CONTRACEPTION
MADE EASY

This concise book helps healthcare professionals to provide up to date and practical guidance on all the commonly used contraceptive methods:

• combined oral contraceptives (COCs), patches, and vaginal rings
• progestogen-only pills (POPs), progestogen-only injectables and implants
• copper intrauterine devices (IUDs) and the levonorgestrel IUS
• diaphragms, cervical caps, and male and female condoms
• natural fertility awareness advice/kits
• emergency contraception
• male and female sterilisation

An opening chapter provides a consultation model to use when seeing patients seeking contraception advice. Subsequent chapters describe each contraceptive method in turn, covering who should use the method, how it works, its efficacy, the advantages and disadvantages, how to start and stop (where appropriate), and how to manage troublesome side-effects. An Appendix provides the full UK Medical Eligibility Criteria for contraceptive use with certain medical conditions.

Contraception Made Easy is the ideal practical reference guide for GPs and other healthcare professionals involved in the provision of contraceptive advice.

From the Foreword:
“The authors have brought together current FSRH national guidance and best practice into a neat, clear and succinct handbook and they are to be congratulated for doing this … I cannot imagine anyone providing women's healthcare not benefiting from having a copy.”

Dr Chris Wilkinson
President of the FSRH
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CONTRACEPTION
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As the President of the Faculty of Sexual and Reproductive Healthcare (FSRH) I am often asked about the best ‘contraceptive’ book to buy. Many want a concise yet complete text that is up to date and covers all the salient areas. I was beginning to think that textbooks were a thing of the past and then Contraception Made Easy pops up.

The authors are well known to many. Both have published widely, Dr Laura Percy, a senior community sexual and reproductive health trainee, was the first winner of the Anne Szarewski Memorial prize for clinical practice innovation. Dr Diana Mansour is a Consultant in Community Gynaecology and Reproductive Healthcare and leads the integrated sexual health service in Newcastle upon Tyne. She has been an Honorary Lecturer at the University of Newcastle since 1997 and is the Honorary Treasurer and an Officer for the FSRH.

The authors have brought together current FSRH national guidance and best practice into a neat, clear and succinct handbook and they are to be congratulated for doing this. The introduction states that “this short book provides up-to-date information, often in note form, about the commonly used contraceptive methods available in high resource countries and is aimed at healthcare professionals working in primary, community and secondary services”. It does exactly that. I cannot imagine anyone providing women’s healthcare not benefiting from having a copy.

Dr Chris Wilkinson, President FSRH
August 2015
About the authors

Dr Laura Percy is a ST5 specialist registrar in Community Sexual and Reproductive Health at the New Croft Clinic in Newcastle upon Tyne. She is the winner of the inaugural Anne Szarewski Journal Memorial Award, and has published several articles on Contraception and Women’s Health. She completed her MBBS from the University of Newcastle upon Tyne in 2006, began working in contraception in 2008 and joined the Faculty of Sexual and Reproductive Health’s Speciality Training programme in 2012. She has an MSc in Health Education and Health Promotion, and a BSc in Human Biology from King’s College, London.

Dr Diana Mansour is a Consultant in Community Gynaecology and Reproductive Healthcare and Head of Sexual Health Services in Newcastle. She has been an Honorary Lecturer at the University of Newcastle since 1997. In addition Dr Mansour is the Honorary Treasurer and an Officer for the Faculty of Sexual and Reproductive Healthcare. She is a member of the FIGO Menstrual Disorders Committee and her areas of expertise include acceptability of contraceptive methods, non-contraceptive benefits of contraception, development of long-term methods of contraception, changes in health service provision, medical management of heavy menstrual bleeding, menopause and hormone replacement therapy.

Dr Mansour was the first accredited subspecialty trainee in Community Gynaecology and Reproductive Healthcare of the Royal College of Obstetricians and Gynaecologists. She is first author to over 80 peer-reviewed publications.
Abbreviations

ART antiretroviral therapy
BMD bone mineral density
BMI body mass index
CHC combined hormonal contraception
CIN cervical intraepithelial neoplasia
COC combined oral contraceptive
CTP combined transdermal patch
CVE cardiovascular event
CVR combined vaginal ring
DMPA depot medroxyprogesterone acetate
DVT deep vein thrombosis
EC emergency contraception
EVA electronic vacuum aspiration
FPA Family Planning Association
FSH follicle-stimulating hormone
hCG human chorionic gonadotrophin
HMB heavy menstrual bleeding
IBD inflammatory bowel disease
<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>IMB</td>
<td>intermenstrual bleeding</td>
</tr>
<tr>
<td>IUC</td>
<td>intrauterine contraceptive</td>
</tr>
<tr>
<td>IUD</td>
<td>intrauterine device</td>
</tr>
<tr>
<td>IUS</td>
<td>intrauterine system</td>
</tr>
<tr>
<td>IVF</td>
<td><em>in vitro</em> fertilization</td>
</tr>
<tr>
<td>LARC</td>
<td>long-acting reversible contraception</td>
</tr>
<tr>
<td>LH</td>
<td>luteinizing hormone</td>
</tr>
<tr>
<td>LNG</td>
<td>levonorgestrel</td>
</tr>
<tr>
<td>MI</td>
<td>myocardial infarction</td>
</tr>
<tr>
<td>MIV</td>
<td>minimally invasive vasectomy</td>
</tr>
<tr>
<td>MVA</td>
<td>manual vacuum aspiration</td>
</tr>
<tr>
<td>NET-EN</td>
<td>norethisterone enanthate</td>
</tr>
<tr>
<td>NICE</td>
<td>National Institute for Health and Care Excellence</td>
</tr>
<tr>
<td>NSAID</td>
<td>non-steroidal anti-inflammatory drug</td>
</tr>
<tr>
<td>NSV</td>
<td>no-scalpel vasectomy</td>
</tr>
<tr>
<td>PCB</td>
<td>post-coital bleeding</td>
</tr>
<tr>
<td>PE</td>
<td>pulmonary embolism</td>
</tr>
<tr>
<td>PEPSE</td>
<td>post-exposure prophylaxis following sexual exposure</td>
</tr>
<tr>
<td>PID</td>
<td>pelvic inflammatory disease</td>
</tr>
<tr>
<td>POP</td>
<td>progestogen-only pill</td>
</tr>
<tr>
<td>RCOG</td>
<td>Royal College of Obstetricians and Gynaecologists</td>
</tr>
<tr>
<td>STI</td>
<td>sexually transmitted infection</td>
</tr>
<tr>
<td>UKMEC</td>
<td>UK Medical Eligibility Criteria</td>
</tr>
<tr>
<td>UPA</td>
<td>ulipristal acetate</td>
</tr>
<tr>
<td>UPSI</td>
<td>unprotected sexual intercourse</td>
</tr>
<tr>
<td>VTE</td>
<td>venous thromboembolism</td>
</tr>
</tbody>
</table>
Chapter 5
Progestogen-only pill

The progestogen-only pill (POP) is taken by about 6% of women aged 16–49 years in the UK, although it is less popular in other European countries.

5.1 Potential users

5.1.1 Most appropriate users

Almost all women who require contraception can take a POP (see UKMEC in Appendix).

5.1.2 Not suitable for the following users

The POP may not be effective in women taking liver enzyme inducing drugs and should be avoided in women who:

- have had a hormone-dependent tumour (e.g. breast cancer) in the last 5 years
- have active viral hepatitis, severe decompensating liver disease, or liver tumours
- are sensitive to any of the components of the POP
- are currently taking a POP and develop ischaemic heart or cerebrovascular disease.

5.2 Available POPs in the UK

These are listed in Table 5.1.

Table 5.1. POPs currently available in the UK

<table>
<thead>
<tr>
<th>Trade name</th>
<th>Progestogen and dose</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Micronor</td>
<td>Norethisterone, 350 mcg</td>
<td>3 × 28-tab pack = £1.80</td>
</tr>
<tr>
<td>Noriday</td>
<td></td>
<td>3 × 28-tab pack = £2.10</td>
</tr>
<tr>
<td>Norgeston</td>
<td>Levonorgestrel, 30 mcg</td>
<td>35-tab pack = £0.92</td>
</tr>
<tr>
<td>Cerazette</td>
<td>Desogestrel, 75 mcg</td>
<td>3 × 28-tab pack = £8.68</td>
</tr>
<tr>
<td>Desogestrel</td>
<td></td>
<td>3 × 28-tab pack = £4.30</td>
</tr>
</tbody>
</table>

Data from BNF, 2015.
5.3 Mechanism of action

The mechanisms of action are illustrated in Figure 5.1.

- Ovulation may be suppressed in up to 60% of cycles in POPs containing levonorgestrel or norethisterone, but up to 97–99% in those containing desogestrel.
- All POPs alter the cervical mucus to reduce sperm penetration into the upper genital tract.
- POPs induce changes in the endometrium to prevent sperm survival and implantation of the blastocyst.
- Sperm motility and function is affected, preventing fertilization.

Figure 5.1. Mechanism of action for POPs.

5.4 Efficacy of POPs

The POP is very effective when taken consistently and correctly, with a ‘perfect use’ failure rate of less than 1%. However, the typical failure rate is 9% in the first year of use (see Table 1.1). The desogestrel POP is first line for most women as it is thought to be more effective than traditional POPs (as it usually inhibits ovulation and has a 12 rather than 3 hour safety window), but this has not been shown in any published study.

5.5 Pros and cons of POPs

5.5.1 Advantages

- Unrelated to sexual intercourse.
- Simple, convenient to use, and under the woman’s control.
- Can be taken when breast-feeding.
- May help to reduce dysmenorrhea and also severity of migraines.
- Ideal for women who suffer from oestrogenic side-effects when using CHC, e.g. breast tenderness, headaches including migraines, fluid retention, leg cramps or nausea.
• Suitable for women over 35 years who smoke.
• Can be used in overweight or obese women with no dose adjustment.
• Can be taken by those with medical illnesses where CHCs are contraindicated, e.g. women with hypertension, migraine with focal aura, or with a previous personal history of VTE.
• No evidence of an increased risk of cardiovascular disease, thromboembolism or stroke.
• Minimal alteration in carbohydrate and lipid metabolism, therefore a useful option for diabetics, even those with neuropathic or nephropathic complications.

5.5.2 Disadvantages

• Some women complain of nuisance side-effects such as breast tenderness, mood changes, headaches or acne.
• Possible risk of ectopic pregnancy in the event of POP failure.
• Can alter ovulation, thereby disrupting the menstrual bleeding pattern, with users reporting increased breakthrough bleeding, spotting and amenorrhoea.
• Functional ovarian cysts may develop in a small number of women; however, these tend to be transient and rarely require surgical intervention.

5.6 Using the POP

The POP is taken every day with no break. Following oral ingestion the effect on the cervical mucus reaches its peak within 2–3 hours then slowly wanes over the next 22 or so hours. POPs containing desogestrel differ from more traditional POPs because the main mode of action is to inhibit ovulation and so these POPs have a 12 hour rather than a 3 hour safety window. This means that women who normally take their traditional POP at 8 am have up to 11 am that day to take their pill. Those taking a desogestrel POP have until 8 pm that night (see advice on missed pills in Section 5.6.2).

The efficacy of the POP may be affected by vomiting or severe diarrhoea:
• If vomiting occurs within 2 hours of taking the POP, another pill is taken and no further action is required.
• If vomiting continues and/or she is 3 or more hours later than normal taking the pill (12 hours for a desogestrel POP), then the missed pill guidance should be followed.

The efficacy of the POP can be affected by concomitant use of a liver enzyme inducing drug, such as carbamazepine, phenobarbital, phenytoin, topiramate (200 mg or more a day), rifabutin, rifampicin, some antiretrovirals, ulipristal acetate, bosentan, and St John’s wort.
• When these drugs are used short term, an additional method such as condoms should be used during the time of drug administration and for 4 weeks after stopping the medication.
• An alternative method such as an injectable or intrauterine contraceptive should be chosen if the liver enzyme inducing drug is to be used long term.
5.6 – Using the POP

5.6.1 Starting regimens

<table>
<thead>
<tr>
<th>Circumstances</th>
<th>Start when?</th>
<th>Extra precautions for 48 hours?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quick start</td>
<td>At any time if it is reasonably certain that the woman is not pregnant</td>
<td>Yes</td>
</tr>
<tr>
<td>Menstruating</td>
<td>Up to and including day 5 of the cycle</td>
<td>No</td>
</tr>
<tr>
<td></td>
<td>After day 5 of the cycle</td>
<td>Yes</td>
</tr>
<tr>
<td>Amenorrhoea</td>
<td>At any time if it is reasonably certain that the woman is not pregnant</td>
<td>Yes</td>
</tr>
<tr>
<td>Post abortion or miscarriage</td>
<td>Within 5 days</td>
<td>No</td>
</tr>
<tr>
<td></td>
<td>After 5 days</td>
<td>Yes</td>
</tr>
<tr>
<td>Post-partum Breast-feeding or bottle feeding</td>
<td>Up to day 21 post-partum</td>
<td>No</td>
</tr>
<tr>
<td></td>
<td>From day 22 onwards</td>
<td>Yes</td>
</tr>
<tr>
<td>Switching from other hormonal methods (other than IUS)</td>
<td>Immediate start</td>
<td>No</td>
</tr>
<tr>
<td></td>
<td>If previous method was DMPA, switch when next injection is due</td>
<td>No</td>
</tr>
<tr>
<td>Switching from a non-hormonal method (other than IUD)</td>
<td>Up to and including day 5</td>
<td>No</td>
</tr>
<tr>
<td></td>
<td>After 5</td>
<td>Yes</td>
</tr>
<tr>
<td>Switching from an IUD or IUS</td>
<td>POP initiated at time of IUD/IUS removal</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>(avoid unprotected sex or use condoms for 7 days before the removal of an IUD/IUS)</td>
<td>No</td>
</tr>
<tr>
<td></td>
<td>POP started at least 2 days before the IUD/IUS is removed</td>
<td>No</td>
</tr>
</tbody>
</table>

5.6.2 Advice about missed pills

- POPs are effective if taken consistently and correctly.
- If a norethisterone or levonorgestrel POP is forgotten for less than 3 hours from the normal administration time (the window is 12 hours for desogestrel POPs) the missed pill should be taken and the pack continued as normal. No additional cover such as condoms is required.
- If more than 3 hours has elapsed from the normal administration time (12 hours for desogestrel POP) then the last missed pill is taken, the pack continued as normal, but condoms should also be used as back-up contraception for the next 48 hours.
- If less than 3 hours has elapsed from the normal administration time (12 hours for desogestrel POP) and unprotected sex has occurred the missed pill should be taken, the POP continued and condoms used for the next 48 hours.
- If more than 3 hours has elapsed from the normal administration time (12 hours for desogestrel POP) and unprotected sex has occurred, emergency contraception should be considered (see Chapter 13).
5.7 Routine follow-up

After the first prescription for a POP women are given advice about when to return, normally in the next 3 months unless they have concerns. Once settled taking a POP they can be reviewed on an annual basis. POPs can be continued until the age of 55 when 98% of women are at least 1 year after their last natural period. For additional information see Chapter 3.

5.8 Return to fertility

There is no delay in return to fertility. Most women ovulate within 2–3 weeks of discontinuing POPs.

5.9 Managing side-effects

Non-specific symptoms such as headache, fatigue and mood change are common in the general population. Treatment-associated serious adverse reactions are very rare with POPs but an irregular bleeding pattern is common and some patients report possible progestogen-associated side-effects.

- In women taking POPs bleeding is unpredictable: 20% will have no periods, 40% irregular bleeding and 40% will have regular cycles. Those taking desogestrel rather than traditional POPs are more likely to have no or infrequent periods after 1 year of use.
- Encourage women to continue with the method for at least 3 months. In those with persistent troublesome bleeding, check compliance and drug interactions, exclude any STIs and pregnancy, examine the cervix and perform cervical cytology if due. Consider a change in POP or contraceptive method.
- Progestogen-associated side-effects may include acne, bloating, mood change and loss of libido. Again, encourage women to continue with the method for at least 3 months. If symptoms persist consider changing the POP to a different progestogen or consider a different method.
- There is no evidence that POPs increase or decrease weight.

5.10 Myths and misconceptions

- **POPs are not very effective in women weighing over 70 kg and these women need to take 2 POPs daily** – there is no evidence that POPs are less effective in overweight or obese women and so standard dosing regimens should be followed.
- **Women taking POPs and having amenorrhoea will have problems getting pregnant** – some women will not bleed while taking a POP. The endometrium is thin and atrophic. This is seen as an additional benefit, with many reporting reduced period pain too. On discontinuation of the POPs most women ovulate within the first 3 weeks and menstruate within the next 6 weeks. It has no effect on fertility.
- **Women with migraine with aura cannot take POPs** – this is not true. In fact many women with migraine with aura choose to take a POP for contraception because it may help reduce the intensity and frequency of the headache and aura.
EXAMPLE

An 18 year old woman presents with painful, heavy periods; she also needs contraception. She would like to take the COC. History-taking establishes that her father experienced an unprovoked VTE at the age of 38 years, but there is no other family history of VTE. The family were genetically screened because her father was found to have factor V Leiden; only her sister was found to carry the gene for factor V Leiden.

What do you advise?

1. Using UKMEC this family history suggests that the risks of taking a COC outweigh any potential benefits (UKMEC 3), even though her thrombophilia screen was normal. This is because we can only look for known mutations and she may carry an increased VTE risk from an unknown alteration in genetic sequencing. This should be explained to the patient.

2. Alternatives with a lower risk for this woman would be a desogestrel POP, DMPA or a LNG-IUS.

References


UKMEC (2009) *UK Medical Eligibility Criteria for Contraceptive Use*
Chapter 6
Injectable contraception

Progestogen-only injectables have been available for over 40 years with a good safety record. About 3% of UK women aged between 16 and 49 years use a progestogen-only injectable as their method of contraception, with most users receiving depot medroxyprogesterone acetate (DMPA). Monthly combined injectables containing oestrogen and progestogens are available in Latin America but in few European countries. This chapter will discuss progestogen-only injectables, focusing on those containing medroxyprogesterone acetate.

6.1 Potential users

6.1.1 Most appropriate users

Injectable contraceptives can be used by women of reproductive age up to the age of 50 years. For those with no contraindications and who would prefer to continue, it can be used up to the age of the menopause because the benefits outweigh the potential risks of use.

6.1.2 Not suitable for the following users

Injectable contraceptives are not suitable (for further information look at UKMEC in Appendix) for women with:

• cardiovascular or cerebrovascular disease
• significant multiple risk factors for arterial cardiovascular disease
• current or recent breast cancer
• diabetic nephropathy, retinopathy or neuropathy
• active viral hepatitis
• severe decompensating cirrhosis or liver tumours
• unexplained vaginal bleeding
• at high risk of developing osteoporosis.