CONTRACEPTION PROTOCOLS

Aim

To provide accessible, acceptable and safe family planning advice

Objectives

§ Contraception as per protocols
§ To give patients a full choice of available contraception. (When possible patients are given a longer appointment following KPA guidelines.)

First prescription of the combined pill

History

absolute contraindications
- focal migraine (visual disturbance, hemiplegia etc)
- high risk for VTE - past H/O VTE
- strong FH VTE (<50yrs)
- severe varicose veins
- BMI>39
- immobile
- high risk for MI/CVA - smoking if >30 years
- diabetes
- hypertension, IHD, CVA
- hyperlipidaemia
- MI/CVA in rels < 50
- breast feeding
- on interacting drugs
- unexplained vaginal bleeding
- pregnant
- personal H/O breast cancer

relative contraindications
- strong FH breast cancer
- epilepsy (due to drug interactions)
- SLE
- Crohns
- BMI 30-39

History required
- past medical/surgical history
- drug history
- family history
- previous rubella vaccination
- current gynae symptoms
- date of last smear

Examination
- blood pressure
- 5-yearly CVS

Advice/explanation

- mode of action
- risks/benefits/side effects
- how to take it/when to start
- what to do if you forget (7 day rule)
- interaction with antibiotics
- what to do in the event of diarrhoea and vomiting
- things to look out for (e.g. DVT, migraine)
- who to contact if problems occur
- give FPA leaflet

Prescription

The 2nd generation monophasic 30-35µg oestrogen with low dose progesterone in general is used first, but any pill may be used first with counselling of risk/benefits and patient choice taken into consideration.

Follow up for the combined pill

Most pill follow up will be straightforward

- discuss problems
- reiterate 7 day rule and interactions
- check BP
- provide prescription
- check smear recall is up-to-date

Patients with no problems with their pill and with no significant past medical history can be reviewed 12/12ly. (Every other 6/12 script can be given on repeat.)

Potential Hormonal Side-Effects of the Combined Oral Contraceptive Pill

Oestrogen Side-Effects	Progestogen Side-Effects
Breast enlargement and tenderness Bloating Weight gain (fluid retention) Carpal tunnel syndrome Headaches Vaginal moistness Nausea, chloasma	Acne Hirsuitism Weight gain (increased appetite) Depression Decreased libido Vaginal dryness Greasy hair

Hormonal Dominance of Various Combined Oral Contraceptive Pills

Oestrogen Dominant Pills	Progestogen Dominant	Neutral
Brevinor Ovysmen Neocon 1/35	Loestrin 20	Cilest *Triadene/*Triminulet

Norimin Trinovum **Ovran **Norinyl-l **Ortho Novin 1/50	Loestrin 30 Microgynon/Ovranette Trinordiol/Logynon	*Marvelon *Minulet/*Femodene *Mercilon

Notes :
Full details of all combined pills are found in Tables 3.1 and 3.2
*signifies third generation pill
**signifies 50 mcg oestrogen pills
Neutral pills are listed in decreasing oestrogen dominance
For women with oestrogen side-effects, choose a lower dose oestrogen pill or swap to a more progestin dominant pill and vice versa
Dianette (ethinyloestradiol/cyproterone acetate) not included. This should only be used if other co-factors are present such as acne or hursutism and should be stopped 3-4 months after the problem has resolved.

First prescription of the progesterone only pill (POP)

History

absolute contraindications
- past or current severe arterial diseases
- undiagnosed PV bleeding
- liver adenoma
- recent trophoblastic disease until HCG is undetectable in blood as well as urine
- previous ectopic (not applicable to Cerazette)
- previous ovarian cysts (not applicable to Cerazette)

relative contraindications
- multiple risk factors for CVS disease
- sex-steroid-dependent cancer
- current liver disorder with abnormal LFT
- concurrent administration of enzyme inducers (e.g. anti-epileptics)

History required
- past medical/surgical history
- drug history
- family history
- previous rubella vaccination
- current gynae symptoms
- date of last smear

Examination
- blood pressure
- 5-yearly CVS
- ?weight (POP less effective in women > 70kg

Advice/explanation
- mode of action
- failure rate (2-6 per 100 women years)
- risks/benefits/side effects – especially menstrual irregularity
- how to take it (daily with no breaks) / when to start (remember 3 hour rule – 12 hour Cerazette)
- what to do if you forget (7 day rule)
- interaction with enzyme inducers (NOT antibiotics)
- what to do in the event of diarrhoea and vomiting
- things to look out for
- who to contact if problems occur
- give FPA leaflet
- irregular cycle may settle after 6-9 months

Notes.
If patients develop amenorrhoea on the POP (as about 50% do) it is important to exclude pregnancy before reassuring them this is normal. If they are amennorhoeic, they may become hypo-oestrogenic as well. We don't know if this is a risk factor for osteoporosis or not (c.f. depot).
For missed pills 48 hours is probably sufficient rather than 7 days for extra precautions, but this isn't licensed, so it's probably best to advise 7 days.

Prescription
- Levonorgestrol is better if breastfeeding
- Obese women (>70kg) - 2 pills a day (unless Cerazette – still 1daily)

POP follow up

Most pill follow up will be straightforward

- discuss problems, including bleeding pattern
- reiterate 7 day rule and interactions
- check BP
- provide prescription
- check weight – may need to increase/decrease pill if great change

Patients with no problems with their pill and with no significant past medical history can be reviewed 12/12ly. (Every other 6/12 script can be given on repeat.)

Missed pill

If fully breastfeeding only need emergency contraception if more than 12 hours late. 7-day additional precautions is still needed.

IUCD

Clinical Lead = Dr Wells

The copper-containing IUCD is an excellent method of contraception, particularly in a woman in her 30's, with a stable relationship and having had a child. This does not mean it is not also suitable for younger woman and for nullips, and it is important to have it in mind as a method of contraception whenever counselling someone.

History

absolute contraindications

- unexplained uterine bleeding
- current/recent pelvic infection
- immunosupression (but not steroids)
- HIV
- distorted uterine cavity
- Wilson's disease
- copper allergy
- heart valve replacement or h/o bacterial endocarditis

relative contraindications

- heart valve disease – SBE risk, use antibiotics
- hip replacement (may be infection risk)
- h/o ectopic – use Cu 380-T or LNG-IUS
- h/o definite PID – use LNG-IUS
- lifestyle risk of STD - counsel
- severely scarred uterus (e.g. post- myomectomy)
- menorrhagia (use LNG-IUS)
- endometriosis
- after endometrial ablation

History required

- past medical/surgical/gynae/obstetric history
- sexual history – particularly no. of partners
- current gynae symptoms
- previous rubella vaccination
- date of last smear

Counselling

Explain
- infection risk
- failure rate (0.4/100 women years for Cu 380-T)
- checking of threads
- perforation risk
- ectopic risk (no increased risk, but PROPORTION of ectopics increased)
- how device is fitted
- importance of reporting pain/bleeding
- how long it will last

Choice of device

Device	*Uterine size*	*Advantages*	*Disadvantages*	*Effective Life of device*
T-safe Copper 380	>6.5cm	Very effective – as effective as pill	Slightly wider than others to insert	8 years*
Nova-T	>6.5cm	Thin, so easy to insert	Slightly less effective Shorter life	5 years*
Novagard	>5.5cm	Can be used in smaller uteri Thin, so easy to insert	Slightly less effective Shorter life	5 years*

* All coils, if inserted in women over the age of 40, can be left in and removed after the menopause (2 years after LMP if <40, 1 year after LMP if >40)

If patient seen who wants an IUCD

- counsel as above and provide PIL
- arrange swabs to be taken 2 weeks before coil is to be fitted
- a prescription is needed for Mirena coils
- appointment with KW during next period

OR

- inform of available FPC (see list on Intranet)

When to Insert

Normally, insert within 5 days of start of LMP. This ensures that the patient is not pregnant and that the cervix will be slightly open. See Emergency Contraception section for timing of use as post-coital cover.

Pre-insertion

Most IUCD-associated infections occur within 21 days of insertion. It is therefore suggested that except in exceptional circumstances swabs should be done and the results obtained prior to insertion. **This means an HVS and a chlamydia swab in everyone.**

Insertion

Equipment
- speculum

- uterine sound
- Vulsellum forceps
- long Spencer-Wells forceps
- sponge-holding forceps
- uterine scissors
- dressing pack
- cleaning solution
- IUCD
- resuscitation equipment

Ensure adherence to the **Practice infection control guidance**.

There should always be a third party present in case of cervical shock.

If shock develops
- stop procedure
- place patient head down
- maintain airway
- if severe bradycardia, give atropine 0.6mg
- administer O_2 via mask or ambubag

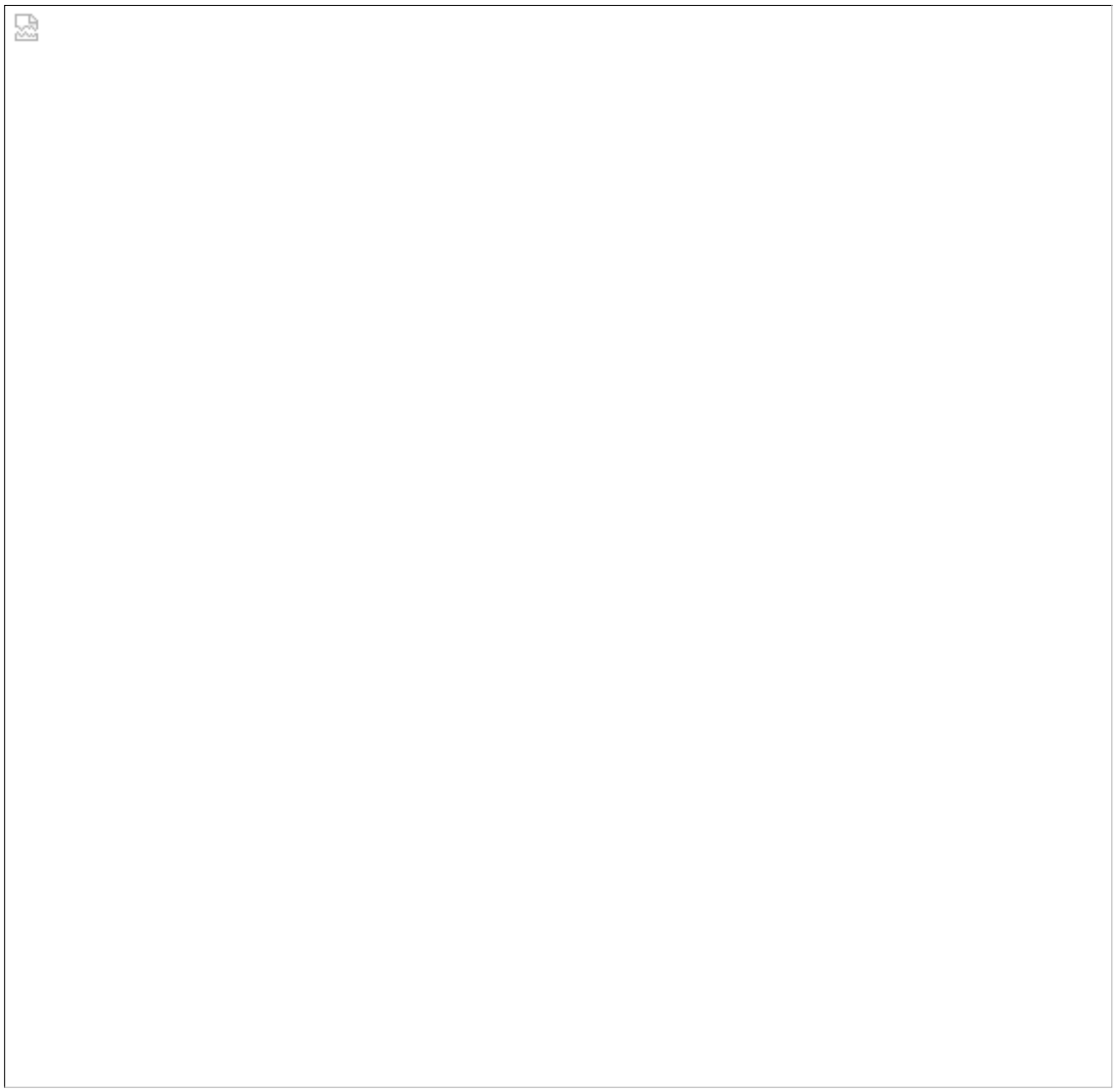
Advice to patient after insertion
- feeling for threads
- bleeding in first 24 hours is to be expected
- pain – NSAID should control the cramp-like pain
- watch out for sudden acute pain/discharge – need to see doctor
- TCI if miss a period
- use of condoms to prevent infection

Follow up
See after 6-8 weeks to check no problems
See annually to check for threads and any problems

Lost threads

Possible causes:

Pregnant	*Not pregnant*
Unrecognised expulsion + pregnant	Unrecognised expulsion + not yet pregnant
Perforation + pregnancy	Perforation + not yet pregnant
Device in situ + pregnant	Device in situ and malpositioned or threads short



Actinomyces-like organisms (ALOs)

These organisms are frequently reported on smears in patients with IUCDs in situ. They *can* cause a pelvic infection, but it is very rare. Current guidance suggests that we should only be concerned if there are relevant symptoms (discharge, pain, dyspareunia, tenderness), in which case the IUCD should be removed, and the IUCD sent for culture. If culture is positive, Rx with penicillin will be needed for many months. If they are asymptotic, then the most recent guidance from the Faculty of Family planning is to do nothing, but advise patients what symptoms to look out for.

Pregnancy

If a patient becomes pregnant with IUCD in situ, remove before 12 weeks whether or not the patient is continuing with the pregnancy.

The Levonorgestrol-releasing intrauterine system (LNG-IUS)

This is basically shaped like a Nova-T and releases 20microg/24 hours of levnorgestrol.
NB
The LNG-IUS is NOT suitable for use as a post-coital contraceptive

Advantages/indications

- very efficient – failure rate 0.2/100 woman-years
- return of fertility rapid and complete
- reduction in menstrual blood loss and dysmenorrhoea
- can be used as the progestogenic component of an HRT regime (although not yet licensed for this indication) so ideal in perimenopausal women
- reduces risk of PID
- reduced risk of ectopic

Disadvantages/side-effects

- usual risks associated with IUCD insertion – perforation/expulsion
- heavy/irregular bleeding in first few months
- small incidence of progestogenic SE

History

absolute contraindications

- allergy to levonorgestrol
- suspected pregnancy
- unexplained uterine bleeding
- recent proven STD
- severely distorted uterine cavity
- current active liver disease or tumour
- past attack of SBE or valve replacement
- severe immunodeficiency
- current active trophoblastic disease with raised HCG
- current active arterial disease

History required

- PMH/PSH
- gynae/obstetric history
- sexual history – particularly no. of partners
- current gynae symptoms
- previous rubella vaccination
- date of last smear

Counselling pre-insertion

- failure rate (0.4% failure rate at 5 years; 0.09/100 women years – similar to sterilization)
- checking of threads
- perforation risk (1:1000)
- bleeding
- how device is fitted
- importance of reporting pain/bleeding
- how long it will last

Insertion

See IUD section – insertion is identical to an ordinary IUCD
See after 6-8 weeks to check no problems

See annually to check for threads
IUS inserted after 45 years of age may be retained for up to 7 years rather than 5 years
If IUS is used as progestogen component of HRT it needs to be changed 3-yearly, not 5-yearly

Monitoring and audit

- 3/12ly monitoring search on all patients with IUCD fitted:
  - Ø invite due or overdue annual checks for review
  - Ø invite overdue or missed 6-8 week checks for newly fitted IUCDs
- Annual audit:
  - Ø No of annual checks
  - Ø No of removals and reason for removal
  - Ø No of complications and types of complications

Emergency contraception

Oral – levonorgestrel 1.5 g single dose

Absolute contraindications
- Severe liver disease
- Acute porphyria
- At time of presentation >72 hours since UPSI or menstruation overdue and previous UPSI

History
- LMP
- time of SI
- contraceptive intentions

Counselling
- how to take
- SE (few)
- what to do if vomit/diarrhoea
- TCI if period late – check pregnancy test – occasionally some women bleed in pregnancy

Give prescription and FPA leaflet. Arrange future contraception.

Emergency IUCD

This is an under-used form of emergency contraception, as it also provides on-going contraception. It is very effective, and can be used up to 5 days after the risk event, **OR up to 5 days after the earliest possible date of ovulation.**

History

Contraindications
- as for IUCD under usual circumstances, although it can be used in some women with relative contraindications as a temporary measure and removed after a couple of cycles. This is relevant in women who had unprotected sex more than 72 hours ago.

History required
- current state of health
- exact history of risk event – timing, contraception used, point in cycle (particularly relevant) PMH/past gynae history

Counselling
- failure rate
- usual IUCD counselling
- discuss future contraception

Insertion

As usual IUCD insertion., except that swabs should be done at the same time as insertion.

Follow up

See after next period to discuss future contraceptive needs.

First Prescription for Depot

absolute contraindications
- undiagnosed vaginal bleeding
- pregnancy
- active liver disease
- h/o breast cancer
- severe arterial disease

relative contraindications
- h/o depression
- FH osteoporosis

history required
- menstrual history
- drugs
- FH
- Rubella vaccinate
- last smear
- general medical history
- smoking status

examination
- exam
- weight

advice/explanation
- mode of action
- risks/SE (delayed return of fertility up to 1 year, increased risk of osteoporosis for young women, but no increased risk of fracture – bone density returns to normal after stopping – review 2-yearly to consider alternatives [study showed reduced density if used >5 years)
- irregular bleeding
- weight gain 2-3 kg over 1 year
- headaches
- give FPA leaflet
- when to come - 12 weeks – can come in for early injection from 9 weeks onwards if breakthrough bleeding starts (check no STI or other cause)
- who to contact if problems

give injection
- If given Day 1-5 of period cover starts immediately. (At any other time needs 7 days alternative contraception.)
- Ensure details of the injection are recorded (use template)

file consultation
check under diary entries and give patient review date

Depot Follow-Up

problems?
- bleeding - consider early injection
- added oestrogen

weigh

give injection

- If given Day 1-5 of period cover starts immediately. (At any other time needs 7 days alternative contraception.)
- Ensure details of the injection are recorded (use template)

file consultation
check under Diary entries and give patient review date

Implanon

Direct patient to FPC.