Hormonal Intervention for the Prevention of Chuppat Niddah

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Although the Rambam (Hilchot Ishut 10:6) indicates that a wedding that takes place when the wife is *niddah* is not valid, this is not the accepted opinion in halacha (Shulchan Aruch E.H. 61:2) Nevertheless, having a wedding when the wife is *niddah* is something that most couples try to avoid as 1) it requires minor changes in the ceremony that indicate that the wife is *niddah*[1] 2) physical contact is forbidden at this point and 3) the couple will not be allowed to be alone unchaperoned until such time as the wife immerses in the mikveh. In recent years, medical intervention has been used to prevent this phenomenon. It can be used either to change the date of menses ifthe wedding inadvertently comes out at the wrong time of the month or it can be used to prevent changes in the cycle. The second use, or relying on hormonal manipulation and thus not scheduling the date according to the natural menstrual cycle is becoming more and more common[2]. The wisdom of this phenomenon needs to be carefully examined.

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Medical Background

Menstruation is due to an orderly buildup of the uterine lining orchestrated by hormones from the pituitary gland. At first, a hormone known as FSH (follicule stimulating hormone) stimulates the ovaries to build follicles containing ova (eggs). Later in the cycle (about day 14 in a classic 28 day cycle but it can vary markedly between women) a surge in a second hormone LH (lutenizing hormone) causes the egg of one of these follicles to burst out of the ovary in a process known as ovulation. The egg is swept up by the fallopian tubes and makes its way over a number of days to the uterus. In the meantime, the cells surrounding this follicle (now known as the corpus luteum or yellow body) secrete progesterone. This leads to a buildup of the uterine lining in anticipation of the implantation of a pregnancy. In the absence of fertilization, after approximately 14 days the ovarian lining is shed. This shedding is known as menstruation. This natural process can be overridden by external hormones. This type of manipulation is what is done when pills are given to prevent *chuppat niddah.*

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Progesterone only

The common drugs used are norethisterone acetate (Primolut-Nor) or medroxy-progesterone acetate (Aragest, Provera). As progesterone helps maintain the uterine lining, giving external

1. While efforts are made to keep this as private as possible with the minimum of people knowing, it still can be somewhat embarrassing to the bride and groom.
2. In a recent book on hilchot niddah [Shaare Orah by Rav Sholomo Levi], it stated that since most women today use the pill to regulate their cycle prior to the wedding, there was no longer the need to plan the wedding date around the brides menstrual cycle.

progesterone starting at least 5 days prior to the anticipated date of the next period will most likely succeed in delaying the onset of menses. Thus, if the woman has a fairly predictable menstrual period and what is needed is to just push off the menses by a few days progesterone only may be used. After the first episode of intercourse, the hormone is stopped leading to a withdrawal bleeding after about 2-4 days. This bleeding is likely to be heavier than usual. In the absence of pregnancy, the uterine lining is meant to shed; thus with prolonged used of progesterone (more than about 10 days) there is likely to be breakthrough bleeding. An alternate approach when longer delaying of the cycle is needed and it is a few months prior to the wedding is to gradually delay menses over a number of cycles.

Combination pills

The combination pills were designed primarily for use as contraceptives. By exposure to an artificially high level of estrogen, the pituitary is fooled into thinking that the woman is pregnant and the FSH remains low. There is thus no ovulation and pregnancy cannot result. The progesterone in the pill leads to some build up of the uterine lining (although often less than in a natural cycle). When the pills are stopped, the uterine lining is shed in what is known as withdrawal bleeding. This generally occurs 2-4 days after taking the last pill.

The difference between the pills is slightly different formulations both in the type of estrogen or progesterone and in the quantity of each. Combination pills are generally categorized by the amount of estrogen they contain. Those containing 15 mcg (such as Minesse) are known as very low dose, 20 mcg (Feminet, Harmonet, Mercilon), as low dose, 30 mcg (Gynera,Microdiol), Microgynon, Minulet, Nordette, Yasmin) as medium dose (Ortho-cyclen has 35 mcg) and 50 mg as high dose (This is no longer available in Israel). The lower the estrogen, the more likely the breakthrough bleeding. This is an important point: when chosen for contraception (longer term use) the medical tendency is to choose the lowest dose estrogen possible in the hopes of having the fewest side effects. When being used for preventing *chuppat niddah* (short term use without too many cycles to make adjustments) a medium dose should probably be the place to start.

As the combination pills completely override the natural cycle, one can completely change the time that a woman is going to be *niddah*. One way to use this to prevent *chuppat niddah* is for a woman to remain on this pill until after *beilat mitzvah* (first intercourse). She then stops taking the pill and has a withdrawal bleed within 2-4 days. If the pill is started a few months prior to the wedding this can also be used to change the time that she expects her period.

Considerations in the decision to medically intervene to prevent *chuppat niddah*

When the wedding date has already been set at what will clearly be the wrong time of the month, or a woman's cycle has changed and now will clearly have a *chuppat niddah*, there is little debate about the use of hormonal intervention to prevent this if possible. There is a growing trend, however, to encourage question the prophylactic use of hormones for women with regular cycles or not to take the natural cycle into account when setting the wedding date. In these cases, a number of points should be taken into consideration.

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1. Risk of the pill

An underlying medical principle is "first of all do not harm." In the use of any medication, there is always the possibility of unwanted side effects. For oral contraceptives, there are a number of severe possible

complications such as heart attack,[3] stroke[4] and pulmonary embolism[5]. While these are rare, they do happen. These complications are less common when progesterone alone is used but still can happen. When discussing the use of hormones as a contraceptive method, it is generally pointed out that these are side effects of pregnancy as well and in fact the incidence during pregnancy is greater than that from hormonal contraceptive usage. However, we are talking about a bride who is not planning to prevent pregnancy at this point and thus this is not a justification. If this particular bride is the one case, we have created an unnecessary tragedy.

Many women have less serious but nonetheless unpleasant reactions, nausea, vomiting, emotional changes such as irritability or depression and weight gain. The last two in particular may be just what a woman does not want right before her wedding. The woman for whom the possibility of not using hormones exists should be fully aware of these possibilities as she makes an informed choice as to what to do.

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A particular point should be kept in mind for women getting remarried. Estrogen is known to decrease libido and lead to dry vaginal lining that can make intercourse uncomfortable. While a woman who is getting married for the first time may not realize this, women with previous marital experience may be acutely aware of the difference and should be counseled about this effect as well.

2. Efficacy in preventing *chuppat niddah*

In making the decision to use hormonal manipulation of the menstrual cycle, it should be remembered that breakthrough bleeding occurs 10-30% the time. This more likely the first cycle or two that the pill is used but can persist longer.

3. Time left until the wedding

It is very important to remember that individual women may react differently than expected. Thus the fact that a particular pill is reported to cause minimal breakthrough bleeding, it still may do so for an individual woman. Sometimes, changing the brand (and thus composition) will solve the problem. Sometimes, trials of a number of different formulations are needed. There is no way to know what will happen before one tries. Thus it is often best to stick to the natural cycle when ever possible.

When should the decision be made?

A physician should be approached for advice as soon as possible after engagement. A complete history should be taken to assure that there are no historical factors (previous history of blood clots, current liver disease for example) that contraindicate the use of estrogen or progesterone. It is also important to observe the body habitus of the woman as heavy women have a higher incidence of breakthrough bleeding (due to the natural estrogen secreted by fat cells) and this may influence the pill chosen. Furthermore, questions should be asked if in the past stressful events (trips etc) have caused changes in her cycle. A baseline blood pressure should be taken as hypertension is a relative contraindication for oral contraceptive pill (OCP) use. This should be repeated after a month of use to see if the OCP cause a significant BP elevation which might put her at greater risk of complications.

3. Twice the risk of non-users.
   Khader YS Riic J John L Abueiit O. Oral contraceptives use and the risk of myocardial infarction: a meta-analysis. Contraception 2003 Jul;68(1):11-17.
4. Two-five times the incidence of non users.
   Tanis BC Rosendall FR. Venous and arterial thrombosis during oral contraceptive use: risks and risk factors. Semin Vasc Med 2003 Feb;3(1):69-84.
   The risk for a 20 year old woman who suffers from migraines is 10/100,000 and for one who is 40 it is 100/100,000
   The Contraception Report Volume 14 No 1 June 2003 p 9
5. The risk is 1.72/100,000.
   Hedenmlm K Samuelson D Spigset O. Pulmonary embolism associated with combined oral contraceptives: reporting incidences and potential risk factors for a fatal outcome. Acta Obstet Gynecol Scand 2004 Jun;83(6):576-85.

As breakthrough bleeding is a common occurrence, especially with the first cycle of use, it is best to start at least 3 months in advance to allow the body to adjust to the new hormonal milieu and allow for changes the next cycle in case the problem does not resolve. The fact that we do not know how a particular woman will react to the pill is yet another reason, when hormonal manipulation is chosen, it is so important to start the process EARLY to allow time for manipulation if needed.

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Summary of recommendations:

A woman with a predictable cycle who can schedule her wedding on about the third week of the cycle (late enough to assure that she will be able to finish the required seven "clean" days but prior to the earliest days that she generally sees her period) is best off NOT using hormones to change anything. If there is a change in her regular cycle then she should reconsult the physician to see if hormones may be needed at that point to delay a period at an unexpected time. Setting the wedding date based on the natural cycle without the need for medicinal intervention should be encouraged as much as possible.

A woman with a menstrual cycle that can vary as much as week may need OCP to help assure that she does not have a *chuppat niddah*. In this case, the intervention should be started at least 3 months in advance to allow the body to adjust to the hormones being given and for changes in formulation if needed.

If a woman consults the physician after the date has been set, and it turns out that the date will most likely be a *chuppat niddah*, or for whom there are other reasons the wedding has to be scheduled for an inappropriate time, she should be given OCP to prevent *chuppat niddah* unless clearly contraindicated. The further in advance that the therapy can be started the better, to allow for gradual rather than sudden changes.