Contraception

Dr Liz Stonell

Contraception – a Patient Perspective

- http://www.youtube.com/watch?v=CIrd34dQTzY&feature=player_detailpage


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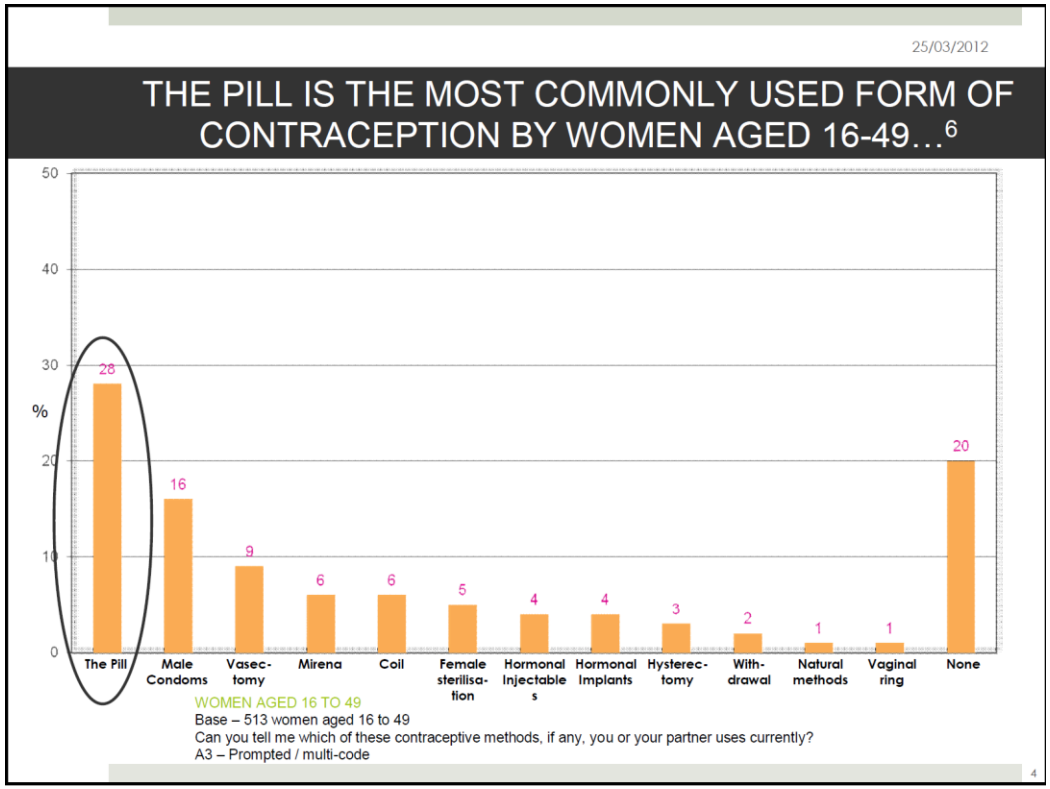
NATURAL BIRTH CONTROL

Choice

- Barrier Methods
- Combined Pill (Or Patch or Ring)
- Progesterone only Pill
- Injectables
- Nexplanon
- Copper Coil
- Mirena Coil
- Emergency Contraception

Combined Oral Contraceptive Pill

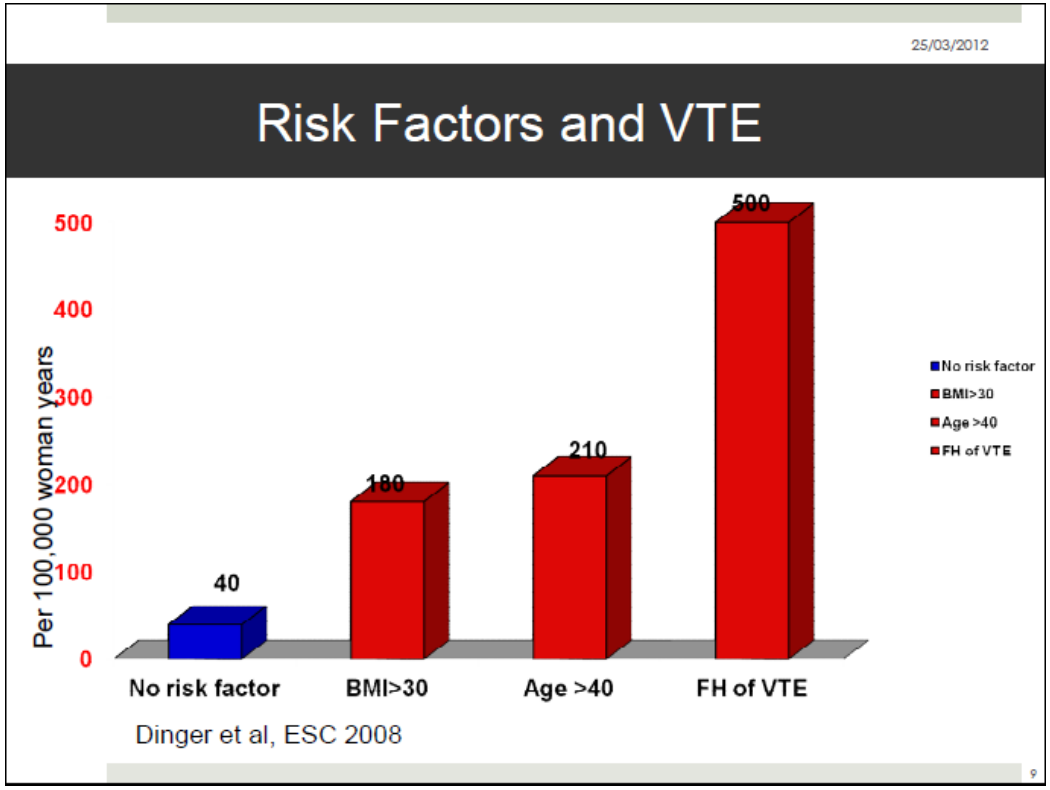


Contraindications

- Personal or family history of VTE
- Aged >35 and smoker
- BP consistently >160/95
- BMI >35
- Migraine with aura

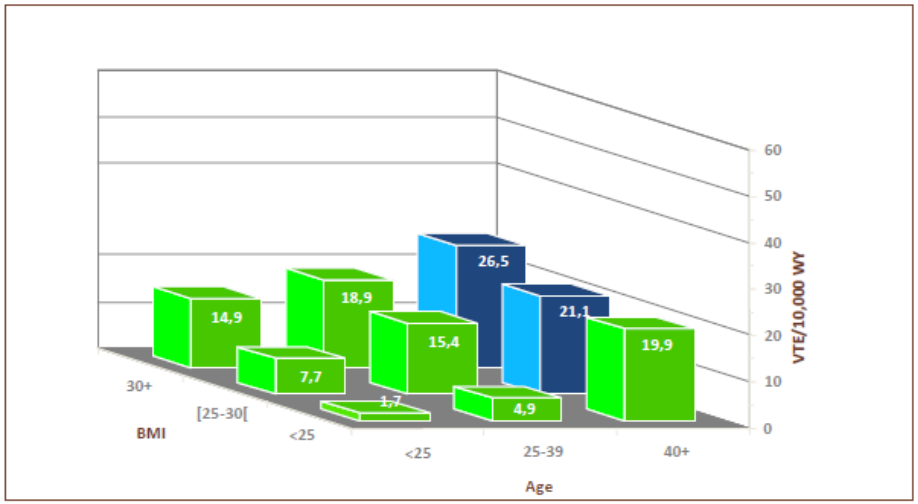
- Efficacy no longer thought to be affected by short term antibiotics (unless cause diarrhoea / vomiting)

BMI and COCP – EURAS Study



25/03/2012

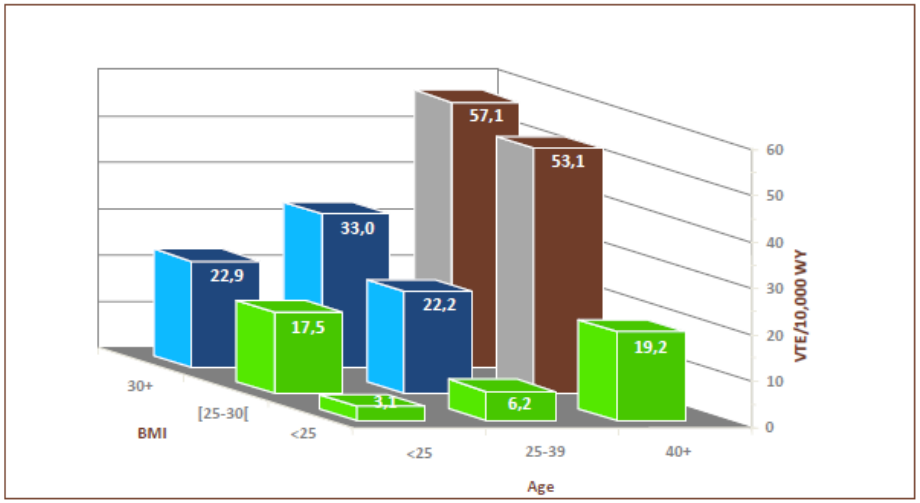
EURAS results: Impact of age and BMI in VTE incidence in OC users WITHOUT other known risk factors[1]



1. EURAS study, data on file

25/03/2012

EURAS results: Impact of age and BMI on VTE risk during OC use (including other risk factors)[1]



1. EURAS study, data on file

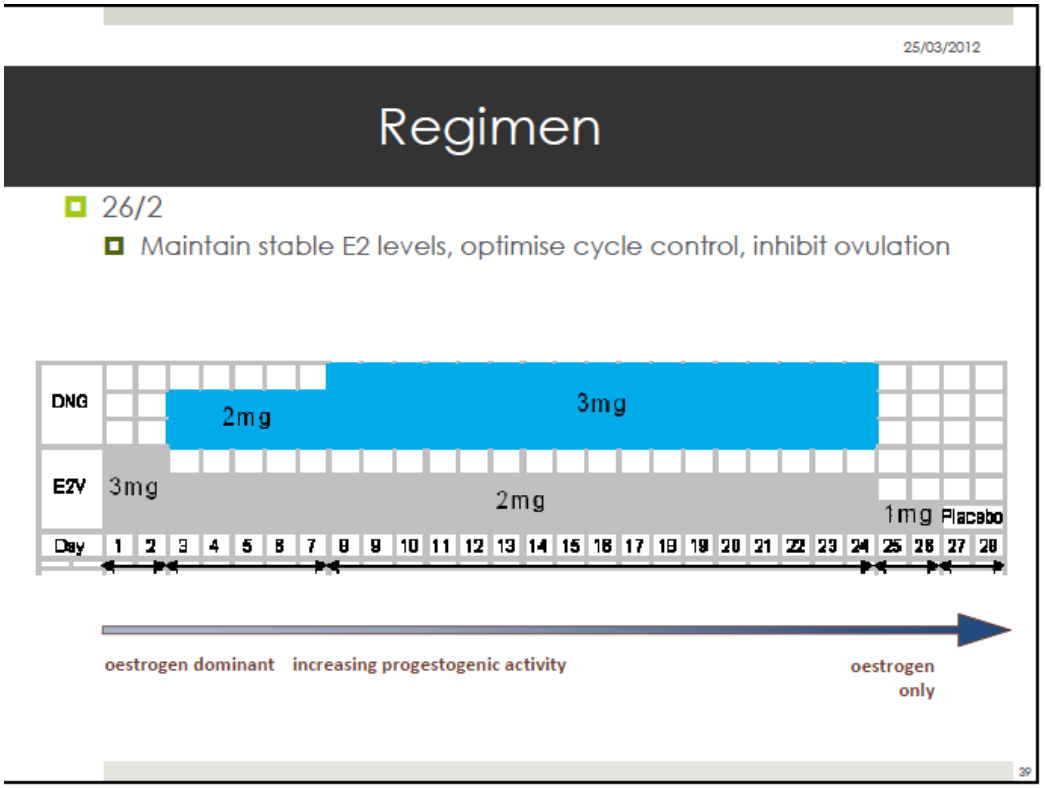
Regimens

- Standard cycle (Licensed use)
- Tricycling
- Shortened pill free interval (4/7)
- Extended use

Which Pill?

- Dianette licensed only for acne
- Controversy regarding the risk of VTE with Yasmin vs levonorgestrel following Danish cohort study in 2009.
- Reanalysis published 2011 confirms findings.
- However even reanalysis flawed because those taking Yasmin likely to be of higher BMI and at greater risk
- Increased risk of VTE among COC users is a class effect.
- MHRA currently feel levonorgestrel containing pills are safest and should be used first line but acknowledge all available pills are safe to use.

Qlaira (Estradiol valerate and Dionogest) - Quadraphasic

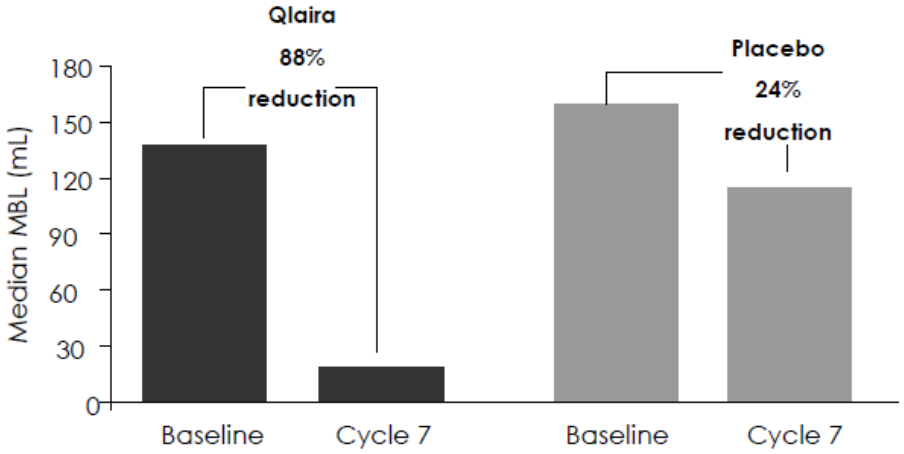


How does Qlaira compare with other hormonal treatments for HMB?

Product	Reduction in MBL	Reference(s)
LNG-IUS	<96%	Mirena SmPC
Other COCs	35 – 43%	Fraser et al. 1991; Shabaan et al. 2011; Farquhar et al. 1991
Qlaira	88%	Fraser et al. 2010.

1. Mirena Summary of Product Characteristics, July 2010.; 2. Fraser IS & McCarron G. *Aust NZ J Obstet Gynecol.* 1991;31:66-70.
3. Shabaan MM *et al. Contraception.* 2011;83:48-54.; 4. Farquhar C. *The Cochrane Library.* 2009. Issue 4.
5. Fraser IS et al. *Poster presented at COGI 2010.*

Change in menstrual blood loss from baseline



1. Qlaira Summary of Product Characteristics; November 2010.

Missed Pill Rules

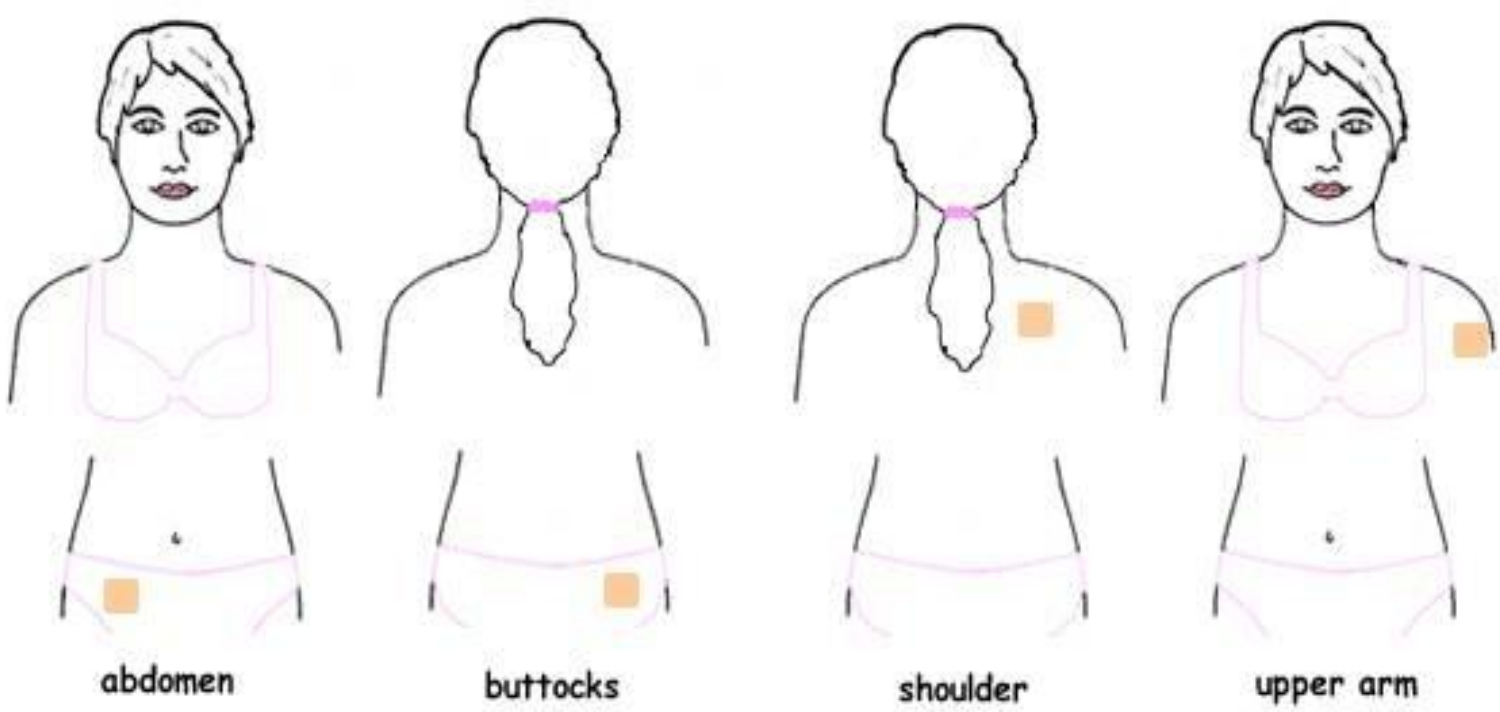
Reviews

- 3/12 – BP
- Annually there after – BP / BMI / Health changes

Stopping the COCP

- Consider lower dose COCP in >40s
- FSH levels unreliable when taking COCP
- Switch to POP at 50

Evra



Nuvaring

- Latex Free
- Insert vaginally for 3 weeks then one week ring free break
- Needs to be refrigerated until dispensed then can be stored at room temp for up to 4/12
- Therefore only prescribe 3/12 at a time

Progesterone Only Pill

- Concordance with Cerazette improved by 12 hour pill window making it a reasonable first choice.
- BUT in the older woman may contribute to vaginal dryness.
- No evidence that efficacy of any pills is increased by taking 2 in women who weigh >70kg.
- Can be given 12/12 supply of medication initially and at follow up appointments with no need to check BP or weight.

The Seven Dwarves of Menopause

Itchy, Bitchy, Sweaty, Sleepy, Bloated, Forgetful & Psycho

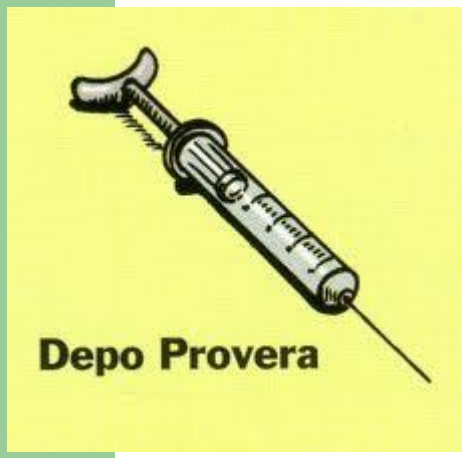
Stopping the POP

- Continue until aged 55

- Check FSH twice 6 / 10 weeks apart.
- If both >30 can assume ovarian failure.
- If >50 continue POP 1 year.
- If <50 continue POP 2 years.

Depo

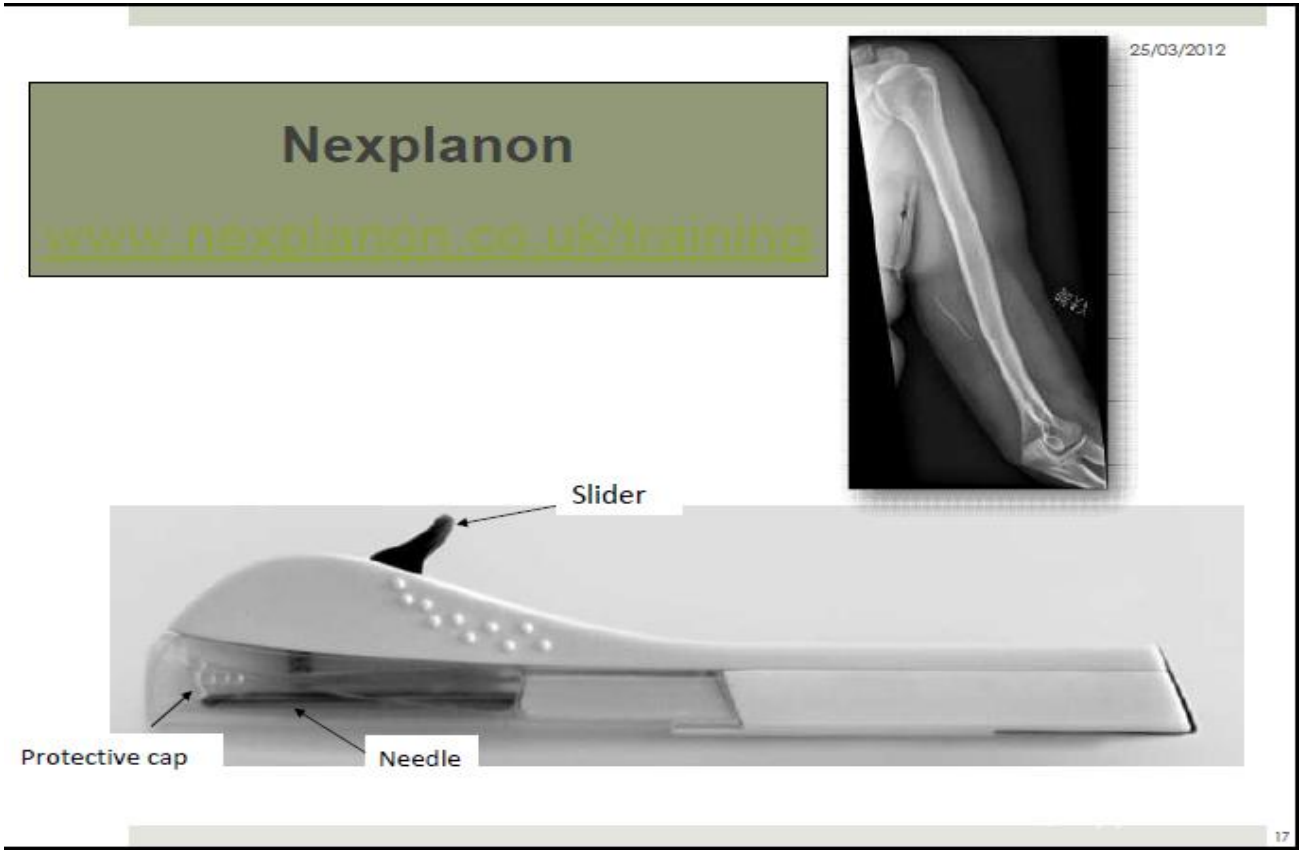
- Delay in return of fertility
- Associated with weight gain
- BMD: - Is associated with small loss of BMD which is reversed when stopped.
  - No evidence on long term fracture risk
  - <18 can be used but consider alternatives first
  - Review individuals every 2 years to consider risks and benefits.
  - Can continue to 50



Timing of injections

- Ideally 12 weekly.
- Between 10 and 14 weeks requires no additional contraceptive.
- Above 14 weeks need to consider risk of pregnancy

Nexplanon


Nexplanon
www.nexplanon.co.uk/training
25/03/2012
Slider
Protective cap
Needle
17

Bleeding

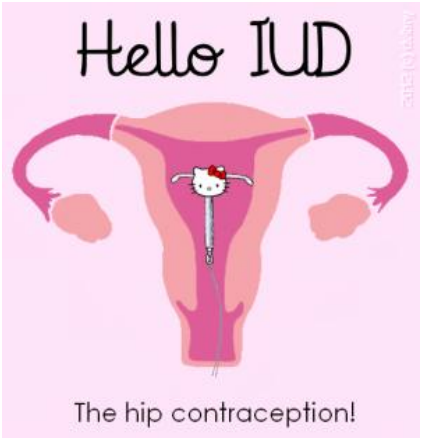
- 20% amenorrhoeic
- Usually improves after 6/12
- Irregular bleeding should be investigated with swabs +/- USS if indicated
- 3/12 COCP if not contraindicated
- Mefenamic Acid 500mg BD
- 3/12 Cerazette

IUD / IUS

- Pre-insertion swabs only if high risk (<25 or >25 with new sexual partner or >1 sexual partner in last year (unless requested by patient).
- Alternatively give high risk women prophylactic antibiotics.
- Routine follow up should be arranged 3-6 weeks after insertion BUT annual follow up is NOT recommended by FSRH or NICE.

Stopping the Coil

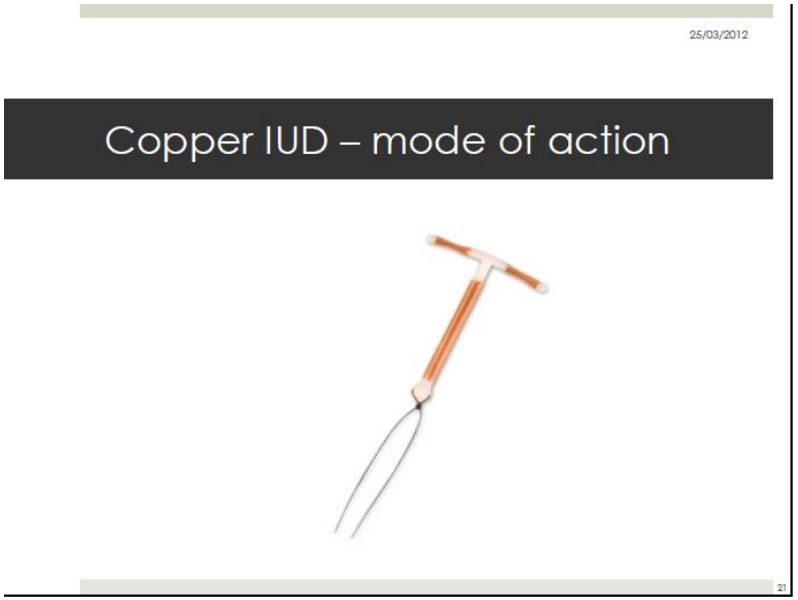
- IUD – If fitted >40 retain until 1 year after last menstruation if >50 (2 years if <50)
- IUS – If fitted >45 and amenorrhoeic retain until menopause (55) or contraception no longer required.



Emergency Contraception

IUD

- Most effective method
- Up to 120 hours after first episode of UPSI or within 5 days of earliest expected day of ovulation.
- Should be offered to all women



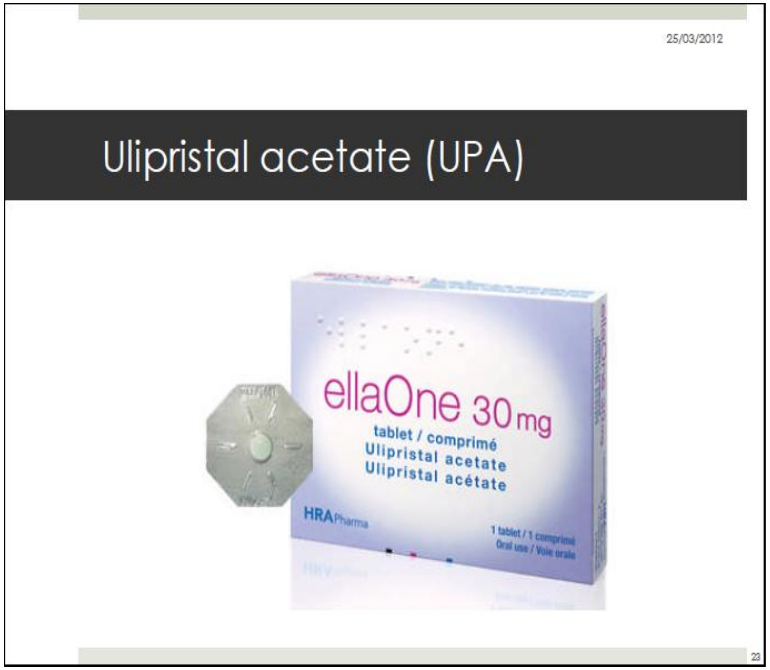
Levonelle

25/03/2012

Levonorgestrel (LNG)

Ella One

- Synthetic selective progesterone receptor modulator
- Inhibits or delays ovulation
- Delays follicular rupture
- Effective even if LH levels have begun to rise



Levonelle vs Ella One

- Licensed for 72 hours
- Less effective
- If on hormonal contraception need to use extra precautions for 7 days. (2 days for POP, 9 days for Qlaira).
- Patients on liver inducers can take 2 tablets (3mg).
- No interaction with gastric drugs
- Can be used more than once in same cycle.

- Licensed for 120 hours
- More effective
- 14 days (9 days for POP, 16 days for Qlaira)
- Efficacy unproven in patients on liver inducers.
- Interacts with antacids, PPIs and H2 antagonists.
- Use only once per cycle.

Contraindications for Ella One

- Hepatic / renal impairment
- Pregnancy
- Poorly controlled asthma
- Hypersensitivity
- Galactose intolerant and other rare hereditary disorders

Therapeutic Norethisterone (Primolut N)

- Used to provide cycle control and to delay menstruation
- Shown to be partly metabolised to ethinylestradiol
- At therapeutic doses should be considered a ‘combined’ product and used with caution in patients at risk of VTE
- Alternative is medroxyprogesterone acetate 10mg TDS

References

- Mansour D. Safer prescribing of therapeutic norethisterone for women at risk of VTE. JFPRHC 2012 38 148-149.
- Dinger J and Shapiro S Combined Oral Contraceptives, VTE and the problem of interpreting large but incomplete datasets. JFPRHC 2012 38 2-6.
- Draper, Haque and McManus. Routine intrauterine device checks: are they advisable? JFPRHC 2012 38 15-18.
- Szarewski, A. Choice of Contraception. Obstetrics, Gynecology and Reproductive Medicine 2009 19 (11) 323-326.
- Reid et al. Oral Contraceptives and VTE. JFPRHC 2010 36 (3) 117-122.