Contraception update 2023

BELMATT
HEALTHCARE TRAINING

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Combined Oral Contraception Latest Guidance

- FSRH released new guidance in Jan 2019 (updated feb 2019)
- Women should be given information about both standard and tailored CHC regimens to broaden contraceptive choice.
- The FSRH supports off-label use of tailored CHC regimens using monophasic CHC that are licensed to be taken as a 21/7 regimen
- Regimens vary from shortened PFI to no interval at all
- Consider using a 20mcg preparation first line and increase to 30mcg if bleeding doesn’t settle

Why a new regimen?

- Tailored combined hormonal contraceptive regimens can reduce the frequency of withdrawal bleeds and can reduce withdrawal symptoms associated with the hormone-free interval

- The traditional 21/7 CHC regimen with a monthly withdrawal bleed confers no health benefit over other patterns of CHC use. If using this consider a 21/4 regimen instead

- Symptoms associated with the PFI can be problematic and ovarian activity during a 7-day HFI could risk escape ovulation

- Having no PFI reduces pregnancy risk

What are the possible issues?

- Women should be advised that use of tailored CHC regimens is outside the manufacturer's licence but is supported by the Faculty of Sexual & Reproductive Healthcare (FSRH).
- This means manufacturer's will not be likely to change their packaging or instructions
- Unscheduled bleeding is more common with tailored regimens so careful discussion about when to take breaks if bleeding occurs is needed
- Too much choice leads to less compliance?

Non Contraceptive Benefits of CHC

- Use of CHC can reduce heavy menstrual bleeding and menstrual pain and improve acne.
- Use of CHC may be beneficial for women with premenstrual syndrome symptoms.
- Use of CHC (particularly continuous CHC regimens) can reduce risk of recurrence of endometriosis after surgical management.
- CHC can be used for management of acne, hirsutism and menstrual irregularities associated with polycystic ovary syndrome.

Health Risks of CHC

- Current use of CHC is associated with increased risk of VTE; some CHC formulations are associated with a greater risk of VTE than others, dependent on progestogen type and estrogen dose.

- Current use of CHC is associated with a very small increased risk of breast cancer which reduces with time after stopping CHC.

- Current use of CHC is associated with a very small increased risk of myocardial infarction (MI) and ischaemic stroke that appears to be greater with higher doses of estrogen in COC.

Other Key Changes

CONSULTATIONS ABOUT CHC DO NOT NECESSARILY HAVE TO BE FACE-TO-FACE; ONLINE/TELEPHONE CHC PROVISION IS POSSIBLE

AT THE FIRST CONSULTATION, MANY WOMEN CAN SAFELY BE PRESCRIBED A ONE YEAR SUPPLY OF CHC INSTEAD OF THE CURRENT THREE MONTH SUPPLY

IUS and IUD options

COPPER IUD – NON HORMONAL

MIRENA IUS

KYLEENA (AND JAYDESS) LOW DOSE IUS

IUS/IUD Contraception

- Safe option for most women
- Need to consider STI risk and screening for Chlamydia and gonorrhoea prior to fitting. Can use prophylactic antibiotics if results not available, Azithromycin 1g stat plus 500mg next 2 days, consider Doxycycline as alternative due to resistance
- UKMEC 4 = current PID, pregnancy, septic abortion, puerperal sepsis, cervical Ca, endometrial Ca, unexplained vaginal bleeding, anatomical distortion of uterine cavity e.g. Large fibroids
- In addition IUS also CI in active liver disease/tumours, current breast cancer

Copper Non Hormonal IUD's

- First line = T-Safe 380 10 year coil as most reliable
- Consider a smaller 5 year device in difficult fits eg Nova T, Mini TT380
- Obvious advantage of no hormones so allows natural cycle pattern and no risk of hormonal side effects
- Main side effect is heavier, longer, more painful periods
- Can be used as emergency contraception

Copper Non Hormonal IUD's

- 0.5-2% failure rate
- 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 IUS

- Irregular bleeding very common in first 3-6 months. May also feel more hormonal initially
- Long term approx. 80% achieve amenorrhoea or infrequent bleeding
- Also benefits for patients with endometriosis, PCOs and possibly PMS, acne

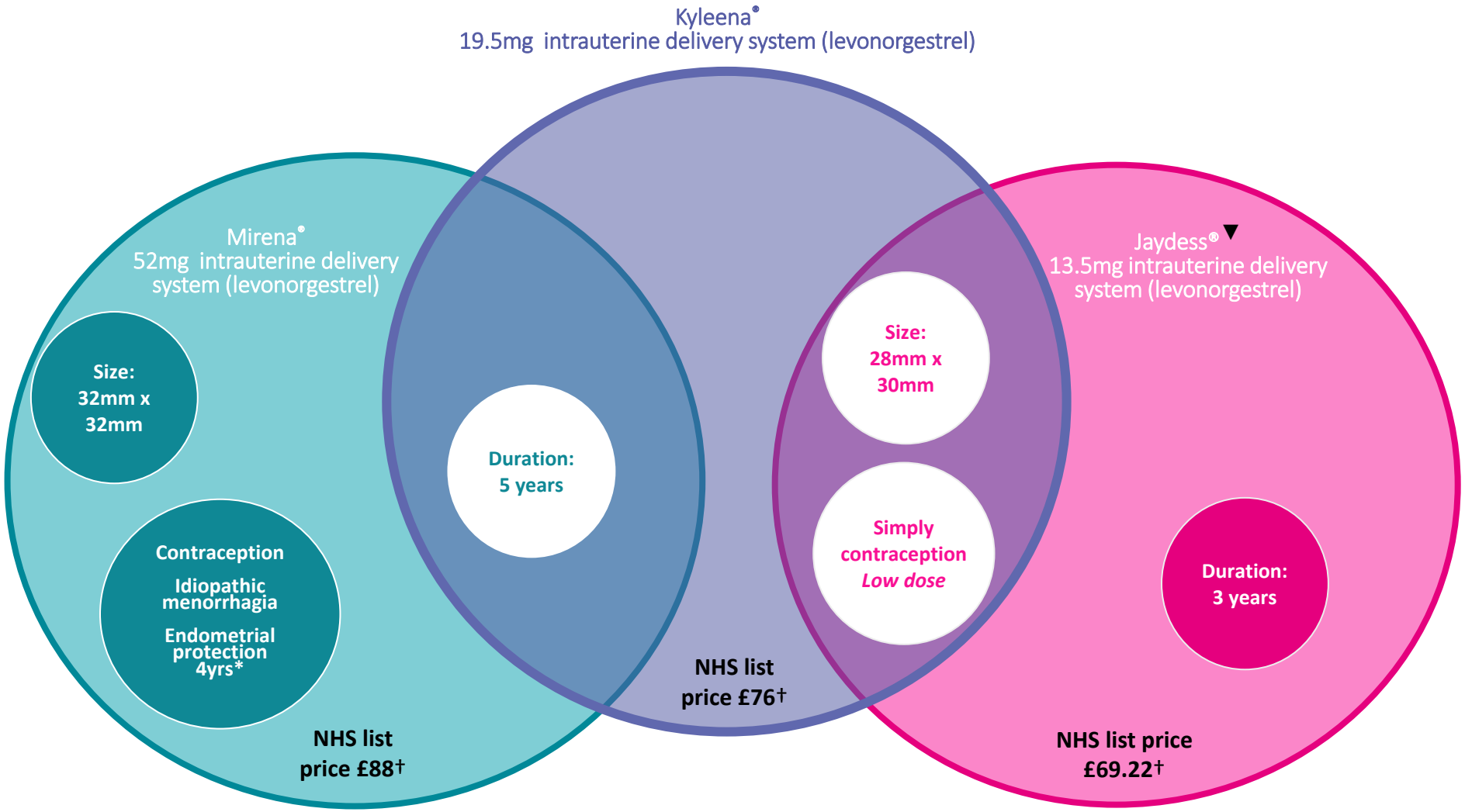
IUS/IUD Contraception

- T-safe 380 licensed for 10 years but if inserted after age 40 can be retained until confirm menopause
- Mirena licensed for **5 years for contraception and menorrhagia, 4 years for endometrial protection (but FSRH guidelines support for 6 years contraception and 5 years for HRT)**
- If inserted after age 45 provides effective contraception until 55 years.
- If using for bleeding and contraception not needed then can keep it for as long as it is working

Kyleena IUS

- Lower dose IUS
- Smaller and easier to fit on nullips or difficult canals
- Less hormonal side effects with an improvement in bleeding compared to using non hormonal IUD’s
- Approx 20% achieve amenorrhoea in the 5 years
- Has replaced Jaydess for most as dose more or less the same with 5 year license and no black triangle around ectopic pregnancy risk

Kyleena® : simply contraception for up to 5yrs



Choose an IUS that best meets her needs

1. Mirena Summary of Product Characteristics (SmPC). Feb 2018
2. Jaydess Summary of Product Characteristics (SmPC). Sept 2017
3. Kyleena Summary of Product Characteristics (SmPC). March 2018

*Endometrial protection during oestrogen replacement therapy

† Price accurate as of January 2018

Emergency contraception – Taking The History

3 Important elements to an Emergency Contraception History:

1) Emergency contraception requirements

2) Ongoing contraception needs

3) STI risk

Emergency contraception – Taking The History

Assessing Emergency Contraception needs:

LMP

Normal cycle length

Date(s) of UPSI and where in the cycle that was

Previous EHC in this cycle

Current contraception

Previous contraception methods tried

Who was the sex with, regular or casual partner

Medical history

Levonelle

- Levonelle can be given up to 72 hours post UPSI. It can be given after this time (0ff licence) 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
- No effect on other hormones so can immediately quick start an ongoing method of contraception and use after recent hormones
- Need to double dose if weight >70KG or on enzyme inducers
- No issues with breast feeding

ELLA ONE

- Licensed for use up to 120hrs after UPSI.
- First line now in women not on any progesterone 7 days before or 5 days after taking it
- Less effective if have been on other hormonal contraception in last 7 days
- Less effective if taken Levonelle in last 7 days
- Need to balance risk of pregnancy now vs ongoing risk pregnancy if unable to quickstart
- Can also now be used more than once in a cycle
- Not as affected by weight like Levonelle
- **Neither are 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

CASE 1- Coil Expulsion

- 43YR old lady with Mirena IUS last 2 years
- Getting on well, no real periods and happy with it
- Felt threads low in her vagina when in shower this morning
- Last SI 2 days ago
- No pain or other symptoms

CASE 1 – Coil Expulsion

- Asked to come down to clinic later that morning for coil check
- On arrival explains that IUS has since fully expelled
- Keen to have another one put back in asap as has 4 children and not wanting anymore

Case 1 – Coil Expulsion

- Initial conversation about current pregnancy risk
- Unknown time IUS has been incorrectly sited so ?already small pregnancy risk from recent SI
- Discussed as IUS not able to fit as emergency coil so potential risk if re-fitted that day
- Suggested option of oral EC and resite IUS after 3 weeks with negative PT but not able to have Ella One as ?progesterone present in last 7 days

Case 1 – Coil Expulsion

- Patient agreed would like to take Levonelle
- Planned to rebook in 3 weeks time for IUS fit
- However ……..
- Asked patient to check PT as a precaution that day and sadly PT was already POSITIVE
- Patient referred to EPAU for assessment to exclude ectopic pregnancy

Case 1 – Coil Expulsion

- Take home learning points:
- If a coil device has expired we can’t be sure how long beforehand it has been low lying or inaccurately placed
- IUS can’t be refitted if recent pregnancy risk
- If using oral EC remember interaction of Ella One with progesterone in last 7 days
- Always check PT first

Case 2 – Patient on Enzyme Inducers

- 25 year old lady inpatient at local MH facility brought in by carer for implant replacement
- Previous implant inserted by her GP 3 years ago, due to expire soon
- Has had current one for 3 years and got on well so happy to have another one
- Is sexually active with a boyfriend who visits regularly

Case 2 – Patient on Enzyme Inducers

- Seen by one of the consultants and implant successfully removed and replaced
- 2 weeks later I was asked to call the carers as since replacement patient had been feeling unwell and vomiting. Had been having regular SI since the replacement, last SI 2 days earlier
- Carers had read the patient information leaflet given to them after the fitting and were concerned about a potential interaction with her medication
- During telephone consultation staff advised patient was taking Topiramate

Case 2 – Patient on Enzyme Inducers

- Patient's records checked and Dr who had done the replacement had listed Topiramate in her regular meds but had not discussed potential interaction with staff or patient
- Staff advised to ask her to start using condoms with immediate effect and check a PT. Appt made to follow up patient in my clinic in 3 weeks so PT could be rechecked
- Initial PT confirmed by staff to be negative
- Advised in meantime to get review with GP to exclude other causes for her symptoms

Case 2 – Patient on Enzyme Inducers

- Patient attended clinic 3 weeks later. Symptoms seemed to have settled after a course of abx for possible UTI
- Staff confirmed she had not been sexually active since I had called 3 weeks ago. Repeat PT negative that day
- Discussed potential reduced efficacy of the implant due to being on enzyme inducing drugs and patient and staff keen to change method
- Patient opted for Depo Provera which was given that day and plans to remove the implant a couple of weeks later. Advised to use condoms for next 7 days

Case 2 – Patient on Enzyme Inducers

01

Take home learning points:

02

Always check medical hx and drugs carefully. In this case the patient had been using the implant previously for 3 years despite being on enzyme inducers, so easy to assume with a replacement that it has been checked before

03

Best methods for those on enzyme inducers are Depo or IUD/IUS as less likely to have any interaction

04

Don’t forget not all symptoms are caused by contraception, consider other causes to!!

Case 3 – Bleeding issues in Perimenopause

50 year old attended for implant removal as due to expire

Had been using implants back to back for last 9 years mainly to help bleeding so not had a period in a long time

Decided not to have a new implant this time as not having regular SI for some time

Wanted to get an idea of whether she was menopausal or not as recently started having some mild hot flushes and felt may not need it for periods anymore

Case 3 – Bleeding issues in Perimenopause

2 weeks after implant removed attended as had a PV bleed and was concerned. Bleed had lasted 3 days and was heavy enough to need a pad

Seen by one of my GP colleagues who was worried about PMB

Had checked FSH which was raised, had never been checked before

After discussion we agreed to watch and wait as more likely not yet postmenopausal. More likely a normal period as implant now removed

Patient had another similar bleed approx. 4 weeks later

Case 3 – Bleeding issues in Perimenopause

- Same patient returns to see my colleague again 3 months later and is having heavy monthly bleeds again
- Wants to restart the implant as stopped her bleeding before. No current partner and not sexually active for some time. Started to have some mild hot flushes and increased anxiety recently
- My partner comes to ask for advice on whether she is too old for an implant and whether it can be used for bleeding issues. Wanted advice on alternative options for this lady

Case 3 – Bleeding Issues in Perimenopause

- Discussed options
- No upper age limit for use of implant if needed for contraception
- No licence for bleeding issues alone but could justify if also still of fertile age
- May be better options for this lady. Would be a good candidate for Mirena IUS to help the bleeding
- Mirena would have added benefits alongside HRT if needed
- Also if contraception not needed then could consider combined HRT to control bleeding and other symptoms

Case 3 – Bleeding issues in Perimenopause

- Take Home Learning Points:

- During early stages of perimenopause periods are likely to still occur quite frequently and regularly
- To diagnose someone as post menopausal they need to have not had a period for 12 months (24 months if less than 50 yrs). Amenorrhoea can't be counted if it has been hormone induced
- A single FSH is not helpful on it's own. Normally need 2 readings with levels higher than 30, at least 6 weeks apart and then 12 months after they are likely to not need contraception

- Although PMB is a serious symptom and should not be ignored, always consider if it really is PMB before doing 2ww referral

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