Hormonal Intervention for the Prevention of Chupat Niddah

By: DEENA R. ZIMMERMAN

Introduction

Chupat niddah, a wedding that occurs while the bride is a *niddah,* is a situation that couples generally wish to avoid due to its impact on the beginning of married life. First, *chupat niddah* requires minor changes in the ceremony that may reveal the couple's status to careful observers.[1] More importantly, however, physical contact is forbidden, and the couple is prohibited from being alone unchaperoned for as long as the wife remains a *niddah*. While Rambam (*Hilchot Ishut* 10:6) goes so far as to indicate that a *chupat niddah* invalidates the wedding, this is not the accepted opinion in Halachah (*Shulchan Aruch, Even HaEzer* 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 pre-selected wedding date falls at a time when the bride is likely to be a *niddah* or when the wedding must take place during a specific time such as school vacation. Many brides, however, 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 and therefore 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 bal-

[1] While efforts are made to keep this as private as possible—with only a minimum of people knowing—it can still be embarrassing to the bride and groom.

Deena R. Zimmerman, MD MPH IBCLC, is a pediatrician with a lifelong love of Judaic Studies. One of the first graduates of Nishmat's Keren Ariel Program as a Yoetzet Halachah, she has authored *A Lifetime Companion to the Laws of Jewish Family Life* and *Mi Dor L'Dor: Genetics and Genetic Diseases: Jewish Legal and Ethical Perspectives,* and numerous articles related to women's health issues and *halachah*. She is the director of Nishmat Women's Health and Halacha website www.yoatzot.org and co-author of Nishmat's on-line interactive textbooks—the *Kallah Companion* and the *Marriage Companion*.

ancing of risks and benefits. The goal of this paper is to review what intervention is possible and the potential side effects so that an informed decision can be made in each 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 RSH (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 mid-cycle (typically day 14 in a classic 28-day cycle), the pituitary sends out an 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 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 formations available on the market for this purpose: 1) progesterone-only, and 2) a combination of estrogen and progesterone. There are advantages and disadvantages to each type as will be described in the coming sections.

Progestins

Artificial progesterones are known as progestins. Initiating a progestin in the second half of the menstrual cycle prolongs the progesterone support of the uterine lining and prevents shedding. The most commonly used progestin for this indication is known as norethindrone or norethisterone acetate (common brand names are Primolut N and Aygestin). This same formulation is used at a much lower dose and in a different manner as contraception in the "mini-pill," a form of hormonal birth