Faculty of Sexual and Reproductive Healthcare Guidelines

LONDON SOCIETY OF CONTRACEPTION AND SEXUAL HEALTH

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MARYAM NASRI MRCGP MFSRH

ASSOCIATE SPECIALIST CNWL

FSRH guidance : Quick starting contraception April 2017

Maryam Nasri LSCSH 13.3.2018

Definition of Quick starting

Commencement of a contraceptive method at any time other than the start of the menstrual cycle is termed quick starting

- If pregnancy can be excluded then no method is contraindicated
- If there is a potential for pregnancy from a recent UPSI and it is too early to exclude with pregnancy test then not all methods are suitable

Additional contraception required when quick starting (excluding after Ella one)

Method	Day of menstrual cycle	Additional days of protection required if started after these days
COC	1-5	6 onwards -7
CHC	1-5	6 onwards -7
DMPA and SDI	1-5	6 onwards -7
POP	1-5	6 onwards -2
IUS	1-7	8 onwards -7
IUD	Anyday	0

Criteria for reasonably excluding pregnancy

Healthcare practitioners can be reasonably certain that a woman is not currently pregnant if any one or more of the following criteria are met and there are no symptoms or signs of pregnancy:

- She has not had intercourse since the start of her last normal (natural) menstrual period, since childbirth, abortion, miscarriage, ectopic pregnancy or uterine evacuation for gestational trophoblastic disease.
- She has been correctly and consistently using a reliable method of contraception. (She is within the first 5 days of the onset of a normal (natural) menstrual period.
- She is less than 21 days postpartum (non-breastfeeding women). She is fully breastfeeding, amenorrhoeic AND less than 6 months postpartum.
- She is within the first 5 days after abortion, miscarriage, ectopic pregnancy or uterine evacuation for gestational trophoblastic disease.
- She has not had intercourse for >21 days AND has a negative high-sensitivity urine pregnancy test

- **If these criteria are met then any method can be quick started .**

Potential advantages of quick starting

- reduction of the time during which the woman is at risk of pregnancy ,eg women who have taken EC or have irregular Cycles
- Prevent a woman from forgetting information
- Avoid waning enthusiasm for the message
- Avoid costs and barriers of returning for contraception, transport ,time ,childcare
- Reduce Healthcare costs

Concerns for the practitioner

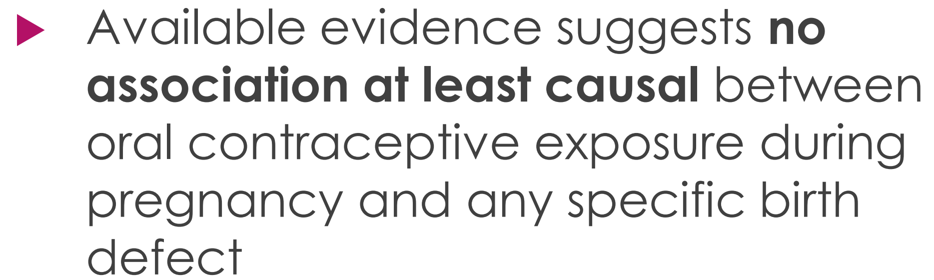
- Am I causing an abortion ?
- What if she changes her mind and decides to keep the pregnancy ?
- Will the child have any birth defects ?
- Is the out come affected ?

Potential disadvantages of quick starting contraception –when there is a potential risk of very early pregnancy

- The risk that the woman is already pregnant or the EC will fail and she will conceive from recent unprotected sexual intercourse
- Diagnosis of pregnancy may be delayed if amenorrhoea is assumed to be due to the contraceptive method or if bleeding associated with the contraception is mistaken for a period and it may be late for a termination
- Theoretical concerns that HC could be harmful to the foetus

Foetal exposure to contraception pregnancy outcomes and risk of foetal abnormality

- foetal Demise
- preterm birth and small for gestational age
- foetal abnormalities
- specific birth defects
- congenital heart disease
- neural tube defects
- limb reduction defects
- urogenital abnormalities



- Available evidence suggests **no association at least causal** between oral contraceptive exposure during pregnancy and any specific birth defect

Which methods can be Quick Started(if there is a potential for very early pregnancy)

- CHC(excluding CHC containing cyproterone acetate)can be quick started
- Progesterone only pills can be quick started
- Implant can be quick started
- DMPA can **only** be quick started if other methods are not suitable
- IUCD can only be quick started if the criteria for emergency contraception is met
- **IUS can not be quick started**

Ethical issues

- The purpose of using a medication outside its licence should be justifiable and in line with a recognised body of opinion.
- HCPs should be satisfied that they have sufficient information to administer an unlicensed or 'off label' drug safely.
- Patients must be given sufficient information
- The Nursing and Midwifery Council (NMC) advises that nurse or midwife independent prescribers may prescribe outside the product licence if they are satisfied that this would better serve the patient's needs and there is a sufficient evidence base to demonstrate safety and efficacy.

Quick starting

- 1.If there is potential risk of very early pregnancy from recent unprotected sexual intercourse do a pregnancy test .
- 2.If indicated use emergency contraception
- 3.Choose a method to start
- 4.Consider bridging
- 5.Advise of repeat pregnancy test if needed

If a woman falls pregnant…

- SDI :continue her method of contraception with no additional contraceptive precautions after abortion.
- CHC or POP : stop her method of contraception and restart contraception immediately after abortion with no additional contraceptive precautions.
- DMPA :can continue her method of contraception but should be advised that there may be a slightly higher risk of continuing pregnancy (failed abortion) if DMPA is administered at the time of mifepristone administration. So to delay it up to 5 days post TOP.

Continued

- In all cases of pregnancy with an IUD ,if pregnancy is less than 12 weeks' gestation ,IUC should be removed, as long as the threads are visible or it can be easily removed from the endocervical canal.
- In an intrauterine pregnancy with IUC in situ the risk of adverse pregnancy outcomes is greater than that for pregnancies without IUC in situ.
- In an intrauterine pregnancy with IUC in situ removal of the IUC in the first trimester could improve pregnancy outcomes, but is associated with a small risk of miscarriage.

FSRH guidance :Contraception for women aged over 40 years ,Nov 2017

Maryam Nasri LSCSH 13.3.2018

The importance of contraception in women over 40

- The trend to start having children later in life -2000-2015 the number of live births in women over 40 doubled in England
- Between 1980-2005 number of women having their first child over 40 increased 10 fold
- Of pregnancies over 40, 28.1 % ended in termination

The importance of a separate guidelines for women ov ver the age of 40

- Increased likelihood of medical co morbidities such as HTN ,VTE, obesity ,CVD and breast problems
- Increased likelihood of gynaecological malignancies
- Transition to menopause a) diagnosis b)need for contraception c)use of traditional herbal remedies for HRT
- STI risk is ignored by women and clinicians
- Lack of resources for older women

IUD

- Cu-IUD is associated with heavier more painful and prolonged bleeding
- It may not be appropriate for women with heavy menstrual bleeding or perimenopausal women
- Licenced for 5 to 10 years of use
- If inserted at age 40 or over and contains equal to or more than 300 sq mm copper can remain until the age of 55
- Should be removed after 55 because can act as a reservoir for infection

IUS(Mirena)

- Can be used for HMB and improve QOL as much as hysterectomy
- Can be used for HRT –up to 5 years
- There is little or no increased risk of MI or stroke or VTE
- For women with breast cancer ,it has to be discussed with the oncologist
- Consider additional investigation such as full blood count ,pelvic ultrasound and endometrial biopsy prior to or at the same time as insertion in a woman who has heavy or irregular bleeding and in a woman whose bleeding pattern has changed or hasn't settled 3 to 6 months afterwards
- Insertion and removal can both be difficult in women who have undergone ablation and hysteroscopy and women should be counselled about it

When does an IUS(Mirena) have to be removed ?

Depends on usage

For HRT : 5 years

For contraception :There is evidence that it is effective after 7 years .This use is out of licence therefore if a woman has been above 45 and has a Mirena inserted they can keep it until menopause –remove by 55

For HMB :As long as bleeding is controlled and woman is asymptomatic

Progesterone implant

- Is the most effective form of contraception available with 0.0 5% failure rate
- There is no age restriction to its use
- Licenced for contraception for 3 years
- Is not associated with increased risks of VTE, stroke or MI and does not affect the BMD
- May alleviate menstrual and ovulation pain
- It's irregular bleeding side effect is not any different in women over 40

DMPA

- Shown to alleviate menstrual pain and endometriosis
- Potentially protective effect from endometrial and ovarian cancer
- Women using DMPA experience initial bone loss ,this initial bone loss is not repeated or worsened by menopause
- Some reassuring evidence that there is no link between DMPA and the risk of MI or stroke . Possible weak association between current use and breast cancer ,at any rate increased risk is likely to be small and reduces with time
- There is no causal relationship between DMP and VTE

DMPA continued

- After 45 DMPA moves from category 1 of UK MEC to category 2
- Review every 2 years
- If any additional risk factors :smoking ,inactivity ,family history ,vitamin D deficiency advise to consider alternative methods
- Do not offer routine bone density scan or monitoring of serum lipids or use of oestrogen

- Women over 50 should be counselled on alternative methods if they do not wish to stop then consideration should be given to continuation providing the benefits and risks are understood

POP

- DSG pill may have a role in the management of pain of endometriosis ,menstruation and ovulation
- There is no evidence of an association between POP , VTE ,stroke or MI
- Limited available evidence shows no association with BMD
- Increased risk between breast cancer and POP use cannot be completely excluded but if it exists it's likely to be small and reduce with time
- Should be stopped at 55

CHC

- Can control bleeding and alleviate menopausal symptoms
- Can reduce menstrual pain
- Is associated with reduced risk of ovarian and endometrial cancer
- Has a positive effect on bone mineral density

Continued CHC

- The background risk of VTE increases sharply around 40
- There is a potential increased risk of stroke and MI for women who use CHC
- Slight increased risk of breast cancer but no significant risk 10 years after cessation
- Small increased risk of cervical cancer –risk of cervical cancer decreases after 40

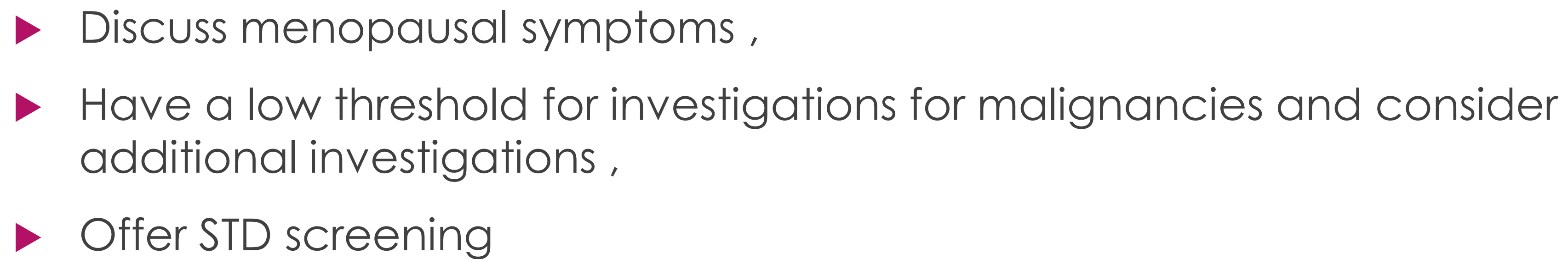
- Background risk of cardiovascular diseases should be taken in to account
- The type of the COC that is preferred is a low dose oestrogen Ethinylestradiol 20 microgram and the older generation of progesterone Levonorgestrol and Norethisterone
- Continuous pill taking can maintain the non contraceptive benefits and is safe , effective and well tolerated in this population
- Zoely and Qlaira
- CHC should be stopped at 50

When is contraception no longer needed ?

- At 50 :DMPA and CHC –switch to other methods
- At 55 all methods are stopped
- IUD s should be removed and can not stay indefinitely
- IUCDs inserted after 40 can remain till 55
- IUS inserted after 45 can remain in situ till 55 unless for HRT or woman's pattern of bleeding changes

HRT and contraception

- HRT does not suppress ovulation
- All progesterone only methods can be used with HRT
- Contraception is needed up to a year after menopause if >50
- Contraception is needed up to 2 years after menopause if <50
- FSH measurement can be reserved for women with amenorrhoea on progesterone only methods
- No need for oestradiol or LH measurements


Discuss menopausal symptoms ,
Have a low threshold for investigations for malignancies and consider additional investigations ,
Offer STD screening

Intrauterine beads

References

- https://www.oconmed.com/fileadmin/user_upload/Ocon-IUB-Doctors-Overview-DO_EN_090215_2.pdf
- https://www.fsrh.org/standards-and-guidance/current-clinical-guidance/quick-starting-contraception/
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