Contraception For Advanced Practitioners

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Objectives

- Understanding emergency contraception
- Young people and contraception
- Contraception in over 40-year-olds
- Caya diaphragm

Emergency Contraception

- Levonorgestrel 1500micrograms (Levonelle) – LNG
  - To be used within 72hrs of UPSI
  - Off licence 72-96hrs after UPSI
  - Can be used more than once in cycle

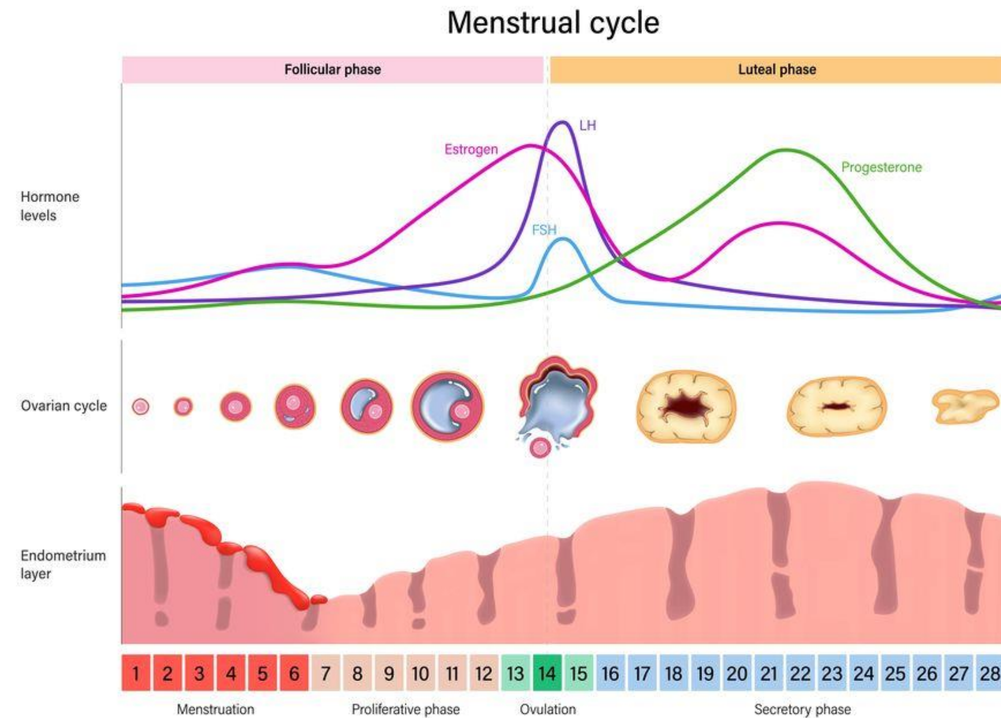
- Ulipristal acetate 30mg (Ella One) – UPA
  - To be used within 120hrs of UPSI
  - Can be used more than once in cycle

- Copper-IUD

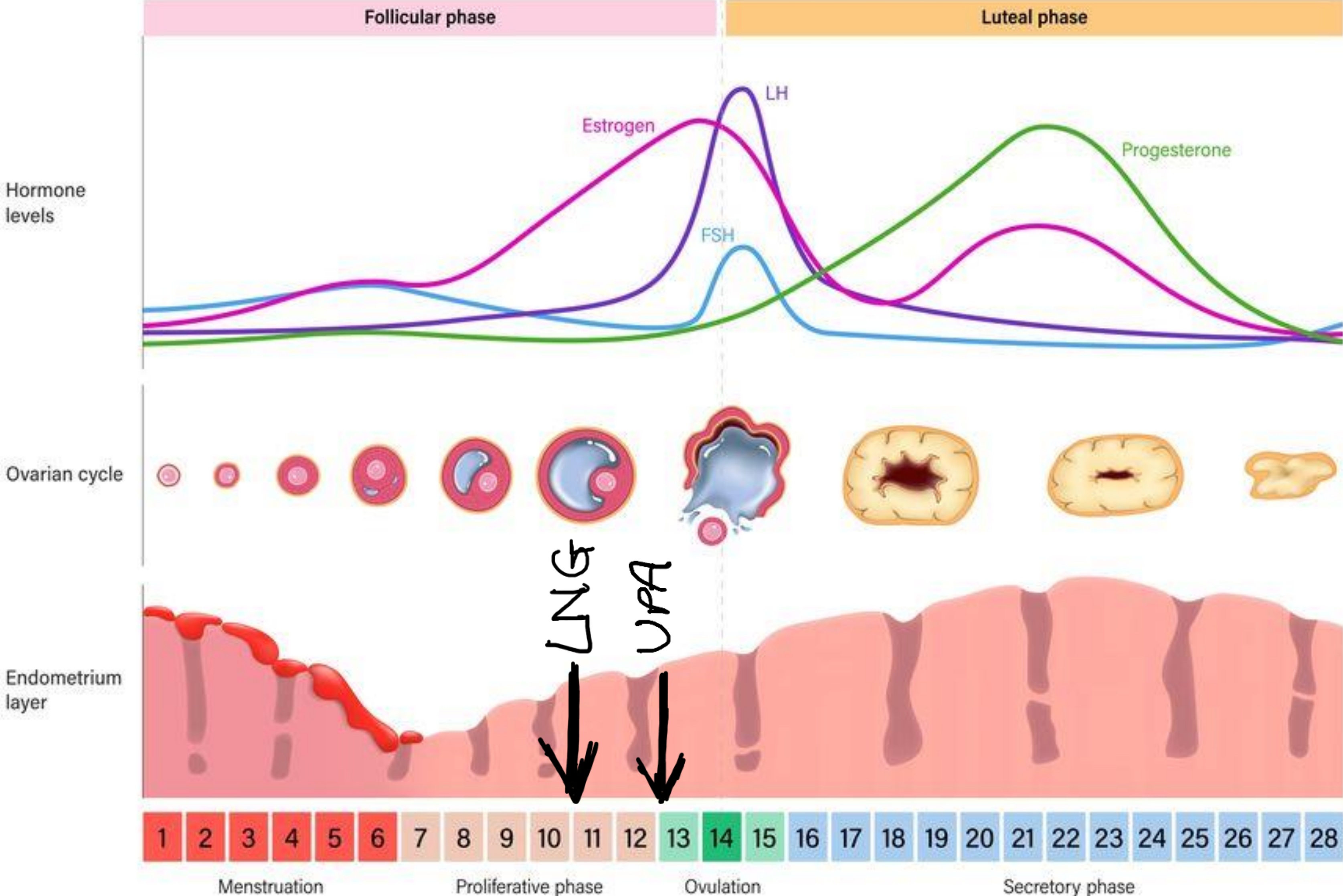
How Effective is Emergency Contraception?

- About 1 in 1000 women will get pregnant after having an emergency IUD fitted
- About 10-20 in 1000 women will get pregnant after taking oral EC

Oral Emergency Contraception



- A woman is at highest risk of pregnancy just before or on the day of ovulation
- Oral EC acts by delaying ovulation
- It has no effect after ovulation
- No evidence to suggest there is effect after fertilisation

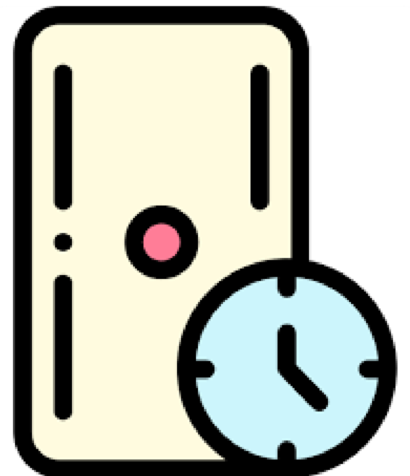

Menstrual cycle
Follicular phase
Luteal phase
Hormone levels
LH
Estrogen
Progesterone
FSH
Ovarian cycle
LNG
UPA
Endometrium layer
1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28
Menstruation
Proliferative phase
Ovulation
Secretory phase

When may emergency contraception be less effective?

- Post ovulation
- Vomiting within 3h
- High Body Mass Index (BMI) or weight
  - LNG less effective with woman weighs >70kg/BMI>26 – can double dose
  - UPA less effective if a woman weighs >85kg/BMI>30
- Malabsorption syndromes, such as acute/active inflammatory bowel disease or Crohn’s disease
- Interaction between progestogens (including LNG and UPA)
  - If LNG has been taken, do not offer UPA in the following 7days
  - If UPA has been taken do not offer LNG in the following 5days
- Patient taking enzyme inducers

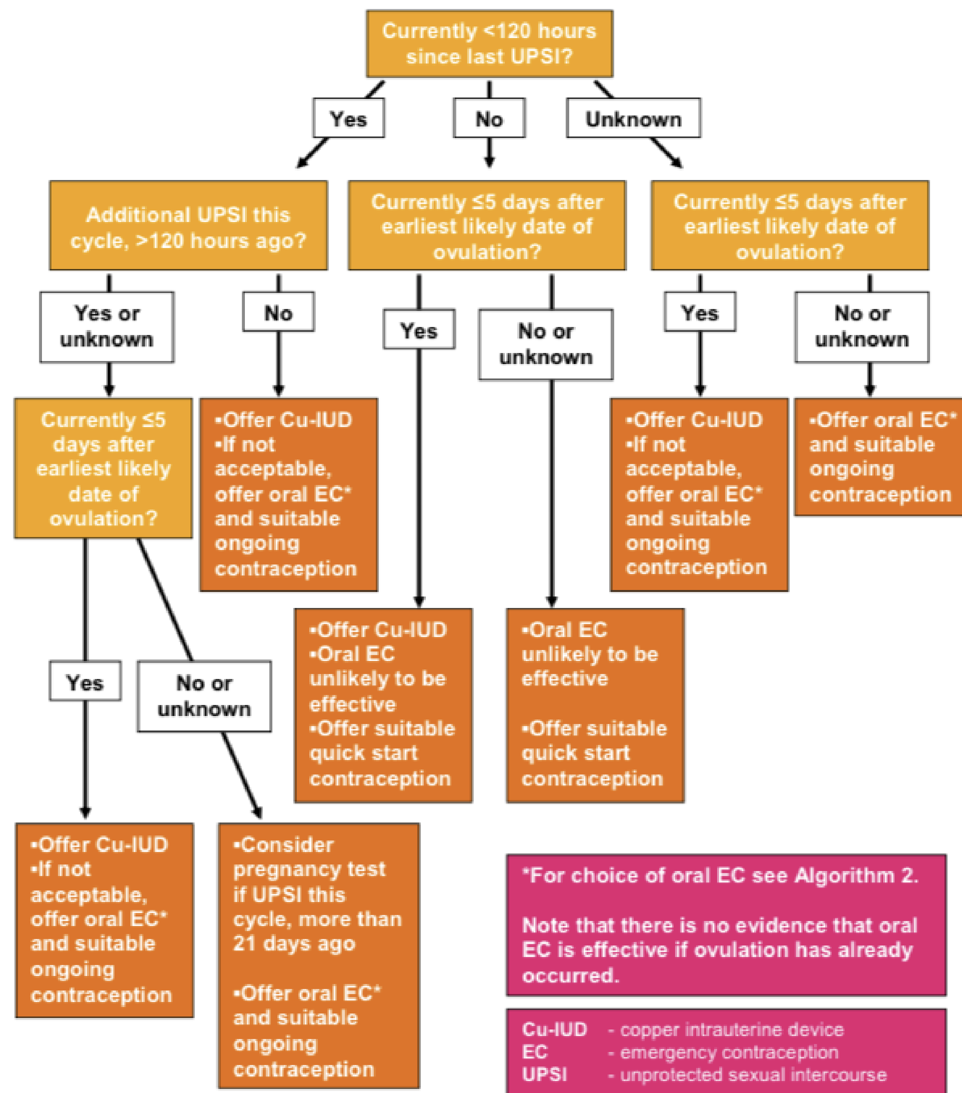
Why and when would you offer LNG over UPA?

- If the UPSI was not likely to be during the fertile window, (especially if UPSI was at a time of very low risk of pregnancy), remember:
  - Initiation of hormonal contraception must be delayed for 5 days after UPA-EC
  - UPA-EC is much more expensive than LNG-EC



EC-IUD
When is it used?

- Within 5days of first UPSI in cycle
- Up to 5days post ovulation



Decision-making Algorithms for Emergency Contraception
Algorithm 1: Decision-making Algorithm for Emergency Contraception (EC):
Copper Intrauterine Device (Cu-IUD) vs Oral EC
Currently <120 hours since last UPSI?
Yes
No
Unknown
Additional UPSI this cycle, >120 hours ago?
Currently ≤5 days after earliest likely date of ovulation?
Currently ≤5 days after earliest likely date of ovulation?
Yes or unknown
No
Yes
No or unknown
Yes
No or unknown
Currently ≤5 days after earliest likely date of ovulation?
•Offer Cu-IUD •If not acceptable, offer oral EC* and suitable ongoing contraception
•Offer Cu-IUD •If not acceptable, offer oral EC* and suitable ongoing contraception
•Offer oral EC* and suitable ongoing contraception
Yes
No or unknown
•Offer Cu-IUD •Oral EC unlikely to be effective •Offer suitable quick start contraception
•Oral EC unlikely to be effective
•Offer suitable quick start contraception
•Offer Cu-IUD •If not acceptable, offer oral EC* and suitable ongoing contraception
•Consider pregnancy test if UPSI this cycle, more than 21 days ago
•Offer oral EC* and suitable ongoing contraception
*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

Young People

- In England, Wales and Northern Ireland, those under 13 are considered unable to legally consent to sexual activity
- The age of consent to sexual activity in the UK is 16years
- Although it is unlawful, mutually agreed sexual activity between under 16-year-olds of a similar age would not generally lead to prosecution unless there was evidence of abuse or exploitation

CONSENT

- Clinicians should assess a young person's competence to consent to treatment by their ability to understand information provided, to weigh up the risks and benefits, and to express their own wishes

- This should be assessed and documented at each visit for under 16-year-olds

- You may wish to use the Fraser guidelines or a similar checklist to assess competence when providing contraception advice or treatment

CONFIDENTIALITY

- Young people should always be made aware of your local confidentiality polices, including the circumstances in which confidentiality may need to be breached

‘Everything we discuss in confidential unless I’m concerned about your safety or that of someone else…’

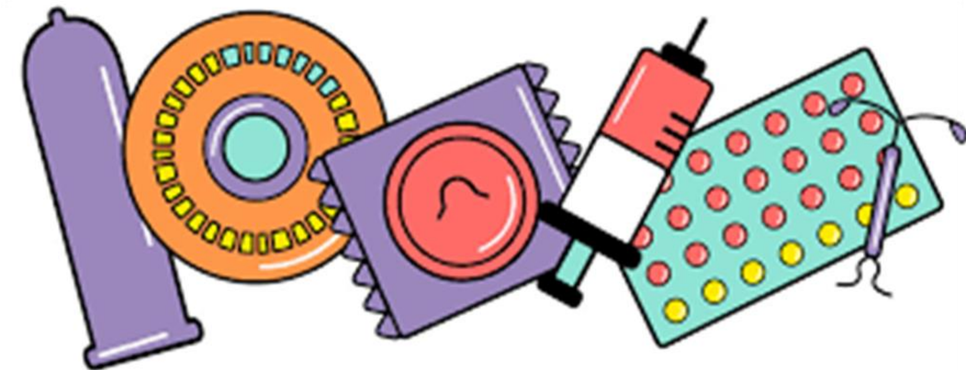
SAFEGUARDING

- If you are working with young people, you should have received appropriate training to alert them to the possibility of exploitation or coercion.

- You should know who you can contact for advice and your local policy and procedures

What we know about young people and contraception use

- Most commonly used methods – pills and condoms
- Less commonly used methods – LARC
  - Trending upwards
- The use of progesterone-only injectables and implant is greater in young women compared to older women



Factors influencing choice

- Effectiveness
- Discreetness
- Safety
- Side effect profile
- Invasiveness
- Knowledge of the method
- Ease of use
- How difficult it is to forget

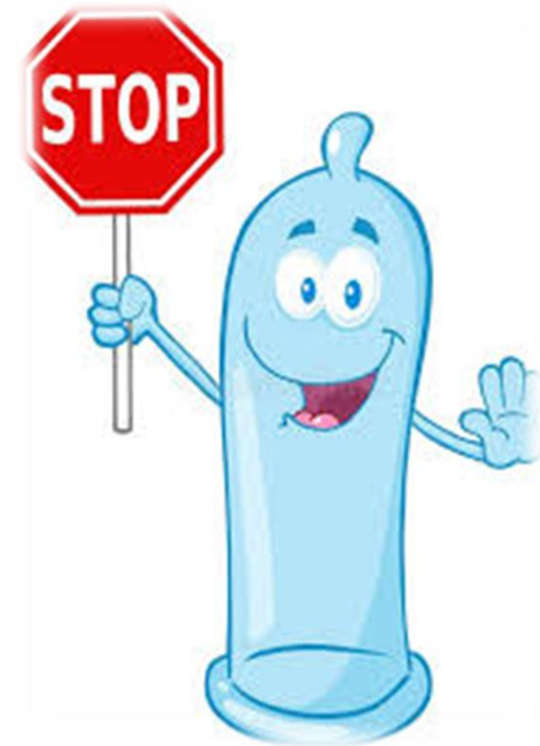
- Provide a wide but appropriate choice of methods
- Address specific health concerns
- Discuss potential health benefits
- Provide follow up
    - ?advise to return after 3months from initiation to discuss side effects and other concerns
- Back up verbal information with written information

Consider

- Ability to adhere to contraception
- Eating disorders
- Family situation
- Obesity
- Recreational drug/alcohol use

Starting hormonal contraception

- CEU does not support the use of regular hormonal contraception prior to menarche
- Condoms should be used in those requiring contraception
- Progesterone only EC can be given if required



Remember…

- Remember to offer EC IUD in eligible individuals

WEIGHT GAIN

- No evidence of weight gain with COC
- DMPA may be associated with 2-3kg weight gain over 1 year
  - Studies have shown those at higher risk are:
    - Black adolescents
    - BMI >30
- Little evidence of a casual association between other PO methods and weight gain

ACNE

- COC use can improve acne
- If COC fails to improve acne – try a COC with high oestrogen or less androgenic progesterone
- Implant may be associated with improvement, worsening or new onset acne

MOOD CHANGES

- Hormonal contraception may be associated with mood changes
- No evidence of it causing depression

FERTILITY

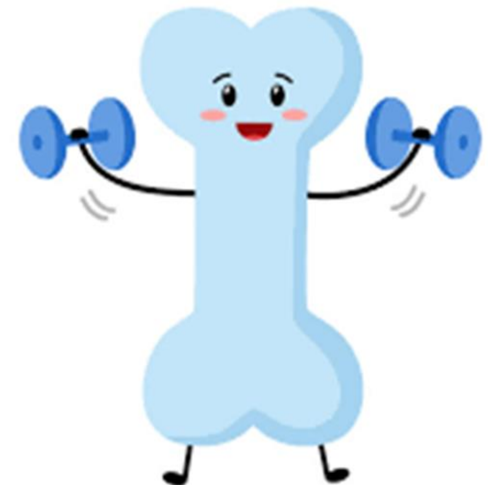
- No delay in returning of fertility following discontinuation of POP, CHC, IUC, Implant
- There can be a delay of up to a year in the return of fertility after discontinuation of DMPA

BLEEDING PATTERNS

- Discuss bleeding patterns as they can be altered by hormonal contraception
- This will help with adherence and tolerance

BONE HEALTH

- PO injectables are associated with a small loss of bone mineral density
  - Usually recovered after discontinuation
- DMPA can be used in under 18s after other methods have been considered
- Review women on DMPA every 2 years to assess risks and benefits



STIs

- Correct and consistent condom use reduces the risk of transmission of STIs
- STI test 2 and 12 weeks after UPSI

Over 40s

- Although natural fertility declines with age, and spontaneous pregnancy is rare after age 50, effective contraception is required until menopause to prevent an unintended pregnancy
- Pregnancy and childbirth after age 40 confer a greater risk of adverse maternal and neonatal outcomes than women under 40
- The number of live births per year to women over 40 in England and Wales has nearly doubled from 2000-2015
    - Contraception discussions with women over 40 may be part of a wider fertility agenda

Remember…

- Many individuals over 40 may be entering new relationships – casual or long term
- This population should be advised about condom use to protect from STIs, even if contraception is no longer required

Transition to menopause

- Perimenopause is the transition phase preceding menopause and ending 1 year after the last menstrual period, during which women move from normal ovulatory menstrual cycles to the cessation of ovulation and menstruation

- Typically starts mid-to-late 40s and lasts 4-5years

- Start with fluctuating oestrogen, progesterone and FSH
  - Causing intermittent or persistent – hot flushes, mood changes, mood swings, anxiety, depression, sleep disturbance, chronic tiredness, joint/muscular pain

- Oestrogen levels finally decrease in late perimenopause with a sustained increase in FSH and LH

Don’t forget…

- Women over 40 with a significant change in their bleeding pattern should have appropriate gynaecological assessment and investigations – whether or not they are using a contraceptive method
- Should be asked about urogenital symptoms or sexual issues they may be experiencing
  - Vaginal dryness, dysparaunia, bladder problems
    - Consider vaginal oestrogen and lubricants
  - Loss of libido is common – multifactorial

Background risk increase

- Cardiovascular disease
- Breast cancer
- Endometrial cancer
- Ovarian cancer
- Higher risk of osteoporotic fractures (lower BMD)

Can contraception effect menopause?

- No!
- Masks signs and symptoms

CU-IUS

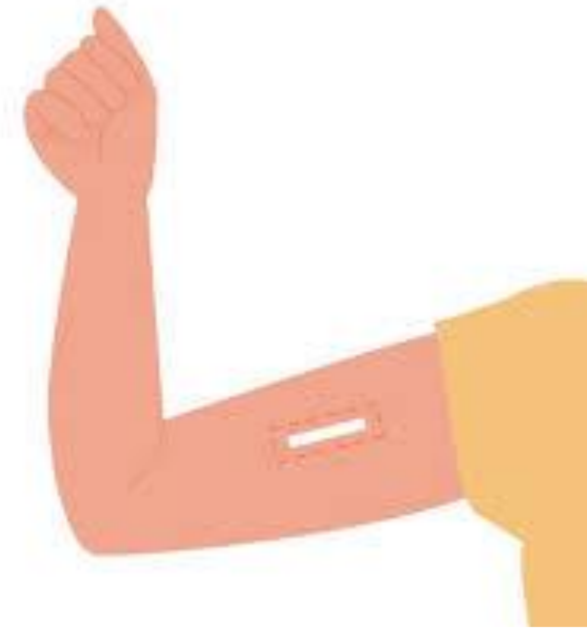
- Extended use until menopause if fitted at age 40 or over

LNG-IUS

- Women using 52mg LNG-IUS for endometrial protection as part of HRT must have the device changed every 5 years
- Extended us of 52mg LNG-IUS until age 55 if inserted at age 45 or over – if not being using as part of the progesterone component of HRT

IMPLANT

- No effect on BMD
- Most effective form of contraception available
- Currently extended use not supported; however, a study has suggested it may be effective for 4 years

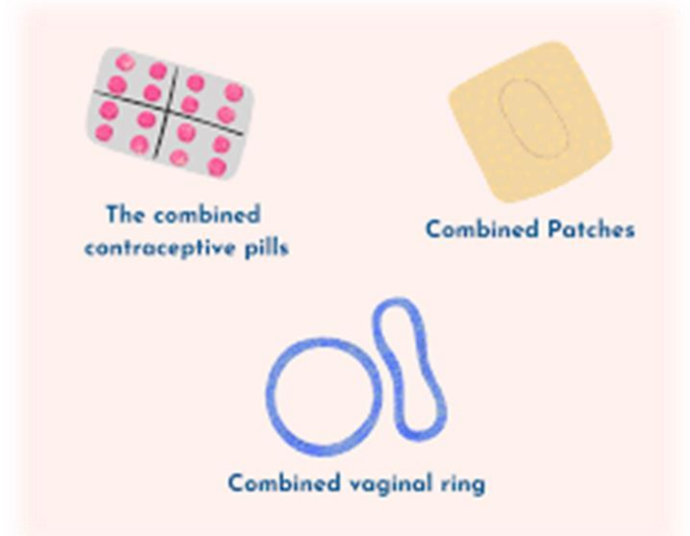


PO INJECTABLES

- Women over 50 should be counselled on alternative methods
- Women over 40 should be reviewed regularly to assess risks and benefits
- Evidence suggested bone loss is not worsened by onset off menopause

CHC

- 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
- CHC may help to maintain BMD compared with non-use of hormones in the perimenopause
- Reduced risk of ovarian and endometrial cancer that lasts for several decades after cessation



CHC

- Women aged 50 and over should be advised to stop taking CHC
- 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 other preparations
- COC with </=30ug ethinylestradiol should be considered first line COC preparations for women over 40 due to the potentially lower risks of VTE, CVD and stroke compared to formulations containing higher doses of oestrogen

When is contraception not needed?

- Menopause – clinical diagnosis – 1 year of amenorrhoea (most women do not require measurement of serum hormone levels to diagnose – focus on symptoms)
- If needed women over 50 using progesterone only contraception can have serum FSH measurements undertaken to check menopausal status
- Women using CHC or HRT have suppressed levels of oestradiol and gonadotrophins – measuring these hormones does not give accurate information on which to base advice regarding menopausal status and when to stop contraception

When do you stop contraception?

- All women can cease contraception at the age of 55 even if still experiencing menstrual bleeding – conception at this age is exceptionally rare
- IUC should not be left in situ indefinitely after it is no longer required as it could become a focus of infection

FSRH

Table 8: Recommendations regarding stopping contraception

<table>
<tr><th>Contraceptive method</th><th>Age 40–50 years</th><th>Age >50 years</th></tr>
<tr><td>Non-hormonal</td><td>Stop contraception after 2 years of amenorrhoea</td><td>Stop contraception after 1 year of amenorrhoea.</td></tr>
<tr><td>Combined hormonal contraception</td><td>Can be continued</td><td>Stop at age 50 and switch to a non-hormonal method or IMP/POP/LNG-IUS, then follow appropriate advice.</td></tr>
<tr><td>Progestogen-only injectable</td><td>Can be continued</td><td>Women ≥50 should be counselled regarding switching to alternative methods, then follow appropriate advice.</td></tr>
<tr><td rowspan="2">Progestogen-only implant (IMP)

Progestogen-only pill (POP)

Levonorgestrel intrauterine system (LNG-IUS)</td><td rowspan="2">Can be continued to age 50 and beyond</td><td>Stop at age 55 when natural loss of fertility can be assumed for most women.
▶ If a woman over 50 with amenorrhoea 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.</td></tr>
<tr><td>A 52mg LNG-IUS inserted ≥45 can remain in situ until age 55 if used for contraception or heavy menstrual bleeding.</td></tr>
</table>

FSH, follicle-stimulating hormone; IU, international unit.

Caya Diaphragm

- https://www.youtube.com/watch?v=x03m8A64b6Y

Questions...