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# Response to Eglash re: "The Risk of Breakthrough Bleeding Justifies the Use of Combined Hormonal Contraception Over Progesterone-Only Pills While Breastfeeding": Combined Hormonal Contraception Is Not Without Disadvantages, But Is Acceptable During Lactation

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THANK YOU FOR THE OPPORTUNITY to respond to the concerns raised by the honorable Dr. Anne Eglash in her correspondence titled: "Combined Hormonal Contraception During Lactation Is Not Without Risk and Requires Shared Decision Making."[1] The correspondence is authored in response to our recent perspective titled: "The Risk of Breakthrough Bleeding Justifies the Use of Combined Hormonal Contraception Over Progesterone-Only Pills While Breastfeeding,"[2] in which we report that physicians are divided in their opinion of whether or not to prescribe combined hormonal oral contraception (CHC) in case of a nursing mother, 3 months postpartum, suffering from breakthrough bleeding (BTB) associated with progesterone only pills (POPs). Here, we respectfully provide a point-by-point response to these concerns.

First, as a potential limitation to our perspective, Eglash states that there is no evidence that POP is associated with BTB during lactation. We respectfully disagree and kindly refer the reader to a number of publications,[3,4] as well as the textbook of Fritz and Speroff that notes the following side effect of POPs (p.1039): "It is not surprising that irregular menstrual bleeding is the major clinical problem…. This is a major reason why women discontinue the minipill method of contraception."[5] Likewise, our studies show that BTB is associated with POP, and is reduced by adding norethisterone.[6] Regardless of lactation, these data provide ample evidence of POP association with BTB.

Second, as another potential limitation, Eglash states that the L2 lactation risk category of CHC is an evidence of impact on lactation. We do not claim that CHC is always compatible for nursing mothers, as defined by the L2 category. However, L2 also categorizes the drug as probably compatible for use by breastfeeding mothers, and the risk of impact on lactation as remote.

Third, as a potential limitation, Eglash correctly states that there is insufficient evidence that CHC is safe for nursing women at high risk, and we agree that risk factors such as a predisposition for thrombosis, cardiovascular disease, smoking, rheumatic diseases, migraines with aura, prolonged immobility, active liver disease, active cancer, and advanced age are important contraindications, as detailed online at (www.cdc.gov/reproductivehealth/contraception/mmwr/mec/appendixd.html).

Fourth, as another potential limitation, Eglash states that her personal experience suggests that CHC reduces milk production, in agreement with half of the respondents in our survey.[2] Our experience shows that this is not the case, in agreement with the other half of our respondents. To settle this difference in opinion, we are currently conducting clinical trials that measure the effect of CHC and POPs on milk production, and that evaluate their potential transfer to breast milk.

Finally, as a potential limitation, Eglash correctly states that the final decision should rest in the hands of the patient, and we fully agree that mothers have the final say, after being presented with all relevant information.

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