Contraception Dilemmas

Lecture Handout

NEGs Conference

Nov 20th 2010

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General contraception guidance

CEU Guidance - Quick Starting Contraception	September 2010
The UK Medical Eligibility Criteria for Contraceptive Use - November 2009	pdf updated May 2010
The UK Medical Eligibility Criteria for Contraceptive Use - Summary Sheets	pdf updated May 2010
Management of Unscheduled Bleeding in Women Using Hormonal Contraception	May 2009
UK Selected Practice Recommendations for Contraceptive Use (2002)	2002

Method specific guidance

CEU advice - Yasmin® and VTE	April 2010
Progestogen-only Pills	Updated June 2009
Progestogen-only Injectable Contraception	Updated June 2009
Recommendation from the CEU: Antibiotic prophylaxis for intrauterine contraceptive use in women at risk of bacterial endocarditis	July 2008
Progestogen-only Implants	April 2008
Intrauterine Contraception	November 2007
Female Barrier Methods	June 2007
Condoms - Male and Female	January 2007

WHO Medical Eligibility Criteria

1. unrestricted use
2. benefits outweigh risks
3. risks outweigh benefits
4. unacceptable health risk

Case 1

Rebecca, age 18, requests to start “the pill”. Smokes 10/day. BP 110/70. BMI 24

No personal /family history of VTE or migraine.

Wants a pill that will not make her put on weight.

What will you prescribe?

1. A 30ug EE pill with Lng (Ovranette)
2. A 20 ug EE pill with desogestrel
   (Mercilon)
3. A 30ug EE pill with drosperinone (Yasmin)
4. A 20ug EE pill with Lng (Microlite)

Background

- **A monophasic COC containing 30 μg EE with norethisterone or levonorgestrel is a suitable first pill.**
- **There is no current evidence to justify claimed benefits for newer more expensive pills especially for starters. They are also more oestrogenic and have higher VTE risk.**
- **No scientific evidence for causal relationship between OC use and weight gain.**

Follow up for COC & POP

- **Yearly visits for established users**
- **Update full history**
- **Check BP for COC**
- **Record BMI**

If Rebecca's BMI was 36 instead of 24,

what would you consider prescribing for her?

1. A 30ug EE pill with Lng (Ovranette,)
2. A 20ug EE pill with desogestrel (Mercilon)
3. The new Oestradiol Valerate + dionegest pill (Qlaira)
4. A “mini pill”

Background

- **BMI 30-34 – UKMEC Category 2 for COC**
- **BMI >35 – UKMEC Category 3 for COC**
- **? Cerazette preferred POP for younger women**

Cerazette

- POP, contains 75mcg Desogestrel
- Taken daily, no breaks.
- Much better ovulation inhibition.
- May be as effective as COC.
- Can be taken up to 12 hours late.
- Irregular bleeding common.
- Safe for smokers, obese, hypertension
- Ok with hx Ectopic
- Now the 2nd most prescribed OC in the UK.

Case 2

Monday morning surgery.
Vanessa is on Ovranette and comes for repeat script.
Her LMP was 6 days ago and she should have restarted her pill on saturday but had run out.
She had UPSI four days ago in the pill free interval.

(Summary: Missed Saturday and Sunday's pills)

What is your preferred choice?

1. **Offer her emergency contraception, restart the pill today and use extra precautions for 7/7?**

2. **Restart the pill today and not give emergency contraception as there is no risk?**

Answer

- **Best**

  Restart her pill today and not give EHC as there is no risk

- **?Acceptable (but overkill)**

  Offer her EHC, start the COC and use extra precautions for 7/7

Missed Pill Rules

30 mcg COC

- **Up to two – ok – take as soon as possible**
- **Three or more – EP 7/7 & run packs together**

20 mcg COC

- **Up to one – ok – take as soon as possible**
- **Two or more – EP 7/7 & run packs together**

CEU & FPA (04/05) WHO based

Minimising the Risk of Pregnancy

Extending the pill-free interval is risky, therefore:

If pills are missed in the first week of pill taking (pills 1-7)

EC should be considered if she had unprotected sex
in the pill-free interval
or
In the first week
of pill taking

If pills are missed in the second week of pill taking (pills 8-14)

NB. After seven consecutive pills have been taken Seven can be missed (as occurs in the pill free interval) without the need for EC

If pills are missed in the third week of pill taking (pills 15-21)

She should
OMIT THE PILL FREE INTERVAL
by finishing the pills
in her current pack
and starting
a new pack
the next day

Case 3

Mary takes Cerazette
She forgot Monday's pill.
She took her pill on Tuesday .
Condom broke on Wednesday at 8am.
Phones you on Thursday morning for advice.
Her period was 12 days ago.
(Summary: Missed one pill)

Would you:

1. Reassure her that she does not need to come in for EC for just one missed pill

2. Advise her she needs emergency contraception..

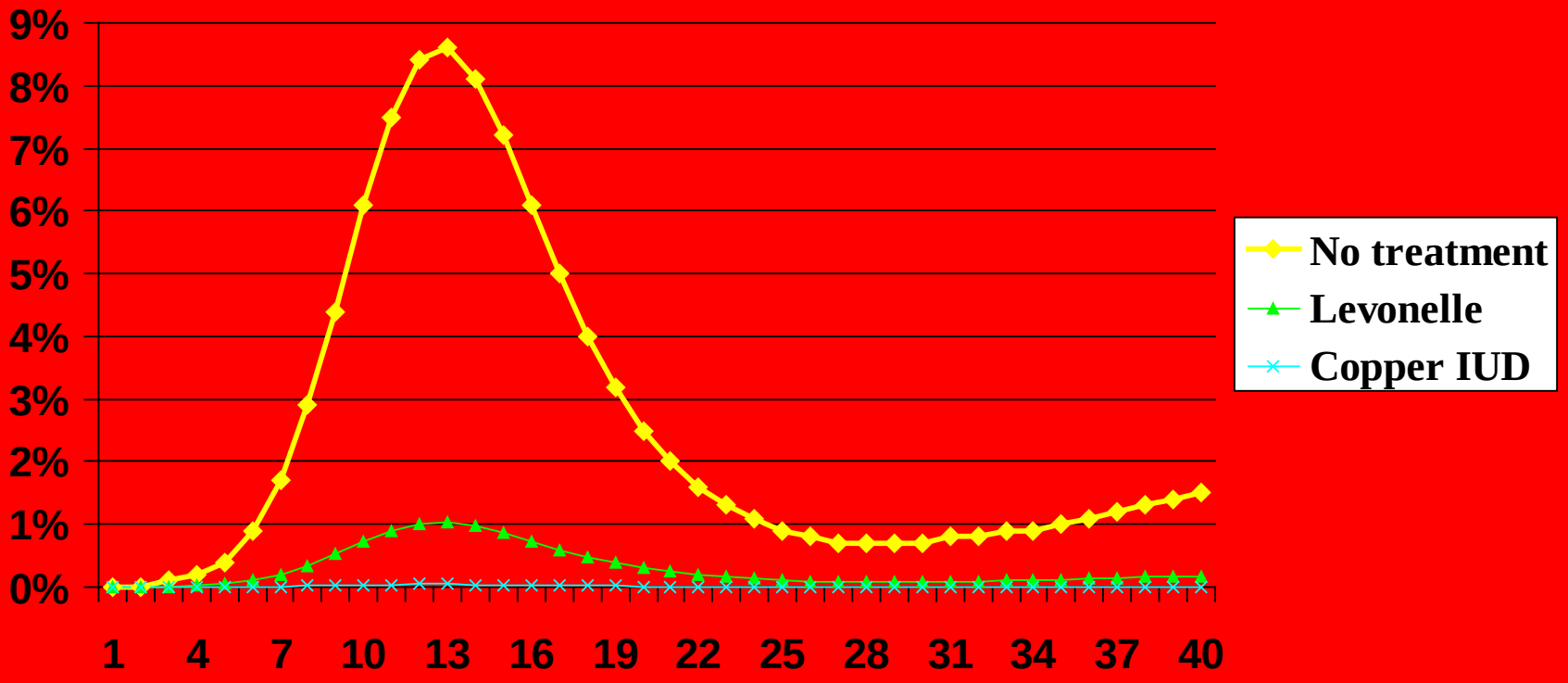
Answer

- **Best**
  Tell her she needs EC.

Missed pill rules –

POP

- **>3 hours late (12 hours for Cerazette)**
- **Extra precautions for 48 hours**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No treatment
Levonelle
Copper IUD

Case 5

Sheila 21, nulliparous, in two year relationship.
Condoms burst last night.
Her LMP was 15 days ago.
Her cycle 5/28.
Another condom might have burst on day 5 of the cycle.
(Summary: two episodes of UPSI on day 5 and day 14 of a 28 day cycle)

Which is your preferred choice?

1. **Suggest EC-IUD to cover both risks.**
2. **Say there is nothing you can do as there was a risk more than 5 days ago.**
3. **Offer levonelle.**

Answer

- **Best**
  Suggest EC-IUD to cover both risks

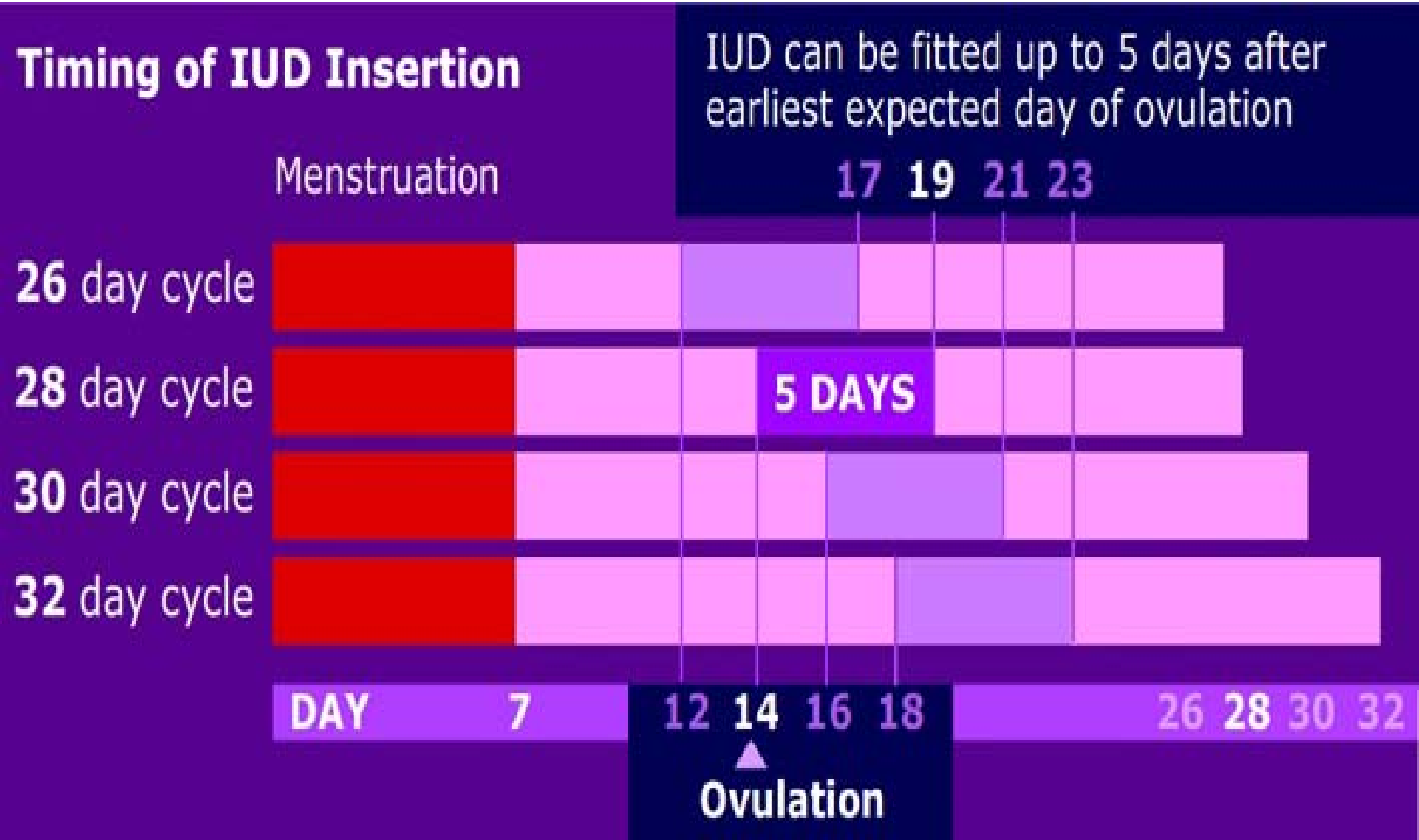
Background

- **EC IUD can be fitted up to 5 days after the earliest expected date of ovulation irrespective of time since last UPSI or number of episodes**

- **Nulliparity is not a contraindication to IUD**

CEU EC guidance IUD guidance

EC-IUD


Timing of IUD Insertion
IUD can be fitted up to 5 days after earliest expected day of ovulation
Menstruation
17 19 21 23
26 day cycle
28 day cycle
5 DAYS
30 day cycle
32 day cycle
DAY 7
12 14 16 18
26 28 30 32
Ovulation

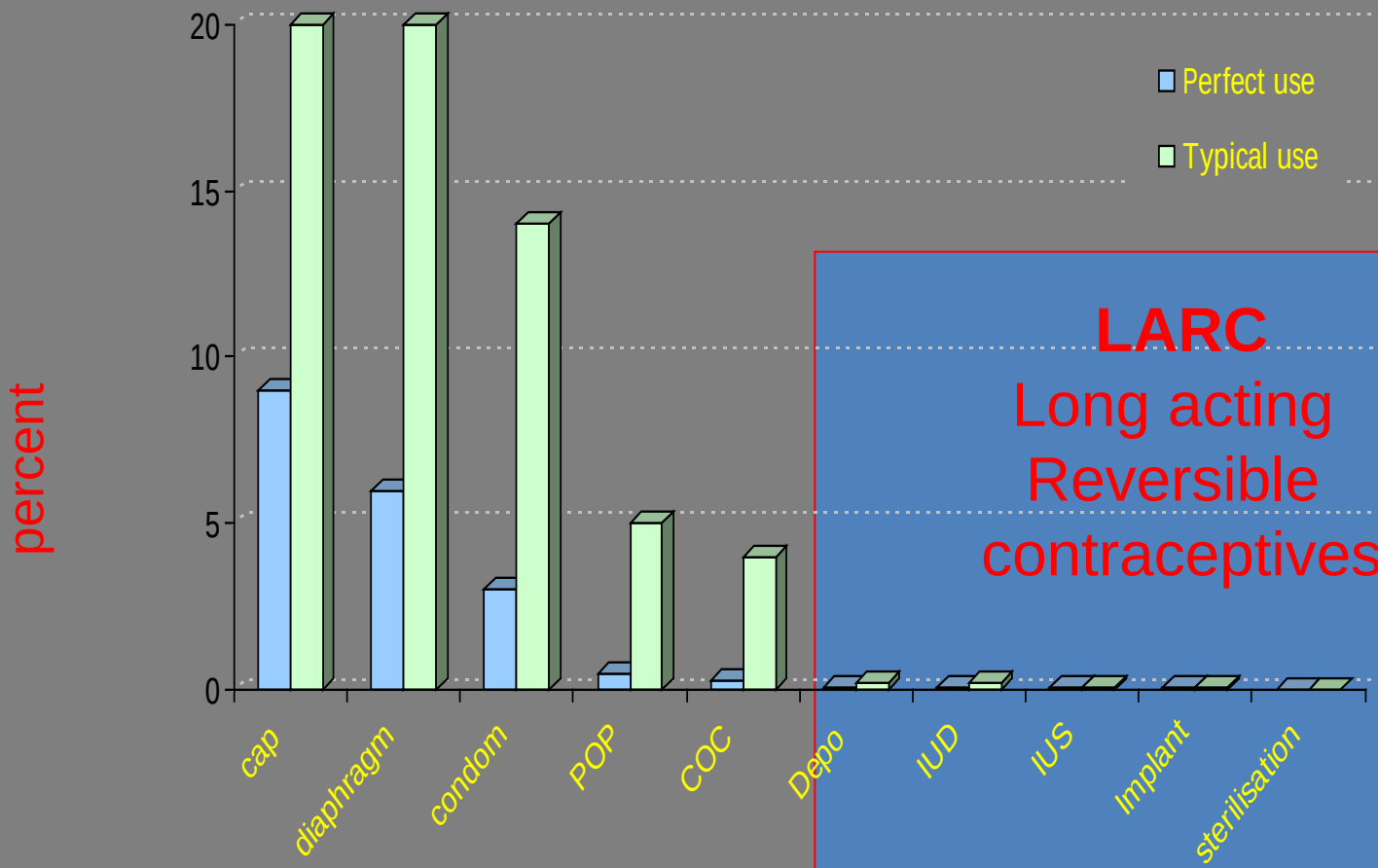
Myths concerning IUDs

- **IUDs cause pelvic infection - NO**
- **IUDs cause infertility - NO**
- **IUDs increase ectopic risk - NO**
- **IUDs unsuitable for Nullips - NO**
- **Must be “on period” to have IUD fitted - NO**

Chlamydia Testing

- **Do STI risk assessment**
- **CT test prior to IUD insertion.**
- **Consider prophylactic antibiotics if no result and high risk**

  CEU guidance
- **NAAT tests (nucleic acid amplification techniques)**
- **Test for gonorrhoea and chlamydia, on first pass urine or endocervical/urethral swab, stable for 30 days, kits from Virus Ref Lab, UCD.**



LARC

Long acting Reversible contraceptives

Trussell J. Contraceptive efficacy. In: Hatcher RA, Trussell J, Stewart R. Contraceptive Technology, ed 17. NY: Ardent Media, 1998;800-801

Case 7

Katie, 19 years old, subdermal implant (Implanon) inserted 4 months ago. Complains of erratic, frequent heavy bleeding as well as spotting PV and wonders if the

implant should be removed

as it clearly doesn't

suit her.

Your preferred choice:

1. Agree with her that the Implanon is not suiting her and arrange for removal.
2. Put her on the combined pill for a few months

Implanon bleeding problems

- **60% have irregular bleeding they can live with**
- **20% have Amenorrhoea by year one,**
- **20% have unacceptable bleeding**

Treatment options:

COC 3/12, mefanamic acid, POP

Backround

- A first-line COC may be Considered for up to 3 months either continuously or in the usual cyclical regimen (only in women who are eligible for COC – check UKMEC)
- No evidence that reducing injection interval for DMPA improves bleeding, however the injection can be given early.
- Mefenamic acid 500mg twice daily for 5 days can be tried to reduce length of bleeding episode on DMPA,but no likely benefit with long-term Use.
- Cerazette, Doxycycline and mifepristone may be beneficial for reducing bleeding on Implanon, but limited evidence available so far

CEU guidance 2009

icgp

Contraceptive method	Bleeding pattern in first 3 months	Bleeding pattern in the longer term
Injectable	Bleeding disturbances (spotting, light, heavy or prolonged bleeding) are common BUT up to 35% are amenorrhoeic at 3/12	Up to 70% are amenorrhoeic at 1 year
Implant	Bleeding disturbances in first 3-6/12 are common.	After 6 months use, 30% have infrequent bleeding; 10-20% have prolonged bleeding. NICE LARC Guideline suggests: 20% amenorrhoeic; 50% have infrequent, frequent or prolonged bleeding, which may not settle with time
Lng-IUS	Irregular, light or heavy bleeding is common in first 6 months	65% are amenorrhoeic or have light bleeding at 1year. 90% reduction of menstrual blood loss over first 12 months of use

Implanon NXT

“”

Spring loaded inserter
Radio opaque device

Case 4

Bernie, 31 ,Smokes 10/day.

2 children + 1 TOP.

On DMPA (Depo-Provera) three years. Amenorrhoeic.

Returns for her next injection, horrified as she muddled the dates. It is nearly 14 weeks since the last injection. Has had intercourse 2 days earlier.

Would you:

1. Tell her to stop DMPA and advise her to use Implanon instead as she is at risk of osteoporosis
3. Give her EC and the next injection of DMPA today.
4. Give her the next injection of DMPA today

Answer

- **Best**

  Give her the next injection today

Background

- **Repeat DMPA can be delayed up to 14 weeks without need for EC; UK license 12 wks+3 days, USA 14 weeks, UKMEC 2005 14 weeks**

Background

- Though there is evidence of bone mass reduction with long term DMPA use – no evidence that this is directly related to increased fracture risk. Full recovery of bone mass 1 year after stopping use.
- May be used first line in young people if other methods unsuitable or unacceptable
- Review risks/ benefits at 2 years
- Women with significant risk factors of osteoporosis should consider other methods
- No lab tests or imaging procedures required as a routine

CEU 2004

Case 6

Maureen, 24 years old, relying on condoms, day 14 of cycle, cycle 6/29, condom burst last night, requesting EC. History of epilepsy, takes carbamazepine.

What would you offer

her as EC?

What long term choices

does she have?

Enzyme Inducing Drugs

- **EIDs affect the efficacy of:**

  POP, COC, Implanon, Levonorgestrel

- **No reduction in efficacy of:**

  DMPA, Cu IUD, IUS

- **Remember to ask about St. John's Wort.**

Case 8

Mary, 50 years old. Had IUS (Mirena) inserted 5 years ago for heavy periods as well as contraception.

Amenorhoeic for past 3 years

Experiencing some hot

flushes.

Comes for IUS change.

Your preferred choice:

1. Change the IUS.
2. Leave the IUS in situ and arrange to review her after checking FSH levels
3. Remove the IUS and check FSH levels.

Background

Can leave IUS fitted in women aged 45 or over beyond licensed duration ? 7 years

Check 2 FSH levels 6 weeks apart. If both high menopause confirmed. If menopause confirmed after 50, leave in for further 12 months.

CEU guidance

When to stop?

Non Hormonal Contraception

- **Under 50, stop contraception after 2 years amenorrhoea.**
- **Over 50, stop contraception after 1 year amenorrhoea**

When to stop?

COC

- **If on COC stop at 50 and use non- hormonal method or POP, Implant, IUS**

When to stop?

Implant, POP, IUS

- **If amenorrhea, check FSH levels and if serum FSH is high on two occasions 6 weeks apart then stop method after 1 year if > 50.**

OR

- **Stop at age 55 years when natural loss of fertility can be assumed for most women.**

Ella-One

- **Emergency contraception in UK**
- **Not licensed in Ireland**
- **Ulipristal acetate**
- **Inhibits / delays ovulation (and changes to endometrium)**
- **Efficacy demonstrated till 120 hrs**
- **More effective than LNG**
- **Similar side effects to LNG – none serious**
- **20% get delayed period by up to one week**

Seasonelle

- **Will become available soon in the UK**
- **Three strips of Microgynon/Ovranette in one – new packaging**
- **Continuous pill taking over many cycles can be offered with all monophasic COcs**
- **?? Give cheapest option (outside licence prescribing)**

Qlaira

- Oestradiol Valerate / Dienogest
- Variation in dosage of each throughout the pack – 4 phases
- ?? “body friendly” oestrogen -will take a long time to prove this in studies.
- Contra-indications same as for any COC
- ?? Dienogest may provide better endometrial stabilisation and hence better bleeding patterns (compared to a 20ug standard pill)
- Warn re 20% absent withdrawel bleed

YAZ

- 20 microg EE + 3mg Drospirenone like Yasminelle
- 24 consecutive days on / 4 days off
- Bleed typically arrives as she restarts the next packet
- Different pill taking regimen should ↓ BTB
- Uses 4 placebos instead of asking patient to remember which day to restart

New delivery systems

EVRA Patch

- 20mcg EE/ 150mcg norelgestromin
- “Cilest via the skin”
- VTE risks same as Cilest (Jick SS 2006)
- Effectiveness same as COC
- Higher compliance in studies ? In real life
- Not affected by GI disturbances
- Possible less drug interactions (tetracyclines)
- Skin reactions, breast discomfort, nausea, dysmenorrhoea more common

NuvaRing

- 1 ring per cycle
- 3 weeks of ring use, 1 ring free week
- Ring delivers 15mcg EE and 120mcg etonogestrel
- Like “mercilon via vagina”
- Possibly better cycle control
- Refrigeration required – shelf life only four months after dispensing

Websites

- www.crisispregnancy.ie Think Contraception leaflet
- www.fsrh.org.uk for faculty guidance and UK MEC
- www.rcpg.org.uk evidence based college guidelines on male and female sterilisation, infertility and menorrhagia
- www.who.int WHO's eligibility criteria
- www.nice.org.uk LARC guideline
- www.fpa.org.uk patient information leaflets
- www.brook.org.uk Similar to FPA but for <25s
- www.ippf.org directory of hormonal contraception