Contraceptive Update

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Family Planning

World Health Organisation (WHO) Definition:

"family planning allows individuals and couples to anticipate and attain their desired number of children and the spacing and timing of their births. It is achieved through the use of contraceptive methods and the treatment of involuntary infertility. A woman's ability to space and limit her pregnancies has a direct impact on her health and well-being as well as on the outcome of each pregnancy."

Dr Farah Chaudhry

UKMEC 2016

- Online/searchable
- Expanded introductory section - ***how to use UKMEC, multiple conditions etc***
- Typical and perfect use
- Drug interaction online tools
- Conditions posing sig risk during pregnancy
- Reordering by effectiveness
- UPA
- Additional guidance eg migraine

Drug Interaction On-line Tools

- On-line drug interaction checker - http://reference.medscape.com/drug-interactionchecker
- HIV medications – www.hiv-druginteractions.org/interactions.aspx


FSRH
The Faculty of Sexual & Reproductive Healthcare
FSRH Guideline
Contraception After Pregnancy
January 2017 | FSRH

Contraception after Childbirth

- Women should be advised that an interpregnancy interval (IPI) of less than 12 months between childbirth and conceiving again is associated with an increased risk of preterm birth, low birthweight and small for gestational age (SGA) babies.
- Effective contraception after childbirth should be initiated by both breastfeeding and non-breastfeeding women as soon as possible, as sexual activity and ovulation may resume very soon afterwards.
- The choice of contraceptive method should be initiated by 21 days after childbirth.
- A woman's chosen method of contraception can be initiated immediately after childbirth if desired and she is medically eligible.
- Women should be advised that intrauterine contraception (IUC) and progestogen-only implant (IMP) can be inserted immediately after delivery.

Contraception after childbirth cont..

- Women should be advised that although contraception is not required in the first 21 days after childbirth, most methods can be safely initiated immediately, with the exception of combined hormonal contraception (CHC)
- Emergency contraception (EC) is indicated for women who have had unprotected sexual intercourse (UPSI) from 21 days after childbirth, but is not required before this.
- Women should be advised that additional contraceptive precautions (e.g. barrier method/abstinence) are required if hormonal contraception is started 21 days or more after childbirth. Additional contraceptive precaution is not required if contraception is initiated immediately or within 21 days after childbirth.

Breastfeeding

- Women who are breastfeeding should be informed that the available evidence indicates that progestogen-only methods of contraception (LNG-IUS, IMP, POI and POP) have no adverse effects on lactation, infant growth or developmen
- Women who are breastfeeding should wait until 6 weeks after childbirth before initiating a CHC method.
- Women who are breastfeeding should be informed that there is currently limited evidence regarding the effects of CHC use on breastfeeding. However, the better quality studies of early initiation of CHC found no adverse effects on either breastfeeding performance (duration of breastfeeding, exclusivity and timing of initiation of supplemental feeding) or on infant outcomes (growth, health and development).

Postpartum – Breastfeeding/VTE risk

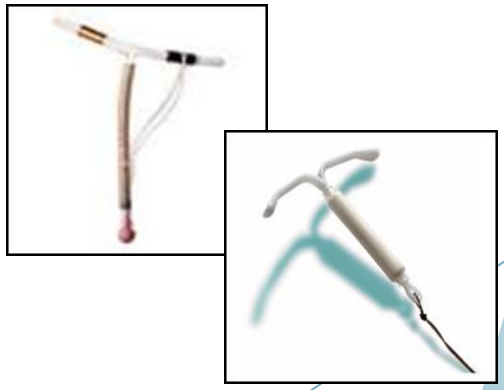
CONDITION	Cu-IUD	LNG-IUS	IMP	DMPA	POP	CHC
	I = Initiation, C = Continuation					
PERSONAL CHARACTERISTICS AND REPRODUCTIVE HISTORY						
Breastfeeding						
a) 0 to <6 weeks	See below		1	2	1	4
b) ≥6 weeks to <6 months (primarily breastfeeding)			1	1	1	2
c) ≥6 months			1	1	1	1
Postpartum (in non-breastfeeding women)						
a) 0 to <3 weeks						
(i) With other risk factors for VTE	See below		1	2	1	4
(ii) Without other risk factors			1	2	1	3
b) 3 to <6 weeks						
(i) With other risk factors for VTE	See below		1	2	1	3
(ii) Without other risk factors			1	1	1	2
c) ≥6 weeks			1	1	1	1
Postpartum (in breastfeeding or non breastfeeding women, including post caesarean section)						
a) 0 to <48 hours	1	1	See above			
b) 48 hours to <4 weeks	3	3				
c) ≥4 weeks	1	1				
d) Postpartum sepsis	4	4				

Lactational Amenorrhoea Method (LAM)

- Women may be advised that, if they are less than 6 months postpartum, amenorrhoeic and fully breastfeeding, the lactational amenorrhoea method (LAM) is a highly effective method of contraception.
- Women using LAM should be advised that the risk of pregnancy is increased if the frequency of breastfeeding decreases (e.g. through stopping night feeds, starting or increasing supplementary feeding, use of dummies/pacifiers, expressing milk), when menstruation returns or when more than 6 months after childbirth.

IUC

- IUC can be safely inserted immediately after birth (within 10 minutes of delivery of the placenta) or within the first 48 hours after uncomplicated caesarean section or vaginal birth. After 48 hours, insertion should be delayed until 28 days after childbirth.



IMP, POI, POP

- …can be safely started at any time after childbirth including immediately after delivery

CHC

- All women should undergo a risk assessment for VTE postnatally. CHC should not be used by women who have risk factors for venous thromboembolism (VTE) within six weeks of childbirth. These include thrombophilia, immobility, transfusion at delivery, body mass index (BMI) ≥30 kg/m2, postpartum haemorrhage, post-caesarean delivery, pre-eclampsia or smoking. This applies to both women who are breastfeeding and not breastfeeding.
- Women who are not breastfeeding and are without additional risk factors for VTE should wait until 21 days after childbirth before initiating a CHC method.

Contraception after Abortion

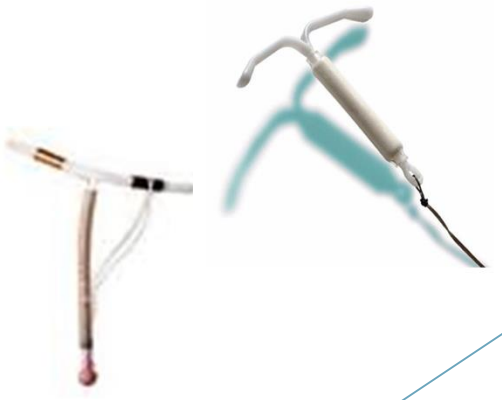
- Choice of contraception should be initiated at the time of abortion or soon after, as sexual activity and ovulation can resume very soon after abortion.
- A woman's chosen method of contraception should be initiated immediately after abortion (medical and surgical).
- Clinicians should be aware that insertion of intrauterine contraception (IUC) at the time of abortion is convenient and highly acceptable to women. This has been associated with high continuation rates and a reduced risk for another unintended pregnancy than when provision of IUC is delayed.
- Clinicians should be aware that insertion of progestogen-only implants (IMP) at the time of abortion is convenient and highly acceptable to women. This has been associated with high continuation rates and a reduced risk for another unintended pregnancy than when provision of IMP is delayed.
- Clinicians should be aware that women who choose to commence LARC immediately after abortion have a significantly reduced likelihood of undergoing another abortion within 2 years, compared with women provided with medium-acting, short-acting or no contraceptive methods.

Contraception after Abortion cont..

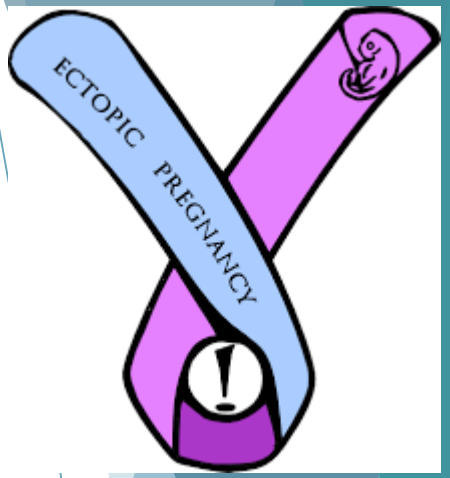
- Emergency contraception (EC) is indicated for women who have had unprotected sexual intercourse (UPSI) from 5 days after abortion.
- Women should be advised that additional contraceptive precautions (e.g. barrier methods/abstinence) are required if hormonal contraception is started 5 days or more after abortion. Additional contraceptive precaution is not required if contraception is initiated immediately or within 5 days of abortion.

IUC

- IUC can be safely used by women after an uncomplicated abortion. Women may be advised that they may benefit from reduced uterine bleeding when using levonorgestrel-releasing intrauterine system (LNG-IUS).
- With medical abortion, IUC can be inserted any time after expulsion of the pregnancy.
- With surgical abortion, IUC can be inserted immediately after evacuation of the uterine cavity.



Contraception after Miscarriage/Ectopic



- If a woman wishes to delay or prevent a further pregnancy, effective contraception should be initiated as soon as possible as sexual activity and ovulation may resume very soon after ectopic pregnancy or miscarriage.
- Women who wish to conceive after miscarriage can be advised there is no need to delay as pregnancy outcomes after miscarriage are more favourable when conception occurs within 6 months of miscarriage compared with after 6 months.
- Women who have been treated with methotrexate should be advised that effective contraception is recommended during and for at least 3 months after treatment in view of the teratogenic effects of this medication.
- Women should be advised that effective contraception can be started on the day of methotrexate administration or surgical management of ectopic pregnancy.

Emergency contraception is indicated for a woman who has had unprotected sexual intercourse after childbirth from:

- a. 7 days
- b. 14 days
- c. 21 days
- d. 28 days

Emergency contraception is indicated for a woman who has had unprotected sexual intercourse after childbirth from:

- a. 7 days
- b. 14 days
- c. 21 days
- d. 28 days

FSRH The Faculty of Sexual & Reproductive Healthcare

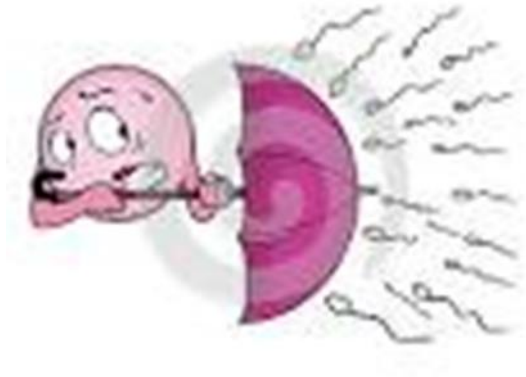
FSRH Guideline

Emergency Contraception

Dr Farah Chaudhry


KEEP CALM
AND
PLEASE
DON'T SHOOT
THE MESSENGER

When is EC indicated?



- UPSI that has taken place on **any day** of a natural menstrual cycle
- UPSI from **Day 21** after childbirth
- UPSI from **Day 5** after abortion, miscarriage, ectopic pregnancy
- **Regular contraception has been compromised or has been used incorrectly**
- *CU-IUD can be offered up to **day 13** of HFI*

How effective are different methods?

- Cu-IUD is the most effective
- UPA 120hrs
- LNG 72hrs license (ineffective after 96hrs)
- UPA more effective than LNG
- Oral EC after ovulation ineffective

BMI

- Cu-IUD not affected by weight/BMI
- Oral EC effectiveness may be reduced
- Especially LNG

BMI cont…

- ..the evidence presented suggests that LNG-EC could be less effective in women weighing >70 kg or with a BMI >26 kg/m2.
- If a Cu-IUD is not indicated or not acceptable, the GDG recommends that such women can be offered UPA-EC. If UPA-EC is not suitable, a double dose (3 mg) of LNG-EC can be used. The effectiveness of 3 mg LNG-EC for these women is unknown.

- ..the GDG concludes that the data suggest that UPA-EC could potentially be less effective for women >85 kg or with a BMI >30 kg/m2 than for women <85 kg and with BMI <30 kg/m2.
- For women weighing >85 kg or with a BMI >30 kg/m2, it is not known whether UPA-EC or 3 mg LNG-EC is more effective.

Drug interactions

- Enzyme-inducing drugs could reduce effectiveness of UPA and LNG
- Offer Cu-IUD
- 3mg LNG – effectiveness unknown
- ***UPA effectiveness could be reduced if progestogen taken in 5 days after***
- ***UPA effectiveness could be reduced if progestogen taken in 7 days prior***
- Drugs that increase gastric pH - clinical significance of interaction with UPA unknown
- www.medscape.com

Breastfeeding

- Cu-IUD - Increased risk of perf (6x)
- UPA – express and discard breast milk for **1 week**
- LNG – **no adverse effect** on breastfeeding or on their infants
- The SPC for Levonelle advises that LNG is secreted into breast milk and that potential exposure of the infant to levonorgestrel can be reduced if the woman takes the tablet immediately after feeding and avoids nursing for at least 8 hours.
- However studies report no evidence of an adverse effect on the infant or on lactation …the GDG consider that women can be advised to continue to breastfeed after using LNG-EC.

Which method should be offered?

- **All women should be offered Cu-IUD**
- **5days afer first UPSI** or up to **5days after likely date of ovulation**
- Oral EC should be taken as soon as possible if UPSI in past 5 days
- Consider UPA first-line oral EC for UPSI 96-120hrs
- ***Consider UPA first-line for UPSI within last 120hrs if likely to have taken place in 5 days prior to estimated ovulation***
- ***Oral EC after ovulation ineffective***
- All methods inc Cu-IUD should be offered post SA

Previous UPSI earlier in cycle

UPA or LNG…

- **Do not disrupt existing pregnancy**
- **Not associated with fetal abnormality**

EC use more than once in a cycle

- Already taken **UPA** – can offer **UPA** again
- Already taken **LNG** – can offer **LNG** again
- Already taken **UPA** – ***LNG should not be taken in next 5 days***
- Already taken **LNG** – ***UPA theoretically less effective if taken in following 7 days***

Women whose regular contraception has been compromised or used incorrectly: CHC

- Missed pills: 2+ missed in week 1
- Patch detachment/ring removal >48hr in week 1
- Extension of pill-free, patch-free or ring-free interval by >48hr

- If the HFI is extended, a Cu-IUD can be offered up to 13 days after the start of the HFI assuming previous perfect use

- If CHC has been used in the 7 days prior to EC, the effectiveness of UPA-EC could theoretically be reduced. Consider use of LNG-EC.

POP

- >36hrs since last desogestrel pill
- >27hrs since last traditional POP

- Timing of ovulation after missed pills cannot be accurately predicted. A Cu-IUD is therefore only recommended up to 5 days after the first UPSI following a missed POP

- If POP has been taken in the 7 days prior to EC, the effectiveness of UPA-EC could theoretically be reduced. Consider use of LNG-EC.

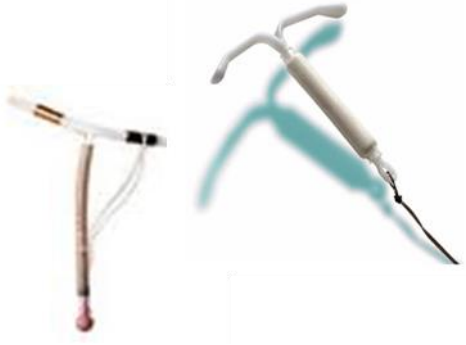
POI

- >14wks since last DMPA
- Timing of ovulation after expiry of the progestogen-only injectable is extremely variable. A Cu-IUD is only recommended up to 5 days after the first UPSI that takes place >14 weeks after the last DMPA injection.
- The effectiveness of UPA-EC could theoretically be reduced by residual circulating progestogen. Consider use of LNG-EC.

IMP

- Women can be advised that the risk of pregnancy in the fourth year of use of the progestogen-only implant Nexplanon is extremely low.
- The effectiveness of UPA-EC in the presence of progestogen from a recently expired IMP is unknown.
- Clinicians may consider use of LNG-EC in this situation with immediate quick start of appropriate hormonal contraception.
- If UPA-EC is given, hormonal contraception should not be started/restarted for 5 days after the UPA-EC has been taken

IUC



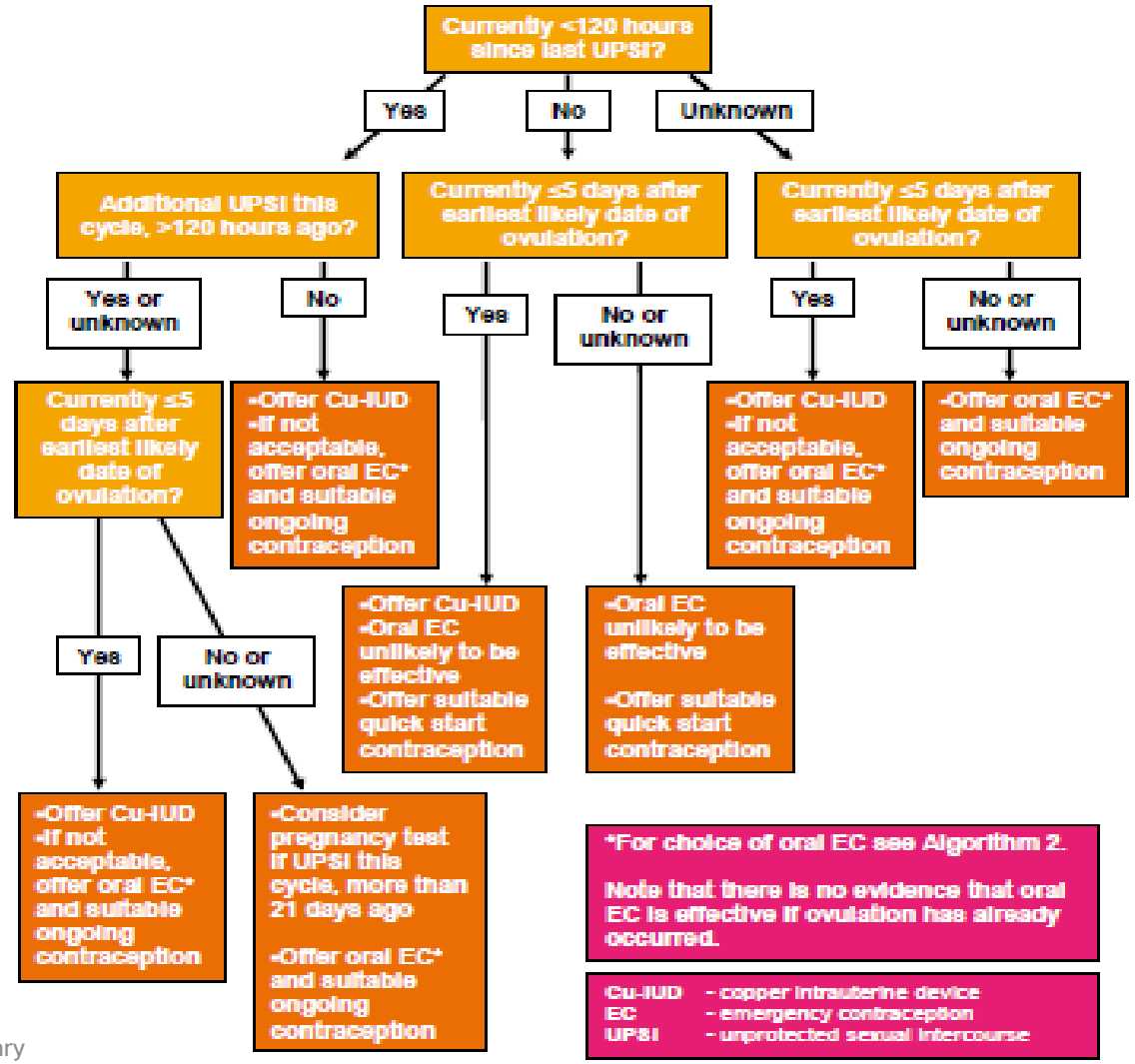
- Removal without immediate replacement; partial or complete expulsion; threads missing and IUC location unknown
- UPSI within last 5 days
- Women can be advised that the risk of pregnancy in the sixth year of use of the 52 mg LNG-IUS Mirena® is extremely low.
- The effectiveness of UPA-EC in the presence of progestogen from a recently expired LNG-IUS is unknown.
- Clinicians may consider use of LNG-EC in this situation with immediate quick start of appropriate hormonal contraception.
- If UPA-EC is given, hormonal contraception should not be started/restarted for 5 days after the UPA-EC has been taken

Future Contraception

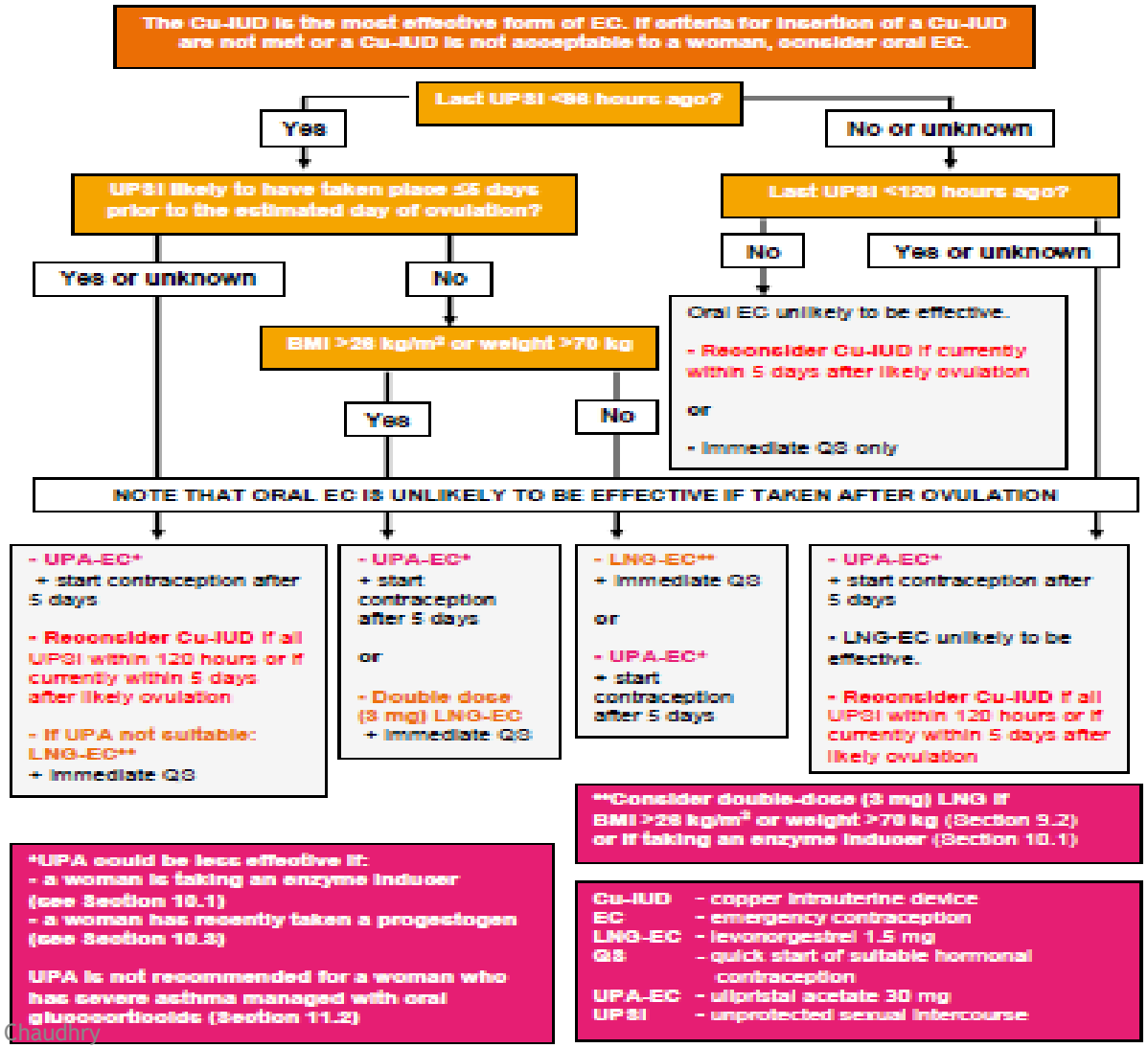
- Cu-IUD – effective ongoing contraception
- Pregnancy risk from further UPSI after oral EC
- LNG – start suitable hormonal contraception **immediately**, abstain/condoms till effective
- UPA – **wait 5 days** before starting hormonal contraception, abstain/condoms till effective
- Consider LNG and immediate start if UPSI unlikely to have occurred in fertile periods

Decision-making Algorithms for Emergency Contraception

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



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



Pop quiz! Again!

Dr Farah Chaudhry

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%

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%

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/m2.
- d. Has had UPSI 2 days ago, on Day 3 of a regular, 28-day cycle and is keen to have Nexplanon insertion today.

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).
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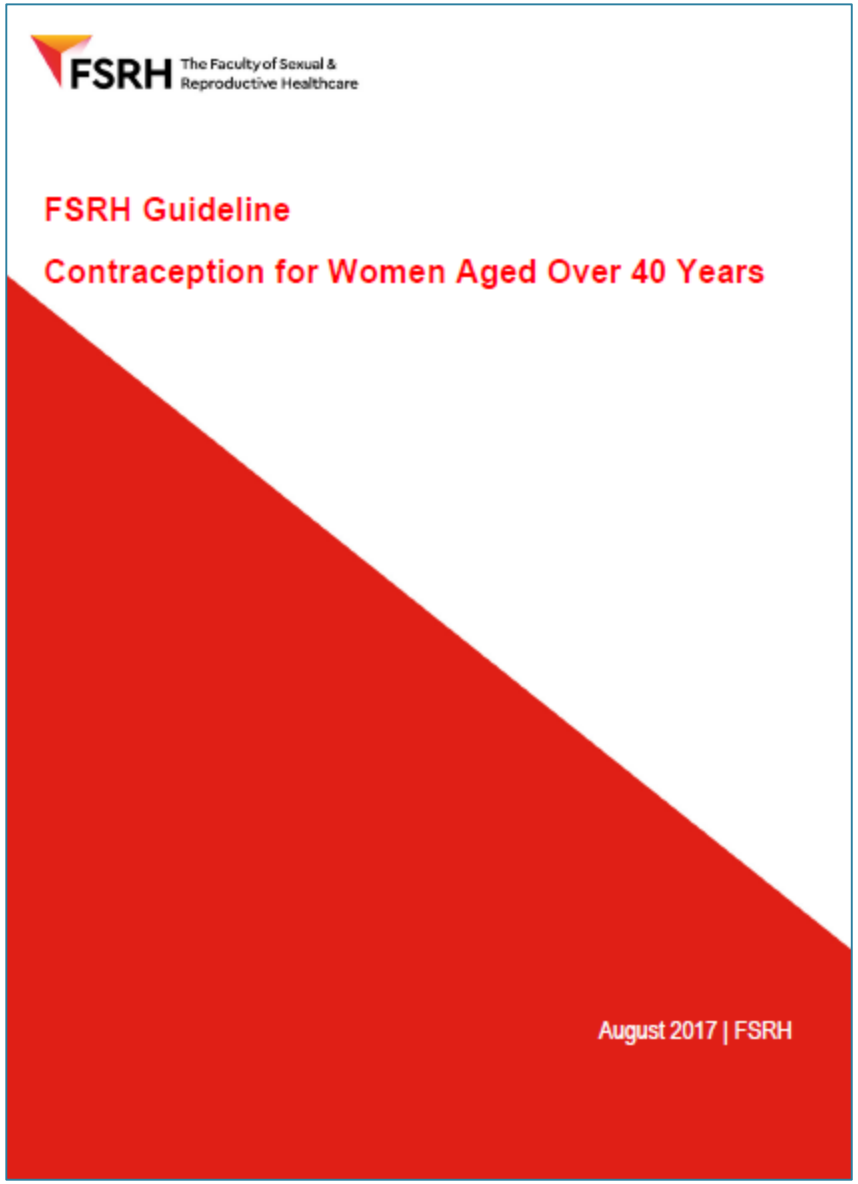

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Contraceptive Need in >40s

- **Natural decline in fertility >40yrs**
- **Pregnancy and childbirth confer a greater risk of adverse maternal and neonatal outcomes >40yrs**
  - postpartum haemorrhage
  - placental praevia
  - gestational diabetes
  - pregnancy-induced hypertension
  - Caesarean section
  - Miscarriage
  - Ectopic
  - Stillbirth
  - Perinatal mortality
  - Preterm delivery
  - Congenital abnormalities (genetic and non-genetic)
- **Effective contraception required until menopause to prevent unintended pregnancy**

Why a Separate Guideline?

- **Change in baseline risk**
  - cardiovascular disease
  - Obesity
  - Breast cancer
  - Gynaecological cancers

- **Transition to menopause**
  - Hormonal symptoms
  - Changes in bleeding patterns
- **Women should be informed that contraception does not affect the onset or duration of menopausal symptoms but may mask the signs and symptoms of menopause.**

Table 3: UK Medical Eligibility Criteria for Contraceptive Use (UKMEC) summary table for hormonal and intrauterine contraception methods[79]

Condition	Cu-IUD	LNG-IUS	IMP	DMPA	POP	CHC
Age (years)	Menarche to <20 = 2 ≥20 = 1	Menarche to <20 = 2 ≥20 = 1	After menarche = 1	Menarche to <18 = 2 18–45 = 1 >45 = 2	After menarche =1	Menarche to <40 = 1 ≥40 = 2

CHC, combined hormonal contraception; Cu-IUD, copper intrauterine device; DMPA, depot medroxyprogesterone acetate; IMP, progestogen-only implant; LNG-IUS, levonorgestrel intrauterine system; POP, progestogen-only pill.

Table 4: Percentage of women, by age group, using contraception*

Contraceptive method	Age (years)			
	20–24	35–39	40–44	45–49
None	22	23	25	28
Pill	54	27	10	13
Male condom	50	24	21	11
Withdrawal	7	5	6	4
LNG-IUS	4	3	3	4
Cu-IUD	6	12	9	11
Injection	6	2	2	4
Implant	5	0	0	1
Patch	0	1	1	–
Natural method	–	2	4	5
Other	3	0	0	1
Female sterilisation	3	10	18	19
Vasectomy	1	22	28	30

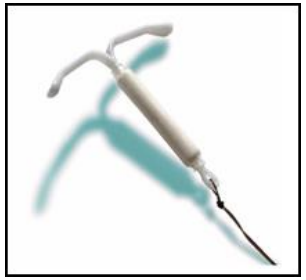
*Adapted from ONS survey on contraception and sexual health (2009).[80]

Cu-IUD, copper intrauterine device; LNG-IUS, levonorgestrel intrauterine system.

Cu-IUD

- Supports extended use of the copper intrauterine device until menopause when inserted at age 40 or over
- Method may be associated with heavier, more painful or prolonged bleeding and so may not be appropriate for women with HMB
- A Cu-IUD containing ≥300 mm2 copper inserted at or after age 40 can remain *in situ* until 1 year after the LMP if it occurs when the woman is 50 or older
- If a woman is under 50, the Cu-IUD can remain *in situ* for 2 years after the LMP
- In general, all women can cease contraception at age 55 as spontaneous conception after this age is exceptionally rare even in women still experiencing menstrual bleeding

LNG-IUS



- **Supports extended use of a Mirena® levonorgestrel intrauterine system (LNG-IUS) for contraception until the age of 55 if inserted at age 45 or over, provided it is not being used as the progestogen component of hormone replacement therapy (HRT) for endometrial protection**

- **Non-contraceptive benefits**
  - reduces menstrual blood loss
  - reduce pain associated with primary menstrual pain, endometriosis and adenomyosis
  - Effective medical treatment for endometrial hyperplasia

Mirena IUS Refit

- **Women using a Mirena for contraception who were under 45 at the time of Mirena insertion:**
  - **NO SI IN PAST 7/7!**
  - may have an **immediate replacement** of their device **between 5 and 7 years** if a **pregnancy test is negative**
  - If they have had intercourse in the **preceding 3 weeks** then, for completeness, another pregnancy test is advised no sooner than **3 weeks** after the last episode of intercourse
  - If **more than 7 years** have elapsed, replacement should be delayed until the woman has a **negative pregnancy test at least 3 weeks after the last episode of intercourse**

Removal and Replacement of Mirena IUS

- If inserted at or after age **45**, Mirena can remain *in situ* until menopause even if the woman is not amenorrhoeic
- Women using Mirena for **HMB** only can keep the device *in situ* for as long as it is effective in controlling symptoms, irrespective of the age at which it was inserted
- Women using Mirena for **endometrial protection** in an HRT regimen must have their device changed every **5** years
- As the risk of pregnancy is extremely low once a woman reaches age **55**, contraception can be stopped at that age even in women still experiencing menstrual bleeding

Stopping IUC

- As the risk of pregnancy is extremely low once a woman reaches age **55**, contraception can be stopped at that age even in women still experiencing menstrual bleeding.

- For personal reasons, an individual woman may wish to continue using a LNG-IUS beyond this age for reasons relating to perceived non-contraceptive benefits

- The FSRH recommends **always removing IUC ultimately** as those devices left *in situ* may be a focus for complications in later years

Progestogen-Only Implant

- Most efficacious method (0.05% failure rate)
- No age restriction on use
- Progestogen-only implant (IMP) is not associated with increased risks of venous thromboembolism (VTE), stroke or myocardial infarction (MI) and has not been shown to affect bone mineral density (BMD)
- May alleviate menstrual and ovulatory pain
- Causes irregular bleeding in most women - some women may prefer a method that confers more predictable bleeding patterns or with higher levels of amenorrhoea
- As the risk of pregnancy is extremely low once a woman reaches age **55**, contraception can be stopped at that age
- For personal reasons, an individual woman may wish to continue IMP beyond this age for reasons relating to perceived non-contraceptive benefits

DMPA (Depo-Provera/Sayana-Press)

- Women over 40 using depot medroxyprogesterone acetate (DMPA) should be reviewed regularly to assess the benefits and risks of use
- Women over 50 should be counselled on alternative methods of contraception
- Compared to non-DMPA users, women using DMPA experience initial loss of bone density due to the hypoestrogenic effects of DMPA but the evidence suggests that this initial bone loss is not repeated or worsened by onset of menopause
- May be a slight increased risk of VTE for women using DMPA with other risk factors for VTE (e.g. smoking, family history, a causal relationship between DMPA and VTE has not been demonstrated
- Limited available evidence regarding stroke and MI risk for women using DMPA does not confirm or exclude an association

POP

- Women can be informed that the progestogen-only pill (POP) is not associated with increased risks of VTE, stroke or MI and has not been shown to affect BMD
- Risk of pregnancy is extremely low once a woman reaches age 55, contraception can be stopped at that age
- For personal reasons, an individual woman may wish to continue POP beyond this age for reasons relating to perceived non-contraceptive benefits

CHC

- Combined oral contraception (COC) with levonorgestrel or norethisterone should be considered first-line COC preparations for women over 40 due to the potentially lower VTE risk compared to formulations containing other progestogens.
- COC with ≤30 µg ethinylestradiol should be considered first-line COC preparations for women over 40 due to the potentially lower risks of VTE, cardiovascular disease and stroke compared to formulations containing higher doses of estrogen.
- Combined hormonal contraception (CHC) can reduce menstrual bleeding and pain, which may be particularly relevant for women over 40.
- HCPs can offer an extended or continuous CHC regimen to women for contraception and also to control menstrual or menopausal symptoms.
- Women aged 50 and over should be advised to stop taking CHC for contraception and use an alternative, safer method.

CHC Risks

- COC is associated with a reduced risk of ovarian and endometrial cancer that lasts for several decades after cessation.
- CHC may help to maintain BMD compared with non-use of hormones in the perimenopause
- Meta-analyses have found a slight increased risk of breast cancer among women using COC, but with no significant risk of breast cancer by 10 years after cessation.
- Women who smoke should be advised to stop CHC at 35 as this is the age at which excess risk of mortality associated with smoking starts to become clinically significant.

Ethinylestradiol/Levonorgestrel				
Elevin	Med Rx	30	150	29.25
Levest	Morningside	30	150	1.80
Maexeni	Lupin	30	150	1.88
Microgynon 30 (also ED)	Bayer	30	150	2.82 2.99(ED)
Ovranette	Pfizer	30	150	2.20
Rigevidon	Consilient Health	30	150	1.89
Ethinylestradiol/Norethisterone				
Brevinor	Pfizer	35	500 (norethisterone)	1.99
Loestrin 20	Galen	20	1000 (norethisterone acetate)	2.70
Loestrin 30	Galen	30	1500 (norethisterone acetate)	3.90
Norimin	Pfizer	35	1000 (norethisterone)	2.28

Table 5: Venous thromboembolism (VTE) risk for all women by type of combined hormonal contraception (CHC) used[165,166]

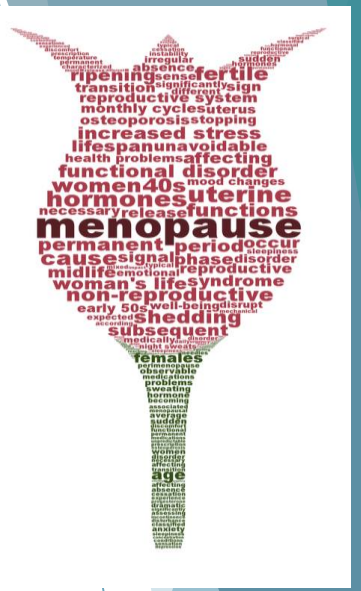
Type of CHC used	Risk of VTE per 10 000 healthy women over 1 year
No CHC, not pregnant	2
No CHC, pregnant	29[167]
Ethinylestradiol with levonorgestrel, norgestimate or norethisterone	5–7
Ethinylestradiol with etonogestrel (ring) or norelgestromin (patch)	6–12
Ethinylestradiol with gestodene, desogestrel, drospirenone or cyproterone acetate	9–12
CHC containing dienogest, nomegestrol or mestranol	Unknown

Note: 300-400 per 10 000 in immediate post-natal period

Emergency Contraception

- **Women over 40 who still require contraception should be offered emergency contraception after unprotected sexual intercourse if they do not wish to become pregnant**
  - **LNG**
  - **UPA**
  - **Cu-IUD**

Diagnosing Menopause



- Menopause is usually a clinical diagnosis made retrospectively after 1 year of amenorrhoea
- Most women do not require measurement of their serum hormone levels to make the diagnosis.
- If needed, women over 50 using progestogen-only contraception, including DMPA, can have serum FSH measurements undertaken to check menopausal status
- Women using CHC or HRT have suppressed levels of estradiol and gonadotrophins; measuring these hormones does not give accurate information on which to base advice regarding menopausal status and when to stop contraception

Stopping Contraception

- In general, **all women can cease contraception at the age of 55** as spontaneous conception after this age is exceptionally rare even in women still experiencing menstrual bleeding.
- If a woman age 55 or over does not wish to stop a particular method, consideration can be given to continuation providing the benefits and risks for her as an individual have been assessed and discussed with her.
- IUC should not be left *in situ* indefinitely after it is no longer required as it could become a focus of infection

Table 8: Recommendations regarding stopping contraception

Contraceptive method	Age 40–50 years	Age >50 years
Non-hormonal	Stop contraception after 2 years of amenorrhoea	Stop contraception after 1 year of amenorrhoea.
Combined hormonal contraception	Can be continued	Stop at age 50 and switch to a non-hormonal method or IMP/POP/LNG-IUS, then follow appropriate advice.
Progestogen-only injectable	Can be continued	Women ≥50 should be counselled regarding switching to alternative methods, then follow appropriate advice.
Progestogen-only implant (IMP) Progestogen-only pill (POP) Levonorgestrel intrauterine system (LNG-IUS)	Can be continued to age 50 and beyond	Stop at age 55 when natural loss of fertility can be assumed for most women. ▶ If a woman over 50 wishes to stop before age 55, FSH level can be checked. ▶ If FSH level is >30 IU/L the IMP/POP/LNG-IUS can be discontinued after 1 more year. ▶ If FSH level is in premenopausal range then method should be continued and FSH level checked again 1 year later.
		A Mirena® LNG-IUS inserted ≥45 can remain *in situ* until age 55 if used for contraception or heavy menstrual bleeding.

Contraception and HRT

- Women using sequential hormone replacement therapy (HRT) should be advised **not to rely on this for contraception**.
- Women may use a Mirena levonorgestrel intrauterine system (LNG-IUS) with estrogen for up to **5 years** for endometrial protection as part of an HRT regimen. Women using Mirena for this purpose must have the device changed every 5 years.
- At the present time, POP, IMP and DMPA are not licensed for and cannot be recommended as endometrial protection with estrogen-only HRT.
- All progestogen-only methods of contraception are safe to use as contraception alongside sequential HRT.
- CHC can be used in eligible women under 50 as an alternative to HRT for relief of menopausal symptoms and prevention of loss of BMD
- HCPs may consider extended or continuous regimens in order to avoid occurrence of menopausal symptoms in the HFI

Table 9: Contraceptive options in conjunction with hormone replacement therapy (HRT)

Contraceptive method	Safety with HRT	Role in HRT	
		Women aged <50	Women aged ≥50
Levonorgestrel intrauterine system (LNG-IUS)	Safe to use as contraception alongside estrogen of choice.	Mirena® is licensed for endometrial protection when combined with estrogen. It is currently the only LNG-IUS approved for this purpose. It may be used up to 5 years for endometrial protection and needs to be replaced regularly when used for this purpose, regardless of age at insertion.	
Progestogen-only injectable (DMPA)	Safe to use as contraception alongside sequential HRT but consider change to lower-dose progestogen-only method.	Highly likely to be effective for endometrial protection with estrogen as part of HRT but cannot be recommended as unlicensed for this indication.	
Progestogen-only implant (IMP)	Safe to use as contraception alongside sequential HRT.	Cannot be recommended at the present time for endometrial protection as part of HRT as no evidence to support efficacy.	
Progestogen-only pill (POP)	Safe to use as contraception alongside sequential HRT.	Cannot be recommended at the present time for endometrial protection as part of HRT as no evidence to support efficacy.	
Combined hormonal contraception (CHC)	Do not use in combination with HRT.	Can be used in eligible women <50 as an alternative to HRT.	Women should be advised to switch to a progestogen-only method of contraception at age 50; see above for alternative options as they relate to HRT.

Pop quiz – again!

Dr Farah Chaudhry

A 44-year-old woman attends for contraception. She states that her periods have become more irregular and heavier over the past year. What can you advise?

a. You can advise her that heavy menstrual bleeding (HMB) and abnormal bleeding patterns are more common in women over 40.
b. Pelvic ultrasound scan and endometrial biopsy may be indicated.
c. Mirena and Levosert are licensed for the management of HMB.
d. Combined oral contraception (COC) containing estradiol valerate/dienogest is licensed for HMB.
e. The National Institute for Health and Care Excellence includes all COC as a treatment option for HMB.
f. All of the above.

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It is suggested that women using depot medroxyprogesterone acetate (DMPA) experience initial bone loss due to the hypoestrogenic effects of DMPA but that this initial bone loss is not repeated or worsened by menopause. This statement is:

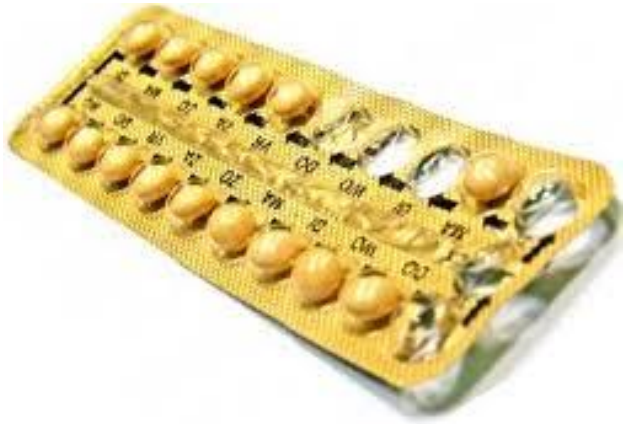
a. True
b. False.

It is suggested that women using depot medroxyprogesterone acetate (DMPA) experience initial bone loss due to the hypoestrogenic effects of DMPA but that this initial bone loss is not repeated or worsened by menopause. This statement is:

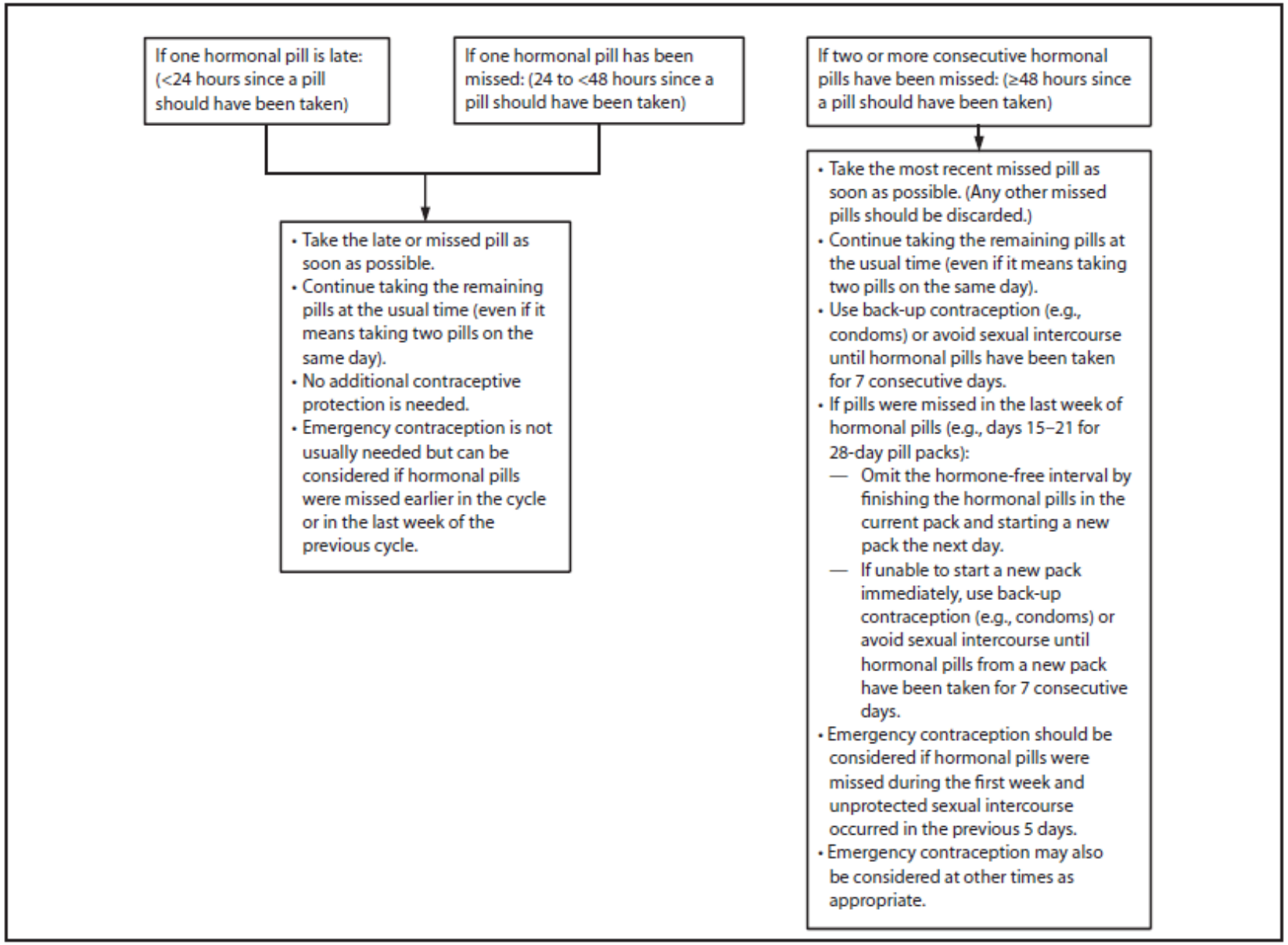
a. True
b. False.

Missed Pill Rules

- 1 pill – doesn't matter
- 2+ pills:
  - Week 1:
    - ?EC
    - Extra precauitons 7/7
  - Week 2:
    - Extra precautions 7/7
  - Week 3:
    - Omit PFW
    - Extra precautions 7/7



Missed pill advice



Control of bleeding with LARC

- Manage expectations
- Exclude pathology
  - ?STI screening
  - ?Cx cytology
  - ?Speculum exam

CEU GUIDANCE

Table 1 Expected bleeding patterns after commencing hormonal contraception and in the longer term[2–13, 20]

Contraceptive method	Bleeding patterns in women in the first 3 months	Bleeding patterns in women in the longer term
COMBINED HORMONAL CONTRACEPTION (pill, patch or ring)	Up to 20% of combined oral contraception users have irregular bleeding. No significant differences between pill or patch use.[2–4]	Bleeding usually settles.[19] Ovarian activity is effectively suppressed.
PROGESTOGEN-ONLY CONTRACEPTION		
Progestogen-only pill	One-third of women have a change in bleeding and 1 in 10 have frequent bleeding.[5]	Bleeding may not settle with time and ovarian activity is incompletely suppressed. Approximately 10–15% are amenorrhoeic; up to 50% have a regular bleed; 30–40% have irregular bleeding.[10]
Progestogen-only injectable	Bleeding disturbances (spotting, light, heavy or prolonged bleeding) are common.[7,20] Up to 35% are amenorrhoeic at 3 months.[6]	Up to 70% are amenorrhoeic at 1 year.[6]
Progestogen-only implant	Bleeding disturbances are common.[9]	After 6 months use, 30% have infrequent bleeding; 10–20% have prolonged bleeding.[6,12] Long-acting reversible contraceptive (LARC) guidance suggests: 20% are amenorrhoeic; 50% have infrequent, frequent or prolonged bleeding, which may not settle with time.[6]
Levonorgestrel-releasing intrauterine system	Irregular, light or heavy bleeding is common (in the first 6 months).[20]	65% have amenorrhoea or reduced bleeding at 1 year.[6] A 90% reduction in menstrual blood loss has been demonstrated over 12 months of use.[11,13]

Control of Bleeding

- Watchful waiting
- NSAID - mefenamic acid 500mg TDS/PRN
- Tranexamic acid 1g TDS d1-4
- COC - mercilon/femodette
- POP – micronor/noriday/cerazette

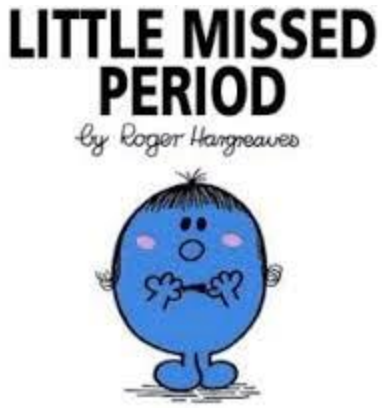
Final Pop quiz!

Dr Farah Chaudhry

A 24 year old woman requesting contraception expresses a preference for a method that is likely to stop her periods.

Which of the following is most likely to result in amenorrhoea?

- Copper IUD
- Depo-Provera
- Jaydess
- Mirena
- Nexplanon



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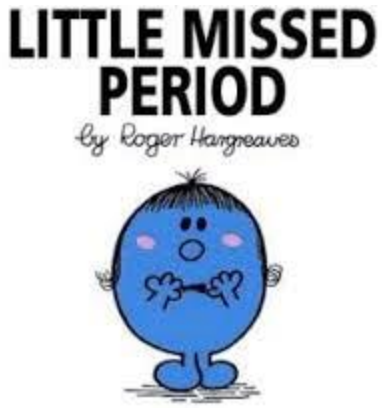

Questions?

Thank you for listening

farah.chaudhry@nhs.net