CONTRACEPTION UPDATE 2016

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Declaration of interests

- Freelance writer and editor for a variety of organisations including RCGP, Pulse, MIMS, BMJ
- No pharma interests to declare
Session summary

- UKMEC 2016 update
- Emergency contraception and quickstart
- Resolving problems with LARC
UKMEC 2016 update

■ 1996 → WHO medical eligibility criteria for contraceptive use
■ UK version 2006, updated 2009 and 2016
UKMEC - basics

- Covers safety, not efficacy

<table>
<thead>
<tr>
<th>UKMEC</th>
<th>DEFINITION OF CATEGORY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Category 1</td>
<td>A condition for which there is no restriction for the use of the method</td>
</tr>
<tr>
<td>Category 2</td>
<td>A condition where the advantages of using the method generally outweigh the theoretical or proven risks</td>
</tr>
<tr>
<td>Category 3</td>
<td>A condition where the theoretical or proven risks usually outweigh the advantages of using the method. The provision of a method requires expert clinical judgement and/or referral to a specialist contraceptive provider, since use of the method is not usually recommended unless other more appropriate methods are not available or not acceptable</td>
</tr>
<tr>
<td>Category 4</td>
<td>A condition which represents an unacceptable health risk if the method is used</td>
</tr>
</tbody>
</table>
UKMEC - basics

- Safety may be different for initiation versus continuation of a method

- Tables for each method and summary tables for each medical category
2016 changes - general

- Much more user friendly online version
2016 changes - general

- Much more user friendly online version
<table>
<thead>
<tr>
<th>CONDITION</th>
<th>CATEGORY</th>
<th>CLARIFICATION/EVIDENCE</th>
</tr>
</thead>
<tbody>
<tr>
<td><em>See additional comments at end of section</em></td>
<td>Initiation</td>
<td>Most evidence available relates to COC use. However, this evidence also applied to use of the contraceptive patch and ring.</td>
</tr>
</tbody>
</table>

### PERSONAL CHARACTERISTICS AND REPRODUCTIVE HISTORY

#### Pregnancy

- **Age**
  - Menarche to <40 years: 1
  - 249 years: 2

#### Parity

- Nulliparous: 1
- Parous: 1

#### Postpartum (in breastfeeding women)

- 0 to <6 weeks: 4
- 26 weeks to <6 months (primarily breastfeeding): 2
- 26 months: 1

#### Postpartum (in non-breastfeeding women)

- 0 to <3 weeks
  - With other risk factors for VTE: 4
  - Without other risk factors: 3
- 3 to <6 weeks
  - With other risk factors for VTE: 3
  - Without other risk factors: 2
- 26 weeks: 1

#### Post-abortion

- Clariification: Includes induced abortions and spontaneous miscarriage <24 weeks gestation.
2016 changes

- No split categories
- Conditions added and removed

<table>
<thead>
<tr>
<th>Added</th>
<th>Removed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bariatric surgery</td>
<td>Schistosomiasis (refer to WHOMEC)</td>
</tr>
<tr>
<td>Cardiomyopathy</td>
<td>Malaria (refer to WHOMEC)</td>
</tr>
<tr>
<td>Post transplant</td>
<td>Raynaud’s phenomenon (risk relates to underlying disease)</td>
</tr>
<tr>
<td>Cardiac arrhythmias</td>
<td>Drug interactions (refer to up to date resources)</td>
</tr>
<tr>
<td>Rheumatoid arthritis</td>
<td></td>
</tr>
<tr>
<td>Positive antiphospholipid antibodies</td>
<td></td>
</tr>
</tbody>
</table>
## 2016 changes

- Layout of summary tables prioritises LARCs

<table>
<thead>
<tr>
<th>CONDITION</th>
<th>Cu-IUD</th>
<th>LNG-IUS</th>
<th>IMP</th>
<th>DMPA</th>
<th>POP</th>
<th>CHC</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>CARDIOVASCULAR DISEASE (CVD)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Multiple risk factors for CVD (such as smoking, diabetes, hypertension, obesity and dyslipidaemias)</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>3</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Hypertension</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>a) Adequately controlled hypertension</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>b) Consistently elevated BP levels (properly taken measurements)</td>
<td></td>
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<td></td>
<td></td>
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</tr>
<tr>
<td>(i) Systolic &gt;140–159 mmHg or diastolic &gt;90–99 mmHg</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>(ii) Systolic &gt;160 mmHg or diastolic ≥100 mmHg</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>c) Vascular disease</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>3</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>History of high BP during pregnancy</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Current and history of ischaemic heart disease</td>
<td>1</td>
<td>I</td>
<td>C</td>
<td>I</td>
<td>C</td>
<td>3</td>
</tr>
<tr>
<td></td>
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</tr>
<tr>
<td>Stroke (history of cerebrovascular accident, including TIA)</td>
<td>1</td>
<td>I</td>
<td>C</td>
<td>I</td>
<td>C</td>
<td>3</td>
</tr>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Known dyslipidaemias</td>
<td>2</td>
<td>3</td>
<td>2</td>
<td>3</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Venous thromboembolism (VTE)</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
</tr>
</tbody>
</table>
2016 changes - postpartum

- Fully/near fully breastfeeding from 6/52 to 6/12 goes from 3 to 2 for CHC
- Fitting of an IUCD or IUS within 48 hours now category 1
2016 changes - bariatric surgery

- All methods category 1 with regard to the surgery itself
- Normal BMI limits apply for CHC
2016 changes - transplant surgery

■ Uncomplicated = category 2
■ Complicated = CHC and insertion of IUCD are category 3
2016 changes - CVS risk factors and CHC

- Dyslipidaemia changes from 2/3 to 2
- Multiple risk factors for CVS disease changes from 3/4 to 3
- Smokers over 35 unchanged:
  - $\geq 15 = 4$
  - $<15 / \text{within one year of stopping} = 3$
  - Stopped for more than a year = 2
Emergency contraception - ulipristal

- Selective progesterone receptor modulator
- Inhibits or delays ovulation and may alter endometrium
- Licensed to 120 hours after UPSI
- More expensive than levonorgestrel
STATEMENT FROM THE CLINICAL EFFECTIVENESS UNIT
September 2015

Faculty of Sexual and Reproductive Healthcare (FSRH) response to new data on quick-starting hormonal contraception after use of ulipristal acetate 30mg (ellaOne®) for emergency contraception.
Quickstart

■ Starting contraception not at the next period
  - If reasonably sure that the woman is not pregnant/at risk of pregnancy
  - If pregnancy cannot be excluded (e.g. after administration of EC) but a woman is “likely to continue to be at risk of pregnancy or has expressed a preference to start contraception without delay”
FSRH statement

■ 2 concerns:

1. Ulipristal may affect efficacy of any hormonal contraception quickstarted at the same time

2. Quickstarting a hormonal contraception may affect the ability of ulipristal to prevent pregnancy
2. Quickstarting a hormonal contraception may affect the ability of ulipristal to prevent pregnancy
“After UPA alone, ovulation occurred within five days of administration in only one out of 29 cycles studied. In contrast, when desogestrel 75mcg was quick-started immediately after UPA administration, ovulation occurred within five days (when sperm would remain potentially viable) in 13 out of 29 cycles. The difference in ovulation rate is significant (p=0.0054).”

“In the absence of evidence regarding other POP formulations and other hormonal contraceptive methods, the CEU would recommend that after taking UPA for EC, a woman should not start a hormonal contraceptive method for at least 5 days and be advised to use barrier methods or to abstain from sex until effective hormonal contraceptive cover has been achieved.”
### FSRH statement

<table>
<thead>
<tr>
<th>UPA = day 0</th>
<th>Methods</th>
<th>Requirement for additional contraception</th>
</tr>
</thead>
<tbody>
<tr>
<td>UPA then wait at least 5 days</td>
<td>Combined oral contraceptive pill (except Qlaira®)</td>
<td>7 days</td>
</tr>
<tr>
<td></td>
<td>Qlaira®) Combined oral contraceptive pill</td>
<td>9 days</td>
</tr>
<tr>
<td></td>
<td>Combined vaginal ring/ transdermal patch</td>
<td>7 days</td>
</tr>
<tr>
<td></td>
<td>Progestogen-only pill (traditional/ desogestrel)</td>
<td>2 days</td>
</tr>
<tr>
<td></td>
<td>Progestogen-only implant or injectable</td>
<td>7 days</td>
</tr>
</tbody>
</table>
Resolving problems with LARCs

- Bleeding with implant
- BV with IUCD
Implant and bleeding

- 20% are amenorrhoeic
- 30% have infrequent bleeding (<3 episodes in 3/12)
- <10% have frequent bleeding (>5 episodes in 3/12)
- 20% have prolonged bleeding (for ≥ 14/7)
Implant and bleeding

- Advise women of the likely bleeding before insertion
- Exclude other causes/STI/pregnancy and consider speculum examination
- Check smear history
Implant and bleeding - first line

- COC for up to three months, continuously or cyclical
- Mefenamic acid
- Tranexamic acid
- Mifepristone
- Doxycycline
“Extended dual use of the COC and progestogen-only implant has not been studied and therefore any risks associated with this practice are unknown. The decision to co-administer the COC and progestogen-only implant beyond 3 months is a matter of individual clinical judgement.”
IUCD and BV

■ FSRH 2016 “BV is associated with use of the Cu IUCD ...association between BV and the LNG-IUS is unclear”

■ “Cu-IUD users with recurrent BV may wish to consider an alternative method of contraception”
IUCD and BV

- General advice - avoid douching or antibacterial soap
- Treatment of episodes - metronidazole/clindamycin
- Recurrence:
  - Metronidazole gel 0.75% twice weekly 4-6 months (CDC/BASHH/FSRH)
  - PO metronidazole 2g monthly with fluconazole 150mg (CDC)
  - Probiotic lactobacilli (BASHH)
  - Acidifying gels e.g. Balance Activ (FSRH)
Questions?