. Not unreasonably, many women are unwilling to be sterilized as a primary form of contraception, even if they have severe heart disease and pregnancy would carry a very high risk.

Some women will struggle to accept the finality of no longer being able to have children. There are risks associated with the procedure itself and, although rare, it does have a failure rate, and definite adverse effect psychological impact on the patient. Recently, the role of sterilization has been reduced by the availability of other highly reliable and reversible contraceptive techniques, such as subdermal implants and Levonogestrel-IUS.

**Emergency contraception**

Emergency contraception can be a valuable back-up in case of unprotected intercourse. A single dose of 1.5 mg of Levonogestrel is very efficient with a 1.1% failure rate if taken within 72 h after unprotected intercourse. Its mechanism of action is mainly through delaying ovulation. Therefore, its efficacy is limited once ovulation has occurred. A single dose of Mifepristone 25 mg and Ulipristal acetate 30 mg, two progesterone receptor modulators, seem to be more effective than Levonogestrel and can be taken up to 120 h after unprotected intercourse. In addition to the inhibition of ovulation, these agents may also prevent implantation and reduce tubal motility. Besides minor side effects like nausea, vomiting, and headache, these methods are generally considered safe, even in women with heart disease. Patients should be made aware that menstruation is often delayed. The most effective approach remains the insertion of a copper-IUD within 120 h after intercourse (0.09% failure rate), which, as well as preventing pregnancy, will offer long-term contraception.

Two doses of levonorgestrel (750 μg) have a small effect on blood clotting parameters with an increase in fibrinogen at 24 and 48 h and a reduction in anti-thrombin III lasting from 2–12 h post treatment (oestrogen-based methods have a more marked effect). However, despite these changes, there was no evidence of an increased risk of thrombosis in users of post-coital contraception. On the contrary, a case report described a potentiation of warfarin by levonorgestrel, perhaps by the displacement of warfarin from its main transport protein, α1-acid glycoprotein. Indeed, there may exist a strong and potentially dangerous interaction between high-dose levonorgestrel and warfarin urging the need for extra INR control in the first days. Consequently, it may be better to insert a copper IUD for post-coital contraception in a woman taking warfarin.

**Contraceptive advice in women with specific cardiac lesions**

There is a paucity of published information and very little evidence about contraception in women with all forms of heart disease. These women are a heterogeneous group, meaning that risk stratification and contraceptive advice has to be individualized and should be based not only on the nature of the cardiac problem, but also on the presence of other medical conditions, the age of the woman and her partner, number of previous children, cultural and religious beliefs, and individual wishes.

**Compromised cardiac function**

Pregnancy in women with previously diagnosed idiopathic, familial, or peripartum cardiomyopathy carries a risk of heart failure and occasionally death. Deterioration of left-ventricular function is reported in up to 50% of cases in the peripartum period, despite optimal medical therapy. Maternal mortality figures typically include deaths that occur during pregnancy or in the first 42 days after delivery. However, deaths related to peripartum cardiomyopathy may occur after this limit and the linkage with the preceding pregnancy lost. The cause of death can be intractable heart failure, sudden death due to ventricular arrhythmia or due to a thrombo-embolic event, occurring as a result of the poorly contractile left and/or right ventricles. Therefore, pregnancy is high-risk in women with a left-ventricular ejection fraction (LVEF) below 45% (WHO Class III) and is contraindicated if LVEF is below 30% (WHO Class IV). In patients with peripartum cardiomyopathy, the occurrence of heart failure has been reported even after a termination of pregnancy or stillbirth, further supporting the need for reliable contraception to prevent unplanned pregnancies. Therefore, in these women, effective contraception is essential and while there is no absolute contraindication to use of any method, an individualized approach should be taken, which includes consideration of the risk of thromboemboli, the use of anticoagulation, and the occurrence of arrhythmias. Although some fluid retention may occur, there is no evidence that the contraceptive steroid hormones aggravate heart failure. However, combined oral contraceptives are contraindicated in women who have a reduced ejection fraction after a myocardial infarction, especially when other risk factors, such as smoking and hypertension, are present.

**Contraception in women with heart disease requiring anticoagulation**

Women with mechanical valves, Fontan-circulation, and pulmonary hypertension have an increased risk of thrombosis, which is commonly managed using Vitamin K antagonists. In these women, the cardiovascular and thrombogenic risks of (unplanned) pregnancy often outweigh the inherent risks of most contraceptive methods.

However, in women on anticoagulation, the incidence of heavy and prolonged menstrual bleeding as well as intermenstrual and postcoital bleeding is increased. They can even experience ovarian haemorrhage at ovulation, potentially leading to severe abdominal bleeding on a rare occasion. Both oestrogens and progestins can potentiate the anticoagulative effects of coumarins, necessitating a re-evaluation of the INR several weeks after initiation. Therefore, in the context of a woman taking anticoagulants, a reliable contraceptive method without increased thrombotic risk, that reduce menstrual blood loss and inhibits ovulation would be most suitable. Progestrone-only methods, especially the long-acting reversible contraceptives and the Levonogestrel-IUS are therefore the method of choice in these women, although being on anticoagulants may increase the tendency...
to irregular bleeding patterns, most women would experience a reduction in vaginal blood loss. Indeed, this approach is sometimes used in anticoagulated women solely to reduce menstrual blood loss, despite earlier sterilization.60–63

While DMPA injections induce some fluid retention and can be complicated by intramuscular haematoma, it rarely seems to be of clinical significance, even in patients on anticoagulation.11,20,21,61

There are no good data on whether the increased thrombogenic risk of combined oral contraceptives is controlled by appropriate anticoagulation.74,79,80 Given this uncertainty, and the severe consequences of a thrombotic event in this patient population, most guidelines state that combined oral contraceptives are contraindicated (WHO-MEC 4) in women with a history of thrombosis, a mechanical heart valve (particularly the older single leaflet valves like the Bjork Shiley or Starr Edwards), Fontan operation, cyanotic heart disease, pulmonary hypertension, coronary artery disease, or atrial arrhythmias despite appropriate anticoagulation.10–12,21 Nevertheless, there is debate among experts about these recommendations as scientific support is lacking and combined oral contraceptives offer important non-contraceptive benefits such as improved cycle control, particularly in women who wish to discontinue progesterone-only methods due to unpredictable bleeding.61,81

While certainly not first choice, we believe that combined oral contraceptives can be considered in these women after appropriate counseling.

Contraceptive interventions in high-risk women

The pain and cervical manipulation during insertion and removal of an IUD can elicit a vagal reaction in as many as 5% of women.11,20,21,61,79,82 While this is usually benign in most women, it is potentially dangerous in those with pulmonary hypertension or a Fontan repair. Consequently, we recommend that insertion and removal of an IUD in these women occurs in a setting with cardiovascular monitoring, with anaesthetic support on standby, and using appropriate pain relief, either paracervical block or systemic opioids, to prevent a vagal reaction. Taking this into account, Levonogestrel-IUS may therefore be less suited in these women who wish to discontinue progesterone-only methods due to unpredictable bleeding.61,81

Sterilization through laparoscopic tubal ligation requires the creation of a pneumoperitoneum and is therefore contraindicated in women with pulmonary hypertension or Fontan repair. If desired, an open or laparoscopic procedure with minimal inflation under general, spinal/epidural, or even local anaesthesia can be considered, but it also requires temporary cessation of the anticoagulation and contains a procedure inherent risk of haemorrhage and thrombosis.11,21,61,84

The new methods of tubal occlusion, achieved by hysteroscopic insertion of tubal stents, have been used successfully in a group of women with severe heart disease and may be a good option. Ultrasonic assessment of tubal patency after several months is required before effective contraception can be expected.21,61,85–87 As for IUD insertion, antibiotic coverage can be considered despite the current guidelines and adequate monitoring and pain relief to prevent an eventual vagal reaction should be assured in these women.

Sterilization does not offer the non-contraceptive benefits (e.g. reduction in menstrual blood loss) of other methods. With the contraceptive efficacy of Levonogestrel-IUS and subdermal implants implants exceeding that of sterilization, the indications for the latter is limited in this patient population.

Contraception in women with arrhythmias

Women with arrhythmias often use medication that is teratogenic (i.e. amiodarone), consequently, effective contraception is essential. When a change of antiarrhythmic medication is decided upon, it should be implemented when the mother is still using contraception, since this allows time to judge the tolerance and effectiveness of the new medication. In the case of anticoagulant medication, the change can be made in early pregnancy.

A small increase in heart rate was demonstrated in women using oestrogen-containing contraceptives,88 but not with oestradiol alone.89 Theoretically, an increase in heart rate could reduce myocardial perfusion and promote cardiac arrhythmias, however, the rise in heart rate in these studies was minor and is therefore unlikely to be of clinical significance. There is no other evidence that contraception of any kind triggers the occurrence of arrhythmias. Therefore, the most important issue is the elevated thrombo-embolic risk with use of combined contraceptives in women with an arrhythmia. In women with isolated arrhythmias (i.e. isolated supraventricular or ventricular extra beats, AVNRT, or VT’s in long QT-syndrome), combined contraceptives can be used. However, when atrial flutter or fibrillation is present, either paroxysmal or permanent, caution in the use of combined hormonal contraceptives is advised, because of elevated risk of thrombo-embolism (WHO-MEC 3).11,61,90,91

Conclusion

Contraception is a delicate, sometimes difficult issue, which carries many ethical, moral, and medical dilemmas. Contraceptive counseling should begin early, and the choice of method based on the impact of (an unplanned) pregnancy, the risks, and benefits of the contraceptive type and the individual’s preferences. Complex cases will require the input of both a cardiologist and an obstetrician and the absence of any good quality studies mean that the decision is almost always based on expert opinion. In many situations, the ease of use and efficacy of the progestogen-only long-acting reversible contraceptive methods make them a good method for patients with cardiovascular disease.

Conflict of interest: none declared.

References


