TRÁNH THAI Ở NGƯỜI TRẺ

Contraceptive Options for Young People

✓ Young people should be informed about all methods of contraception, highlighting the benefits of long-acting reversible contraception (LARC).

✓ Young people may be advised to return for follow-up within 3 months of starting hormonal contraception. This allows side effects or other concerns to be addressed and helps ensure correct use of the method.

C Young people should be encouraged to return at any time if they develop problems with contraception.

C Age alone should not limit contraceptive choices, including intrauterine methods.

✓ Young people should be made aware of the different types of emergency contraception (EC) available, when they can be used and how they can be accessed.

✓ Even if presenting for EC within 72 hours of unprotected sexual intercourse (UPSI), women of all ages should be offered the copper-bearing intrauterine device or advised how they can access it.

Addressing Young People's Health Concerns and Risks

Weight Gain

B Young people may be advised that there is no evidence of weight gain with combined hormonal contraception (CHC) use.

C Young people may be advised that weight gain can occur with depot medroxyprogesterone acetate (DMPA) use but there is little evidence of a causal association between other progestogen-only methods and weight gain.

Acne

B Young people may be advised that combined oral contraception (COC) use can improve acne.

✓ Young women whose acne fails to improve with COC may wish to consider switching to a COC containing a less androgenic progestogen or one with a higher estrogen content.

crypto acetate

C Co-cyprindiol (Dianette®) is indicated to treat severe acne that has not responded to oral antibiotics. In those with less severe symptoms it should be withdrawn 3-4 months after the condition has resolved. For women with known hyperandrogenism, longer use with specialist review may be warranted.

C Young people should be advised that the progestogen-only implant may be associated with improvement, worsening or onset of acne.

Mood Changes and Depression

C Young people may be advised that hormonal contraception may be associated with mood changes but there is no evidence that hormonal contraceptives cause depression.

COC có thể làm giảm mụn trứng cá

Implant có thể giảm cũng có thể tăng mụn trứng cá

Fertility

C Individuals should be advised that there is no delay in return of fertility following discontinuation of the progestogen-only pill or CHC.

B Individuals should be advised that there is no delay in return of fertility after discontinuation of intrauterine contraception or the progestogen-only implant.

C Individuals should be advised that there can be a delay of up to 1 year in the return of fertility after discontinuation of DMPA.

POP, CHC, IUD ko có delay có thay sau khi ngưng tránh thai

DMPA thì có thể delay đến 1 năm

Bleeding Patterns and Dysmenorrhoea

C Individuals should be informed that altered bleeding patterns can occur with hormonal contraception use.

B Primary dysmenorrhoea may improve with use of CHC.

Bone Health

B Young people should be informed that use of the progestogen-only injectable contraceptive is associated with a small loss of bone mineral density which is usually recovered after discontinuation.

C DMPA can be used in women under the age of 18 years after consideration of other methods.

✓ Women who wish to continue using DMPA should be reviewed every 2 years to reassess the benefits and risks.

Addressing Young People's Health Concerns and Risks (continued)

Cancer

B Young people may be advised that COC use is not associated with an overall increased risk of cancer.

B Young people may be advised that COC use reduces the risk of ovarian cancer and that the protective benefit continues for 15 or more years after stopping.

B Young people may be advised that any increase in breast cancer with hormonal contraception use is likely to be small and to reduce after stopping.

B Young people may be advised that there may be a very small increase in the risk of cervical cancer with prolonged COC use.

Sexually Transmitted Infections and Young People

B The correct and consistent use of condoms should be advised to reduce the risk of transmission of sexually transmitted infections (STIs).

✓ When advising condom use, young people should be informed about correct use of condoms and lubricants, different sizes, types and shapes of condoms, and how to access further supplies, STI screening and EC.

C Young people should be advised to have STI tests 2 and 12 weeks after an incident of UPSI.

5.7 Thrombosis

The incidence of venous thromboembolism (VTE) in young women is very low. CHC methods are known to be associated with an increased risk of VTE. Please refer to Table 3. See FSRH Clinical Guideline *Combined Hormonal Contraception.*[42]

Table 3: European Medicines Agency estimated risk of developing a venous thromboembolism (VTE) in a year according to type of combined hormonal contraception (CHC) used[141]

Type of CHC used	Risk of developing a VTE in a year (incidence in 10 000 women)
Women **not using** combined hormonal pill/patch/ring and not pregnant	~2
Women using CHC containing **levonorgestrel, norethisterone** or **norgestimate**	~5–7
Women using CHC containing **etonogestrel** or **norelgestromin**	~6–12
Women using CHC containing **drospirenone, gestodene** or **desogestrel***	~9–12

*Evidence suggests that co-cyprindiol is associated with similar VTE risk to combined oral contraceptive containing drospirenone, gestodene or desogestrel.[230]

Discussion Points for Contraceptive Choices for Young People

The following discussion points have been developed by the FSRH Education Committee.

Discussion Points

1 A 13-year-old girl attends clinic asking for contraception advice. She is having consensual intercourse with her regular boyfriend also aged 13 years:
(a) What are the issues to consider?
(b) Would this differ if the girlfriend was 12 years old?
(c) Would this differ if the boyfriend was 16 years old?

2 How can we encourage increased uptake of long-acting reversible contraception (LARC) methods among young people?

3 Should emergency contraception be available in schools?

Questions for Contraceptive Choices for Young People

The following questions and answers have been developed by the FSRH Education Committee.

Indicate your answer by ticking the appropriate box for each question	***True***	***False***
1 By the age of 16 years approximately one in five young people have had sexual intercourse.	☐	☐
2 Condoms are not necessary if intercourse is pre-menarche.	☐	☐
3 Administration of progestogen-only emergency contraception (POEC) between 72 and 120 hours for emergency contraception (ED) is outside the terms of the product licence.	☐	☐
4 If a young person attends for EC within 72 hours of unprotected sexual intercourse (UPSI), it would be inappropriate to fit a copper-bearing intrauterine device.	☐	☐
5 Advanced provision of EC has not been shown to reduce the unintended pregnancy rate.	☐	☐
6 There is no clear evidence that combined oral contraception affects body weight.	☐	☐
7 If confidentiality is to be breached, the consent of the young person is required.	☐	☐
8 Use of depot medroxyprogesterone acetate is contraindicated in young people aged <18 years (UKMEC 3) due to concerns about bone mineral density.	☐	☐
9 Young people accounted for 65% of the chlamydia cases diagnosed in UK genitourinary medicine clinics in 2007.	☐	☐
10 Young people may be offered sexually transmitted infection screening immediately after UPSI or condom failure.	☐	☐

Answers

1 False, 2 False, 3 True, 4 False, 5 True, 6 True, 7 False, 8 False, 9 True, 10 True

TRÁNH THAI KHẨN CẤP

Regular contraceptive	Time of ovulation	Recommendations
Combined hormonal contraceptive	Ovulation cannot reliably be predicted if error occurs in week one; this should be considered an extension of the hormone-free interval Earliest ovulation is 8 days after last correctly taken dose of combined oral contraceptive	Cu-IUD can be inserted up to 13 days after the start of the hormone-free interval provided the combined hormonal method was previously used correctly
Progestogen-only pill (POP)	Earliest ovulation probably 9 days after last correctly taken dose (if POP used correctly previously)	Cu-IUD can be inserted up to 5 days after the first UPSI following the first missed POP (whether desogestrel or traditional POP)
Recently expired depot medroxyprogesterone acetate (DMPA)	Return of ovulation ranges between 15 and 49 weeks after the last injection	Cu-IUD is only recommended up to 5 days after the first UPSI that takes place >14 weeks since the last DMPA injection
Recently removed etonogestrel implant (Nexplanon)	Ovulation returns rapidly after removal of implant	Cu-IUD can be inserted up to 5 days after the first UPSI following implant removal
Levonorgestrel intrauterine system (IUS)	Ovulation could have occurred at any time prior to or after removal	Providing that a woman abstained from UPSI during the 5 days prior to removal of the levonorgestrel IUS, a Cu-IUD can be inserted up to 5 days after the first UPSI following removal
UPSI = unprotected sexual intercourse		

Table 1. FSRH recommendations for Cu-IUD insertion after incorrect use of regular contraception[1]

Adolescent women	• Emergency contraception of choice is a Cu-IUD • Cu-IUD insertion is not more difficult than in older women and continuation rates are high • If an oral option is preferred and concordance with ongoing contraception seems unlikely, levonorgestrel plus immediate insertion of a progestogen-only implant should be considered • If UPSI is thought to have occurred in the 5 days before ovulation, ulipristal acetate is first choice
Perimenopausal women	• Women who have been naturally amenorrhoeic for a year (age >50 years) or two years (age <50 years) do not need contraception but ovulation cannot be excluded (especially in the under-45s) • Discuss the need for emergency contraception individually • If contraception taken incorrectly, offer emergency contraception • Hormone replacement therapy (HRT) is not contraceptive
Sexual assault	• Emergency contraception of choice is a Cu-IUD with antibiotic prophylaxis against sexually-transmitted infection • If the woman consents to a forensic examination, IUD insertion should be delayed until this is complete; oral emergency contraception should be offered in the interim in case the delay is prolonged • Clinicians must ensure women are fully informed about their choices
More than one UPSI in a cycle	• Embryo is not susceptible to teratogenesis in the first 2 weeks • Neither ulipristal acetate nor levonorgestrel disrupt or adversely affect pregnancy • If UPSI occurred in the last 5 days and possibly more than 21 days previously with no normal menstrual period since, a high-sensitivity urine pregnancy test should be done before oral emergency contraception is taken
More than one use of emergency contraception in a cycle	• Both ulipristal acetate and levonorgestrel can be repeated within a cycle • Levonorgestrel should not be taken within 5 days of ulipristal acetate • The effectiveness of ulipristal acetate may be reduced by taking levonorgestrel within the following 7 days
UPSI = unprotected sexual intercourse	

Table 2. Specific indications for emergency contraception[1]

What drug interactions are relevant to use of EC?

D	**EC providers should advise women using enzyme-inducing drugs that the effectiveness of UPA-EC and LNG-EC could be reduced.**
✓	**Women requiring EC who are using enzyme-inducing drugs should be offered a Cu-IUD if appropriate. A 3 mg dose of LNG can be considered but women should be informed that the effectiveness of this regimen is unknown. A double-dose of UPA-EC is not recommended.**
✓	**EC providers should be aware that the effectiveness of UPA-EC could be reduced if a woman takes progestogen in the 5 days after taking UPA-EC.**
✓	**EC providers should be aware that the effectiveness of UPA-EC could theoretically be reduced if a woman has taken progestogen in the 7 days prior to taking UPA-EC.**

Can oral EC be used more than once in a cycle?

D	**If a woman has already taken UPA-EC once or more in a cycle, EC providers can offer her UPA-EC again after further UPSI in the same cycle.**
D	**If a woman has already taken LNG-EC once or more in a cycle, EC providers can offer her LNG-EC again after further UPSI in the same cycle.**
✓	**EC providers should be aware that if a woman has already taken UPA-EC, LNG-EC should not be taken in the following 5 days.**
✓	**EC providers should be aware that if a woman has already taken LNG-EC, UPA-EC could theoretically be less effective if taken in the following 7 days.**

Hormonal contraceptive method	Time additional contraception required after starting method
Combined oral contraceptive (not Qlaira)	7 days
Qlaira	9 days
Combined vaginal ring/transdermal patch	7 days
Progestogen-only pill (traditional or desogestrel)	2 days
Progestogen-only implant or injectable	7 days

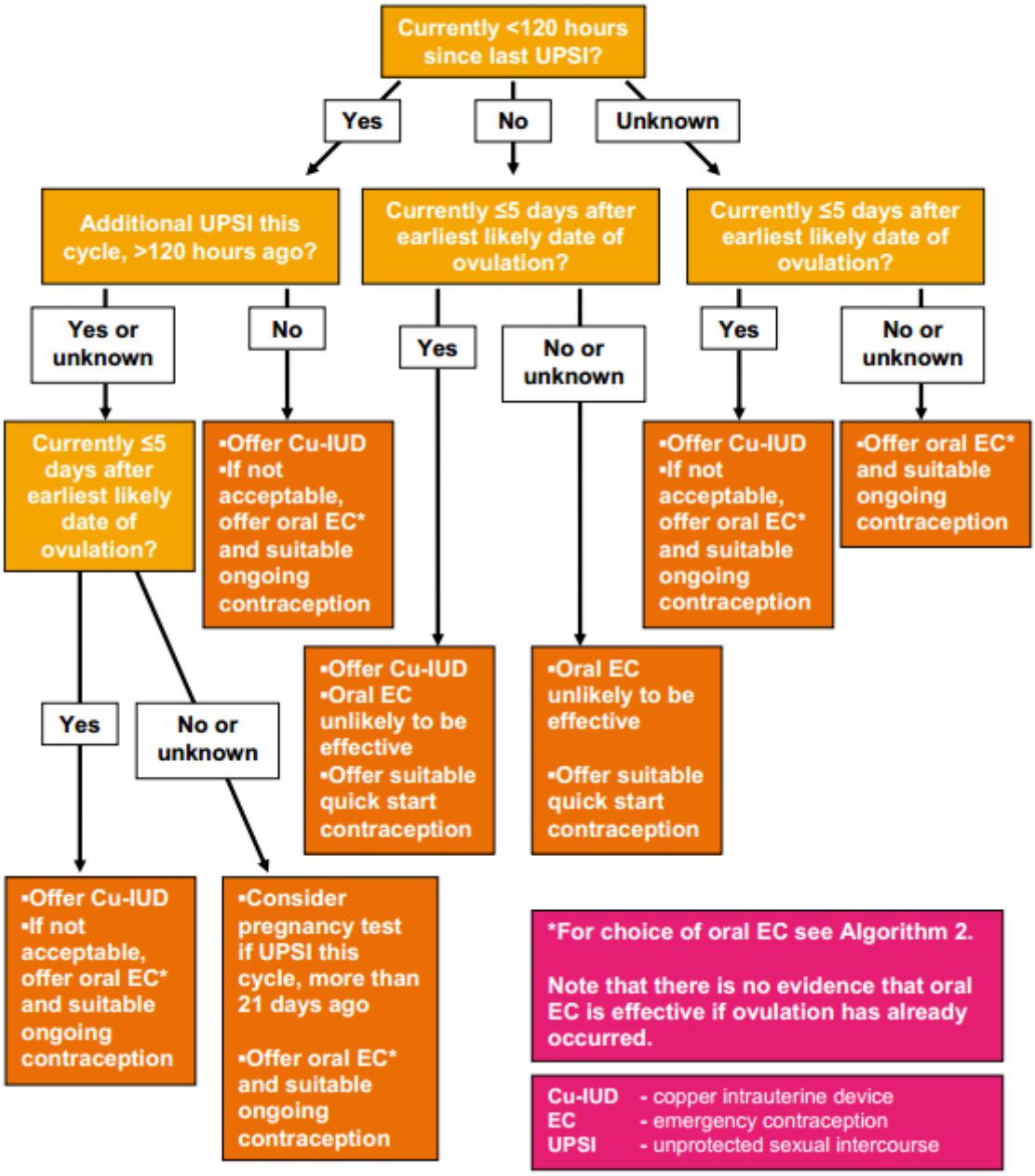
Table 3. Time period during which abstention or barrier contraception is required, depending on hormonal contraceptive method started 120 hours after ulipristal acetate emergency contraception[1]

- Next menstrual period is delayed by more than 7 days
- Lighter than usual menstrual bleeding
- Menstruation associated with abdominal pain that is not typical of the woman's usual dysmenorrhoea
- Women starting hormonal contraception soon after emergency contraception even if they have bleeding (bleeding associated with the contraceptive method may not represent menstruation)

Table 4. Indications for a pregnancy test after emergency contraception

Decision-making Algorithms for Emergency Contraception

Algorithm 1: Decision-making Algorithm for Emergency Contraception (EC): Copper Intrauterine Device (Cu-IUD) vs Oral EC

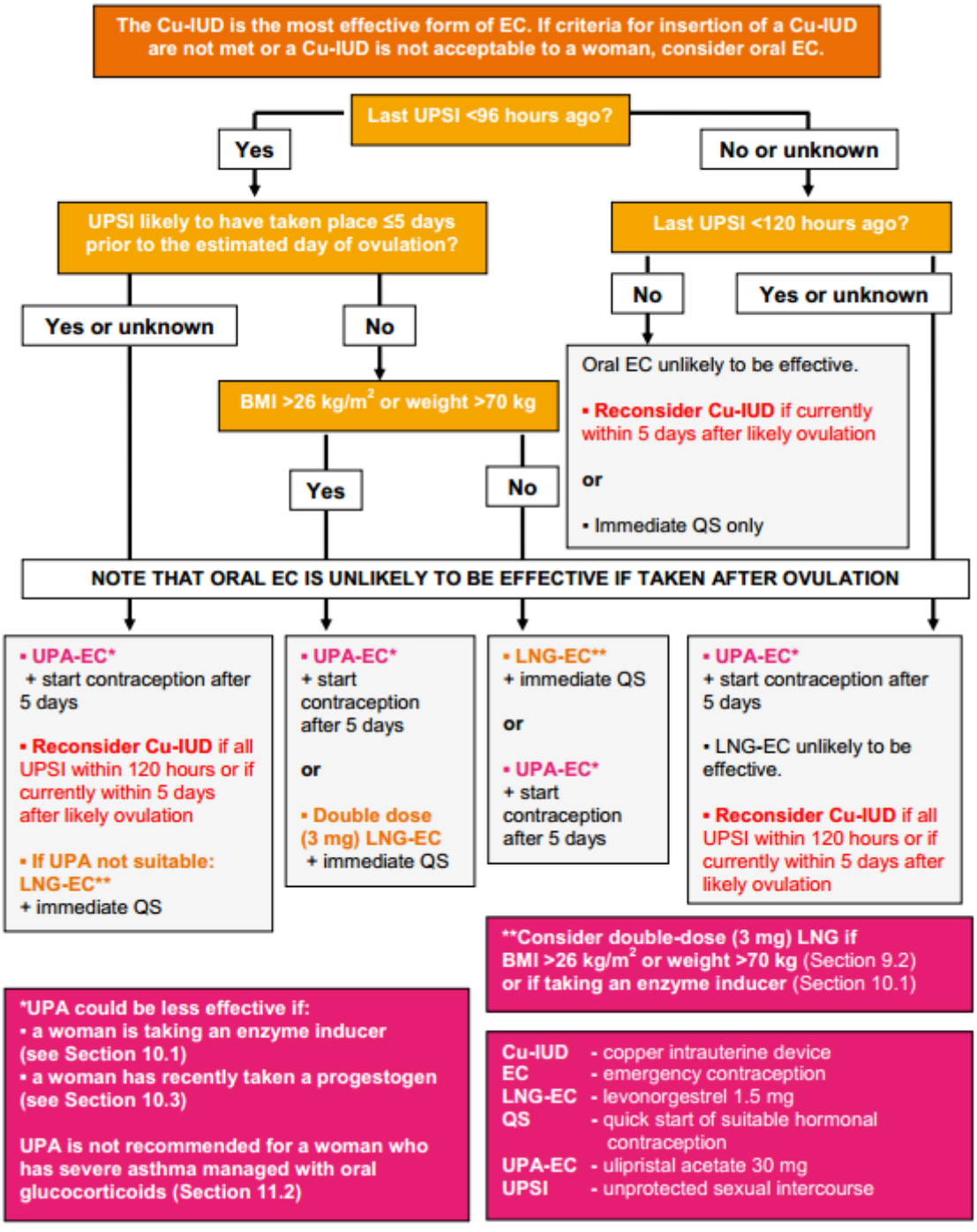


*For choice of oral EC see Algorithm 2.

Note that there is no evidence that oral EC is effective if ovulation has already occurred.

Cu-IUD	- copper intrauterine device
EC	- emergency contraception
UPSI	- unprotected sexual intercourse

Algorithm 2: Decision-making Algorithm for Oral Emergency Contraception (EC): Levonorgestrel EC (LNG-EC) vs Ulipristal Acetate EC (UPA-EC)



Questions for Continuing Professional Development

The following multiple choice questions (MCQ) have only one correct answer and have been developed for continuing professional development (CPD). The answers to the questions and information on claiming CPD points can be found in the 'members-only section' of the FSRH website (www.fsrh.org), which is accessible to all Diplomates, Members, Associate Members and Fellows of the FSRH.

1 **During a woman's fertile period, the pregnancy risk following a single episode of unprotected sexual intercourse (UPSI) has been estimated to be up to:**
   a. 10%
   b. 20%
   c. 30%
   d. 40%

2 **How does emergency contraception (EC) work? Which of the following statements is false?**
   a. The primary mechanism of contraceptive action of the copper intrauterine device (Cu-IUD) is inhibition of fertilisation by its toxic effect on sperm and ova.
   b. If fertilisation does occur, the local endometrial inflammatory reaction resulting from the presence of the Cu-IUD prevents implantation.
   c. Given that the earliest implantation is believed to occur 6 days after ovulation, a Cu-IUD can be inserted up to 6 days after the first UPSI in a cycle.
   d. The mechanism of contraceptive action of oral EC is to delay or inhibit ovulation for at least 5 days.

3 **The Cu-IUD is the most effective method of EC. A 2012 systemic review reported an overall pregnancy rate of:**
   a. <0.01%
   b. <0.1%
   c. <1%
   d. <10%

4 **Which of the following statements is false? EC providers should consider ulipristal acetate EC (UPA-EC) as first-line oral EC for a woman who:**
   a. Has had UPSI 96–120 hours ago (even if she has also had UPSI within the last 96 hours).
   b. Has had UPSI within the last 5 days and it is likely to have taken place during the 5 days prior to ovulation.
   c. Has a weight >70 kg and BMI >26 kg/m^2.
   d. Has had UPSI 2 days ago, on Day 3 of a regular, 28-day cycle and is keen to have Nexplanon insertion today.

5 **A woman requesting EC is taking hepatic enzyme-inducing drugs. Which of the following statements is false:**

a. A single dose of 60 mg UPA-EC (double the licensed dose) can be used off-licence.
b. The effectiveness of UPA-EC and levonorgestrel EC (LNG-EC) could be reduced.
c. A Cu-IUD should be recommended if the criteria for use are met.
d. A single dose of 3 mg LNG (double the licensed dose) can be used off-licence.

6 **Regarding oral EC, which of the following is false?**

a. Regular contraception should be started as soon as possible after EC because of the risk of pregnancy due to delayed ovulation in the same cycle.
b. Oral EC can be offered if there has been UPSI or oral EC has already been given earlier in the same cycle.
c. Use of LNG-EC rather than UPA-EC may be considered if the woman has taken any progestogen in the week prior to EC.
d. If LNG-EC is used, progestogen-containing drugs should not be started for 5 days afterwards.

7 **Contraindications to the insertion of a Cu-IUD for EC are the same as those for routine IUD insertion. Which of the following is a relative contraindication?**

a. Between 48 hours and 28 days after childbirth
b. Risk of sexually transmitted infection
c. Previous ectopic pregnancy
d. Young age and nulliparity

8 **Which of the following is true? UPA-EC may be less effective if a woman:**

a. Has severe asthma managed with oral glucocorticoids.
b. Is taking truvada and raltegravir given for post-exposure HIV prophylaxis after sexual exposure (PEPSE).
c. Commences a hormonal contraceptive on the same day.
d. Takes UPA-EC between 0 and 72 hours after UPSI.

9 **A woman presents for a Cu-IUD for EC after using her combined hormonal contraception incorrectly only during Week 1. A Cu-IUD can be inserted for EC up to how many days after the start of the hormone-free interval?**

a. 5 days
b. 10 days
c. 13 days
d. 15 days

10 **Regarding oral EC, which of the following is false?**

a. 10% of women experience side effects of headache, nausea and dysmenorrhoea.
b. Repeat EC should be given if a woman vomits within 3 hours of taking oral EC.
c. After UPA-EC, 75% of women will have their next menstrual period within 7 days of the expected time.
d. After LNG-EC, 30% of women will have a delay in their menstruation by more than 7 days.