BELMATT
HEALTHCARE TRAINING

CONTRACEPTION AND SEXUAL HEALTH

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AIMS OF SESSION

- To be able to offer women an effective choice consultation for contraception
- To be able to deal with simple contraception problems
- To have a brief insight into what's new in the contraception world

CONTRACEPTION – WHY BOTHER?

- **50%** of unintended pregnancies occur in women not using any contraception in the month they conceive

- **4 in 10** women are using their method inconsistently/incorrectly

- Only **1 in 20** unintended pregnancies are attributable to method failure

GENERAL PRINCIPLES (1)

- Many individual factors affecting a couples choice of contraception
- Advice should be given on all methods that are medically eligible
- To be effective, contraception must be used consistently and correctly
- For long acting methods to be cost effective the continuation rate must be high

UKMEC ELIGIBILTY CRITERIA

- 1 = A condition for which there is no restriction for the use of the contraceptive method
- 2 = A condition where the advantages of using the method generally outweigh the theoretical or proven risks
- 3= A condition where the theoretical or proven risks usually outweigh the advantages of the method
- 4= A condition which represents an unacceptable health risk if the contraceptive method is used

COMBINED ORAL CONTRACEPTION

- Works primarily by inhibiting ovulation via it's action on the hypothalamo-pituitary axis, reducing LH and FSH
- Additional effects on the endometrium and cervical mucus
- **First 7 pills of a packet inhibit ovulation**, the rest maintain anovulation
- New guidance moved towards continual regimen

COMBINED ORAL CONTRACEPTION

- Failure rate in perfect use 0.1% but in typical use averages at 5%
- The most used hormonal method. Can be used from menarche to **age 50** depending on risks
- Important potential harms which need to be assessed with all first prescriptions.
- Should not be given to smokers over 35 unless stop for over 1 year

COMBINED ORAL CONTRACEPTION

- Not recommended in women of any age if hx of migraine with aura. Not used in women >35 if migraine without aura
- Liver enzyme inducing drugs reduce the efficacy so consider alternatives.
- Not recommended if BMI >35 due to increased VTE and MI risk. Remember to ask about FH VTE in first degree relatives >45 years age

PROGESTERONE ONLY PILLS

- SAFE FOR THE MAJORITY
- ONLY UKMEC 4 IS CURRENT BREAST CANCER

MODE OF ACTION

- All POPs alter cervical mucus to prevent sperm penetration into the upper reproductive tract

- For some women ovulation is inhibited
- 60% on levonorgestrel, 95% on desogestrel

- Take same time every day with no pill-free interval. 99% effective if taken regularly, increases with age and parity

MISSED PILLS

- >3hrs late (12hrs with desogestrel)
- Take late pill when remember and next pill at usual time. Barrier methods for next 48hrs
- Sex before missed pill is still protected

SIDE EFFECTS

- Altered bleeding pattern

- 2 in 10 no bleeding
- 4 in 10 regular bleeding
- 4 in 10 irregular bleeding

- 10-25% discontinue use at 1 year due to bleeding

FINAL POINTS

- Can continue until 55 years of age when natural loss of fertility can be assumed
- No longer any evidence to support the taking of 2 POPs a day if >70kg
- No delay in fertility following discontinuation of POP

DEPO - PROVERA

- Works primarily by inhibiting ovulation
- Thickening of cervical mucus inhibiting sperm penetration into the upper reproductive tract
- Also changes the endometrium making it unfavourable for implantation
- Introduction of new subcut version (Sayana Press) which allows self administration after teaching

DEPO - PROVERA

- Failure rates if given regularly are <4 in 1000 over 2 years
- No max duration of use, review every 2 years in over 40's. Can continue using until age of 50
- Causes a delay in fertility following discontinuation of up to 1 year, but no evidence of reduced fertility long term

DEPO - PROVERA

- More cost effective than COCP after just 12 months due to reduction in number of unwanted pregnancies
- UKMEC 4 – CURRENT BREAST CANCER
- **No interaction with Liver Enzyme-Inducing drugs. This is especially important in patients on anti-epileptic drugs or St. Johns wort**

INITIATION

- Day 1-5 of cycle for immediate cover. 7 days of additional contraception if any other time of cycle

- Return every 12 weeks but can be given after 10 weeks if needed. Can leave up to **14 weeks** without need for additional contraception

SIDE EFFECTS (1)

- 80% have altered bleeding pattern
- Up to 70% amenorrhoeic at 1 yr of use
- Association between depo and weight gain, mean gain 3kg at 2yrs
- Data varies but up to 50% discontinue at 1 yr due to bleeding or weight gain

SIDE EFFECTS (2)

- No proven association with mood change, libido, headache or cardiovascular disease
- Concerns on Bone Mineral Density if <18yrs and in older women. Recovers after discontinuation. Therefore review every 2 years and only use <18 or >40 if other methods unacceptable
- Reconsider use if any risks of osteoporosis

IMPLANON

- Single sub dermal rod, licensed for 3 years
- Contains 68mg etonogestrel
- UKMEC 4 = current breast cancer

IMPLANON

- Primary mode of action is inhibition of ovulation
- Also alters cervical mucus to prevent sperm penetration and inhibits normal endometrial development
- Pregnancy rate <1 in 1000 over 3yrs, very few true failures

IMPLANON

- No reduction in efficacy if BMI >30 so no restriction of use but manufacturers still suggest reviewing changing after 2 years
- No delay in fertility after removal
- Can use in migraine with or without aura unless develop new symptoms whilst using
- Efficacy affected by liver enzyme inducing drugs but not non liver enzyme inducing antibiotics

SIDE EFFECTS

- Altered bleeding common.
- 20% get no bleeding
- 50% infrequent, frequent or prolonged bleeding

- 25% discontinue at 1yr, up to 43% by 3 yrs

- Acne can improve or worsen

- No causal association with weight change, mood change, reduced libido or headache

INTRAUTERINE CONTRACEPTION

- Safe option for most women
- Need to consider STI risk and screening for Chlamydia and gonorrhoea prior to fitting
- UKMEC 4 = current PID, pregnancy, septic abortion, puerperal sepsis, cervical Ca, endometrial Ca, unexplained vaginal bleeding, anatomical distortion of uterine cavity e.g. Fibroids
- In addition IUS also CI in active liver disease/tumours, current breast cancer

INTRAUTERINE CONTRACEPTION

- Efficacy determined by many factors such as sexual activity, age, parity
- In women who are high risk STI with no swab results antibiotic cover should be given e.g. Single dose 1g azithromycin
- TCU380 appears more effective than other copper IUDs
- At 5 years use failure rate <2% with TCU380 and <1% with IUS

INTRAUTERINE CONTRACEPTION

- TCU380 licensed for 10 years
- If inserted after age 40 can be retained until confirm menopause
- Mirena licensed for **5 years for contraception and menorrhagia, 5 years for endometrial protection in HRT**
- If inserted after age 45 provides effective contraception until 55 years. Can be retained until menopause is confirmed or until contraception no longer required

COPPER IUD

- Copper is toxic to ovum and sperm and inhibits sperm penetration
- Works primarily by inhibiting fertilisation
- Endometrial inflammatory reaction which has an anti-implantation effect

MIRENA - IUS

- Effect mediated by progestogenic effect on the endometrium which prevents implantation
- Within 1 month of insertion high intrauterine concentrations of levonorgestrel (releases 20mcg day)induce endometrial atrophy
- Reduction in sperm motility and penetration through cervical mucus
- Has little effect on the hypothalamic-pituitary-ovarian axis so estradiol concentrations not reduced and majority continue to ovulate

MIRENA – MAIN BENEFITS

- Overall reduced menstrual flow
- Reduced No. Bleeding days
- Less dysmenorrhoea and premenstrual syndrome
- Progestogenic arm of HRT
- Only contraception with separate license for menorrhagia
- Reduced need for hysterectomy

- "REVERSIBLE STERILISATION"

JAYDESS/KYLEENA

- Licensed for contraception only
- Jaydess for 3 years and Kyleena for 5 years
- Smaller, narrower coil so easier to fit on nullips and young girls
- Lower doses of hormone – less likely to cause amenorrhoea (20%) but lighter bleeds generally
- Same fitting mechanism as Mirena

NUVARING

- Combined contraceptive vaginal ring. Releases 15mcg ethinylestradiol and 120mcg etonogestrel a day. Same CI's currently as COCP
- Insert for 3 weeks and then 1 week without. Excellent cycle control
- Change for new ring each time
- Costs approx £9 month
- Only has 4 month shelf life once out of fridge so prescribe max 3 month supply

EMERGENCY CONTRACEPTION

Emergency contraception

- Levonelle can be given up to 72 hours post UPSI. It can be given after this time but patients need to know it is unlikely to be effective
- There is no limit to how many times a patient can have Levonelle in any one cycle
- Copper IUD can be inserted up to 5 days post UPSI, or 5 days after expected date of ovulation

ELLA ONE

- Licensed for use up to 120hrs after UPSI.
- First line now in women over 70kg and those not on any progesterone 7 days before or 5 daysafter taking it
- Can also now be used more than once in a cycle
- Still not as effective as emergency IUD

EMERGENCY IUD

- Copper IUD can be inserted up to 5 days post UPSI, or 5 days after expected date of ovulation
- Most reliable method of EC as working on preventing implantation rather than ovulation, so can be used effectively after ovulation has already occurred
- Provides a good method of ongoing contraception after
- Most patients decline due to invasiveness of procedure. Can be very uncomfortable on young girls who are nullips and mid cycle

Sexual Health

Causes of Vaginal Discharge

Management of common Vaginal infections

STI management

Vaginal Discharge

- **Normal physiological vaginal discharge** is a white or clear, non-offensive discharge that can vary over time. For example:

  - It is thick and sticky for most of the menstrual cycle but becomes clearer, wetter, and stretchy for a short period around the time of ovulation.
  - It is heavier and more noticeable during pregnancy, with contraceptive use, and with sexual stimulation.
  - It decreases in volume at menopause due to a fall in oestrogen levels.

Vaginal Discharge

- **Abnormal vaginal discharge** is characterized by a change of colour, consistency, volume, and/or odour, and may be associated with symptoms such as itch, soreness, dysuria, pelvic pain, or intermenstrual or post-coital bleeding.

- It is most commonly caused by infection; however, there can be non-infective causes.

Vaginal Discharge

- **Vaginal infections,** such as:
  - Bacterial vaginosis (the most common cause of abnormal vaginal discharge) — caused by an overgrowth of anaerobic bacteria, particularly *Gardnerella vaginalis*
  - Vaginal candidiasis — caused by fungal infection with *Candida albicans*
  - Trichomoniasis (less common) — a sexually transmitted infection (STI) caused by the protozoan *Trichomonas vaginalis*.
- **Endocervical infections** caused by sexual transmission of chlamydia or gonorrhoea
  - The infection may remain localized causing cervicitis, or ascend to the upper genital tract causing pelvic inflammatory disease (PID).

Vaginal Discharge

- **Noninfective causes :**

- A retained foreign body, such as a tampon, condom, or vaginal sponge.
- Inflammation due to allergy or irritation eg deodorants, lubricants, and disinfectants.
- Tumours of the vulva, vagina, cervix, and endometrium.
- Atrophic vaginitis in post-menopausal women.
- Cervical ectopy or polyps.
- Fistulae.
- Recent childbirth or vaginal surgery
- Physiological causes — the nature of physiological discharge can vary over time

Vaginal Discharge

- **. Take a detailed medical history:**

- **Ask about:** Characteristics of the discharge, onset, duration, colour, odour, consistency, and associated symptoms.
  - **Bacterial vaginosis (BV)** is characterized by a fishy-smelling, thin, grey/white homogeneous discharge that is not associated with itching or soreness.
  - **Vaginal candidiasis** is characterized by a white, odourless, curdy discharge that may be associated with vulval itching and superficial soreness.
  - **Trichomoniasis** is characterized by a fishy-smelling, yellow/green frothy discharge that may be associated with itching, soreness, and dysuria.
  - **Cervicitis or pelvic inflammatory disease (PID)** is characterized by vaginal discharge associated with post-coital or intermenstrual bleeding, dysuria, deep dyspareunia, or lower abdominal pain.

Vaginal Discharge

- Any exacerbating factors (such as after intercourse).
- Any treatments tried (prescription or over-the-counter) and their effects.
- The use of vaginal products, such as douches, deodorant, and vaginal washes.
- Cyclical symptoms.
- Past medical history.
- Drug history, including contraceptive use.

Vaginal Discharge

- The recommendation is to consider referring women at high risk of a STI or with characteristic features of trichomoniasis, cervicitis, or pelvic inflammatory disease (PID) to a genito-urinary medicine (GUM) clinic
  - *Chlamydia trachomatis* and *Neisseria gonorrhoeae* are cervical organisms, and the infection may remain localized causing cervicitis, or ascend to the upper genital tract causing PID.
  - Trichomoniasis is difficult to diagnose in primary care (and should always be treated in the GUM clinic).
  - Referral to GUM clinic will facilitate screening for other infections and partner notification (which is required for anyone with microbiologically confirmed gonorrhoea, chlamydia, or trichomoniasis).
  - The prescriber should take a thorough history and not simply rely on the woman's self-diagnosis.
  - Women with recurrent symptoms or those who fail to improve should be examined and investigated.

Vaginal Discharge

- **Consider a suspected cancer pathway referral (for an appointment within 2 weeks)** for women with suspected gynaecological cancer

  - **Arrange referral (for same day assessment) to a genito-urinary medicine (GUM) clinic for investigation and management** for women with suspected pelvic inflammatory disease (PID).

- **Management in primary care:**
  - **Manage infective causes of abnormal vaginal discharge.**
    - For women with suspected bacterial vaginosis or vaginal candidiasis, prescribe empirical antibiotic treatment.
    - For symptomatic women with cervicitis, treat for chlamydia while awaiting swab results)
    - For symptomatic women with suspected PID if same day treatment in a GUM clinic is not possible, prescribe empirical antibiotic treatment.

Chlamydia

- If chlamydia is confirmed or suspected it is highly recommended to refer to GUM clinic
- If patient is unable or refuses to attend then swab and start treatment in primary care. No need to wait for swabs
- Treatment with Doxycyline 100mg BD for 7 days or Azithromycin 1g stat and then 500mg OD next 2 days if pregnant or intolerant

Chlamydia

- Advise patient to avoid all SI (including oral) until after patient and partner have completed course of treatment (or 7 days after azithro)
- Provide written info on chlamydia infection. A good patient info leaflet is available from BASHH
- Strongly advise screening for other STIs as often have more than one at a time
- If result comes back positive should be referred to GUM for partner notification

Gonorrhoea

- STI caused by Neisseria Gonorrhoeae.
- Uncomplicated localised and primarily affects the mucous membranes of the urethra, endocervix, rectum, pharynx and conjunctiva
- In women can test for GC on same swab as chlamydia
- Treatment is with Ceftriaxone 1g IM stat so better to refer to GUM
- Requires partner notification and test for other STIs

Trichomonas

- STI caused by flagellated protozoan Trichomonas Vaginalis
- Most common non viral STI
- Ideally should be treated in a GUM clinic. If refuses then patient info available from FPA (trichomonas vaginalis – looking after your sexual health)
- Treat with metronidazole oral 400-500mg BD for 5-7 days
- Treat current partner simultaneously and any other partners in last 4 weeks
- Refrain from SI for at least 1 week until both treated

Genital Herpes

- Consider diagnosis with any new painful genital ulcers
- Commence oral antivirals within 5 days of start of symptoms
- Caused by HSV, usually type II but can be type 1
- Treat with oral acyclovir 400mg TDS for 5-10 days or 200mg 5 times a day for 5-10 days
- Consider local anaesthetic cream/gel to help with the pain