Modern contraception began in the 1960s with the introduction of combined oestrogen and progestogen (COC) pills and intrauterine devices made of thermoplastic. By the end of that decade, it became apparent that COCs containing over 50 µg of mestranol or ethinyl-estradiol carried a risk of producing venous thrombosis and thromboembolism. In the following years, the role of the 19-nor-testosterone-derived progestins in the production of arteriovascular problems in COC users became apparent; this was particularly true of women who were older, smoked and were predisposed to cardiovascular disease, and was assumed to be due to the relative androgenicity of the first- and second-generation estrane and gonane progestins and their impact on lipids and other metabolic parameters.

The third- and fourth-generation progestins were anti-androgenic and it was hoped that they would produce less arteriovascular impact; unfortunately, they produced venous thromboembolism (VTE) at a rate marginally higher than that associated with the second-generation progestins. Newer preparations have emerged which contain natural estradiol (E₂) and nor-progesterones. The cardiovascular impact of these preparations is not yet fully quantified. However, it is the development of the most recently discovered estrogen, estetrol (E₃) and nor-progesterones. The cardiovascular impact of these preparations is not yet fully quantified. However, it is the development of the most recently discovered estrogen, estetrol (E₃) and nor-progesterones.

A possible new dawn for contraception

Dr. D. Goldstock
Department of Obstetrics and Gynaecology, Faculty of Medicine and Health Sciences, University of Stellenbosch, Cape Town, South Africa


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