

Hormonal Intervention for the Prevention of Chupat Niddah

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Chupat niddah, a wedding that occurs while the bride is in niddah, is a situation couples generally wish to avoid as it significantly impacts the wedding and early married life. Initially, a chupat niddah requires minor changes in the ceremony that may reveal the couple's status to careful observers.¹ However, more importantly, physical contact is forbidden, and the couple is prohibited from being alone unchaperoned for as long as the wife remains a niddah. While the Rambam (Hilchot Ishut 10:6) even goes as far as indicating that a chupat niddah invalidates the wedding, this is not the accepted opinion in halacha (Shulchan Aruch EH 61:2). Traditionally, chupat niddah was avoided by scheduling the wedding at the appropriate time in a woman's cycle.

Medical advances of the past few decades offer the ability to use hormonal medication to prevent chupat niddah. There are times when such intervention is clearly needed, such as when the date of menses comes when the pre-selected wedding date falls at a time when the bride is like to be a niddah or when the wedding must take place during a specific time such as school vacation. However, many brides have begun to believe that all women use such intervention. This is based on a prevalent belief that stress can lead to changes in the cycle so hormones should be used "just in case". This is a problematic situation as intervention may, at times, not be needed, and the decision to intervene hormonally needs careful balancing of risks and benefits. The goal of this paper is to review what intervention is possible and what are potential side effects so that an informed decision can be made in each individual case.

Medical Background

Menstruation results from an orderly buildup of the uterine lining orchestrated by a combination of hormones from the pituitary gland in the brain and the ovaries. At the beginning of the menstrual cycle, the pituitary secretes FSH (follicle stimulating hormone), which in turn stimulates the ovaries to select and grow a follicle, which contains an ovum (egg). Estrogen produced by the growing follicle signals the lining of the uterus to start developing in preparation for possible implantation later in the cycle. Around the midcycle, (typically day 14 in a classic 28 day cycle) the pituitary sends out a LH (luteinizing hormone) surge, which both matures the egg for fertilization and triggers the release of the egg from the ovary in a process called ovulation. The egg is then swept up by the fallopian tubes, where fertilization occurs if viable sperm is present. The egg (or if fertilized, the embryo) makes its way to the uterus over the course of 3-5 days. In the meantime, the follicle (now known as the corpus luteum or yellow body) switches from estrogen to progesterone production. This supports the uterine lining by increasing special blood vessels in the uterus called spiral arteries. In the absence of implantation, the corpus luteum will stop producing

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.

progesterone and the uterine lining will break down. The subsequent shedding is known as menstruation.

Exogenous (external, generally artificially produced) hormones can be used to alter the natural cycle in predictable ways, making them a useful tool in preventing a chupat niddah. There are two categories of hormonal formulations available on the market for this purpose. These methods either contain only progesterone or a combination of estrogen and progesterone. There are advantages and disadvantages to each type as will be described in the coming sections.

Progesterone only

Initiating a progesterone only medication in the second half of the menstrual cycle, approximately 5-7 days prior to the expected next period, prolongs the progesterone support of the uterine lining and prevents shedding. Common classes of progesterone-only formulations are the norethindrone (also known as norethistrone) class, which includes the acetate subgroup, most notably norethindrone acetate (Aygestin or Primolut-Nor), which is frequently used to delay the onset of menstruation prior to a wedding. This same formulation is used at a much lower dose and in a different manner as contraception in the "minipill", a form of hormonal birth control used when one wants to avoid estrogen use. There is a second class of progesterones which includes medroxyprogesterone acetate (most commonly used in pill form as Provera or Aragest). This is less commonly used for cycle regulation. Additional progesterone only medications exist, but they are generally not used for preventing chupat niddah.

In the case of a bride with a predictable cycle whose wedding may fall out close to her expected period, she can start one of these medications a week or so prior to the expected period and continue until after the first episode of intercourse. At that point she can stop the medication and within in 2-4 days she will experience a "withdrawal bleed," shedding of the uterine lining with the loss of progesterone as one would with a natural cycle. This method is most useful if the cycle needs to be delayed by less than a week. Longer delay is possible with this method but may be susceptible to breakthrough bleeding. If a longer delay is necessary, it can be accomplished with gradually delaying the onset of bleeding over the course of several cycles rather than just the cycle immediately prior to the wedding.

Progesterone only methods are usually well tolerated but may have some side effects such as drowsiness, bloating, and constipation. These are typically minor and will resolve once the medication is stopped. Occasionally, the withdrawal bleed following the use of these medication may be heavier than a typical period. The bride's cycles will resume as normal from the date of her withdrawal bleed (ie; if she has 28 day cycles, she can expect her next period 28 days from the onset of the withdrawal bleeding).

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² A case series related to successful use of norethindrone to prevent chupat niddah is published yutorah.org. [[download.yutorah.org/2009/1053/733773.pdf](https://www.yutorah.org/2009/1053/733773.pdf)] However, it should be noted that the dosage and dosing described is not the only possible approach..

It should be noted that many progesterone only methods are also forms of contraception. However, use of progestins for delaying menses as we describe here would not be an adequate form of contraception and should not be viewed as such.

Estrogen and Progesterone Combination Methods

The combination of exogenous estrogen and progesterone has been utilized as an effective form of birth control for the past 50 years. Most commonly used in pill form, the Oral Contraceptive Pill (OCP) is one of the most widely used birth control method worldwide. However estrogen and progesterone combination methods are now found in other formulations, such as vaginal rings and patches. The steady level of estrogen and progesterone suppress the pituitary and prevent the initiation of the menstrual cycle and subsequent ovulation and pregnancy. The estrogen stimulates a mild thickening of the uterine lining and when the active form of the method is stopped (either at the end of active pills or when the patch/ring is removed), the drop in progesterone causes a withdrawal bleed.

Different oral contraceptive pills (OCP) vary by 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 10-15 mcg (such as Lo-loestrin, Lo-Minastrin, Minesse) are known as very low dose, 20 mcg (Loestrin, Menastrin, Junel, Yaz, Feminet, Harmonet, Mercilon), as low dose, 30 mcg (Apri, LoOvral, Gynera, Microdiol, Microgynon, Minulet, Nordette, Yasmin) as medium dose. Some formulations have higher levels (Ortho-cyclen, Ortho-Novum, Sprintec all have 35 mcg) but older formulations with high doses of estrogen (50 mcg) are no longer recommended.

The risks associated with combination methods are often attributed to the dose of estrogen. Therefore, physicians may prefer to prescribe lower estrogen formulations. However, the higher the estrogen dose the less likely the woman will experience breakthrough bleeding. When attempting to prevent a *chupat niddah* a formulation with medium dose of estrogen is typically preferable. Most physicians would have few safety concerns for young otherwise healthy women, especially in the short term.

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 *chupat niddah* is for a woman to remain on this pill until after *beilat mitzvah*. 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 *chupat niddah*.

When the wedding date has already been set or a woman's cycle has changed and she will clearly have a *chupat niddah*, there is little debate about the use of hormonal. When deciding about the prophylactic use of hormones for women with regular cycles or planning the wedding date without taking the natural cycle into account, one should take the following considerations.

1. Risk of hormonal intervention

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. Women on hormonal contraceptives are at risk for several severe, albeit rare (about 2 per 100,000³), complications such as stroke and pulmonary embolism.⁴ Complications are less common with progesterone only methods, but can still happen. These hormonal methods remain a popular form of contraception because, in fact, the risk of these complications is even higher in pregnancy. However, accepting even a small risk of severe complications for convenience rather than pregnancy prevention is more difficult to justify.

Many women have less serious side effects, nausea, vomiting, emotional changes such as irritability or depression⁵ and weight gain. Oral contraceptives may also decrease sexual desire⁶ and enjoyment for some women.⁷ These may not be life threatening but are unpleasant nonetheless. Weight gain and emotional changes may be particularly troublesome for a woman right before her wedding. Women who have the option of scheduling their wedding without relying on hormonal intervention should weigh the risks and benefits in order to make a fully informed decision.

2. Efficacy in preventing chupat niddah

In general, hormonal interventions are successful in altering a woman’s cycle to prevent a chupat niddah. However, one should remember that breakthrough bleeding occurs at rates ranging from 10-30% of women using medium dose oral contraceptives (those containing 30-35mcg of estrogen⁸ For formulations containing 10-20mcg, the rate of breakthrough bleeding is even higher.⁹ ¹⁰Breakthrough bleeding typically occurs in the first cycle or two and can be worse when doses are not taken consistently.

3. Time left until the wedding

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As breakthrough bleeding is a common occurrence for combination hormonal contraception, 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. One must remember that individual women may respond differently to any particular intervention. Sometimes, trials of a number of different hormonal formulations are needed to achieve the best result (minimal breakthrough bleeding and minimal side effects). Therefore, if there is only a short time from the time the question is asked until the wedding, the risks of bleeding from the first cycles of using hormones may be greater than the risk of the cycle changing. In these cases, a predictable natural cycle may be more reliable for some women than hormonal intervention.

When should the decision be made to use?

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 make the use of estrogen or progesterone too risky. Body weight is also important, 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, in deciding if intervention is needed at all, the kallah should report 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 OCP use. This should be repeated after a month of use to see if the OCP cause a significant blood pressure elevation which might put her at greater risk of complications.

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.

Summary of author's 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 *shivah nekiim* 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 cycle, she should re-consult the physician as hormones may be used at that point, if needed. It is this author's opinion, that 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 prevent chupat niddah. In this case, the intervention should be started at least three 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 chupat 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 chupat niddah unless clearly contraindicated. The further in advance that the therapy can be started the better to allow for gradual rather than sudden changes.

