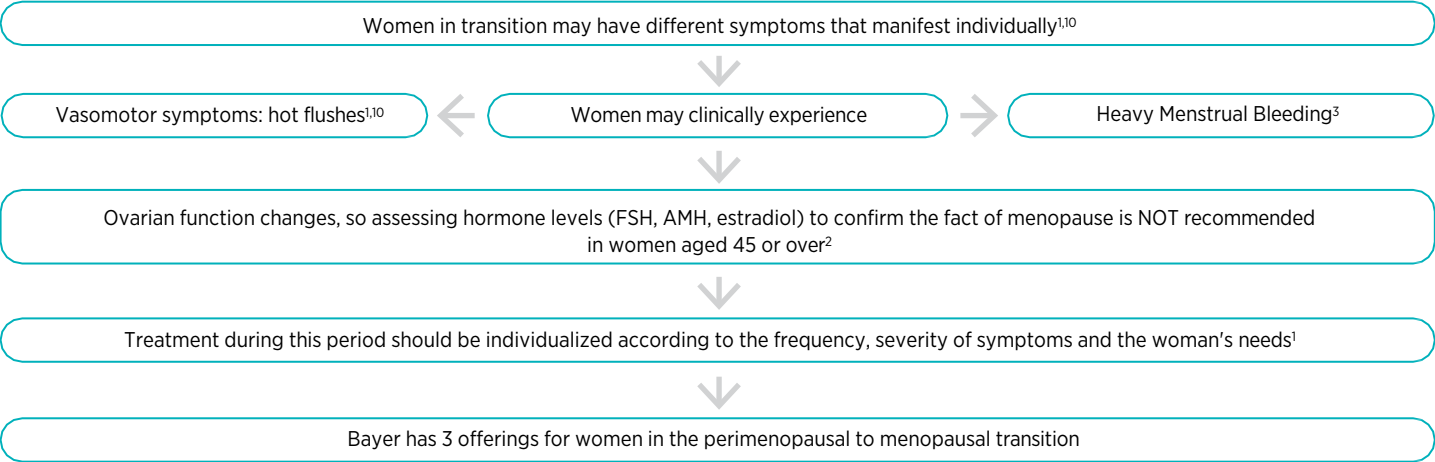


OPTIONS FOR MANAGEMENT OF PATIENTS DURING THE MENOPAUSAL TRANSITION



A VIEW BASED ON RECOMMENDATIONS AND SCIENTIFIC EVIDENCE



	COC with E2V/DNG ^{4,5} (Qlaira®)*	Hormone Therapy (Angeliq®) ⁷ Angeliq cannot be used as a contraceptive	Combination of estrogens with LNG-IUS 52 mg (Mirena®) ^{6,8,9}
Indications	Contraception⁵ <i>According to a 2014 report by the Korean Women's Development Institute, the percentage of unintended pregnancies among women aged ≥40 years was 26.9%, which was higher than 3.3% and 17.88%, found for those in their 20s and 30s, respectively⁴</i>	- For the treatment of symptoms associated with the climacteric syndrome including vasomotor symptoms (such as hot flushes and sweating attacks), and atrophic urogenital conditions in women with an intact uterus - To reduce the risk of postmenopausal osteoporosis in women with an intact uterus	Indications for Mirena® - Contraception - Idiopathic menorrhagia - Protection from endometrial hyperplasia during HRT with estrogens Indications for estrogens as part of HT - Treating menopause symptoms - Prevention of postmenopausal osteoporosis
Distinct Features	- The first estradiol containing COC in a unique 26/2 regimen^{5,12} 1 pill once a day without a break- may help improve compliance^{5,11}	- Patient can continue as long as the benefits outweigh the risks⁷ - DRSP is a unique anti-androgenic/anti-aldosterone progestogen leading to moderate increase in sodium and water excretion as well as a slight reduction in BP^{7,16}	- Five year efficacy. Fit and forget - Mirena® is 99.8% effective in contraception, similar to female sterilization
What else can be taken into account, when considering a treatment option	- For contraception during the transition period, COCs containing E2V can help manage menstrual blood loss, alleviate early hot flushes and regulate the cycle¹⁴ - Qlaira® contains estradiol valerate, an estrogen identical to the body's own, delivered in a dynamic dosing regimen of 3→2→1 mg (estrogen step-down)⁵ - A 26/2 regimen with only 2 estrogen-free days may reduce the likelihood of HWS symptom recurrence compared to the traditional 21/7 COC regimen^{5,13} - Qlaira® may enhance sexual desire and arousal in individuals experiencing sexual dysfunction caused to their COC¹⁵ - Dienogest exerts a potent anti-inflammatory action on the endometrium,^{18,19} leading to a reduction in dysmenorrheic pain²⁰	- Reduces the incidence of hot flushes and sweating episodes by 88% and 63% respectively¹⁷ 85-90% of Angeliq® users have bleed-free cycles after one year¹⁶	COC- combined oral contraceptive, FSH- follicle stimulating hormone, AMH - anti-Müllerian hormone, MT- menopausal therapy, E2V/DNG- estradiol valerate/dienogest, BP- blood pressure, DRSP- drospirenone, HWS- hormone withdrawal associated symptoms † Compared to 21/7 regimens²⁰ References: 1. NAMS Position Statement. The 2022 hormone therapy position statement of The North American Menopause Society. Menopause: The J of the NAMS. 2022;29(7):767-794. 2. NICE guideline. Menopause: identification and management. National Institute for Health and Care Excellence (NICE). Last updated Nov 2024. Accessed 8 Aug 2025. https://www.nice.org.uk/guidance/ng23. 3. Vannuccini S, Jain V, Critchley H et al. From menarche to menopause, heavy menstrual bleeding is the underrated compass in reproductive health. Fertility and Sterility. 2022;188(4):625-636. 4. Cho MK. Use of Combined Oral Contraceptives in Perimenopausal Women. Chonnam Med J. 2018;54:153-158. 5. Qlaira® Professional Information, Sept 2011. 6. Mirena® Professional Information, June 2019. 7. Angeliq® Professional Information, Oct 2024. 8. Harper-Harrison G, Carlson K, Shanahan MM. Hormone Replacement Therapy. Available at https://www.ncbi.nlm.nih.gov/books/NBK493191/ [Accessed on 8 Aug 2025]. 9. Anderson K, Odilind V, Rybo G. Levonorgestrel-releasing and copper-releasing (Nova T) IUDs during five years of use: A randomized comparative trial. Contraception. 1994;49:56-72. 10. Avis NE, Crawford SL, Green R. Vasomotor Symptoms Across the Menopause Transition: Differences Among Women. Obstet Gynecol Clin North Am. 2018;45(4):629-640. 11. Aubeny E, Buhler M, Colau JC et al. Oral contraception: patterns of non-compliance. The Coraline study. Eur J Contracept Reprod Health Care. 2002;7(3):155-161. 12. Dinger J, Minh TD, Heinemann K. Impact of estrogen type on cardiovascular safety of combined oral contraceptives. Contraception. 2016;94:328-339. 13. Macias G, Merki-Feld GS, Parke S et al. Effects of a combined oral contraceptive containing oestradiol valerate/dienogest on hormone withdrawal-associated symptoms: Results from the multicentre, randomised, double-blind, active-controlled HARMONY II study. J of Obstet and Gynaecol. 2013;33:591-596. 14. Grandi G, Di Vinci P, Sgandurra A et al. Contraception During Perimenopause: Practical Guidance. Int J of Women's Health. 2022;14:913-929. 15. Davis SR et al. Change to either a nonandrogenic or androgenic progestin-containing oral contraceptive preparation is associated with improved sexual function in women with oral contraceptive-associated sexual dysfunction. J Sex Med 2013;10:3069-3079. 16. Warming L, Ravn P, Nielsen T, Christiansen C. Safety and efficacy of drospirenone used in a continuous combination with 17β-estradiol for prevention of postmenopausal osteoporosis. Climacteric. 2004;7:103-111. 17. Schürmann R, Holler T, Benda N. Estradiol and drospirenone for climacteric symptoms in postmenopausal women: a double-blind, randomized, placebo-controlled study of the safety and efficacy of three dose regimens. Climacteric. 2004;7:189-196. 18. Ichioka M et al. Dienogest, a synthetic progestin, down-regulates expression of CYP19A1 and inflammatory and neuroangiogenesis factors through progesterone receptor isoforms A and B in endometrial cells. J Steroid Biochem Mol Biol 2015;147:103-110. 19. Yamanaka K et al. Dienogest inhibits aromatase and cyclooxygenase-2 expression and prostaglandin E2 production in human endometrial stromal cells in spheroid culture. Fertil Steril 2012;97(2):477-482. 20. Petraglia F et al. Estradiol valerate plus dienogest versus ethinylestradiol plus levonorgestrel for the treatment of primary dysmenorrhea. Int J Gynaecol Obstet 2014;125(3):270-274.

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The Stages of Reproductive Aging Workshop (STRAW) +10: Staging system for reproductive aging in women¹



	Menarche				Final Menstrual Period						
											
Stage	-5	-4	-3b	-3a	-2	-1	+1a	+1b	+1c	+2	
Terminology	REPRODUCTIVE				MENOPAUSAL TRANSITION		POST MENOPAUSE				
	EARLY	PEAK	LATE		EARLY	LATE	EARLY		LATE		
					Perimenopause						
Duration of stage	Variable				Variable	1-3 years		2 years (1+1)		3-6 years	Remaining lifespan
PRINCLIPAL CRITERIA											
Menstrual cycle	Variable to regular	Regular	Regular	Subtle changes in flow length	Variable length Persistent ≥7-day difference in length of consecutive cycles	Interval of amenorrhea of ≥60 days					
SUPPORTIVE CRITERIA											
Endocrine FSH AMH Inhibin B			Low Low -	Variable* Low Low	↑ Variable* Low Low	↑ >25IU/L** Low Low	↑ Variable Low Low	Stabilizes Very Low Very Low			
Antral Follicle Count			Low	Low	Low	Low	Very Low	Very Low			
DESCRIPTIVE CHAR	ACTERISTICS										
Symptoms						Vasomotor symptoms Likely		Vasomotor symptoms Most Likely			Increasing symptoms of urogenital atrophy

FSH- follicle stimulating hormone AMH- anti-müllerian hormone *Blood draw on cycle days 2-5 ↑= elevated **Approximate expected level based on assays using international pituitary standards
References: 1. Harlow SD, Gass M, Hall JE, et al. Executive summary of the Stages of Reproductive Aging Workshop + 10: addressing the unfinished agenda of staging reproductive aging. Menopause, 2012;19(4):347-395.

