

BEFORE COMMENCING CONTRACEPTION

- A full medical and sexual history should be taken and BP and BMI measured and rechecked annually
- Reference to United Kingdom Medical Eligibility Criteria (UKMEC) guidelines and FSRH guidelines (both available on www.fsrh.org) should be accessed where there is uncertainty about prescribing
- The patient should be offered all choices available and a leaflet regarding the method(s) chosen (can be accessed on www.fpa.org.uk). Onward referral to obtain the method chosen should occur if not provided at the point of care
- Encourage use of condoms as a back up to contraception and to help protect against sexually transmitted infections (STIs)
- Very long and long acting methods of contraception (vLARC) are the most effective as they include minimal user failure. (v) LARC methods include Subdermal implant (Nexplanon[®] Implanon[®]), intrauterine system (IUS) and intrauterine copper device (IUCD). An available LARC method is Depot medroxyprogesterone acetate (DMPA)
- Combined hormonal contraceptives (CHC) including oral tablet, patch and vaginal ring and the progestogen only pill (POP) are also over 99% effective with perfect use but have a higher user failure than the LARC methods with typical use
- Other less effective contraceptive methods include barrier methods and Natural Family Planning but should be included in a choices consultation.

EMERGENCY CONTRACEPTION (EC)

www.ffprhc.org.uk/admin/uploads/449_EmergencyContraceptionCEUGuidance.pdf

www.ffprhc.org.uk/admin/uploads/UlipristalFAQsCEU.pdf

- Emergency contraception is most effective given as soon as possible after unprotected sexual intercourse (UPSI)
- A copper-bearing intra-uterine device (IUCD) is the most effective method of post-coital contraception (99%) and can be used up to 5 days after UPSI or to day 19 of a 28 day cycle
- Progestogen only emergency contraception (POEC) Levonorgestrel 1500mg (Levonelle1500[®] or Levonelle once[®]) is recommended up to 72 hours after UPSI
- Ulipristal acetate (UPA) (EllaOne[®]) is effective between 0-120 hours

QUICK START AND BRIDGING CONTRACEPTION

<http://www.ffprhc.org.uk/admin/uploads/CEUGuidanceQuickStartingContraception.pdf>

- **Quick start** contraception is starting contraception at the time the woman consults instead of waiting until the next menstrual period and includes starting contraception immediately after emergency contraception is administered.
- 7 days of condoms are required (2 days for POP) unless EllaOne[®] has been used (14 days)
- **Bridging** contraception means starting CHC, POP mid-cycle (plus 7 days condoms) until pregnancy can be excluded and a (v)LARC method started
- No evidence that this type of contraception can cause abnormality to a pregnancy. LARC methods may be started but only after consultation regarding risks with the individual woman (see Faculty guidance “Quick Starting Contraception” guidelines for further information)
- In theory quick starting contraception may reduce the number of unwanted pregnancies, be easier for the woman to remember how to take if started immediately and improve compliance (evidence still required). For further information, please refer to the Faculty Guidelines as above.

WHO IS WHO IN THE CONTRACEPTIVE SPECIALIST SERVICE?

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USEFUL LINKS

Faculty of Sexual and Reproductive Healthcare

www.fsrh.org

Menopause matters

www.menopausematters.co.uk

British Menopause Society

www.thebms.org.uk

FPA

www.fpa.org.uk

Institute of Psychosexual Medicine

www.ipm.org.uk

UNSCHEDULED BLEEDING WITH HORMONAL CONTRACEPTION

www.ffprhc.org.uk/admin/uploads/UnscheduledBleedingMay09.pdf

Points to cover in the clinical history from a woman using hormonal contraception presenting with unscheduled bleeding:

- The woman's concerns
- Current method of contraception and the duration of use
- Use of the current contraceptive method
- Use of medications (including over-the-counter preparations) that may interact or illness affecting absorption
- Cervical screening history
- Risk of sexual transmitted infections (i.e. for those aged <25 years, or at any age with a new partner, or more than one partner in the last year)
- Bleeding pattern before starting hormonal contraception, since starting and currently
- Any other symptoms suggestive of an underlying cause (e.g. abdominal or pelvic pain, postcoital bleeding, dyspareunia, heavy bleeding)
- The possibility of pregnancy

A pregnancy test, STI screen, speculum and vaginal examination should be carried out if pathology is suspected from the history.

Medical therapy options:

Combined hormonal contraceptive users:

In general continue with the same pill for at least 3 months as bleeding may settle.

- May consider increasing the EE dose up to a maximum of 35mg
- May try a different COC but no evidence one better than any other in terms of cycle control
- No evidence changing progestogen dose or type improves cycle but may help on an individual basis
- There are no data on controlling bleeding with the patch. Continue for at least 3 months then consider another method/mode of delivery

Progestogen-only pill users:

- May try a different POP although there is no evidence that changing the type or dose improves bleeding
- No evidence to support the use of two POPs per day to improve bleeding

Progestogen-only implants, injectable or intrauterine System:

- A first-line COC (30-35mg EE with levonorgestrel or norethisterone) may be considered for up to 3 months continuously or in the usual cyclical regimen (unlicensed)
- No evidence reducing injection interval for DMPA improves bleeding, however the injection can be given up to 2 weeks early
- Mefenamic acid 500mg twice or thrice daily for 5 days for women with bleeding on DMPA to reduce the duration of the bleeding interval, no long term benefit

TROUBLESHOOTING MINOR SIDE EFFECTS WITH COMBINED ORAL CONTRACEPTIVES

Many minor side effects improve after 3 months use – encourage initial perseverance

Headache:

Exclude migraine with aura (would require to stop method)

Lifestyle advice

During pill-free week – use extended tricycle regime (unlicensed)

During pill-active weeks – reduce estrogen to 20mcg or reduce progestogen dose

Breast tenderness:

Evening primrose, bra support. If continues at 3 months reduce estradiol dose to 20mg or change to POP

Mood change:

Explore lifestyle, change progestogen component if no obvious cause

Weight gain/bloating:

Explore lifestyle. Offer change of method if requested.

Loss of libido:

Explore lifestyle, possible causes. Change progestogen component

Acne:

Lifestyle and skin care. Other topical/oral skin treatments.

Change progestogen component. If continues Cyproterone acetate

Nausea:

Take at night or after food. Reduce to 20mg estradiol