GPECS Female Contraception guidelines

Methods of Contraception

- **Intrauterine Contraception (IUC)**
  - Copper-Bearing Intruterine Device (Cu-IUD)
  - Levonorgestrel Intrauterine System (LNG-IUS)
- **Progestogen-only Contraception (POC)**
  - Progestogen only implant
  - Progestogen only injectable
  - Progestogen only pill
- **Combined Hormonal Contraception (CHC)**
  - Combined oral contraception
  - Combined transdermal patches
  - Combined Vaginal rings
- **Emergency Contraception (EC)**
  - Copper-Bearing IUD
  - Oral EM
    - Oral Progesterone-Only
    - Ulipristal Acetate (UPA)

Intrauterine contraception devices, progestogen only implant and progestogen only injectable are also called: Long Acting Reversible Contraception (LARC)

Summary of key messages

This guideline should be read in conjunction with the Summaries of Product Characteristics: www.medicines.org.uk/emc/ , the BNF, the UK Medical Eligibility criteria for contraceptive use (UKMEC): https://www.fsrh.org/ukmec/ :

- Women requiring contraception should be given information about and offered a choice of all methods, including long-acting reversible contraception (LARC) methods.
- All currently available LARC methods (intrauterine devices, the intrauterine system, injectable contraceptives and implants) are more cost effective than the combined oral contraceptive pill even at 1 year of use. They are also the most reliable method of contraception and should be used **1st Line**
- IUDs, the IUS and implants are more cost effective than the injectable contraceptives
- Combined Oral Contraceptives: choose a preparation with the lowest oestrogen and progestogen content which gives the good cycle control and minimal side effects in the individual
- A traditional progesterone only pill (POP) is the recommended 1st line when a POP is chosen, unless compliance is known to be a problem.
- Emergency contraception: the copper coil is the most effective method, it should be offered to all women seeking emergency contraception.

- **History:** Take full clinical history (family, sexual, cervical smears, social, medications, previous contraception)
- **Check:** BP, Weight and BMI
- **Exclude:** STI, pregnancy if appropriate

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- Determine patient's preferences for contraception
- Exclude contraindications to chosen method using the UK Medical Eligibility Criteria (UKMEC 2016)
- Promote barrier methods in addition for protection against STI / Discuss Vasectomy as a potential method of contraception

Offer and discuss Long Acting Reversible Contraception (LARC) as 1st Line option → If LARCS declined contraindicated/ intolerance → Consider Combined Hormonal Contraceptives (CHC) → Contraindications or Intolerance to CHC → Progestogen Only Pill

Emergency Contraception (EC)https://www.fsrh.org/standards-and-

- **Within 72 hours of intercourse**
  - **Copper IUD:** Use first line due to low documented failure rate. Copper IUD is particularly useful if a woman intends to continue to use an IUD as long term contraception**. If IUD not available -**
  - **Levonorgestrel: 1.5mg tablet** taken as soon as possible after UPSI preferably within 12 hours but no later than after 72 hours, alternatively 3 mg for 1 dose, taken as soon as possible after UPSI, preferably within 12 hours but no later than after 72 hours,
  - **Higher dose (3mg)** should be considered for patients with body-weight over 70 kg or BMI over 26 kg/m2,or consider ulipristal
- **Within 120 hours of intercourse**
  - **If IUD not available - Ulipristal**: **ellaOne®30mg - 1 tablet** to be taken as soon as possible following UPSI, but no later than 120 hours unsuitable with enzyme inducing drugs, because they can reduce efficacy of hormonal contraception:

Long Acting Reversible Contraception

Copper-Bearing Intrauterine Device (Cu-IUD)
1st Line (10-year license): Copper T380 A®, T-Safe 380A QL or TT380 Slimline®
2nd Line (5-year license): Load 375, Ancora 375 Cu, Multi-Safe 375

Levonorgestrel Intrauterine System (LNG-IUS)
1st Line (5- year license): Mirena®. *May be preferred for women with menorrhagia as it is licensed for it*
2nd Line: Jaydess®**(3-year license)**

Progestogen only subdermal implants (Etonogestrel): Nexplanon® (3 year License)

Progestogen Only Injections (Medroxyprogesterone):
1st Line (10-year license): Depo-Provera®150mg (12 Weekly intramuscular injection)
2nd Line (5-year license): Sayana Press® (12 Weekly Subcutaneous Injection)
Associated with small loss of BMD, which is usually recovered after discontinuation
risks and benefits should be re-assessed every 2 years.

Combined Hormonal Contraception (COC)

Oral COC

1ST Line: ***Monophasic Standard Strength Preparations****: 30-35 mcg Ethinylestradiol (EE)*
Preferred brands:
- **Rigevidon® (30mcg EE/ 150mcg LVN)**
- **Cilique® (3mcg EE/ 150mcg Norgest)**

If progestogen related side effects (acne, headache, depression, breast symptoms, breakthrough bleeding)

- **2nd Line:** *Monophasic Standard Strength Preparations: 30-35 mcg Ethinylestradiol (EE) with 3rd generation progesterone*
- **Millinette30® (30mcg EE/ 75mg Gest)**
- **Gedarel® (30mcg EE/500mcg Desoges)**

Risk of blood clots with low dose cocs is small. Lowest risk those containing Levonorgestrel, Norethisterone , Norgestimate

Women with risk factors for circulatory disease

1ST Line: ***Monophasic low Strength Preparations****: 20 mcg Ethinylestradiol (EE)*
Preferred brands:
- **Millinete 20 (20mg EE /75mcg Gestodene)**
- **Gedarel 20® (20mcg EE/ 150mcg Desog)**

If indication of relative oestrogen excess: Nausea, bloating, some cases of breast tenderness, vaginal discharge without infection, fluid retention

2nd Line: *Monophasic Low Strength Preparations: 20 mcg Ethinylestradiol (EE) with 3rd generation progestogens: Gestodene, Norgestimate*
Preferred brands:
- **Gedarel 20® (20mcg EE/ 150mcg Desog)**
- **Millinette 20® (EE 20 mcg/Gestodene 75mcg)**

If severe acne unresponsive to topical therapy and oral antibiotics

Co-Cyprindiol 2000/35 tabs
Not licensed solely for contraception.
Higher VTE risk:
Discontinue 3-4 cycles after acne has resolved. Continuation of treatment with co-cyprindiol should be under a specialist.

(EE with Drospirenone)
Only if combination deemed necessary- not first choice
Lucette®
Dretine/Yacella/Yiznell
No conclusive evidence of superiority or reduced side effects over other COC

Consider alternative method first - If coc still reqd – Norinyl (mestranol 50mcg/ Norethisterone 1m will be required
Rifampicin/ Rifabutin no COC

Annual Review- medical Hx. FHx, Sexual Hx, Bp and Weight

Non- Oral COC

Useful to consider only if compliance issues with oral CHC and LARC unsuitable

Combined Transdermal patch: Evra® Patches
One patch applied on day 1, changed on day 8 and 15 then 7-day- patch free period

Combined Vaginal Ring: Nuvaring®
1 ring inserted on day 1 of cycle and left in for 3 weeks, followed by 7-day ring free

Progestogen Only Oral Contraceptives

Suitable for older women, heavy smokers, and for those with hypertension, valvular heart disease, diabetes and migraine

1st Line:Cerelle® Desogestrel 75mcg
12 hrs missed pill window, should be used if compliance is likely to be a problem
2nd Line: Norethisterone 350 mcg
Prescribe **Noriday®** 3 hrs missed pill window
Wt>70kg use double dose

Missed Combined Oral Contraception pills

If **ONE** pill has been missed (48 – 72 hours since last pill in current packet or 24- 48 hours late starting first pill in new pack)

Continuing contraceptive cover
- The missed pill should be taken as soon as it is remembered
- The remaining pills should be continued at the usual time

Minimising the risk of pregnancy
Emergency contraception (EC) is not usually required but may need to be considered if pills have been missed earlier in the packet or in the last week of the previous packet

IF **TWO** or **MORE** pills have been missed (>72 since last pill in current packet or >48 hours late starting first pill in new packet)

Continuing contraceptive cover
- The most recent pill missed should be taken as soon as possible.
- The remaining pills should be continued at the usual time.
- Condoms should be used or sex avoided until seven consecutive active pills have been taken. This advice may be over-cautious in the second and third weeks, but the advice is a back-up in the event that further pills are missed.

Minimising the risk of pregnancy
- *If pills are missed in the 1st week (Pills 1-7):* EC should be considered if unprotected sex occurred in the pill-free interval or in the first week of pill taking
- *If pills are missed in the second week (pills 8-14):* No indication for EC if pills in the preceding 7 days have been taken consistently and correctly, provided the pills thereafter are taken correctly and additional contraceptive precautions used
- *If pills are missed in the third week (pills 15-21):* **OMIT THE PILL-FREE INTERVAL** by finishing the pills in the current pack (or discarding any placebo tablets) and starting a new pack the next day

Missed Progesterone Only Pills

Northisterone POPs	Desogestrel POPs
>3 hours late (>27 hours since the last pill was taken)	>12 hours late (>36 hours since the last pill was taken)

- The missed pill should be taken as soon as remembered. If more than one pill has been missed, only one pill should be taken.
- The next pill should be taken at the usual time. This may mean that two pills are taken in one day.
- Additional contraceptive precautions (condoms or avoidance of sex) are advised for 2 days (48 hours) after restarting the POP.
- Emergency contraception is indicated if unprotected sexual intercourse occurred after the missed pill and within 48 hours of restarting the POP.

Approaching Menopause

Choice of Contraception: Methods that can be used without restriction
- Barrier methods
- Copper intra-uterine devices (IUD)
- Levonorgesterel releasing Intrauterine system (IUS)
- Progesterone only pill, progesterone only implant
- Progesterone only injections can be used until age of 50
- Combined hormonal contraception is not contraindicated by age alone but factors like smoking and migraine history must be considered. If suitable, a pill containing 20 mcg of ethinylestradiol is a reasonable first choice.

Non-contraceptive Benefits can influence the choice of contraceptive:
- Vasomotor symptoms (hot flushes): combined hormonal contraception may reduce symptoms.
- Osteoporosis: Combined hormonal contraception may increase bone mineral density. Depot medoxyprogesterone acetate can reduce BMD.
- Menstrual pain, bleeding, and irregularity: combined hormonal contraception may reduce symptoms. Progestogen-only methods may reduce pain
- Heavy menstrual bleeding: The LNG-IUS reduces menstrual bleeding and can cause amenorrhoea.

Advise Women that Hormone Replacement Therapy does not provide contraception

Stopping Contraception

If using a non-hormonal method of contraception: Continue until:
- 1y of amenorrhoea >50 years of age Or 2 years of amenorrhoea <50 years of age
- If a women continues to menstruate >55years, advise contraception use until 1 year of amenorrhoea has passed.

If using a hormonal method of contraception:
If woman wishes to stop contraception aged <50 years: advise to switch to a non-hormonal method and wait until 2 years of amenorrhoea (3 years if switching from progestogen only injections)

Combined hormonal contraception and progestogen only injections
- Continue until aged 50, then switch to a non-hormonal method OR switch to one of the following: POP, Progestogen only implant or LNG-IUS
- Follow advice for chosen method

POP, Progestogen only implant or LNG-IUS
- Continue until aged 55
- if woman still not amenorrhoeic at the age of 55 continue until 1 year of amenorrhoea
- If amenorrhoeic and aged > 50, arrange confirmation of menopause (two FSH readings taken 6 weeks apart and results of both tests are >30) and continue contraception for another year

Risk of Venous Thromboembolism:

- The European Medicines Agency (EMA) review in 2013 concluded that there was good evidence to suggest that the risk of VTE associated with different combined oral contraceptive (COCs) was influenced by progestogen type, with those COCs containing:
    - Levonorgestrel, norethisterone or norgestimate having the lowest risk, Drospirenone, desogestrel or gestodene having the highest risk
- Risk of VTE per 10,000 healthy women over one year:
    - COC containing ethinylestradiol plus levonorgestrel, norgestimate or norethisterone: 5-7
    - COC containing etonogestrel (ring) or norelgestromin (patch): 6-12
    - COC containing ethinylestradiol plus gestodene, desogestrel or Drospirenone: 9-12
- However, the EMA noted that the benefits of combined hormonal contraceptive use generally outweighed the risk of venous thrombosis, which is low overall and is lower than the VTE risk associated with pregnancy and the postpartum period.
- There is no evidence to suggest that the newer, less androgenic progestogens are any safer in terms of arterial thrombosis risk than older progestogens.
- Long-term safety data for new formulations containing estradiol valerate, estradiol hemihydrate, dienogest, and nomegestrol acetate are not yet available. Therefore, the risks and benefits of use must be assumed to be as for other COCs.
- Combined transdermal patch and vaginal ring: Long-term data on VTE risk with the combined ethinylestradiol and norelgestromin transdermal patch are limited. There is less available data for the vaginal ring which contains ethinylestradiol and etonogestrel

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