Contraception - Management

View full scenario

safe practical clinical answers - *fast*

How can I help a woman choose which method of contraception is most suitable for her?

- Discuss:

o What method the woman has in mind, and what she understands about the method.

o Other methods that are available.

o Her requirements for contraception, including future plans for having children.

o Her age, health, and any drugs she is using.

o Pros and cons of suitable methods, including effectiveness, convenience, advantages, disadvantages, and risks.

o Her personal beliefs and views.

o Her circumstances, including the attitudes of her partner and family towards contraception.

o Her previous experience with contraception.

o Her sexual health risks and advice on safer sex.

- Identify any relevant conditions or medication which could affect choice of contraceptive.

In depth

How do anticonvulsants, antibiotics, antifungals, antiretrovirals and St John's wort influence choice?

Anticonvulsants

- For women taking anticonvulsants, see Epilepsy.

Antibiotics

- No contraceptive reduces the antibiotic effect but in certain circumstances the contraceptive effect is reduced.

- **For women taking antibiotics that induce liver enzymes (rifampicin and rifabutin):**

  - Methods that can be used without restriction: depot medroxyprogesterone, copper intrauterine devices (IUDs), the levonorgestrel-releasing intrauterine system (IUS), barrier methods, and natural family planning methods.

  - Methods that generally can be used (advantages generally outweigh the risks): progestogen-only implant or depot norethisterone enantate (the consistent use of condoms is also recommended).

  - Methods that should not usually be used (risks usually outweigh the benefits): combined oral contraceptives (COCs), combined contraceptive patch, combined contraceptive vaginal ring, progestogen-only pill.

- **For women taking antibiotics that do not induce liver enzymes:**

  - Methods that can be used without restriction: progestogen-only pill, progestogen-only injectables and implants, copper IUDs, the levonorgestrel-releasing IUS, and barrier methods.

  - Methods that generally can be used (advantages generally outweigh the risks): COCs, combined contraceptive patch, and combined contraceptive vaginal ring.

  - Additional protection (such as condoms) should be used for the first three weeks of a long antibiotic course, and during a short antibiotic course and for up to 7 days after stopping it.

  - Note: the combined contraceptive vaginal ring can be used with amoxicillin and doxycyline without the need for additional barrier contraception.

  - There are no methods that should not be used.

Antifungals

- **Women taking fluconazole, itraconazole, and ketoconazole, and griseofulvin:** all methods can be used without restriction. Note: antifungal pessaries may increase the risk of ring breakage if used with a combined contraceptive vaginal ring.

Antiparasitics

- All methods can be used without restriction.

Antiretroviral therapy

- Antiretroviral drugs have the potential to either decrease or increase the bioavailability of steroid hormones in hormonal contraceptives. These interactions may alter the safety and effectiveness of the hormonal contraceptive and the antiretroviral drug. Consider consulting a specialist as advances in knowledge are rapid in this area.

- If a woman on antiretroviral therapy decides to start or continue a hormonal contraceptive, the consistent use of condoms is recommended to prevent HIV transmission and to compensate for potential reductions in the effectiveness of the hormonal contraceptive.

- **Nucleoside reverse transcriptase inhibitors:**

  - Methods that can be used without restriction: COCs, combined contraceptive patch, combined contraceptive vaginal ring, progestogen-only pill, depot medroxyprogesterone, and progestogen-only implants.

  - Methods that generally can be used (advantages generally outweigh the risks): copper IUDs and the levonorgestrel-releasing IUS can be inserted or continued if the woman is clinically well on antiretroviral therapy. However, if the woman is not clinically well, a copper IUD or the levonorgestrel-releasing IUS should not usually be inserted (the risks usually outweigh the advantages). Depot norethisterone enantate can generally be used.

- **Non-nucleoside reverse transcriptase inhibitors:**

  - Methods that can be used without restriction: depot medroxyprogesterone.

  - Methods that generally can be used (advantages generally outweigh the risks): COCs, combined contraceptive patch, combined contraceptive vaginal ring, progestogen-only pill, progestogen-only implants, depot norethisterone enantate. Copper IUDs and the levonorgestrel-releasing IUS can be inserted

or continued if the woman is clinically well on antiretroviral therapy. However, if the woman is not clinically well, a copper IUD or the levonorgestrel-releasing IUS should not usually be inserted (the risks usually outweigh the advantages).

- **Ritonavir-boosted protease inhibitors:**

  - Methods that can be used without restriction: depot medroxyprogesterone.

  - Methods that generally can be used (advantages generally outweigh the risks): progestogen-only implants, depot norethisterone enantate. Copper IUDs and the levonorgestrel-releasing IUS can be inserted or continued if the woman is clinically well on antiretroviral therapy. However, if the woman is not clinically well, a copper IUD or the levonorgestrel-releasing IUS should not usually be inserted (the risks usually outweigh the advantages).

  - Methods that should not usually be used (risks usually outweigh the benefits): combined oral contraceptives (COCs), combined contraceptive patch, combined contraceptive vaginal ring, and progestogen-only pills.

- **Sterilization** can be done with extra precautions, and the procedure may need to be delayed if the woman has an AIDS-related illness. The consistent use of condoms is recommended after sterilization.

St John's wort

- Methods that can be used without restriction: progestogen-only injectables, copper IUDs, levonorgestrel-releasing IUS, barrier methods, natural family planning methods, and sterilization.

- Methods that should not usually be used (risks usually outweigh the benefits): COCs, combined contraceptive patch, combined contraceptive vaginal ring, progestogen-only pill, and progestogen-only implants.

In depth

Breastfeeding: how does this influence choice?

- Contraception is not needed in the first 20 days after delivery, but is required from day 21 if the woman is not fully breastfeeding and does not want to become pregnant.

- **Women who are breastfeeding and are < 6 weeks postpartum**

  - Methods that can be used without restriction: lactational amenorrhoea method (if fully or almost fully breastfeeding and amenorrhoeic), progestogen-only pill, progestogen-only implants, copper intrauterine devices (IUDs) and the levonorgestrel-releasing intrauterine system (IUS) (use within 48 hours or from 4 weeks after delivery), and barrier methods.

  - The National Institute for Health and Clinical Excellence recommends that the IUD and IUS be inserted at least 4 weeks after delivery.

  - Methods that can generally be used (advantages generally outweigh the risks): progestogen-only injectables.

  - Methods that are not usually recommended (risks usually outweigh the advantages): copper IUDs (from 48 hours up to 4 weeks after delivery) and the levonorgestrel-releasing IUS (from 48 hours up to 4 weeks after delivery).

  - Methods that should not be used (because of unacceptable health risk): combined oral contraceptives (COCs), combined contraceptive patch, and combined contraceptive vaginal ring.

  - Fertility awareness–based methods: a previous user can start from day 21, but a new user should delay learning to use the method until her periods start.

  - Sterilization is usually delayed until the woman is 6 weeks or more postpartum.

- **Women who are fully or almost fully breastfeeding and are between 6 weeks and 6 months postpartum**

  - Methods that can be used without restriction: lactational amenorrhoea method (if amenorrhoeic), progestogen-only pill, progestogen-only injectables and implants, copper IUDs, levonorgestrel-releasing IUS, barrier methods, and sterilization.

  - Fertility awareness–based methods: a previous user can start, but a new user should delay learning to use the method until her periods start.

- Methods that are not usually recommended: COCs, combined contraceptive patch, and combined contraceptive vaginal ring.

- **Women who are *not* fully or almost fully breastfeeding and are between 6 weeks and 6 months postpartum**

- Methods that can be used without restriction: progestogen-only pill, progestogen-only injectables and implants, copper IUDs, the levonorgestrel-releasing IUS, barrier methods, and sterilization.

- Methods that can generally be used (advantages generally outweigh the risks): COCs, combined contraceptive patch, and combined contraceptive vaginal patch.

- Fertility awareness–based methods: a previous user can start, but a new user should delay learning to use the method until her periods start.

- There are no methods that should not be used (because of unacceptable health risk).

- **For women who are breastfeeding and are 6 months or more postpartum**

- Methods that can be used without restriction: COCs, combined contraceptive patch, combined contraceptive vaginal ring, progestogen-only pill, progestogen-only injectables and implants, copper IUDs, the levonorgestrel-releasing IUS, barrier methods, and sterilization.

- Fertility awareness–based methods: a previous user can start, but a new user should delay learning to use the method until her periods start.

- The lactational amenorrhoea method does not provide adequate protection from unplanned pregnancy after 6 months postpartum.

- For women who have had a recent delivery and are not breastfeeding, see Postpartum (not breastfeeding).

In depth

How does diabetes influence choice?

- **Women with diabetes mellitus (insulin and non–insulin dependent) *and* no vascular disease**

  - Methods that can be used without restriction: copper intrauterine devices (IUDs), barrier methods, and natural family planning methods.

  - Methods that can generally be used (advantages generally outweigh the risks): combined oral contraceptives (COCs), combined contraceptive patch, combined contraceptive vaginal ring, progestogen-only pill, progestogen-only injectables and implants, and the levonorgestrel-releasing intrauterine system (IUS).

  - Sterilization should be undertaken with caution.

  - There are no methods that should not be used.

- **Women with diabetes mellitus and nephropathy, retinopathy, neuropathy, or other vascular disease**

  - Methods that can be used without restriction: copper IUDs, barrier methods, and natural family planning methods.

  - Methods that can generally be used (advantages generally outweigh the risks): progestogen-only pill, progestogen-only implant, and the levonorgestrel-releasing IUS.

  - Methods that should not usually be used (risks usually outweigh the advantages): progestogen-only injectables.

  - COCs, the combined contraceptive patch, and the combined contraceptive vaginal ring should either not be used (unacceptable health risk) or should generally not be used (risks generally outweigh the advantages), depending on the severity of the vascular complications.

  - Sterilization can be used but should be done in a setting with experienced healthcare professionals and back-up medical support.

In depth

How does epilepsy influence choice?

- **Women with a history of epilepsy who are not taking anticonvulsants**

o All methods can be used without restriction.

- **Women taking anticonvulsants that do not induce liver enzymes** (i.e. gabapentin, levetiracetam, valproate, and vigabatrin)

o All methods can be used without restriction, except that sterilization should be undertaken with caution and seizures should be adequately controlled.

- **Women taking anticonvulsants that induce liver enzymes** (phenytoin, carbamazepine, barbiturates, primidone, topiramate, oxcarbazepine)

o Methods that can be used without restriction: depot medroxyprogesterone acetate, copper intrauterine devices, the levonorgestrel-releasing intrauterine system, barrier methods, and natural family planning methods.

o Methods that can generally be used (benefits generally outweigh the risks): progestogen-only implant, depot norethisterone enantate.

o Sterilization can be done with caution.

o Methods that should not usually be used (risks usually outweigh the benefits): combined oral contraceptive, combined contraceptive patch, combined contraceptive vaginal ring, and progestogen-only pill.

o If combined oral contraceptives are chosen, dose adjustment may be needed. For more information about dose adjustment, see Liver enzyme-inducing drugs.

- **Women taking lamotrigine**

o Methods that can be used without restriction: progestogen-only pills, injectables and implants, copper intrauterine devices, the levonorgestrel-releasing intrauterine system, barrier methods, and natural family planning methods.

- Methods that should not usually be used (risks usually outweigh the benefits): combined oral contraceptives, combined contraceptive patch, combined contraceptive vaginal ring.

- If combined oral contraception is chosen, dose adjustment may be needed. For more information about dose adjustment, see Lamotrigine and Drug interactions.

In depth

How does the presence of migrainous or non-migrainous headache influence choice?

- **Women with non-migrainous headaches**

  - Methods that can be used without restriction: *initiation* of combined oral contraceptives (COCs), the combined contraceptive patch, combined contraceptive vaginal ring; progestogen-only pill, progestogen-only injectables and implants, copper intrauterine devices (IUDs), the levonorgestrel-releasing intrauterine system (IUS), barrier methods, and natural family planning.

  - Methods that can generally be used (advantages generally outweigh the risks): continuation of COCs, the combined contraceptive patch and combined contraceptive vaginal ring in women who develop non-migrainous headaches while taking combined hormonal contraceptives.

- **Women with migraine without aura, at any age**

  - Methods that can be used without restriction: copper IUDs, *initiation* of progestogen-only pill, barrier methods, and natural family planning.

  - Methods that can generally be used (advantages generally outweigh risks): *initiation* of COCs, the combined contraceptive patch, combined contraceptive vaginal ring; *continuation* of progestogen-only pills; progestogen-only injectables and implants, the levonorgestrel IUS.

  - Methods that should generally not be used (risks usually outweigh advantages): *continuation* of COCs, the combined contraceptive patch, combined contraceptive vaginal ring.

- **Women with migraine with aura, at any age**

o Methods that can be used without restriction: copper IUDs, barrier methods, and natural family planning.

o Methods that can generally be used (advantages generally outweigh the risks): progestogen-only pill, progestogen-only implants and injectables, and the levonorgestrel-releasing IUS.

o Methods that should not be used (unacceptable risk): COCs, the combined contraceptive patch, and the combined contraceptive vaginal ring.

- **Women with a past history (>= 5 years ago) of migraine with aura, at any age**

o Methods that can be used without restriction: copper IUDs, barrier methods, and natural family planning.

o Methods that can be used without restriction: initiation of the progestogen-only pill, copper IUDs, barrier methods, and natural family planning.

o Methods that can generally be used (advantages generally outweigh the risks): the progestogen-only pill, progestogen-only implants and injectables, and the levonorgestrel-releasing IUS.

o Methods that are not usually recommended (risks usually outweigh the advantages): COCs, the combined contraceptive patch, and combined contraceptive vaginal ring.

In depth

How does the presence of hypertension influence choice?

Women with hypertension that is adequately controlled

o Methods that can be used without restriction: progestogen-only pill, progestogen-only implants, copper intrauterine devices (IUDs), levonorgestrel-releasing intrauterine system (IUS), barrier methods, and natural family planning.

o Methods that can generally be used (advantages generally outweigh risks): progestogen-only injectables.

- Sterilization can be used with caution (extra preparation, precautions and counselling), with blood pressure controlled before surgery.

- Methods that are not usually recommended (risks usually outweigh the advantages): combined oral contraceptives (COCs), the combined contraceptive patch, and combined contraceptive vaginal ring.

▪ **Women with consistently increased systolic blood pressure of more than 140 mmHg and less than 160 mmHg, or diastolic blood pressure more than 90 mmHg and less than 95 mmHg, without vascular disease:**

- Methods that can be used without restriction: progestogen-only pill, progestogen-only injectables and implants, copper intrauterine devices (IUDs), levonorgestrel-releasing intrauterine system (IUS), barrier methods, and natural family planning.

- Sterilization can be used with caution (extra preparation, precautions and counselling), with blood pressure controlled before surgery.

- Methods that are not usually recommended (risks usually outweigh the advantages): combined oral contraceptives (COCs), the combined contraceptive patch, and combined contraceptive vaginal ring.

▪ **Women with consistently increased systolic blood pressure 160 mmHg or more, or diastolic blood pressure 95 mmHg or more, without vascular disease**

- Methods that can be used without restriction: progestogen-only pill, progestogen-only implants, copper IUDs, levonorgestrel-releasing IUS, barrier methods, and natural family planning.

- Methods that can generally be used (advantages generally outweigh the risks): progestogen-only injectables.

- Sterilization can be used but should be done in a setting with experienced healthcare professionals and medical support. Blood pressure should be controlled before surgery.

- Methods that should not be used (because of unacceptable risk): COCs, the combined contraceptive patch, and combined contraceptive vaginal ring.

- **Women with hypertension and vascular disease**

o Methods that can be used without restriction: copper IUDs, barrier methods, and natural family planning.

o Methods that can generally be used (advantages generally outweigh the risks): progestogen-only pill, progestogen-only implants, and the levonorgestrel-releasing IUS.

o Sterilization can be used but should be done in a setting with experienced healthcare professionals and medical support. Blood pressure should be controlled before surgery.

o Methods that are not usually recommended (risks usually outweigh the advantages): progestogen-only injectables.

o Methods that should not be used (because of unacceptable risk): COCs, the combined contraceptive patch, and combined contraceptive vaginal ring.

In depth

How does menorrhagia, fibroids, or previous ectopic pregnancy influence choice?

- **Women with idiopathic menorrhagia**

o Methods that can be used without restriction: combined oral contraceptives (COCs), combined contraceptive patch, combined contraceptive vaginal ring, and the levonorgestrel-releasing intrauterine system (IUS) (*initiation*), which all may reduce menstrual blood loss; sterilization.

o Methods that can generally be used (advantages generally outweigh the risks): progestogen-only pill (POP), progestogen-only injectables and implants, copper intrauterine devices (IUDs), the levonorgestrel-releasing IUS (*continuation of use*), barrier methods, and natural family planning methods (if the cycle is regular; if the cycle is irregular, a new user would find it more difficult to learn the method).

o Consider:

o The levonorgestrel IUS (Mirena®) as the first-line contraceptive option (licensed indication).

- The COC as the second line contraceptive option.

- The POP and progestogen-only injectables as third line contraceptive options.

- For information on non-contraceptive treatments, see the CKS topic on Menorrhagia.

▪ **Women with a history of ectopic pregnancy**

- All methods can be used without restriction.

- However, methods of contraception that inhibit ovulation (i.e. COCs, progestogen-only injectables and implants) are particularly suitable, as they reduce ectopic pregnancy to a greater degree compared with other methods.

▪ **Women with uterine fibroids**

- Without distortion of the uterine cavity: all methods can be used without restriction.

- With distortion of the uterine cavity: copper IUDs and the levonorgestrel-releasing IUS should not be used if they cannot be easily fitted. All other methods can be used without restriction.

In depth

How does the presence of multiple risk factors for cardiovascular disease influence choice?

▪ **Women with multiple risk factors for cardiovascular disease** (e.g. older age, smoking, diabetes, hypertension, and obesity)

- Methods that can be used without restriction: copper intrauterine devices (IUDs), barrier methods, and natural family planning.

- Methods that can generally be used (advantages generally outweigh the risks): progestogen-only pill, progestogen-only implants, and the levonorgestrel-releasing intrauterine system (IUS).

- Sterilization can be used but should be done in a setting with experienced healthcare professionals and back-up medical support.

- Methods that are not usually recommended (risks usually outweigh the advantages): progestogen-only injectables.

- Methods that should not be used (because of unacceptable risk): combined oral contraceptives, combined contraceptive patch, and combined contraceptive vaginal ring.

In depth

How does obesity influence choice?

- **Body mass index >= 30–34 kg/m^2**

  - Methods that can be used without restriction: progestogen-only pill, progestogen-only injectables and implants, copper intrauterine devices (IUDs), the levonorgestrel-releasing intrauterine system (IUS), barrier methods, and natural family planning.

  - Methods that can generally be used (advantages generally outweigh the risks): combined oral contraceptives (COCs), combined contraceptive patch, combined contraceptive vaginal ring.

  - Sterilization can be used with caution (i.e. extra preparation, precautions, and counselling).

  - There are no methods that should not be used (because of unacceptable risk).

- **Body mass index >= 35 kg/m^2**

  - Methods that can be used without restriction: progestogen-only pill, progestogen-only injectables and implants, copper IUDs, the levonorgestrel-releasing IUS, barrier methods, and natural family planning.

  - Sterilization can be used with caution (i.e. extra preparation, precautions, and counselling).

  - Methods that are not usually recommended (risks usually outweigh the advantages): COCs, combined contraceptive patch, combined contraceptive vaginal ring.

- **In addition, note that:**

  - Weight greater than 70 kg — the desogestrel-only pill, Cerazette®, should be considered in preference to other progesterone only pills.

  - Weight greater than 90 kg — the combined contraceptive patch should not be used.

  - 'Heavier women' — the progestogen-only contraceptive implant may need to be removed earlier than the licensed 3 years.

In depth

How does recent delivery and not breastfeeding influence choice?

- Contraception is not needed in the first 20 days after delivery, but is required from day 21 if the woman does not want to become pregnant.

- **Women who are not breastfeeding and are less than 3 weeks postpartum**

  - Methods that can be used without restriction: progestogen-only pill, progestogen-only injectables and implants, barrier methods, and natural family planning.

  - Methods that are not usually recommended (risks usually outweigh the advantages): combined oral contraceptive pill (COC), combined contraceptive patch, combined contraceptive vaginal ring, copper IUDs and the levonorgestrel-releasing IUS (use within 48 hours or from 4 weeks after delivery). Fertility awareness–based methods should be delayed — fertility signs and hormonal changes are unlikely to be detectable before 4 weeks postpartum.

  - Sterilization is usually delayed until the woman is 6 weeks or more postpartum.

- **Women who are not breastfeeding and are 3 weeks or more postpartum**

  - Methods that can be used without restriction: COCs, combined contraceptive patch, combined contraceptive vaginal ring, progestogen-only pill, progestogen-only injectables and implants, copper IUDs and the

levonorgestrel-releasing IUS (use within 48 hours or from 4 weeks after delivery), and barrier methods.

- Fertility awareness–based methods: a previous user can start, but a new user should delay learning to use the method until her periods start.

- Sterilization is usually delayed until the woman is 6 weeks or more postpartum.

- There are no methods that should not be used (because of unacceptable health risk).

In depth

How does the presence of, or increased risk for, a sexually transmitted infection or pelvic inflammatory disease influence choice?

- **Women with a history of pelvic inflammatory disease** and with no current risk factors for sexually transmitted infection (STI)

  - All methods can be used without restriction.

- **Women with current pelvic inflammatory disease**

  - Copper IUDs and the levonorgestrel-releasing IUS should not be inserted. However, there is generally no need for removal if the woman wishes to continue their use.

  - All other methods can be used without restriction.

- **Women with a current STI**

  - Chlamydia, purulent cervicitis, or gonorrhoea infection:

  - Copper IUDs and the levonorgestrel-releasing IUS should not be inserted. However, there is generally no need for removal if the woman wishes to continue their use.

  - All other methods can be used without restriction.

  - Vaginitis, other STIs (excluding HIV and hepatitis), and increased risk of STIs:

- Copper IUDs and the levonorgestrel-releasing IUS can generally be used (advantages generally outweigh the risks).
- All other methods can be used without restriction.

In depth

How does smoking influence choice?

- **Women who are < 35 years of age and are currently smoking, or are >= 35 years of age and stopped smoking >= 12 months ago**
  - Methods that can be used without restriction: progestogen-only pill, progestogen-only injectables and implants, copper intrauterine devices (IUDs), the levonorgestrel-releasing intrauterine system (IUS), barrier methods, natural family planning, and sterilization.
  - Methods that can generally be used (advantages generally outweigh the risks): combined oral contraceptives (COCs), combined contraceptive patch, and combined contraceptive vaginal ring.
  - There are no methods that should not be used (because of unacceptable risk).
- **Women >= 35 years who smoke < 15 cigarettes daily, or have stopped smoking in the past 12 months**
  - Methods that can be used without restriction: progestogen-only pill, progestogen-only injectables and implants, copper IUDs, the levonorgestrel-releasing IUS, barrier methods, natural family planning, and sterilization.
  - Methods that are not usually recommended (risks usually outweigh the advantages): COCs, combined contraceptive patch, and combined contraceptive vaginal ring.
- **Women >= 35 years who smoke >= 15 cigarettes daily**
  - Methods that can be used without restriction: progestogen-only pill, progestogen-only injectables and implants, copper IUDs, the levonorgestrel-releasing IUS, barrier methods, natural family planning, and sterilization.

- Methods that should not be used (because of unacceptable risk): COCs, combined contraceptive patch, and combined contraceptive vaginal ring.

In depth

How does venous thromboembolism (current and risk factors for) influence choice?

- **Women with known thrombogenic mutations, history of venous thromboembolism, or taking anticoagulants for current venous thromboembolism**

- Methods that can be used without restriction: copper intrauterine devices (IUDs), barrier methods, and natural family planning.

- Methods that can generally be used (advantages generally outweigh the risks): progestogen-only pill, progestogen-only implants and injectables, and the levonorgestrel-releasing intrauterine system (IUS).

- Methods that should not be used (because of unacceptable risk): combined oral contraceptives (COCs), the combined contraceptive patch, and combined contraceptive vaginal ring.

Contraception - Management

View full scenario

CKS safe practical clinical answers - fast

What ethical and legal issues do I need to consider when providing contraception to girls under 16 years of age?

- Inform young people that confidentiality is to be expected from all members of the healthcare team, but confidentiality might be broken if maltreatment, exploitation, or coercion is suspected.

- In England and Wales, it is lawful to provide contraceptive advice and treatment to girls less than 16 years of age without parental consent, provided that the Fraser guidelines have been met. Similar criteria apply in Scotland. The Fraser criteria are:

- The young person understands the advice given to her by the health professional.

- The young person cannot be persuaded to inform her parents, or to allow the healthcare professional to inform them.

- It is likely that the young person will continue to have sexual intercourse, with or without the use of contraception.
- The young person's physical or mental health may suffer as a result of withholding contraceptive advice or treatment.
- It is in the best interests of the young person for the clinician to provide contraceptive advice or treatment, or both, without parental consent.

- Consider child protection issues.
- Document assessments made of vulnerabilities.

In depth

Under 18 years: how does this influence choice?

- Provided that there are no medical contraindications, any method of contraception can be used, and a girl should choose her own method. However:

- Before menarche: condoms are preferred for sexually active premenarchal girls (as a contraceptive, and to prevent sexually transmitted infection); hormonal methods are not advised.
- Bone mineral density: a progestogen-only injectable may be used if the girl chooses this over other contraceptive methods.
- Prevention of sexually transmitted infections: when a hormonal or intrauterine contraceptive method is chosen, condoms should also be used to prevent sexually transmitted infections.

- Give advice about prevention of sexually transmitted infections.

- The correct and consistent use of condoms should be advised to reduce the risk of sexually transmitted infections.
- Young people should be advised to get tested for sexually transmitted infections 2 and 12 weeks after unprotected sexual intercourse.

- Reassure girls and young women that:

- Combined oral contraceptives (COCs) may improve acne vulgaris. Co-cyprindiol is indicated to treat severe acne which has not responded to oral antibiotics, but the higher risk of venous thromboembolism should be noted.
- Any increase in risk of cancer associated with hormonal contraception is very small and not clinically relevant when weighed against the risk of pregnancy should contraception not be used.
- The risk of venous thromboembolism is increased with use of COCs, but the absolute risk is very low.
- There is no evidence of weight gain with use of COCs or the patch.
- It is unclear whether hormonal contraception has an adverse effect on mood.
- Altered bleeding patterns can occur with hormonal contraception, but dysmenorrhoea may improve with use of combined hormonal contraception

Contraception - Management

View full scenario

CKS safe practical clinical answers - *fast*

How does the approach of menopause influence choice?

- The usual (non age-related) UK Medical Eligibility Criteria apply, but if there are no other contraindications to use:
  - Methods that can be used without restriction by perimenopausal women include:
    - Copper intrauterine devices (IUDs), the levonorgestrel-releasing intrauterine system (IUS), progestogen-only pill, progestogen-only implants, barrier methods, and sterilization.

- Progestogen-only injectables can be used without restriction up to the age of 45 years. In women over the age of 45 years, the benefits generally outweigh the risks.
- Natural family planning is not generally recommended because irregular menstrual cycles in the menopause make this method difficult to learn and use.
- Combined hormonal contraception (the combined contraceptive pill, patch, or vaginal ring) is not contraindicated by age alone in perimenopausal women, however:
  - It should not be used (unacceptable health risk) by women 35 years of age or older who smoke 15 or more cigarettes a day, or who develop migraine without aura while using combined hormonal contraception.
  - It is not usually recommended (risks usually outweigh the advantages) for women 35 years of age or older who smoke less than 15 cigarettes a day, or who quit smoking less than 1 year ago, or for women 35 years of age or older who have a history of migraine without aura.
  - Where the combined oral contraceptive (COC) pill is suitable, a pill containing 20 micrograms ethinylestradiol is a reasonable first choice.

- Non-contraceptive benefits can influence the choice of contraceptive for women with:
  - Vasomotor symptoms (hot flushes): combined hormonal contraception may reduce symptoms.
    - Women experiencing menopausal symptoms while using combined hormonal contraception may wish to try an extended regimen.
  - Osteoporosis: combined hormonal contraception may increase bone mineral density; depot medroxyprogesterone acetate may reduce bone mineral density.
  - Menstrual pain, bleeding, and irregularity: combined hormonal contraception may reduce symptoms.
  - Menstrual pain: progestogen-only methods may reduce symptoms.

- Heavy menstrual bleeding: the levonorgestrel-releasing IUS reduces menstrual bleeding and can cause amenorrhoea.

- Hormone replacement therapy (HRT):
  - Women using combined HRT should not rely on this as contraception.
  - A progestogen-only pill can be used with combined sequential HRT to provide effective contraception and adequate endometrial protection (a progestogen-only pill used with oestrogen-only HRT will not provide an adequate level of endometrial protection; combined continuous HRT regimens are not appropriate in this age group due to bleeding).
  - The levonorgestrel–releasing IUS can be used as the progestogenic component for HRT for 5 years (the licence states 4 years), and provide concurrent contraception.

In depth

How long should contraception be continued at the menopause?

- The copper intrauterine device (IUD) and the levonorgestrel-releasing intrauterine system (IUS) can be retained longer during the perimenopause.
  - Women who have an IUD inserted at age 40 years or older may retain the device until they no longer require contraception.
  - Women who have an IUS inserted at age 45 years or older may retain the device until they no longer require contraception.

- Stopping non-hormonal contraception (copper intrauterine device, condoms) at the menopause
  - Women less than 50 years of age should continue contraception for 2 years after the last period.
  - Women aged 50 years or more should continue contraception for 1 year after the last period.

- Stopping hormonal contraception at the menopause
  - Menstrual bleeding patterns are unhelpful in determining menopause when a woman is using hormonal contraception. Amenorrhoea may be due to

contraceptive hormones (progestogen-only pills, progestogen-only injectables and implants, or the levonorgestrel-releasing IUS). Regular bleeding may be due to use of combined oral contraceptives.

- Combined hormonal contraception (pill, patch or vaginal ring) or a progestogen-only injectable
  - Switch to another suitable contraceptive method at 50 years of age (amenorrhoea may not indicate the menopause).
  - Condoms or another method should be used for 2 years after stopping progestogen-only injectables (return of ovulation can be delayed).
  - The follicle-stimulating hormone (FSH) level is not a reliable indicator of ovarian failure in women using combined hormones, even if measured during the hormone-free interval.
- Progestogen-only pills, progestogen-only implants, or levonorgestrel-releasing IUS
  - Continue use to age 55 years, when natural loss of fertility can be assumed for most women (96%), *or*
  - For women over the age of 50 years who are amenorrhoeic, check FSH on two occasions, with an interval of 6 weeks between tests. If both levels are more than 30 IU/L, this is highly suggestive of ovarian failure, and contraception may be stopped after 1 more year.

Contraception - Management

View full scenario

CKS safe practical clinical answers - fast

Starting a combined oral contraceptive (COC)

How should I assess a woman before providing her with a combined oral contraceptive (COC)?

- In young women and women with special needs, assess their competence to decide, and support them in making their own decisions about contraception.
- Exclude pregnancy.
- Check the woman's blood pressure, weight and body mass index.
- Check the UK Medical Eligibility Criteria to ensure that there are no contraindications.
- Assess the risk for sexually transmitted infection and, when appropriate, advise testing, promote safer sex, and/or refer for counselling.

In depth

Which combined oral contraceptive (COC) should I offer first-line?

- First-line options are monophasic preparations containing 30 micrograms of oestrogen, and either norethisterone or levonorgestrel.
- However, consider the person's preference, as any combined oral contraceptive (COC) can be provided first-line.

In depth

How should a woman start using a combined oral contraceptive (COC) - de novo, or switching from another method or COC?

- Not currently using a regular method of contraception:

- Ideally start the COC on the first day of the period (or up to day 5) for immediate contraceptive cover.
- COCs can be started at any other time in the cycle, if pregnancy has been excluded. Additional contraception is needed for the first 7 days of taking the pill.
- Inform the woman that medical advice may differ from that included in the packet of pills.
- Specific advice for women who are amenorrhoeic, postpartum and breastfeeding, postpartum and not breastfeeding, or post-abortion is summarized in the table below.

- Starting immediately after oral emergency contraception:
  - Levonorgestrel emergency contraception used — advise additional contraception (condoms or avoidance of sex) for the first 7 days of pill taking.
  - Ulipristal acetate emergency contraception used — advise additional contraception (condoms or avoidance of sex) for the first 14 days of pill taking.
  - Advise the woman to take a pregnancy test no sooner than 3 weeks after the last episode of unprotected sex.
- Using another COC, combined contraceptive patch, or progestogen-only pill:
  - The new COC may be started immediately. There is no need to wait for the next menstrual period.
  - However, the woman may want to complete the cycle of her current COC or progestogen-only pill, omitting any hormone-free interval (or the inactive pills of Every Day preparations), before starting the new COC. No additional contraceptive protection is required.
- Using a progestogen-only injectable:
  - The COC should be started when the repeat injection would have been given.

- No additional contraceptive protection is needed if the COC is started < 14 weeks (98 days) after the injection (outside the terms of the product licence).

- Using a copper intrauterine device (IUD) or the levonorgestrel-releasing intrauterine system (IUS):
  - The COC is most conveniently begun within 5 days of the start of menstrual bleeding. No additional contraceptive protection is needed. The IUD or IUS can be removed at that time.
  - The COC can be started at any other time in the menstrual cycle, provided it is reasonably certain that she is not pregnant. However, she will need to abstain from sex or use additional contraceptive protection for the next 7 days.
    - To provide the extra protection removal of the IUD or IUS could be delayed for at least 7 days.
    - The IUD or IUS can be removed immediately *unless she has had sexual intercourse in the past 7 days*. In which case it should be left in until she has taken at least 7 pills sequentially.

In depth

What follow-up arrangement should I consider for a woman using a combined oral contraceptive (COC)?

- Follow up at 10–12 weeks after first prescriptions, and 6–12 monthly thereafter.
- Review blood pressure, risk factors, (e.g. new headaches), correct usage, lifestyle issues, adverse effects, and information on how to manage contraception relating to missed pills, diarrhoea and vomiting, surgery, and drug interactions.

In depth

Missed combined oral contraceptive (COC) pills: what should be done?

- Restart/catch up with the pill cycle.

- When seven or fewer active COC pills have been missed, the woman should resume taking her pills as soon as possible.
    - **Restarting.** If pills are missed in weeks 1, 2, or 3 of the pack: she should take the last missed pill as soon as possible and continue with the usual pill-taking schedule. Depending on when she remembers, she may take two pills at different times (the moment of remembering and her regular time), or two pills at the same time. For users of everyday COCs: if inactive pills are missed in week 4, she should throw away the missed inactive pills and continue the usual pill-taking schedule.
    - **Skipping the pill-free interval.** If pills are missed in week 3 of the pack: she should finish the active pills in the current pack and then immediately start a new pack (omitting the pill-free interval or discarding any inactive tablets).
- When more than seven active COC pills have been missed, the woman needs to restart the COC as if she had not used it before.

- Assess if contraceptive protection has become unreliable.
    - Loss of contraception is most likely if missed pills extend the pill-free (or inactive pill) interval to more than 7 days.
    - The fpa (Family Planning Association) and the Faculty of Sexual and Reproductive Healthcare (FSRH), formerly the Faculty of Family Planning and Reproductive Healthcare (FFPRHC), regard contraception as becoming unreliable if:
        - Two or more 20-microgram ethinylestradiol pills (Loestrin 20®, Mercilon®, Femodette®) are missed — mnemonic: 'Two for twenty'.
        - Three or more 30- or 35-microgram ethinylestradiol pills (all other COCs) are missed — mnemonic: 'Three for thirty'.
    - The BNF (British National Formulary) regards:
        - Contraception as unreliable if the delay is >= 24 hours (especially the first in the packet).

- Lost if more than 2 COC tablets are missed from the first 7 tablets in a packet.

- If contraceptive protection has become unreliable:
  - Advise additional protection, such as condoms or abstinence, until the woman has taken her COC for 7 days in a row.
  - Consider emergency contraception. If contraceptive protection has become unreliable and the woman has been sexually active without taking other precautions, consider the possibility of pregnancy and whether emergency contraception would be appropriate — see the CKS topic on Contraception - emergency.

In depth

Drug interactions with the combined oral contraceptive

What should I advise a woman regarding potential drug interactions with combined oral contraceptives (COCs)?

- Liver enzyme–inducing drugs, some antibiotics, and some natural remedies, can reduce the efficacy of combined oral contraceptives (COCs).
- COCs can alter serum concentrations of other drugs, such as lamotrigine, ciclosporin, and theophylline.

In depth

What should I advise a woman about taking combined oral contraceptives (COCs) with a liver enzyme-inducing drug?

- Liver enzyme–inducing drugs may reduce the efficacy of combined oral contraceptives (COCs). Commonly encountered drugs include:
  - Antibiotics: rifampicin and rifabutin
  - Anticonvulsants: carbamazepine, oxcarbazepine, phenytoin, barbiturates, primidone, topiramate.

- Antiretrovirals: particularly non-nucleoside reverse transcriptase inhibitors and ritonavir-boosted protease inhibitors. Drug interactions between certain antiretroviral agents and hormonal contraceptives could alter the safety and effectiveness of both the contraceptives and the anti-retroviral agents. For further information, see antiretrovirals.
- Herbal remedies: St John's wort

- If a liver enzyme–inducing drug is to be used long-term:
  - An alternative contraceptive method that is unaffected by enzyme-inducing drugs should be considered, for example, a long-acting reversible method such as s depot medroxyprogesterone, levonorgestrel-releasing intrauterine system or a copper intrauterine device (IUD).
  - If the woman wishes to use the COC as her primary contraceptive method while taking a liver enzyme–inducing drug, refer to (or consult with) a specialist. A COC regimen with at least 30 micrograms of ethinylestradiol daily should be used, and/or taking the COC without a pill-free interval — these uses are outside the terms of the product license.
  - The consistent use of condoms is recommended.

- If a liver enzyme–inducing drug is to be used short term (e.g. 3 weeks):
  - Additional contraceptive protection (e.g. condoms) should be used while the liver enzyme–inducing drug is being taken and for at least 4 weeks after stopping it. For women using rifampicin or rifabutin, consider continuing alternative methods for up to 8 weeks after stopping it.

- Emergency contraception should be considered if sexual intercourse has taken place while efficacy of the COC is doubtful and within the past 5 days — see the CKS topic on Contraception - emergency.

In depth

What should I advise a woman about taking a combined oral contraceptive (COC) with an antibiotic?

- **Additional contraceptive precautions are *not* required during or after courses of antibiotics that do not induce liver enzymes.**
- However, women should be advised about the importance of correct contraceptive practice during periods of vomiting or diarrhoea.
- Rifampicin and rifabutin induce liver enzymes. Therefore, if the woman is taking, or needs to take, rifampicin or rifabutin at the same time as a COC, follow the advice for interactions with liver enzyme-inducing drugs.

In depth

Interactions with lamotrigine: what should be done?

- **If the woman is already receiving lamotrigine:**
  - **If she wishes to start a combined oral contraceptive (COC), advise her:**
    - That a COC containing a minimum of 30 micrograms of ethinylestradiol should be used.
    - That seizure control may worsen.
    - That the maintenance dose of lamotrigine may need to be increased as much as two-fold, according to clinical response.
  - **If she wishes to stop a COC, advise her:**
    - That adverse effects associated with lamotrigine can increase.
    - That the maintenance dose of lamotrigine may need to be decreased by as much as 50%, according to clinical response.
- **If the woman is already using a COC and wishes to initiate lamotrigine:**
  - The usual escalation regimen for lamotrigine is recommended.

In depth

Diarrhoea or vomiting, unscheduled bleeding, surgery while taking the COC

Vomiting or diarrhoea while on a combined oral contraceptive (COC): what should be done?

- A woman who vomits (for any reason) within 2 hours of taking a combined oral contraceptive (COC) should repeat the dose as soon as possible.
- If vomiting or severe diarrhoea persists for more than 24 hours, the instructions for missed pill should be followed (see Missed COC pills), counting each day of vomiting and/or severe diarrhoea as a missed pill:
  - Additional contraceptive cover is required during the illness and for 7 days afterwards.
  - If the illness occurs while taking the last 7 tablets, omit any pill-free period (or inactive tablets) and start the next cycle immediately.

In depth

How should I manage a woman with unscheduled bleeding while on combined oral contraceptives (COCs)?

- Identify and manage causes for bleeding irregularities such as missed pills, drug interactions, vomiting, severe diarrhoea.
- Exclude or manage other situations which could result in unscheduled bleeding, such as:
  - Sexually transmitted infections.
    - Risk of STI if the woman is under 25 years, or has a new sexual partner, or more than one partner in the last year.
  - Pregnancy.
  - Gynaecological conditions such as cervical cancer. Provided there is consistent and correct use of contraception, speculum examination is warranted:
    - For persistent bleeding beyond the first 3 months of use.
    - For new symptoms or a change in bleeding after at least 3 months of use.

- If the woman has not participated in a National Cervical Screening programme.
- If requested by the woman.
- After a failed trial of modification of COC treatment (at least 6–8 weeks).
- If there are other symptoms such as pain, dyspareunia, or post coital bleeding. (Note that these symptoms also warrant pelvic examination.)

- After potential causes have been excluded:
  - Encourage persevering for up to three months for new users.
  - Consider stopping the COC for up to 7 days and then restarting (and using an alternative method while protection is lost).
  - Changing to a different COC (with a higher dose of oestrogen, or higher dose of progestogen or different type of progestogen).
  - Changing to another form of contraception.

In depth

How should I advise a woman taking combined oral contraceptives (COCs) about surgery and immobilization?

- Stop the combined oral contraceptive (COC) 4 weeks before any major surgery, surgery to the legs, or surgery with prolonged immobilization of a lower limb.
- If emergency surgery or immobilization (e.g. fractured leg) is necessary, the COC should be stopped and treatment to prevent thromboembolism should be given.
- Advise the use of another method of contraception that will minimize the risk for venous thromboembolism.
- No precautions are necessary for minor surgery where the duration of anaesthesia and immobilization is short (e.g. laparoscopic sterilization, varicose vein surgery, and tooth extraction).
- The COC should normally be recommenced at the first menses occurring at least 2 weeks after full mobilization.

- To restart the COC, take the COC on day 1 of the first menstrual period that occurs at least 2 weeks after full mobilization. If the woman has used a progestogen-only injectable in the interim, the COC can be restarted before the next injection would be due.

In depth

Prescriptions

COC monophasic: EE 30-35mcg+levonorgestrel or norethisterone

Age from 13 to 50 years

Microgynon 30: levonorgestrel 150mcg+ethinylestradiol 30mcg

Microgynon 30 tablets

Take one tablet once a day for 21 days. Start the next packet after a 7-day break. See package insert for full instructions.

Supply 63 tablets.

Age: from 13 years to 50 years

NHS cost: £2.99

Licensed use: yes

Patient information: Take the pill at the same time each day. If you forget one or more pills or experience diarrhoea or vomiting and are unsure what to do, seek the advice of a health professional.

Microgynon 30 ED: levonorgestrel 150mcg+ethinylestradiol 30mcg

Microgynon 30 ED tablets

Take one tablet once a day. See package insert for full instructions.

Supply 84 tablets.

Age: from 13 years to 50 years

NHS cost: £2.69

Licensed use: yes

Patient information: Take the pill at the same time each day. If you forget one or more pills or experience diarrhoea or vomiting and are unsure what to do, seek the advice of a health professional.

Ovranette: levonorgestrel 150mcg + ethinylestradiol 30mcg

Ovranette tablets

Take one tablet once a day for 21 days. Start the next packet after a 7-day break. See package insert for full instructions.

Supply 63 tablets.

Age: from 13 years to 50 years

NHS cost: £2.29

Licensed use: yes

Patient information: Take the pill at the same time each day. If you forget one or more pills or experience diarrhoea or vomiting and are unsure what to do, seek the advice of a health professional.

Levest: levonorgestrel 150mcg + ethinylestradiol 30mcg

Levest 150/30 tablets

Take one tablet once a day for 21 days. Start the next packet after a 7-day break. See package insert for full instructions.

Supply 63 tablets.

Age: from 13 years to 50 years

NHS cost: £2.64

Licensed use: yes

Patient information: Take the pill at the same time each day. If you forget one or more pills or experience diarrhoea or vomiting and are unsure what to do, seek the advice of a health professional.

Rigevidon: levonorgestrel 150mcg+ethinylestradiol 30mcg

Rigevidon tablets

Take one tablet once a day for 21 days. Start the next packet after a 7-day break. See package insert for full instructions.

Supply 63 tablets.

Age: from 13 years to 50 years

NHS cost: £1.89

Licensed use: yes

Patient information: Take the pill at the same time each day. If you forget one or more pills or experience diarrhoea or vomiting and are unsure what to do, seek the advice of a health professional.

Brevinor: norethisterone 500mcg + ethinylestradiol 35mcg

Brevinor 500microgram/35microgram tablets

Take one tablet once a day for 21 days. Start the next packet after a 7-day break. See package insert for full instructions.

Supply 63 tablets.

Age: from 13 years to 50 years

NHS cost: £1.99

Licensed use: yes

Patient information: Take the pill at the same time each day. If you forget one or more pills or experience diarrhoea or vomiting and are unsure what to do, seek the advice of a health professional.

Ovysmen: norethisterone 500mcg + ethinylestradiol 35mcg

Ovysmen 500microgram/35microgram tablets

Take one tablet once a day for 21 days. Start the next packet after a 7-day break. See package insert for full instructions.

Supply 63 tablets.

Age: from 13 years to 50 years

NHS cost: £1.58

Licensed use: yes

Patient information: Take the pill at the same time each day. If you forget one or more pills or experience diarrhoea or vomiting and are unsure what to do, seek the advice of a health professional.

Loestrin 30: norethisterone 1.5mg + ethinylestradiol 30mcg

Loestrin 30 tablets

Take one tablet once a day for 21 days. Start the next packet after a 7-day break. See package insert for full instructions.

Supply 63 tablets.

Age: from 13 years to 50 years

NHS cost: £3.90

Licensed use: yes

Patient information: Take the pill at the same time each day. If you forget one or more pills or experience diarrhoea or vomiting and are unsure what to do, seek the advice of a health professional.

Norimin: norethisterone 1mg + ethinylestradiol 35mcg

Norimin 1mg/35microgram tablets

Take one tablet once a day for 21 days. Start the next packet after a 7-day break. See package insert for full instructions.

Supply 63 tablets.

Age: from 13 years to 50 years

NHS cost: £2.28

Licensed use: yes

Patient information: Take the pill at the same time each day. If you forget one or more pills or experience diarrhoea or vomiting and are unsure what to do, seek the advice of a health professional.

Cilest: norgestimate 250mcg + ethinylestradiol 35mcg

Cilest 250microgram / 35microgram tablets

Take one tablet once a day for 21 days. Start the next packet after a 7-day break. See package insert for full instructions.

Supply 63 tablets.

Age: from 13 years to 50 years

NHS cost: £5.97

Licensed use: yes

Patient information: Take the pill at the same time each day. If you forget one or more pills or experience diarrhoea or vomiting and are unsure what to do, seek the advice of a health professional.

COCs monophasic: EE 30mcg with gestodene or desogestrel

Age from 13 to 50 years

Femodene: gestodene 75mcg + ethinylestradiol 30mcg

Femodene tablets

Take one tablet once a day for 21 days. Start the next packet after a 7-day break. See package insert for full instructions.

Supply 63 tablets.

Age: from 13 years to 50 years

NHS cost: £7.18

Licensed use: yes

Patient information: Take the pill at the same time each day. If you forget one or more pills or experience diarrhoea or vomiting and are unsure what to do, seek the advice of a health professional.

Femodene ED: gestodene 75mcg + ethinylestradiol 30mcg

Femodene ED tablets

Take one tablet once a day. See package insert for full instructions.

Supply 84 tablets.

Age: from 13 years to 50 years

NHS cost: £7.18

Licensed use: yes

Patient information: Take the pill at the same time each day. If you forget one or more pills or experience diarrhoea or vomiting and are unsure what to do, seek the advice of a health professional.

Katya 30/75: gestodene 75mcg + ethinylestradiol 30mcg

Katya 30/75 tablets

Take one tablet once a day for 21 days. Start the next packet after a 7-day break. See package insert for full instructions.

Supply 63 tablets.

Age: from 13 years to 50 years

NHS cost: £5.03

Licensed use: yes

Patient information: Take the pill at the same time each day. If you forget one or more pills or experience diarrhoea or vomiting and are unsure what to do, seek the advice of a health professional.

Millinette 30/75: gestodene 75mcg + ethinylestradiol 30mcg

Millinette 30microgram/75microgram tablets

Take one tablet once a day for 21 days. Start the next packet after a 7-day break. See package insert for full instructions.

Supply 63 tablets.

Age: from 13 years to 50 years

NHS cost: £4.85

Licensed use: yes

Patient information: Take the pill at the same time each day. If you forget one or more pills or experience diarrhoea or vomiting and are unsure what to do, seek the advice of a health professional.

Marvelon: desogestrel 150mcg + ethinylestradiol 30mcg

Marvelon 150microgram/30microgram tablets

Take one tablet once a day for 21 days. Start the next packet after a 7-day break. See package insert for full instructions.

Supply 63 tablets.

Age: from 13 years to 50 years

NHS cost: £6.70

Licensed use: yes

Patient information: Take the pill at the same time each day. If you forget one or more pills or experience diarrhoea or vomiting and are unsure what to do, seek the advice of a health professional.

Gedarel 30/150: desogestrel 150mcg + ethinylestradiol 30mcg

Gedarel 30microgram/150microgram tablets

Take one tablet once a day for 21 days. Start the next packet after a 7-day break. See package insert for full instructions.

Supply 63 tablets.

Age: from 13 years to 50 years

NHS cost: £4.93

Licensed use: yes

Patient information: Take the pill at the same time each day. If you forget one or more pills or experience diarrhoea or vomiting and are unsure what to do, seek the advice of a health professional.

COCs monophasic: EE 30mcg plus drospirenone

Age from 13 to 50 years

Yasmin: drospirenone 3mg + ethinylestradiol 30mcg

Yasmin tablets

Take one tablet once a day for 21 days. Start the next packet after a 7-day break. See package insert for full instructions.

Supply 63 tablets.

Age: from 13 years to 50 years

NHS cost: £14.70

Licensed use: yes

Patient information: Take the pill at the same time each day. If you forget one or more pills or experience diarrhoea or vomiting and are unsure what to do, seek the advice of a healthcare professional.

COCs monophasic: EE 35mcg plus cyproterone (mainly for acne)

Age from 13 to 50 years

Dianette: cyproterone acetate 2mg + ethinylestradiol 35mcg

Co-cyprindiol 2000microgram/35microgram tablets

Take one tablet once a day for 21 days. Start the next packet after a 7-day break. See package insert for full instructions. For contraceptive use.

Supply 63 tablets.

Age: from 13 years to 50 years

NHS cost: £6.51

Licensed use: yes

Patient information: Take the pill at the same time each day. If you forget one or more pills or experience diarrhoea or vomiting and are unsure what to do, seek the advice of a health professional.

COCs monophasic: EE 20mcg plus norethisterone

Age from 13 to 50 years

Loestrin 20: norethisterone acet 1mg+ethinylestradiol 20mcg

Loestrin 20 tablets

Take one tablet once a day for 21 days. Start the next packet after a 7-day break. See package insert for full instructions.

Supply 63 tablets.

Age: from 13 years to 50 years

NHS cost: £2.70

Licensed use: yes

Patient information: Take the pill at the same time each day. If you forget one or more pills or experience diarrhoea or vomiting and are unsure what to do, seek the advice of a health professional.

COCs monophasic: EE 20mcg plus gestodene or desogestrel

Age from 13 to 50 years

Mercilon: desogestrel 150mcg + ethinylestradiol 20mcg

Mercilon 150microgram/20microgram tablets

Take one tablet once a day for 21 days. Start the next packet after a 7-day break. See package insert for full instructions.

Supply 63 tablets.

Age: from 13 years to 50 years

NHS cost: £7.97

Licensed use: yes

Patient information: Take the pill at the same time each day. If you forget one or more pills or experience diarrhoea or vomiting and are unsure what to do, seek the advice of a health professional.

Gedarel 20/150: desogestrel 150mcg + ethinylestradiol 20mcg

Gedarel 20microgram/150microgram tablets

Take one tablet once a day for 21 days. Start the next packet after a 7-day break. See package insert for full instructions.

Supply 63 tablets.

Age: from 13 years to 50 years

NHS cost: £5.98

Licensed use: yes

Patient information: Take the pill at the same time each day. If you forget one or more pills or experience diarrhoea or vomiting and are unsure what to do, seek the advice of a health professional.

Femodette: gestodene 75mcg + ethinylestradiol 20mcg

Femodette tablets

Take one tablet once a day for 21 days. Start the next packet after a 7-day break. See package insert for full instructions.

Supply 63 tablets.

Age: from 13 years to 50 years

NHS cost: £9.45

Licensed use: yes

Patient information: Take the pill at the same time each day. If you forget one or more pills or experience diarrhoea or vomiting and are unsure what to do, seek the advice of a health professional.

Millinette 20/75: gestodene 75mcg + ethinylestradiol 20mcg

Millinette 20microgram/75microgram tablets

Take one tablet once a day for 21 days. Start the next packet after a 7-day break. See package insert for full instructions.

Supply 63 tablets.

Age: from 13 years to 50 years

NHS cost: £6.37

Licensed use: yes

Patient information: Take the pill at the same time each day. If you forget one or more pills or experience diarrhoea or vomiting and are unsure what to do, seek the advice of a health professional.

Sunya 20/75: gestodene 75mcg + ethinylestradiol 20mcg

Sunya 20/75 tablets

Take one tablet once a day for 21 days. Start the next packet after a 7-day break. See package insert for full instructions.

Supply 63 tablets.

Age: from 13 years to 50 years

NHS cost: £6.62

Licensed use: yes

Patient information: Take the pill at the same time each day. If you forget one or more pills or experience diarrhoea or vomiting and are unsure what to do, seek the advice of a health professional.

COC biphasic / triphasic with levonorgestrel or norethisterone

Age from 13 to 50 years

BiNovum: biphasic (norethisterone + ethinylestradiol)

Binovum tablets

Take one tablet once a day for 21 days. Start the next packet after a 7-day break. See package insert for full instructions.

Supply 63 tablets.

Age: from 13 years to 50 years

NHS cost: £2.08

Licensed use: yes

Patient information: Take the pill at the same time each day. If you forget one or more pills or experience diarrhoea or vomiting and are unsure what to do, seek the advice of a health professional.

Logynon: triphasic (levonorgestrel + ethinylestradiol)

Logynon tablets

Take one tablet once a day for 21 days. Start the next packet after a 7-day break. See package insert for full instructions.

Supply 63 tablets.

Age: from 13 years to 50 years

NHS cost: £4.12

Licensed use: yes

Patient information: Take the pill at the same time each day. If you forget one or more pills or experience diarrhoea or vomiting and are unsure what to do, seek the advice of a health professional.

Logynon ED: triphasic (levonorgestrel + ethinylestradiol)

Logynon ED tablets

Take one tablet once a day. See package insert for full instructions.

Supply 84 tablets.

Age: from 13 years to 50 years

NHS cost: £4.12

Licensed use: yes

Patient information: Take the pill at the same time each day. If you forget one or more pills or experience diarrhoea or vomiting and are unsure what to do, seek the advice of a health professional.

TriRegol: triphasic (levonorgestrel + ethinylestradiol)

TriRegol tablets

Take one tablet once a day for 21 days. Start the next packet after a 7-day break. See package insert for full instructions.

Supply 63 tablets.

Age: from 13 years to 50 years

NHS cost: £2.87

Licensed use: yes

Patient information: Take the pill at the same time each day. If you forget one or more pills or experience diarrhoea or vomiting and are unsure what to do, seek the advice of a health professional.

Synphase: triphasic (norethisterone + ethinylestradiol)

Synphase tablets

Take one tablet once a day for 21 days. Start the next packet after a 7-day break. See package insert for full instructions.

Supply 63 tablets.

Age: from 13 years to 50 years

NHS cost: £3.60

Licensed use: yes

Patient information: Take the pill at the same time each day. If you forget one or more pills or experience diarrhoea or vomiting and are unsure what to do, seek the advice of a health professional.

TriNovum: triphasic (norethisterone + ethinylestradiol)

Trinovum tablets

Take one tablet once a day for 21 days. Start the next packet after a 7-day break. See package insert for full instructions.

Supply 63 tablets.

Age: from 13 years to 50 years

NHS cost: £2.89

Licensed use: yes

Patient information: Take the pill at the same time each day. If you forget one or more pills or experience diarrhoea or vomiting and are unsure what to do, seek the advice of a health professional.

COCs triphasic: containing gestodene

Age from 13 to 50 years

Triadene: triphasic (gestodene + ethinylestradiol)

Triadene tablets

Take one tablet once a day for 21 days. Start the next packet after a 7-day break. See package insert for full instructions.

Supply 63 tablets.

Age: from 13 years to 50 years

NHS cost: £9.54

Licensed use: yes

Patient information: Take the pill at the same time each day. If you forget one or more pills or experience diarrhoea or vomiting and are unsure what to do, seek the advice of a health professional.

Contraception - Management

View full scenario

CKS safe practical clinical answers - *fast*

Starting a progestogen-only pill (POP)

How should I assess a woman before providing her with a progestogen-only pill (POP)?

- In young women and women with special needs, assess their competence to decide, and support them in making their own decisions about contraception.
- Exclude pregnancy.

- Assess the risk for sexually transmitted infection and, when appropriate, advise testing, promote safer sex, and/or refer for counselling.
- Check the woman's blood pressure, weight and body mass index (BMI).
- Check the UK Medical Eligibility Criteria to ensure that the woman is eligible for a progestogen-only pill (POP).

In depth

Which progestogen-only pill (POP) should I offer first-line?

- Any licensed progestogen-only pill (POP) may be used first-line.
  - However, rules about missed pills differ between products, and this may affect their acceptability.
  - If the woman weighs more than 70 kg, then consider the desogestrel-only pill, Cerazette®, as the first line option.
  - Irregular bleeding (particularly in the first few months) may be more of a problem with the desogestrel-only pill than with other POPs.

In depth

How should a woman who is not using contraception start the progestogen-only pill (POP)?

- Women who are not amenorrhoeic and have not been pregnant in the past 6 months:
  - Start the progesterone only pill (POP) on the first day of the period (licensed use), or up to day 5 of the cycle (unlicensed use), for immediate contraceptive cover.
  - The POP can started at any other time in the cycle, but additional contraception is needed for the first 48 hours of taking the pill (unlicensed use).
- Inform the woman that the instructions in the packet may differ from those provided by the healthcare professional.

- If starting immediately after oral emergency contraception:
  - Levonorgestrel emergency contraception used — advise additional contraception (condoms or avoidance of sex) for the first 2 days of use.
  - Ulipristal acetate emergency contraception used — advise additional contraception (condoms or avoidance of sex) for the first 9 days of use.
  - Advise the woman to take a pregnancy test no sooner than 3 weeks after the last episode of unprotected sex.
- If the woman is amenorrhoeic:
  - Start the POP at any time, provided that it is reasonably certain that a woman is not pregnant (unlicensed use).
  - Advise additional contraceptive protection (such as condoms) for the first 48 hours of pill taking.
- If the woman is postpartum and not breastfeeding:
  - Contraception is not required before day 21 postpartum.
  - Ideally, start the POP on day 21 postpartum for immediate contraceptive protection — this is the only licensed use for postpartum women.
    - However, the POP can be started before day 21 if requested.
  - If started after day 21, advise additional contraceptive protection (such as condoms) for the first 48 hours of pill taking.
- If the woman is postpartum and breastfeeding:
  - Start on or before day 21 postpartum for immediate contraceptive protection.
  - If started after day 21, advise additional contraceptive protection (such as condoms) for the first 48 hours of pill taking.
  - These are unlicensed uses.

In depth

How should a woman switch to the progestogen-only pill (POP) from another method?

- Changing from a combined oral contraceptive (COC): the progestogen-only pill (POP) may be started immediately.
- Changing from an injectable progestogen-only contraceptive: the POP should be started on the day that the injection would have been given.
- Changing from a copper intrauterine device (IUD) or levonorgestrel-releasing intrauterine system (IUS):
    - The POP is most conveniently begun within 5 days of the start of menstrual bleeding. No additional contraceptive protection is needed. The IUD can be removed at this time.
    - The woman can also start a POP at any other time, if it is reasonably certain that she is not pregnant. Because the POP will become effective after 48 hours, the IUD or IUS should not be removed before this if she has been sexually active in the past 7 days, *or* if she requires interim protection from the IUD or IUS.
- Changing from a non-hormonal method (other than a copper IUD): start the POP within 5 days of the start of menstrual bleeding:
    - If the POP is started outside of day 5, additional contraception should be used for the first 48 hours.

In depth

What follow-up arrangement should I consider for a woman using a progestogen-only pill (POP)?

- First follow up at 10–12 weeks and then at least every 12 months thereafter, provided there are no problems.
- Review should include risk factors, correct use, lifestyle issues, adverse effects, possible drug interactions and information on how to manage contraception relating to missed pills and potential drug interactions.

In depth

Managing common problems when using the progestogen-only pill (POP)

Vomiting or diarrhoea while on a progestogen-only pill (POP): what should be done?

- A woman who vomits (for any reason) within 2 hours of taking a progestogen-only pill (POP) should repeat the dose as soon as possible.
  - If she is now more than 3 hours late (or 12 hours for desogestrel), continues to vomit or has very severe diarrhoea, the woman should follow the instructions for missed pills.
- If vomiting or severe diarrhoea persists for more than 24 hours, the woman should follow the instructions for missed pills, counting each day of vomiting and/or severe diarrhoea as a missed pill:
  - Additional contraceptive cover is required during the illness and for 48 hours afterwards.

In depth

What advice should I give on what to do when progestogen-only pills (POPs) have been missed?

- Missed pill:
  - Desogestrel (Cerazette®): > 12 hours late (i.e. > 36 hours since taking the last pill).
  - Other progestogen-only pills: > 3 hours late (i.e. > 27 hours since taking the last pill).
- If the woman has missed any progestogen-only pills, she should:
  - Take a progestogen-only pill as soon as possible, then continue taking the pills as before. This can mean taking two pills within 24 hours.
  - Use additional contraceptive protection for the next 48 hours.
  - Consider whether emergency contraception is required. For more information, see the CKS topic on Contraception - emergency.

In depth

What advice should I give regarding potential drug interactions with the progestogen-only pill (POP)?

- Some drugs and herbal remedies may interfere with the effectiveness of progestogen-only pills (POPs).
- Women taking liver enzyme–inducing drugs should use additional contraception (e.g. condoms) whilst taking the drug and for 4 weeks after finishing the course:
  - Commonly encountered liver enzyme–inducing drugs are:
    - Antibiotics: rifampicin and rifabutin.
    - Anticonvulsants: carbamazepine, oxcarbazepine, phenytoin, phenobarbital, primidone, topiramate.
    - Herbal remedies: St John's wort.
    - Antiretrovirals: drug interactions between certain antiretroviral agents and hormonal contraceptives could alter the safety and effectiveness of both the hormonal contraceptives and the antiretroviral agents. See antiretrovirals.
  - Antibiotics that do not induce liver enzymes (i.e. all antibiotics except rifampicin and rifamycin) do not reduce the effectiveness of POPs.
- Emergency contraception should be considered if sexual intercourse has taken place in the past 5 days and the efficacy of the POP is doubtful — see the CKS topic on Contraception - emergency.

In depth

What advice should I give about menstrual irregularity to women using a progestogen-only pill (POP)?

- Menstrual irregularities are common. Some women have frequent or prolonged bleeding, whilst some experience amenorrhoea.

- Identify and manage causes for bleeding irregularities such as missed pills, drug interactions, vomiting, severe diarrhoea, pregnancy.
- Exclude or manage other situations which could result in unscheduled bleeding, such as:
    - Sexually transmitted infections.
        - Risk of STI if the woman is under 25 years, or has a new sexual partner, or more than one partner in the last year.
    - Pregnancy.
    - Gynaecological conditions such as cervical cancer. Provided there is consistent and correct use of contraception, speculum examination is warranted:
        - For persistent bleeding beyond the first 3 months of use.
        - For new symptoms or a change in bleeding after at least 3 months of use.
        - If the woman has not participated in a National Cervical Screening programme.
        - If requested by the woman.
        - After a failed trial of modification of POP treatment (at least 6–8 weeks).
        - If there are other symptoms such as pain, dyspareunia, or post coital bleeding. (Note that these symptoms also warrant pelvic examination.)
- If frequent or prolonged bleeding occurs, consider the use of a different progestogen-only pill (POP).
- If the woman experiences amenorrhoea, exclude pregnancy. The POP can then be continued.

In depth

Prescriptions

Progestogen-only Pills (POPs)

Age from 13 to 60 years

Femulen: Etynodiol diacetate 500micrograms

Femulen 500microgram tablets

Take one tablet once a day. See package insert for full instructions.

Supply 84 tablets.

Age: from 13 years to 60 years

NHS cost: £3.31

Licensed use: yes

Patient information: Take the pill at the same time each day. If you forget a pill, take it as soon as you remember, and the next one at your normal time. If you are more than 3 hours late with any pill, it may not work. Take it as soon as you remember, and the next one at your normal time. You must use an extra contraceptive method for the next 2 days (48 hours) or you may become pregnant. You should also do this if you vomit within 2 hours of taking the pill or if you have very severe diarrhoea.

Micronor: Norethisterone 350micrograms

Micronor 350microgram tablets

Take one tablet once a day. See package insert for full instructions.

Supply 84 tablets.

Age: from 13 years to 60 years

NHS cost: £1.76

Licensed use: yes

Patient information: Take the pill at the same time each day. If you forget a pill, take it as soon as you remember, and the next one at your normal time. If you are more than 3 hours late with any pill, it may not work. Take it as soon as you remember, and the next one at your normal time. You must use an extra contraceptive method for the next 2 days (48 hours) or you may become pregnant. You should also do this if you vomit within 2 hours of taking the pill or if you have very severe diarrhoea.

Norgeston: Levonorgestrel 30micrograms

Norgeston 30microgram tablets

Take one tablet once a day. See package insert for full instructions.

Supply 105 tablets.

Age: from 13 years to 60 years

NHS cost: £2.94

Licensed use: yes

Patient information: Take the pill at the same time each day. If you forget a pill, take it as soon as you remember, and the next one at your normal time. If you are more than 3 hours late with any pill, it may not work. Take it as soon as you remember, and the next one at your normal time. You must use an extra contraceptive method for the next 2 days (48 hours) or you may become pregnant. You should also do this if you vomit within 2 hours of taking the pill or if you have very severe diarrhoea.

Noriday: Norethisterone 350micrograms

Noriday 350microgram tablets

Take one tablet once a day. See package insert for full instructions.

Supply 84 tablets.

Age: from 13 years to 60 years

NHS cost: £2.10

Licensed use: yes

Patient information: Take the pill at the same time each day. If you forget a pill, take it as soon as you remember, and the next one at your normal time. If you are more than 3 hours late with any pill, it may not work. Take it as soon as you remember, and the next one at your normal time. You must use an extra contraceptive method for the next 2 days (48 hours) or you may become pregnant. You should also do this if you vomit within 2 hours of taking the pill or if you have very severe diarrhoea.

Cerazette: Desogestrel 75micrograms

Cerazette 75microgram tablets

Take one tablet once a day. See package insert for full instructions.

Supply 84 tablets.

Age: from 13 years to 60 years

NHS cost: £8.85

Licensed use: yes

Patient information: Take the pill at the same time each day. If you forget a pill, take it as soon as you remember, and the next one at your normal time. If you are more than 12 hours late with any Cerazette pill, it may not work. Take it as soon as you remember, and the next one

at your normal time. You must use an extra contraceptive method for the next 2 days (48 hours) or you may become pregnant. You should also do this if you vomit within 2 hours of taking the pill or if you have very severe diarrhoea.

Contraception - Management

View full scenario

CKS safe practical clinical answers - *fast*

Starting a combined contraceptive patch

What is the combined contraceptive patch?

- The combined contraceptive patch is a patch that is stuck to the skin to continuously deliver hormones, providing contraceptive cover.
- One combined contraceptive patch is available in the UK: Evra®.
- It releases 33.9 micrograms of ethinylestradiol (an oestrogen) and 203 micrograms of norelgestromin (a progestogen) per 24 hours for 7 days.

In depth

How should I assess a woman before providing her with a combined contraceptive patch?

- In young women and women with special needs, assess their competence to decide, and support them in making their own decisions about contraception.
- Exclude pregnancy.
- Check the woman's blood pressure.
- Check the UK Medical Eligibility Criteria to ensure that there are no contraindications.
- Assess the risk for sexually transmitted infection and, when appropriate, advise testing, promote safer sex, and/or refer for counselling.

In depth

How should the combined contraceptive patch be started?

- New users with no previous hormonal contraception and no recent childbirth or abortion:
  - Apply the patch on day 1–5 of the menstrual cycle for immediate contraceptive cover.
  - If applied outside days 1–5 of the menstrual cycle, exclude pregnancy and use additional contraceptive cover for 7 days.
- Starting immediately after oral emergency contraception:
  - Levonorgestrel emergency contraception used — advise additional contraception (condoms or avoidance of sex) for the first 7 days of use.
  - Ulipristal acetate emergency contraception used — advise additional contraception (condoms or avoidance of sex) for the first 14 days of use.
  - Advise the woman to take a pregnancy test no sooner than 3 weeks after the last episode of unprotected sex.
- After abortion, or after miscarriage within 24 weeks of gestation:
  - Apply the patch within 7 days of abortion or miscarriage for immediate contraceptive cover.
  - If applied outside day 7 after abortion or miscarriage, use additional contraceptive cover for 7 days.
- Postpartum women who are not breastfeeding (including any pregnancy over 24 weeks gestation):
  - Apply the patch on day 21 postpartum for immediate contraceptive cover.
  - If applied after day 21 postpartum, use additional contraceptive cover for 7 days.
- Advise the woman that recommendations in the packet may differ from these recommendations, and that only application on day 1 is a licensed indication.

In depth

How should the combined contraceptive patch be applied?

- The contraceptive patch should be applied weekly for 3 consecutive weeks. No patch is applied during the fourth week. A new cycle is started the following week. To avoid skin irritation use a different site when changing a patch.

In depth

What follow-up arrangement should I consider for a woman using the combined contraceptive patch?

- Review the woman no longer than 3 months after she starts to use the contraceptive patch, to ensure correct use and that there are no problems.
- Depending on the woman's wishes and anticipated use of the patch, arrange for up to 1 year's supply following this, before requiring a new prescription. Women with specific medical conditions may need more frequent follow-up.
- Advise the woman that she should return at any time if she has any problems.

In depth

Managing common problems when using using a combined hormonal contraceptive patch

Detached (partial or complete) combined contraceptive patch: what should be done?

- A partially detached combined contraceptive patch is treated the same as one that has completely detached.
- **If the patch has been off for less than 48 hours:**
  - Reapply it as quickly as possible, if it is still sticky.
  - If it is not sticky, it may not work, so apply a new patch. Do not use sticking plaster, tape or bandage to hold the old patch in place.
  - No additional contraception is required.
  - Continue to use the patch as normal and change it as usual.

- **If the patch has been off for 48 hours or longer, or if the time it detached is uncertain:**
  - Start a whole new patch cycle by applying a new patch as soon as possible.
  - Additional contraception is advised for the next 7 days.
  - If unprotected sexual intercourse has taken place in the past 5 days, emergency contraception should be considered — see the CKS topic on Contraception - emergency.

In depth

Combined contraceptive patch not changed or new cycle started late: what should be done?

- Replace the old combined contraceptive patch as soon as possible.
- If there is > 48 hours' delay in starting a new patch:
  - Consider the new patch as the start of a new cycle.
  - Use additional contraception for 7 days.
  - Consider emergency contraception if unprotected sexual intercourse has taken place in the past 5 days — see the CKS topic on Contraception - emergency.
- If the woman forgets to take the patch off at the end of week 3 she should remove the old patch and start the next patch cycle as normal.
- No additional contraceptive cover is required provided that the delay in changing the patch (or starting a new cycle) is not more than 48 hours.

In depth

Drug interactions with the combined contraceptive patch: how should I manage?

- The efficacy of the combined contraceptive patch can be reduced by liver enzyme–inducing drugs (which include the antibiotics rifampicin and rifamycin) and non-liver enzyme–inducing antibiotics.

- Precautions to be taken are the same as for women taking a combined oral contraceptive (COC). For further information, see Drug interactions (for a COC).

In depth

Unscheduled bleeding, immobilization or surgery: what should be done?

The management of these problems is similar to that for women using a combined oral contraceptive (COC). For more information, see Diarrhoea or vomiting, unscheduled bleeding, surgery (on a COC). Note: diarrhoea and vomiting do not affect the bioavailability of the combined oral contraceptive patch.

Prescriptions

Combined contraceptive patch low strength

Age from 13 to 50 years

Evra: Ethinylestradiol 20mcg/24hr+Norelgestromin 150mcg/24hr

Evra transdermal patches

Apply one patch once a week for 3 weeks, followed by a 7-day patch free interval and then repeat the course.

Supply 9 patches.

Age: from 13 years to 50 years

NHS cost: £16.26

Licensed use: yes

Patient information: Apply the patch to clean, dry, hair-free skin on either the buttock, abdomen, upper outer arm, or upper torso. Avoid irritated or broken skin, breasts, or skin in contact with tight clothing or cosmetics. If your patch becomes loose, falls off, or if you forget to change it, read the package insert for more information or contact your doctor or pharmacist as soon as possible.

Contraception - Management

View full scenario

Starting the combined vaginal ring

What is the combined contraceptive vaginal ring?

- There is one combined contraceptive vaginal ring currently available in the UK. This is marketed as NuvaRing®, which is a flexible, latex-free, transparent, and colourless to almost colourless vaginal ring.
  - The ring releases etonogestrel and ethinylestradiol at an average amount of 120 micrograms and 15 micrograms respectively per 24 hours, over a period of 3 weeks.

In depth

How should I assess a woman for the combined contraceptive vaginal ring?

- In young women and women with special needs, assess their competence to decide, and support them in making their own decisions about contraception.
- Exclude pregnancy.
- Check the woman's blood pressure.
- Check the UK Medical Eligibility Criteria to ensure that there are no contraindications.
- Assess the risk for sexually transmitted infection and, when appropriate, advise testing, promote safer sex, and/or refer for counselling. Advise the woman that the ring does not protect against HIV or AIDS, or other sexually transmitted diseases.
- Specifically relating to the combined contraceptive vaginal ring, it should not be used if a woman has:
  - Undiagnosed vaginal bleeding.

- Known or suspected malignant conditions of the genital organs, if sex steroid-influenced.
- Prolapse of the uterine cervix, cystocele and/or rectocele, or severe or chronic constipation (may cause difficulty with ring insertion, or increase risk of losing it).
- Hypersensitivity to the active substances and excipients of the combined contraceptive vaginal ring.

In depth

How should the combined contraceptive vaginal ring be started?

- New users with no previous hormonal contraception and no recent childbirth or abortion:
  - Insert the ring on day 1 of the menstrual cycle for immediate contraceptive cover.
  - If inserted on days 2–5 of the menstrual cycle, use additional barrier contraceptive cover for 7 days.
- Starting immediately after oral emergency contraception:
  - Levonorgestrel emergency contraception used — advise additional contraception (condoms or avoidance of sex) for the first 7 days of use.
  - Ulipristal acetate emergency contraception used — advise additional contraception (condoms or avoidance of sex) for the first 14 days of use.
  - Advise the woman to take a pregnancy test no sooner than 3 weeks after the last episode of unprotected sex.
- If changing from a combined hormonal contraceptive, insert the ring at the latest on the day following the usual tablet-free, patch-free or placebo tablet interval of her previous combined hormonal contraceptive. If she has been using the method consistently and correctly and she can exclude pregnancy, she may also switch on any day of the cycle.
- If changing from a progestogen-only method, switch on any day of the progestogen-only pill, implant or levonorgestrel-releasing intrauterine system on the day of its removal, and from

the injection when the next injection is due. Use additional barrier contraceptive cover for 7 days.

  - Note: as there is a small theoretical risk of implantation of a previously fertilized egg once the levonorgestrel-releasing intrauterine system (or other intrauterine device) is removed, women should be additionally advised to abstain from intercourse or use another method of contraception for at least 7 days before planned removal.

- After miscarriage up to 24 weeks:
  - If the ring is started within 7 days of the miscarriage no additional contraceptive method is needed. If started after 7 days, additional barrier contraception is advised for 7 days.
- After miscarriage after 24 weeks:
  - Women should insert the ring 21 days after the miscarriage.
- After first-trimester abortion:
  - Insert the ring immediately within 24 hours after abortion for immediate contraceptive cover.
  - If inserted later, she should use additional barrier contraceptive cover for 7 days after the ring is inserted, and should use an alternative contraceptive method in the meantime.
- Postpartum women who are not breastfeeding, and after second-trimester abortion:
  - Insert the ring 21 days after delivery or abortion for immediate contraceptive cover.
  - If inserted later, use additional barrier contraceptive cover for 7 days.

In depth

How should the combined contraceptive vaginal ring be used?

- Insert one ring high into the vagina for 3 weeks of continuous use per cycle. A new ring is inserted after a 7 day ring-free break.

- Women should be advised to check the presence of the ring regularly.
- The ring may be kept in during tampon use and sexual intercourse (but may be removed for no more than 3 hours if intercourse is uncomfortable with the ring in situ).
- The ring can be removed by hooking the index finger under the ring or grasping it between the index and middle finger.

In depth

How should the combined contraceptive vaginal ring be stored?

- Prior to dispensing, the combined vaginal ring should be stored in a refrigerator (2°C–8°C) for up to 36 months.
- After dispensing:
  - The ring can be stored at room temperature, but should not be stored above 30°C.
  - The ring should be inserted up to 4 months from the date of dispensing or the expiry date, whichever comes first.

In depth

What follow-up arrangements are needed for a women using the combined contraceptive vaginal ring?

- Review the woman no longer than 3 months after she starts to use the combined contraceptive vaginal ring, to ensure correct use and that there are no problems.
  - Check that the woman is using the ring correctly and consistently.
  - Check her knowledge of what to do if she is late removing the ring or late reinserting a new ring.
  - Remind her about possible drug interactions.
  - Check her blood pressure.

- Ask about headaches, especially migraine, and any new risk factors — see UK Medical Eligibility Criteria.
- Address any issues or problems she might have, such as unscheduled bleeding.

- Depending on the woman's wishes and anticipated use of the ring, repeat scripts may be arranged for up to a year following this. Note: due to the shelf life of the ring, it is recommended that women are supplied with up to 3 rings at a time, and each ring should be inserted within 4 months of the date of dispensing.
- Women with specific medical conditions including an observed rise in blood pressure using the ring may need more frequent follow-up.
- Advise the woman that she should return at any time if she has any problems, including any new headache symptoms.

In depth

Managing problems with the combined vaginal ring

Combined contraceptive vaginal ring not changed or new cycle started late: what should be done?

Lengthened ring use

- If the ring has been left in place for *up to 4 weeks* (rather than the recommended 3 weeks), contraceptive efficacy is not reduced. Advise the woman to remove the ring and insert a new ring after one ring-free week.
- If the ring has been left in place for *more than 4 weeks* (rather than the recommended 3 weeks), contraceptive efficacy may be reduced. Advise the woman to rule out pregnancy before inserting a new ring.
- If a woman has not used the ring as recommended and has no withdrawal bleed in the ring-free week, advise her to rule out pregnancy before inserting a new ring.

Lengthened ring-free interval

- Advise the woman to insert a new ring as soon as she remembers.

- Advise her to use additional barrier contraception for the next 7 days.
- If the woman had sexual intercourse in the ring-free interval, advise her to rule out pregnancy and consider emergency contraception (if appropriate) before inserting a new ring.

In depth

Expulsion of the combined contraceptive vaginal ring: what should be done?

- Advise the woman to check the presence of the ring regularly (for example, pre-coitally) as there are reports that it may be expelled if it is not inserted properly, while removing a tampon, during sexual intercourse, or in severe or chronic constipation.
- Prolonged expulsion may lead to contraceptive failure and/or breakthrough bleeding.
- Deliberate removal of the ring is not recommended.
- If the ring is removed or expelled and left outside the vagina for *less than 3 hours*, rinse the ring with cool to lukewarm water and reinsert it as soon as possible, within 3 hours.
- If the ring is expelled and left outside the vagina for *more than 3 hours*, the recommended action depends on the week of use.
    - During the first or second week of use, the woman should reinsert the ring as soon as she remembers. Additional barrier contraception should be used until the ring has been in the vagina continuously for 7 days. Assess the need for emergency contraception.
    - During the third week of use, the woman should discard the ring, and either:
        - Insert a new ring immediately, which will start a new cycle. Advise her that breakthrough spotting or bleeding may occur.
        - Have a withdrawal bleed, and insert a new ring no later than 7 days from when the previous ring was expelled.

In depth

Broken combined contraceptive vaginal ring: what should be done?

- If the ring is found to be broken during use, advise the woman to remove it, reinsert a new ring as soon as possible, and use additional barrier contraception for the next 7 days.
- If it is suspected that unprotected sexual intercourse has taken place in the previous 5 days, emergency contraception should be considered — see the CKS topic on Contraception - emergency.

In depth

Suspected pregnancy: what should be done?

- If pregnancy occurs with a combined contraceptive vaginal ring in situ, the ring should be removed.

In depth

Reduced cycle control with the combined contraceptive vaginal ring: what should be done?

- If irregular bleeding (spotting or breakthrough bleeding) occurs after previously regular cycles while the ring has been used as recommended, then consider other non-hormonal causes. Consider excluding pregnancy and refer the woman according to clinical judgement.
- Some women do not experience a withdrawal bleed in the ring-free week.
    - If the ring has been used as recommended, it is unlikely the woman is pregnant.
    - If the ring has not been used as recommended prior to the first missed withdrawal bleed, or if there are two missed withdrawal bleeds, advise the woman that pregnancy should be ruled out before use of the ring is continued.

In depth

Drug interactions: what should be done?

- The efficacy of the ring may be reduced by liver enzyme-inducing drugs, and non-liver enzyme-inducing antibiotics (excluding amoxicillin and doxycycline which do not appear to be affected).

- If a woman is taking a liver enzyme-inducing drug, advise her to use additional barrier contraception for the duration of treatment and for 28 days after its discontinuation, or choose another method of contraception. If the drug treatment runs beyond the 3 weeks of her cycle, advise her to insert the next ring immediately without a ring-free week.
- If a woman is taking non-liver enzyme-inducing antibiotics (excluding amoxicillin and doxycycline), advise her to use additional barrier contraception for the duration of treatment and for 7 days after their discontinuation. If the drug treatment runs beyond the 3 weeks of her cycle, advise her to insert the next ring immediately without a ring-free week.

In depth

Planned surgery or immobilization?

The management of these problems is similar to that for women using a combined oral contraceptive (COC). For more information, see Diarrhoea or vomiting, unscheduled bleeding, surgery (on a COC). Note: diarrhoea and vomiting do not affect the bioavailability of the combined oral contraceptive patch.

Prescriptions

Combined contraceptive vaginal ring

Age from 13 to 50 years

NuvaRing: Ethinylestradiol 15mcg/24hr+Etonogestrel 150mcg/24hr

Etonogestrel 11.7mg/Ethinylest 2.7mg vaginal delivery system

Insert the ring into the vagina and leave in place for 3 weeks, followed by a 7-day ring free interval and then repeat the course.

Supply 3 rings.

Age: from 13 years to 50 years

NHS cost: £27.00

Licensed use: yes

Black triangle

Patient information: If your ring falls out or gets broken, or if you forget to change it, read the package insert for more information or contact your doctor or pharmacist as soon as possible.

Contraception - Management

View full scenario

CKS safe practical clinical answers - fast

Start injectable progestogen: not using contraception

How should I assess a woman before providing her with a progestogen-only injectable?

- In young women and women with special needs, assess their competence to decide, and support them in making their own decisions about contraception.
- Exclude pregnancy.
- Assess risk for osteoporosis.
- Assess risk for sexually transmitted infection and, when appropriate, advise testing, promote safer sex, and/or refer for counselling.
- Check the woman's blood pressure.
- Check the UK Medical Eligibility Criteria to ensure that the woman is eligible for a progestogen-only injectable.
- Breast and cervical examinations, routine blood tests, and thrombophilia screening are not required to assess eligibility for a progestogen-only injectable.

In depth

Which progestogen-only injectable should I recommend?

- If long-acting contraception is required for a few months, use depot medroxyprogesterone acetate (Depo-Provera®) or norethisterone enantate (Noristerat®).

- If long-acting contraception is required for an extended period (i.e. > 16 weeks), depot medroxyprogesterone acetate (Depo-Provera®) is recommended.

In depth

How should a progestogen-only injectable be started in a woman who is not using contraception?

- Having menstrual cycles and not postpartum, or post-abortion or post-miscarriage:
  - Give the injection during days 1–5 of the menstrual period. Additional contraception is not needed.
  - You can also give the first injection after day 5 (unlicensed use) if reasonably certain the woman is not pregnant. Advise additional contraception for 7 days.
- Amenorrhoeic and reasonably certain not pregnant:
  - Give the first injection at any time (unlicensed use). Advise additional contraception for 7 days.
- Postpartum and *not* breastfeeding:
  - Give the first injection on day 21 — additional contraception is not needed. If the injection is given after day 21, advise additional contraception for 7 days.
  - Injectable progestogens can be started before 21 days if there is good reason to do so. Noristerat® can be used immediately after birth. Depot medroxyprogesterone acetate can be started within 5 days of birth (prolonged heavy bleeding can occur).
- Breastfeeding:
  - **< 6 weeks postpartum:** Noristerat® can be used immediately after birth. Delay using DepoProvera® until at least 6 weeks after birth. If because of the risk of pregnancy, it must be used before this, delay until at least day 21 days postpartum (unlicensed use).
  - **Between 6 weeks and 6 months postpartum, and amenorrhoeic:** give the first injection at any time. Advise additional contraceptive for 7 days unless fully breastfeeding.

- **> 6 weeks postpartum, and menstrual periods have returned:** give the first injection as advised for other women having menstrual cycles.

- Women who are post-abortion or post-miscarriage:
  - Give injections immediately after miscarriage (unlicensed use), or abortion (unlicensed use for depot medroxyprogesterone acetate). If started > 7 days after abortion (unlicensed use), advise additional contraception for 5 days.

In depth

What follow-up arrangement should I consider for a woman using a progestogen-only injectable?

- Norethisterone enantate, arrange for the second injection to be given in 8 weeks.
- Depot medroxyprogesterone acetate, arrange repeat injections at 12-week intervals:
- There is a two-week 'window of safety' if the repeat injection is late.
- At the follow-up visit check the woman's knowledge of what to do if her injection is late, review eligibility for progestogen injectables, and address any problems.
- If problems arise, change to another method (if this is what she wants or needs), or repeat the injection, or change to the other type of injectable.

In depth

Start progestogen injectable: switch from current contraception

How should I assess a woman before providing her with a progestogen-only injectable?

- In young women and women with special needs, assess their competence to decide, and support them in making their own decisions about contraception.
- Exclude pregnancy.
- Assess risk for osteoporosis.

- Assess risk for sexually transmitted infection and, when appropriate, advise testing, promote safer sex, and/or refer for counselling.
- Check the woman's blood pressure.
- Check the UK Medical Eligibility Criteria to ensure that the woman is eligible for a progestogen-only injectable.
- Breast and cervical examinations, routine blood tests, and thrombophilia screening are not required to assess eligibility for a progestogen-only injectable.

In depth

Which progestogen-only injectable should I recommend?

- If long-acting contraception is required for a few months, use depot medroxyprogesterone acetate (Depo-Provera®) or norethisterone enantate (Noristerat®).
- If long-acting contraception is required for an extended period (i.e. > 16 weeks), depot medroxyprogesterone acetate (Depo-Provera®) is recommended.

In depth

How should a woman switch to a progestogen-only injectable from her current contraceptive method?

- Currently using a hormonal method — excluding the levonorgestrel-releasing intrauterine system (IUS):
  - Can have the first injection immediately. If the previous method was another injectable, the woman should have the new progestogen-only injectable when the repeated injection would have been given for the current contraceptive (unlicensed use).
- Currently using a non-hormonal method other than a copper intrauterine device (IUD):
  - Can have the first injection immediately. If it has been > 5 days since menstrual bleeding started (unlicensed use), advise additional contraception for 7 days.

- Currently using a copper IUD or levonorgestrel-releasing IUS:
  - Can have the first injection within 5 days after the start of menstrual bleeding. The IUD or IUS can be removed at that time.
  - Can also start at any other time (unlicensed use), but to provide uninterrupted contraceptive protection, the IUD or IUS should be removed at least 7 days after the injection.
  - If amenorrhoeic or bleeding is irregular, the injection can be given as advised for other amenorrhoeic women — see Start injectable: not using contraception.

In depth

What follow-up arrangement should I consider for a woman using a progestogen-only injectable?

- Norethisterone enantate, arrange for the second injection to be given in 8 weeks.
- Depot medroxyprogesterone acetate, arrange repeat injections at 12-week intervals:
- There is a two-week 'window of safety' if the repeat injection is late.
- At the follow-up visit check the woman's knowledge of what to do if her injection is late, review eligibility for progestogen injectables, and address any problems.
- If problems arise, change to another method (if this is what she wants or needs), or repeat the injection, or change to the other type of injectable.

In depth

Managing common problems when using progestogen-only injectables

What advice should I give on what to do when the repeat progestogen-only injectable is late?

- **Up to 14 days late (i.e. up to 98 days since the last injection):**
  - Repeat the injection. No additional contraception is needed.

- **More than 14 days late (i.e. more than 98 days since the last injection):**
  - Exclude pregnancy before repeating the injection. Use additional contraception for 7 days.
  - If pregnancy cannot be excluded:
    - Consider if emergency contraception is indicated. For more information, see the CKS topic on Contraception - emergency.
    - Advise alternative methods, and delay repeating the injection until there is a negative pregnancy test at least 3 weeks after the last unprotected sex.
    - After the injection, continue with alternative contraception for 7 more days.

In depth

What advice should I give about menstrual irregularity to women using a progestogen-only injectable?

- Advise that many women experience irregularities in menstruation while using a progestogen-only injectable:
  - A few women have very heavy or prolonged bleeding. This can be managed by:
    - Treating with a combined oral contraceptive (either cyclically or continuously) for up to 3 months.
    - Treating with mefenamic acid 500 mg twice or three times a day for 5 days.
    - Changing to another contraceptive method.
  - Some women experience prolonged amenorrhoea; this is most likely in older women and, with forewarning, is usually accepted.
- Exclude or manage other situations which could result in unscheduled bleeding, such as:
  - Sexually transmitted infections.
    - Risk of STI if the woman is under 25 years, or has a new sexual partner, or more than one partner in the last year.

- Pregnancy.
- Gynaecological conditions such as cervical cancer. Provided there is consistent and correct use of contraception, speculum examination is warranted:
  - For persistent bleeding beyond the first 3 months of use.
  - For new symptoms or a change in bleeding after at least 3 months of use.
  - If the woman has not participated in a National Cervical Screening programme.
  - If requested by the woman.
  - After a failed trial of modification of treatment.
  - If there are other symptoms such as pain, dyspareunia, or post coital bleeding. (Note that these symptoms also warrant pelvic examination.)

In depth

Progestogen-only implant

How should I assess a woman before providing her with a progestogen-only implant?

- In young women and women with special needs, assess their competence to decide, and support them in making their own decisions about contraception.
- Exclude pregnancy.
- Assess risk for sexually transmitted infection and, when appropriate, advise testing, promote safer sex, and/or refer for counselling.
- Check the woman's blood pressure.
- Check the UK Medical Eligibility Criteria to ensure that the woman is eligible for a progestogen-only implant.

In depth

When can the progestogen-only implant be inserted?

- Provided that it is reasonably certain that the woman is not pregnant, the progestogen-only implant can be inserted at any time, but the need for additional contraception varies.
- **First implant, or switching from a hormonal method of contraception:**
  - Ideally insert within days 1–5 of the menstrual period.
  - If inserted outside this time, or if the woman is amenorrhoeic, additional contraception is needed for 7 days.
  - If switching from a progestogen-only injectable, the implant should be inserted no later than the time when the next injection is due.
- **Switching from a copper intrauterine device (IUD) or a levonorgestrel-releasing intrauterine system (LNG-IUS):**
  - Insert the implant and remove the IUD or LNG-IUS at least 7 days later.
- **Postpartum:**
  - Ideally insert on day 21 for immediate contraceptive protection.
  - If started after day 21, additional contraception is needed for 7 days, unless she is fully breastfeeding.
- **Post-abortion or post-miscarriage:**
  - If inserted on the same day (for abortion, whether induced or spontaneous, at < 24 weeks' gestation) no additional contraceptive method is required.
  - If started more than 5 days days after abortion or miscarriage, an additional contraceptive method is required for 7 days.

In depth

What follow-up arrangement should I consider for a woman using the progestogen-only implant?

- No routine follow up is needed.
- Review when the implant needs to be removed or if the woman requests early removal.

In depth

What should I advise women about menstrual irregularities when they use the progestogen-only implant?

- A woman who experiences heavy or prolonged bleeding may be treated by:
    - Treating with a combined oral contraceptive (either cyclically or continuously) for up to 3 months
    - Changing another contraceptive method.
- Amenorrhoea is a common adverse effect of the implant, and is not harmful.
- Exclude or manage other situations which could result in unscheduled bleeding, such as:
    - Sexually transmitted infections.
        - Risk of STI if the woman is under 25 years, or has a new sexual partner, or more than one partner in the last year.
    - Pregnancy.
    - Gynaecological conditions such as cervical cancer. Speculum examination is warranted:
        - For persistent bleeding beyond the first 3–6 months of use.
        - For new symptoms or a change in bleeding after at least 3 months of use.
        - If the woman has not participated in a National Cervical Screening programme.
        - If requested by the woman.
        - After a failed trial of modification of treatment.
        - If there are other symptoms such as pain, dyspareunia, or post coital bleeding. (Note that these symptoms also warrant pelvic examination.)

In depth

Prescriptions

Progestogen-only injectables

Age from 13 to 60 years

Medroxyprogesterone acetate 150mg syringe (Depo-Provera®)

Medroxyprogesterone 150mg/1ml suspension for injection pre-filled syringes

Give 150mg (1ml) by deep intramuscular injection.

Supply 1 1ml prefilled syringe.

Age: from 13 years to 60 years

NHS cost: £5.01

Licensed use: yes

Patient information: You may experience altered bleeding patterns whilst you are using this injection.

Medroxyprogesterone acetate 150mg vial (Depo-Provera)

Medroxyprogesterone 150mg/1ml suspension for injection vials

Give 150mg (1ml) by deep intramuscular injection.

Supply 1 1ml vial.

Age: from 13 years to 60 years

NHS cost: £5.01

Licensed use: yes

Norethisterone enantate 200mg injection (Noristerat)

Norethisterone 200mg/1ml solution for injection ampoules

Give 200mg (1ml) by deep intramuscular injection into gluteal muscle.

Supply 1 1ml ampoules.

Age: from 13 years to 60 years

NHS cost: £3.59

Licensed use: yes

Progestogen-only implant

Age from 13 to 60 years

Etonogestrel 68mg implant (Nexplanon®)

Etonogestrel 68mg implant

For subdermal implantation.

Supply 1 implant.

Age: from 13 years to 60 years

NHS cost: £90.00

Licensed use: yes

Contraception - Management

View full scenario

CKS safe practical clinical answers - fast

Starting a copper intrauterine device (IUD)

Which copper intrauterine devices (IUDs) are preferred?

- The preferred copper intrauterine devices (IUDs) contain 380 mm^2 of copper, have banded copper on the arms, and are licensed for longer durations of use.

In depth

What information should I give a woman who is considering the copper intrauterine device (IUD)?

- The advantages, disadvantages and risks of the IUD.
- **Ectopic pregnancy.** The risk of ectopic pregnancy when using an IUD is lower than when using no contraception. The overall risk of ectopic pregnancy when using an IUD is very low, about 1 in 1000 in 5 years. However, if a woman becomes pregnant with the IUD in situ, the

risk of ectopic pregnancy is about 1 in 20, and she should seek advice to exclude ectopic pregnancy.

- **Pregnancy with the copper IUD in situ.** The IUD should be removed.
- **Expulsion of the copper IUD.** The copper IUD can be expelled from the uterus (uncommon), sometimes without the woman knowing.
- **Effect on weight, mood, libido, and cancer-risk.** There is no evidence that a copper IUD affects weight. Any changes in mood and libido are similar whether using IUDs or the levonorgestrel-releasing intrauterine system (LNG-IUS), and the changes are small. There is no evidence of an increase in cancer of the cervix, endometrium or ovaries with copper IUD use.
- **Managing a copper IUD when it is in place:**
  - Offer instruction on how to check for the copper IUD and its threads. Advise that if it is not possible to feel the threads to use an alternative method of contraception until reviewed, as the device may have been expelled.
  - Advise that heavier and/or prolonged bleeding and/or pain associated with copper IUD use can be treated.
  - Advise if menstrual abnormalities persist beyond the initial 6 months of use, to seek medical advice to exclude infection and gynaecological pathology.
  - Advise to seek medical advice if symptoms of pelvic inflammatory disease occur, especially within the first 3–4 weeks after insertion.

What assessment and management are required prior to inserting a copper intrauterine device (IUD)?

- Enquire about the user's preferences and any concerns.
- In young women and women with special needs, assess their competence to decide, and support them in making their own decisions about contraception.
- Exclude pregnancy.
- Check the UK Medical Eligibility Criteria to ensure that the woman is eligible for insertion of a copper intrauterine device (IUD).

- Assess the risk for sexually transmitted infection and, when appropriate, advise testing, promote safer sex, and/or refer for counselling (also consider each time the IUD is reinserted). If testing for sexually transmitted infections is requested, do this before inserting the device.

In depth

When can the copper intrauterine device (IUD) be inserted?

- Provided that it is reasonably certain that the woman is not pregnant, a copper intrauterine device (IUD) can be inserted:
  - At any time during the menstrual cycle.
  - Postpartum (irrespective of mode of delivery): 4 weeks after delivery.
  - Immediately after first- or second-trimester abortion, or at any time thereafter.
- If there is a delay before the IUD can be fitted, combined hormonal contraception (pill, patch, or vaginal ring [not suitable post-partum if the woman is breastfeeding]), the progestogen-only pill, or the progestogen-only injectable can be used as a bridging method.
- When replacing an IUD, consider delaying replacement if the woman has recently had unprotected sexual intercourse.

In depth

When might uterine perforation be suspected, and what should I do?

- If uterine perforation at insertion is suspected, the procedure should be stopped and vital signs and the level of discomfort monitored until stable.
  - Uterine perforation should also be considered if a woman returns within the first few days of insertion complaining of marked pain (which may only be intermittent), and the threads cannot be located.
- Urgent and specific follow-up should be arranged to include ultrasound scan and/or plain abdominal X-ray to locate the device if it has been left in situ.

In depth

What follow-up is required following insertion of the copper intrauterine device (IUD)?

- Review 3–6 weeks after insertion of the copper intrauterine device to exclude infection, perforation and expulsion.
- Advise the woman to return if she cannot find the threads of her device.

In depth

Replacing and removing a copper intrauterine device (IUD)

For how long can a copper intrauterine device (IUD) be left in place?

- The recommended duration of use for the copper intrauterine device (IUD) ranges from 5–10 years, depending on the device.
- Women who are aged 40 or more years at the time of IUD insertion may retain the device until they no longer require contraception, even if this is beyond the duration of the UK Marketing Authorisation.

In depth

When should a copper intrauterine device (IUD) be removed?

- A copper intrauterine device (IUD) can be removed at any time in the menstrual cycle.
- If the woman requires uninterrupted contraception, and is:
    - Switching to a hormonal method: she should start the new method with sufficient time for it to become effective before the IUD is removed — minimum 2 days for the progesterone only pill (POP); 7 days for the other methods.
    - Having her copper IUD replaced with a new copper IUD: she should use an additional method for the 7 days before removal of the device.
    - Having her copper IUD replaced with the levonorgestrel-releasing intrauterine system (IUS): she should use an additional method for the 7 days before

removal of the IUD, and for a further 7 days after insertion of the levonorgestrel-releasing IUS.

- If unprotected sexual intercourse takes place during the 7 days before removal of the copper IUD, the woman should consider either delaying removal or using emergency contraception (for further information see the CKS topic on Contraception - emergency).
- Postmenopausal women aged < 50 years: remove copper IUD 2 years after the last menstrual period.
- Postmenopausal women aged >= 50 years: remove copper IUD 1 year after the last menstrual period.

In depth

Managing common problems when using a copper IUD

What should I do if the woman cannot feel the thread(s) of her intrauterine device (IUD)?

- Assume expulsion until proved otherwise. Confirm the location of the intrauterine device (IUD) by history, clinical examination and, as necessary, by ultrasound and X-ray.
- Expelled IUD
  - Arrange for the woman to resume regular contraception.
  - Consider if emergency contraception is indicated. For further information, see the CKS topic on Contraception - emergency.
- Intrauterine IUD
  - The options are conservative management (leaving the IUD where it is), or replacing it.
- Extrauterine IUD or IUD embedded in uterine wall
  - Refer for specialist management.

In depth

How should I manage a woman using a copper intrauterine device (IUD) who may be pregnant?

- Exclude ectopic pregnancy and advise that the risk of miscarriage, infection, or preterm delivery is increased if the intrauterine device (IUD) is left in place.
- Advise that removal of the IUD is recommended, but there is a small risk of miscarriage.
- If the woman agrees to removal, it should be done as soon as possible and before 12 weeks of gestation.
- If the woman does not wish to continue with the pregnancy, the IUD can be removed at the time of abortion.

In depth

How should I manage vaginal bleeding associated with use of the copper intrauterine device (IUD)?

- Reassure the woman that menstrual irregularities (spotting, light bleeding, heavy and/or prolonged menstruation) are common in the first 3–6 months but usually subside.
- Consider prescribing mefenamic acid for spotting/light bleeding or tranexamic acid for heavy and/or prolonged bleeding.
- To prevent anaemia, provide an iron supplement and/or encourage consumption of foods containing iron.
- Exclude or manage other situations which could result in unscheduled bleeding, such as:
    - Sexually transmitted infections.
        - Risk of STI if the woman is under 25 years, or has a new sexual partner, or more than one partner in the last year.
    - Misplaced device.
    - Pregnancy.
    - Gynaecological conditions such as endometrial polyps, endometrial cancer, cervical cancer, or other gynaecological abnormality.

- Speculum examination is warranted:
  - For persistent bleeding beyond the first 3–6 months of use.
  - For new symptoms or a change in bleeding after at least 3 months of use.
  - If the woman has not participated in a National Cervical Screening programme.
  - If requested by the woman.
  - If there are other symptoms such as pain, dyspareunia, or post coital bleeding. (Note that these symptoms also warrant pelvic examination.)

- Refer if the cause of the bleeding cannot be determined or treated in primary care.

In depth

How should I manage pelvic inflammatory disease in a woman using a copper intrauterine device (IUD)?

- Take a cervical swab to test for *Chlamydia trachomatis* and *Neisseria gonorrhoeae*, and treat with appropriate antibiotics.
- The device should be removed if the woman wishes removal or if symptoms have not resolved within 72 hours.
- If the device is going to be removed:
  - Ask if the woman has had sexual intercourse within the last 7 days and consider offering emergency hormonal contraception. For more information see the CKS topic on Contraception - emergency.
- Review after treatment.

In depth

How should I manage a woman who has actinomyces-like organisms on a cervical smear and is using a copper intrauterine device (IUD)?

- Assess for symptoms of pelvic inflammatory disease:

- Symptomatic: consider investigation and treatment, or referral to specialist services; there is probably no need to remove the copper intrauterine device (IUD).
- Asymptomatic: leave IUD in place.

In depth

Starting the levonorgestrel-releasing intrauterine system (IUS)

What is the levonorgestrel-releasing intrauterine system (IUS)?

- The levonorgestrel intrauterine system (IUS) is a small polyethylene T-shaped frame with a reservoir around the vertical stem that slowly releases levonorgestrel into the uterus.
- One levonorgestrel-releasing IUS is licensed in the UK; it is marketed as the Mirena® IUS.

In depth

What information should I give a woman who is considering the levonorgestrel intrauterine system (IUS)?

- There is no evidence that the levonorgestrel-releasing intrauterine system causes weight gain.

In depth

What assessment and treatment are required prior to inserting the levonorgestrel-releasing intrauterine system (IUS)?

- Enquire about the user's preferences and any concerns about using the levonorgestrel intrauterine system (IUS).
- In young women and women with special needs, assess their competence to decide, and support them in making their own decisions about contraception.
- Exclude pregnancy.
- Check the UK Medical Eligibility Criteria to ensure that the woman is eligible for insertion of the levonorgestrel IUS.

- Assess the risk for sexually transmitted infection and, when appropriate, advise testing, promote safer sex, and/or refer for counselling (also consider each time the IUS is reinserted). If testing for sexually transmitted infections is requested, do this before inserting the device.

In depth

When can the levonorgestrel-releasing intrauterine system (IUS) be inserted?

- Starting the levonorgestrel-releasing intrauterine system (IUS):
  - Ideally insert the device in the first 7 days after the onset of menstruation.
    - Additional contraceptive protection will not be required.
  - However, if this is not possible:
    - Insert the device at any other time in the menstrual cycle provided that it is reasonably certain that a woman is not pregnant. This is an unlicensed use. Advise barrier contraception (such as condoms) for the next 7 days.
    - Alternatively, use a hormonal method in the interim, so the fitting can be scheduled for any mutually convenient time.
  - If there is a delay before the IUS can be fitted, combined hormonal contraception (pill, patch, or vaginal ring [not suitable post-partum if the woman is breastfeeding]), the progestogen-only pill, or the progestogen-only injectable can be used as a bridging method.
- Replacing the device:
  - Insert at any time of the menstrual cycle.

In depth

When might uterine perforation be suspected, and what should I do?

- If uterine perforation at insertion is suspected, the procedure should be stopped and vital signs and the level of discomfort monitored until stable.

- Uterine perforation should also be considered if a woman returns within the first few days of insertion complaining of marked pain (which may only be intermittent), and the threads cannot be located.

- Urgent and specific follow-up should be arranged to include ultrasound scan and/or plain abdominal X-ray to locate the device if it has been left in situ.

In depth

What follow up is recommended following insertion of the levonorgestrel-releasing intrauterine system (IUS)?

- Follow-up after the first menses, or 3–6 weeks after insertion, to exclude infection, perforation or expulsion.

- Advise the woman to return at any time if she wants to discuss problems, if she wants to change her method of contraception, or if it is time to have the IUS removed or changed.

In depth

Replacing and removing an levonorgestrel-releasing intrauterine system (IUS)

For how long can a levonorgestrel-releasing intrauterine system (IUS) be left in place?

- The levonorgestrel-releasing intrauterine system (IUS) may be left in place for up to 5 years.

- However, women who are aged 45 or more years at the time of IUS insertion may retain the device until they no longer require contraception, even if this is beyond the duration of the UK Marketing Authorisation.

In depth

When can a levonorgestrel-releasing intrauterine system (IUS) be removed?

- If the woman wishes to conceive, the levonorgestrel-releasing intrauterine system (IUS) can be removed at any time.

- If the woman does not want to become pregnant, remove the device when the woman is not at risk of becoming pregnant, and ensure unbroken contraceptive cover.

- If the device is to be exchanged for a new IUS, the woman should avoid intercourse or use barrier contraception for the 7 days prior to the procedure in case reinsertion fails.
- If the device is to be changed for a hormonal contraceptive method and the woman is amenorrhoeic, the new method should be used for sufficient time for contraceptive protection to be established before removal of the IUS. Alternatively, if the hormonal contraceptive is started after the removal of IUS, she will need to abstain from sex or use additional contraceptive protection (e.g. condoms) until contraceptive protection is established.
- If the device is to be changed for a copper intrauterine device (IUD), no additional contraceptive protection is required if the copper IUD is inserted immediately after removing the IUS.

In depth

Managing common problems when using levonorgestrel-releasing intrauterine system (IUS)

What should I do if the woman cannot feel the thread(s) of her levonorgestrel-releasing intrauterine system (IUS)?

- Confirm the location of the intrauterine system (IUS) by history, clinical examination and, as necessary, by ultrasound and X-ray.
- Expelled IUS
  - Arrange for the woman to resume regular contraception.
  - Consider if emergency contraception is indicated. For further information, see the CKS topic on Contraception - emergency.
- Intrauterine IUS
  - The options are conservative management (leaving the IUS where it is), or replacing it.
- Extrauterine IUS
  - Refer for surgical retrieval.

In depth

How should I manage abnormal vaginal bleeding associated with use of the levonorgestrel-releasing intrauterine system (IUS)?

- Abnormal bleeding is a particular problem with the levonorgestrel-releasing intrauterine system (IUS):
  - Irregular, light, or heavy bleeding is common in the first 6 months.
  - About 65% of women have amenorrhoea or reduced bleeding at 1 year.
  - Studies have shown that 40% of the levonorgestrel load is still present in the IUS after 5 years of use. It is therefore unlikely that any change in bleeding pattern is a result of hormone 'running out'.
- Consider managing heavy unscheduled bleeding by:
  - Treating with a combined oral contraceptive (either cyclically or continuously) for up to 3 months.
- Exclude or manage other situations which could result in unscheduled bleeding, such as:
  - Sexually transmitted infections.
    - Risk of STI if the woman is under 25 years, or has a new sexual partner, or more than one partner in the last year.
  - Misplaced device.
  - Pregnancy.
  - Gynaecological conditions such as endometrial polyps, endometrial cancer, cervical cancer, or other gynaecological abnormality.
  - Speculum examination is warranted:
    - For persistent bleeding beyond the first 3–6 months of use.
    - For new symptoms or a change in bleeding after at least 3 months of use.
    - If the woman has not participated in a National Cervical Screening programme.
    - If requested by the woman.

- If there are other symptoms such as pain, dyspareunia, or post coital bleeding. (Note that these symptoms also warrant pelvic examination.)

- Refer if the cause of the bleeding cannot be determined or treated in primary care.

In depth

How should I manage a woman using a levonorgestrel-releasing intrauterine device (IUS) who may be pregnant?

- Exclude ectopic pregnancy and advise that there is a risk of miscarriage, infection, or preterm delivery if the intrauterine system (IUS) is left in place.
- Advise that removal of the IUS is recommended, but there is a small risk of miscarriage.
- If the woman agrees to removal, it should be done before 12 weeks' gestation.

In depth

How should I manage pelvic inflammatory disease in a woman using a levonorgestrel-releasing intrauterine device (IUS)?

- Take a cervical swab to test for *Chlamydia trachomatis* and *Neisseria gonorrhoeae*, and treat with appropriate antibiotics.
- The device should be removed if the woman wishes removal or if symptoms have not resolved within 72 hours.
- If the device is going to be removed:
  - Ask if the woman has had sexual intercourse within the last 7 days and consider offering emergency hormonal contraception. For more information see the CKS topic on Contraception - emergency.
- Review after treatment.

In depth

How should I manage a woman who has actinomyces-like organisms on a cervical smear and is using a levonorgestrel-releasing intrauterine device (IUS)?

- If a woman who is using the levonorgestrel-releasing intrauterine device (IUS) has actinomyces-like organisms in a cervical smear:
  - If she is asymptomatic:
    - Advise her that it is not necessary to remove the IUS unless signs or symptoms of infection occur.
  - If she is has symptoms of pelvic inflammatory disease:
    - See the CKS topic on Pelvic inflammatory disease.

In depth

Prescriptions

IUDs: Framed, copper (arms & stem) 380mm2

Age from 13 to 60 years

T-Safe 380A QL

T-Safe 380A QL intrauterine contraceptive device

For insertion into the uterine cavity.

Supply 1 IUD.

Age: from 13 years to 60 years

NHS cost: £10.09

Licensed use: no - misc item available on the NHS

TT380 Slimline

TT380 Slimline intrauterine contraceptive device

For insertion into the uterine cavity.

Supply 1 IUD.

Age: from 13 years to 60 years

NHS cost: £11.70

Licensed use: no - misc item available on the NHS

Intrauterine device (IUD): Flexi-T+ 380

Flexi-T+ 380 intrauterine contraceptive device

For insertion into the uterine cavity.

Supply 1 IUD.

Age: from 13 years to 60 years

NHS cost: £10.06

Licensed use: no - misc item available on the NHS

IUDs: Framed with copper (stem only) 380mm2

Age from 13 to 60 years

Neo-Safe T380

Neo-Safe T380 intrauterine contraceptive device

For insertion into the uterine cavity.

Supply 1 IUD.

Age: from 13 years to 60 years

NHS cost: £12.82

Licensed use: no - misc item available on the NHS

Nova-T380

Nova-T 380 intrauterine contraceptive device

For insertion into the uterine cavity.

Supply 1 IUD.

Age: from 13 years to 60 years

NHS cost: £13.50

Licensed use: no - misc item available on the NHS

UT380 Short

UT380 Short intrauterine contraceptive device

For insertion into the uterine cavity.

Supply 1 IUD.

Age: from 13 years to 60 years

NHS cost: £10.53

Licensed use: no - misc item available on the NHS

UT380 Standard

UT380 Standard intrauterine contraceptive device

For insertion into the uterine cavity.

Supply 1 IUD.

Age: from 13 years to 60 years

NHS cost: £10.53

Licensed use: no - misc item available on the NHS

IUDs: Framed with less than 380mm2 copper

Age from 13 to 60 years

Intrauterine device (IUD): Flexi T-300

Flexi T-300 intrauterine contraceptive device

For insertion into the uterine cavity.

Supply 1 IUD.

Age: from 13 years to 60 years

NHS cost: £9.29

Licensed use: no - misc item available on the NHS

Intrauterine device (IUD): Load 375

Load 375 intrauterine contraceptive device

For insertion into the uterine cavity.

Supply 1 IUD.

Age: from 13 years to 60 years

NHS cost: £8.00

Licensed use: no - misc item available on the NHS

Intrauterine device (IUD): Multiload Cu375

Multiload Cu375 intrauterine contraceptive device

For insertion into the uterine cavity.

Supply 1 IUD.

Age: from 13 years to 60 years

NHS cost: £9.24

Licensed use: no - misc item available on the NHS

Intrauterine device (IUD): Multi-Safe Cu375

Multi-Safe 375 intrauterine contraceptive device

For insertion into the uterine cavity.

Supply 1 IUD.

Age: from 13 years to 60 years

NHS cost: £8.63

Licensed use: no - misc item available on the NHS

Intrauterine devices (IUDs): Frameless

Age from 13 to 60 years

GyneFix

GyneFix intrauterine contraceptive device

For insertion into the uterine cavity.

Supply 1 IUD.

Age: from 13 years to 60 years

NHS cost: £25.62

Licensed use: no - misc item available on the NHS

Levonorgestrel-releasing intrauterine system

Age from 13 to 60 years

Levonorgestrel 20mcg/24hrs intra-uterine system (Mirena®)

Levonorgestrel 20micrograms/24hours intrauterine system

For insertion into the uterine cavity.

Supply 1 device.

Age: from 13 years to 60 years

NHS cost: £83.16

Licensed use: yes

Patient information: You may experience irregular bleeding for about 6 months after insertion of the device. Seek medical advice if this persists.

Contraception - Management

View full scenario

CKS safe practical clinical answers - *fast*

Condoms: male and female

What information should I give to a person who is considering the male condom?

- Provide information:
  - On the advantages and disadvantages of the male condom.
  - About contraceptive efficacy of the male condom and the method currently used.
  - To put on the condom on *before* the penis contacts the partner's genitals, anus, or mouth.
  - To not use oil-based lubricants with latex condoms.
  - To not use in combination with a spermicide.
  - To use a lubricant (not oil-based) for anal sex.
  - Should the condom slip or break, the need to consider the chance of:
    - Infection and the possible need for post-exposure prophylaxis against HIV infection.
    - Pregnancy and the possible need for emergency contraception (to be taken as soon as possible). For further information, see the CKS topic on Contraception - emergency.
  - To check that the package has relevant safety markings (e.g. BS Kitemark) and appropriate expiry date.

In depth

How should I advise someone with suspected allergy or sensitivity to male latex condoms?

- For someone (either partner) with suspected allergy or sensitivity to latex:
  - Confirm the cause if genital irritation appears to be associated with condom use.
  - Check the type of condom being used and if is prelubricated with spermicide — reactions to spermicide are more common than reactions to latex.
  - Advise the person to use condoms made from polyurethane or synthetic polyisoprene. Deproteinized male latex condoms can also be considered.
  - Consider skin latex sensitivity tests and/or specific serum IgE antibodies against latex.

In depth

What information should I give to a woman who is considering the female condom?

- Provide information on:
  - The advantages and disadvantages of the female condom.
  - Correct use of the female condom.
  - Efficacy of the female condom in preventing pregnancy, and in preventing sexually transmitted infections.
    - Female condoms are likely to prevent transmission of all sexually transmitted infections if used consistently and correctly.
    - However, male latex condoms are recommended as being more effective in preventing transmission of HIV, genital herpes simplex virus, syphilis and gonorrhoea.
  - Precautions that may be necessary should the condom be displaced or break:

- If there is a risk of infection, post-exposure prophylaxis against HIV infection should be considered.
- If there is a risk of pregnancy, emergency contraception should be considered. For further information, see the CKS topic on Contraception - emergency.

- Checking the expiry date.
- Consider demonstrating use of the condom.

In depth

Diaphragms and caps

What diaphragms and cervical caps are available?

- Three types of diaphragm are available:
  - Flat spring: suitable for women with normal vaginal muscular support, and are generally offered first-line.
  - Coil spring: can be considered in those for whom a flat spring diaphragm is not suitable, provided that the woman has good vaginal muscle tone. Coil spring diaphragms are more flexible and can be more comfortable than flat springs.
  - Arcing spring: useful for women with poor vaginal muscular support or those in whom the length or position of the cervix makes fitting a coil spring or flat spring diaphragm more difficult.
- Cervical caps made of latex or silicone are available.

In depth

How should I assess a woman prior to fitting the diaphragm or cap?

- Enquire about the woman's preferences and any concerns about using the diaphragm or cap.
- In young women and women with special needs, assess their competence to decide, and support them in making their own decisions about contraception. For these individuals, the

diaphragm and cervical cap might not be appropriate, given their higher failure rates compared to other methods.

- Take a clinical and drug history, and conduct a vaginal examination at the time of fitting.
- Assess the risk for sexually transmitted infection and, when appropriate, advise testing, promote safer sex, and/or refer for counselling.
- Check the UK Medical Eligibility Criteria to ensure that the woman is eligible to use the diaphragm or cap. A woman should use a diaphragm or cervical cap only after consultation with an expert if she is HIV positive, at high risk of HIV infection, allergic to latex, or has a history of toxic shock syndrome.

In depth

How are the diaphragm and cervical cap fitted?

- Diaphragms and caps should initially be fitted by a trained and competent healthcare professional.
    - Initially the diaphragm or cap should be used together with another method (e.g. condoms) until the woman is confident that she can use it correctly.

In depth

What follow up and aftercare are required for the diaphragm and cervical cap?

- Reassess after 1–2 weeks; review the device's fit and the woman's skills in using it.
- When inserted correctly, neither partner should be able to feel the diaphragm or cap.
- If it can be felt or is uncomfortable, the woman should return to reassess fit, or to consider an alternative diaphragm or cap, or another method of contraception.
- The diaphragm or cap should be replaced immediately if there are any holes or puckering.
- The fit of the diaphragm or cap should be rechecked by a trained healthcare professional after childbirth, abortion, or miscarriage, or if the woman gains or loses >= 3 kg in weight, because the vagina and cervix can change shape or size.

In depth

How should the woman use a diaphragm or cervical cap?

- Before insertion, check for any holes or deterioration.
- Use a spermicide in conjunction with the diaphragm and cap.
- Do not allow oil-based products to contact latex diaphragms and caps, as they rapidly damage rubber.
- If sexual intercourse is repeated or occurs more than 3 hours after insertion, insert additional spermicide into the vagina without removing the device.
- Leave the diaphragm or cap in place for at least 6 hours after last episode of sexual intercourse, and remove within 30 hours of insertion.
- After use, wash the item with mild unscented soap, rinse well, and dry carefully before storing in a cool place.
- Should the diaphragm or cap be used incorrectly (including premature removal), consider the possibility of pregnancy and whether emergency contraception is appropriate. See the CKS topic on Contraception - emergency.

In depth

Spermicides

What spermicidal preparations are available?

- Gygel® vaginal cream is the only licensed spermicide marketed in the UK. It contains 2.0% nonoxinol-9.

In depth

How should spermicides be used?

- Spermicides should be used in conjunction with barrier methods such as a diaphragm or cervical cap.
    - A diaphragm or cervical cap can be inserted with spermicides any time before intercourse.

- If sexual intercourse is repeated or occurs more than 3 hours after insertion, additional spermicide should be applied using an applicator without removing the diaphragm or cervical cap.
- The diaphragm or cervical cap must be left *in situ* for at least 6 hours after the last episode of intercourse.

In depth

Prescriptions

Diaphragms: flat spring - latex / rubber

Age from 18 to 60 years

Reflexions diaphragm 55mm

Vaginal contraceptive diaphragm flat spring 55mm

Follow the instructions given inside this pack.

Supply 1 diaphragm.

Age: from 18 years to 60 years

NHS cost: £6.00

Licensed use: no - misc item available on the NHS

Reflexions diaphragm 60mm

Vaginal contraceptive diaphragm flat spring 60mm

Follow the instructions given inside this pack.

Supply 1 diaphragm.

Age: from 18 years to 60 years

NHS cost: £6.00

Licensed use: no - misc item available on the NHS

Reflexions diaphragm 65mm

Vaginal contraceptive diaphragm flat spring 65mm

Follow the instructions given inside this pack.

Supply 1 diaphragm.

Age: from 18 years to 60 years

NHS cost: £6.00

Licensed use: no - misc item available on the NHS

Reflexions diaphragm 70mm

Vaginal contraceptive diaphragm flat spring 70mm

Follow the instructions given inside this pack.

Supply 1 diaphragm.

Age: from 18 years to 60 years

NHS cost: £6.00

Licensed use: no - misc item available on the NHS

Reflexions diaphragm 75mm

Vaginal contraceptive diaphragm flat spring 75mm

Follow the instructions given inside this pack.

Supply 1 diaphragm.

Age: from 18 years to 60 years

NHS cost: £6.00

Licensed use: no - misc item available on the NHS

Reflexions diaphragm 80mm

Vaginal contraceptive diaphragm flat spring 80mm

Follow the instructions given inside this pack.

Supply 1 diaphragm.

Age: from 18 years to 60 years

NHS cost: £6.00

Licensed use: no - misc item available on the NHS

Reflexions diaphragm 85mm

Vaginal contraceptive diaphragm flat spring 85mm

Follow the instructions given inside this pack.

Supply 1 diaphragm.

Age: from 18 years to 60 years

NHS cost: £6.00

Licensed use: no - misc item available on the NHS

Reflexions diaphragm 90mm

Vaginal contraceptive diaphragm flat spring 90mm

Follow the instructions given inside this pack.

Supply 1 diaphragm.

Age: from 18 years to 60 years

NHS cost: £6.00

Licensed use: no - misc item available on the NHS

Reflexions diaphragm 95mm

Vaginal contraceptive diaphragm flat spring 95mm

Follow the instructions given inside this pack.

Supply 1 diaphragm.

Age: from 18 years to 60 years

NHS cost: £6.00

Licensed use: no - misc item available on the NHS

Diaphragms: coil spring - silicone

Age from 18 to 60 years

Milex Omniflex coil spring silicone diaphragm 60mm

Milex omniflex coil spring silicone diaphragm 60mm

Follow the instructions given inside this pack.

Supply 1 diaphragm.

Age: from 18 years to 60 years

NHS cost: £8.35

Licensed use: no - misc item available on the NHS

Milex Omniflex coil spring silicone diaphragm 65mm

Milex omniflex coil spring silicone diaphragm 65mm

Follow the instructions given inside this pack.

Supply 1 diaphragm.

Age: from 18 years to 60 years

NHS cost: £8.35

Licensed use: no - misc item available on the NHS

Milex Omniflex coil spring silicone diaphragm 70mm

Milex omniflex coil spring silicone diaphragm 70mm

Follow the instructions given inside this pack.

Supply 1 diaphragm.

Age: from 18 years to 60 years

NHS cost: £8.35

Licensed use: no - misc item available on the NHS

Milex Omniflex coil spring silicone diaphragm 75mm

Milex omniflex coil spring silicone diaphragm 75mm

Follow the instructions given inside this pack.

Supply 1 diaphragm.

Age: from 18 years to 60 years

NHS cost: £8.35

Licensed use: no - misc item available on the NHS

Milex Omniflex coil spring silicone diaphragm 80mm

Milex omniflex coil spring silicone diaphragm 80mm

Follow the instructions given inside this pack.

Supply 1 diaphragm.

Age: from 18 years to 60 years

NHS cost: £8.35

Licensed use: no - misc item available on the NHS

Milex Omniflex coil spring silicone diaphragm 85mm

Milex omniflex coil spring silicone diaphragm 85mm

Follow the instructions given inside this pack.

Supply 1 diaphragm.

Age: from 18 years to 60 years

NHS cost: £8.35

Licensed use: no - misc item available on the NHS

Milex Omniflex coil spring silicone diaphragm 90mm

Milex omniflex coil spring silicone diaphragm 90mm

Follow the instructions given inside this pack.

Supply 1 diaphragm.

Age: from 18 years to 60 years

NHS cost: £8.35

Licensed use: no - misc item available on the NHS

Diaphragms: arcing spring - silicone

Age from 18 to 60 years

Milex arcing spring silicone diaphragm 60mm

Milex arcing spring silicone diaphragm 60mm

Follow the instructions given inside this pack.

Supply 1 diaphragm.

Age: from 18 years to 60 years

NHS cost: £8.35

Licensed use: no - misc item available on the NHS

Milex arcing spring silicone diaphragm 65mm

Milex arcing spring silicone diaphragm 65mm

Follow the instructions given inside this pack.

Supply 1 diaphragm.

Age: from 18 years to 60 years

NHS cost: £8.35

Licensed use: no - misc item available on the NHS

Milex arcing spring silicone diaphragm 70mm

Milex arcing spring silicone diaphragm 70mm

Follow the instructions given inside this pack.

Supply 1 diaphragm.

Age: from 18 years to 60 years

NHS cost: £8.35

Licensed use: no - misc item available on the NHS

Milex arcing spring silicone diaphragm 75mm

Milex arcing spring silicone diaphragm 75mm

Follow the instructions given inside this pack.

Supply 1 diaphragm.

Age: from 18 years to 60 years

NHS cost: £8.35

Licensed use: no - misc item available on the NHS

Milex arcing spring silicone diaphragm 80mm

Milex arcing spring silicone diaphragm 80mm

Follow the instructions given inside this pack.

Supply 1 diaphragm.

Age: from 18 years to 60 years

NHS cost: £8.35

Licensed use: no - misc item available on the NHS

Milex arcing spring silicone diaphragm 85mm

Milex arcing spring silicone diaphragm 85mm

Follow the instructions given inside this pack.

Supply 1 diaphragm.

Age: from 18 years to 60 years

NHS cost: £8.35

Licensed use: no - misc item available on the NHS

Milex arcing spring silicone diaphragm 90mm

Milex arcing spring silicone diaphragm 90mm

Follow the instructions given inside this pack.

Supply 1 diaphragm.

Age: from 18 years to 60 years

NHS cost: £8.35

Licensed use: no - misc item available on the NHS

Caps: type A - rubber

Age from 18 to 60 years

Dumas vault cap No.1

Dumas Vault Cap No.1

Follow the instructions given inside this pack.

Supply 1 cap.

Age: from 18 years to 60 years

NHS cost: £6.85

Licensed use: no - misc item available on the NHS

Dumas vault cap No.2

Dumas Vault Cap No.2

Follow the instructions given inside this pack.

Supply 1 cap.

Age: from 18 years to 60 years

NHS cost: £6.85

Licensed use: no - misc item available on the NHS

Dumas vault cap No.3

Dumas Vault Cap No.3

Follow the instructions given inside this pack.

Supply 1 cap.

Age: from 18 years to 60 years

NHS cost: £6.85

Licensed use: no - misc item available on the NHS

Dumas vault cap No.4

Dumas Vault Cap No.4

Follow the instructions given inside this pack.

Supply 1 cap.

Age: from 18 years to 60 years

NHS cost: £6.85

Licensed use: no - misc item available on the NHS

Dumas vault cap No.5

Dumas Vault Cap No.5

Follow the instructions given inside this pack.

Supply 1 cap.

Age: from 18 years to 60 years

NHS cost: £6.85

Licensed use: no - misc item available on the NHS

Caps: type B - rubber

Age from 18 to 60 years

Prentif cavity rim cervical cap 22mm

Prentif Cavity Rim Cervical Cap 22mm

Follow the instructions given inside this pack.

Supply 1 cap.

Age: from 18 years to 60 years

NHS cost: £8.10

Licensed use: no - misc item available on the NHS

Prentif cavity rim cervical cap 25mm

Prentif Cavity Rim Cervical Cap 25mm

Follow the instructions given inside this pack.

Supply 1 cap.

Age: from 18 years to 60 years

NHS cost: £8.10

Licensed use: no - misc item available on the NHS

Prentif cavity rim cervical cap 28mm

Prentif Cavity Rim Cervical Cap 28mm

Follow the instructions given inside this pack.

Supply 1 cap.

Age: from 18 years to 60 years

NHS cost: £8.10

Licensed use: no - misc item available on the NHS

Prentif cavity rim cervical cap 31mm

Prentif Cavity Rim Cervical Cap 31mm

Follow the instructions given inside this pack.

Supply 1 cap.

Age: from 18 years to 60 years

NHS cost: £8.10

Licensed use: no - misc item available on the NHS

Caps: type C - rubber

Age from 18 to 60 years

Vimule cap No.1

Vimule Cap No.1

Follow the instructions given inside this pack.

Supply 1 cap.

Age: from 18 years to 60 years

NHS cost: £6.85

Licensed use: no - misc item available on the NHS

Vimule cap No.2

Vimule Cap No.2

Follow the instructions given inside this pack.

Supply 1 cap.

Age: from 18 years to 60 years

NHS cost: £6.85

Licensed use: no - misc item available on the NHS

Vimule cap No.3

Vimule Cap No.3

Follow the instructions given inside this pack.

Supply 1 cap.

Age: from 18 years to 60 years

NHS cost: £6.85

Licensed use: no - misc item available on the NHS

Caps: silicone

Age from 18 to 60 years

FemCap 22mm

FemCap 22mm

Follow the instructions given inside this pack.

Supply 1 cap.

Age: from 18 years to 60 years

NHS cost: £15.29

Licensed use: no - misc item available on the NHS

FemCap 26mm

FemCap 26mm

Follow the instructions given inside this pack.

Supply 1 cap.

Age: from 18 years to 60 years

NHS cost: £15.29

Licensed use: no - misc item available on the NHS

FemCap 30mm

FemCap 30mm

Follow the instructions given inside this pack.

Supply 1 cap.

Age: from 18 years to 60 years

NHS cost: £15.29

Licensed use: no - misc item available on the NHS

Spermicides for use with barrier methods

Age from 18 to 60 years

Gygel 2%

Gygel 2% contraceptive jelly

Follow the instructions given inside this pack.

Supply 30 grams.

Age: from 18 years to 60 years

NHS cost: £4.25

OTC cost: £7.50

Licensed use: yes

Contraception - Management

View full scenario

CKS safe practical clinical answers - *fast*

Male sterilization (vasectomy)

How should I assess a man who is considering vasectomy?

- Assess the man's:
  - Mental capacity to make the decision.

- Level of understanding of the advantages, disadvantages, and relative failure rates of vasectomy and alternative long-term reversible methods of contraception. See Advice and information.
- Risk for later regret. Take additional care when counselling people who are:
  - Less than 30 years of age.
  - Without children.
  - Taking decisions during pregnancy.
  - Taking decisions in reaction to the loss of a relationship.
  - Possibly at risk of coercion by their partner, family, or health or social welfare professionals.
- Cultural, religious, psychosocial, psychosexual, and psychological issues.
- Risk for sexually transmitted infection and, when appropriate, advise testing, promote safer sex, and/or refer for counselling.

- Assess also the man's partner's suitability for sterilization, as the *couple's* clinical history, present symptoms, or abnormal examination findings may influence which partner goes forward to have sterilisation.

In depth

What advice and information should I give a man who is considering vasectomy?

- A man who is requesting sterilization should be given advice and written information about:
  - The advantages, disadvantages and risks of vasectomy.
  - Alternative long-term reversible methods of contraception, including information on the advantages, disadvantages, and relative failure rates of each method.
  - Both vasectomy and tubal occlusion.
  - The possibility of chronic testicular or scrotal pain after vasectomy.

- The success rates associated with reversal, should this procedure be necessary:
  - Men should be informed that the NHS rarely provides reversal operations.
- The need to use effective contraception until azoospermia has been confirmed.

- A man requesting vasectomy can be reassured that:
  - Vasectomy does not increase the risk of testicular cancer or heart disease.
  - Vasectomy probably does not increase the risk of prostate cancer — any association between vasectomy and prostate cancer is unlikely to be causal.

In depth

Female sterilization (tubal occlusion)

How should I assess a woman who is considering sterilization (tubal occlusion)?

- Assess the woman's:
  - Mental capacity to make the decision.
  - Level of understanding of the advantages, disadvantages, and relative failure rates of tubal occlusion and alternative long-term reversible methods of contraception — see Advice for woman considering sterilization.
  - Risk for later regret. Take additional care when counselling people who are:
    - Less than 30 years of age.
    - Without children.
    - Taking decisions during pregnancy.
    - Taking decisions in reaction to the loss of a relationship.
    - Possibly at risk of coercion by their partner, family, or health or social welfare professionals.
  - Cultural, religious, psychosocial, psychosexual, and psychological issues.

- Assess the risk for sexually transmitted infection and, when appropriate, advise testing, promote safer sex, and/or refer for counselling.
- Assess also the woman's partner's suitability for vasectomy, as the *couple's* clinical history, present symptoms, or abnormal examination findings may influence which partner goes forward to have sterilization.

In depth

What should I advise a woman who is considering sterilization (tubal occlusion)?

- A woman who is requesting sterilization should be given advice and written information about:
  - The advantages, disadvantages, and risks of both tubal occlusion and vasectomy.
    - Tubal occlusion has a lifetime failure rate of about 10 in 2000 women. Vasectomy has a 10-year failure rate of about 1 pregnancy per 2000 men.
    - Tubal occlusion has more risk related to the procedure.
  - Alternative long-term reversible methods of contraception, including information on the advantages, disadvantages, and relative failure rates of each method.
  - The success rates associated with reversal, should this procedure be necessary.
    - The success of reversal procedures depends on a number of factors including the age of the woman, the method used for tubal occlusion and the method used for tubal re-anastomosis; as many as 90% of women may be able to become pregnant after reversal of clip sterilization.
  - The need to use effective contraception until the tubal occlusion procedure and to continue until her next menstrual period or otherwise advised.
  - The risk of ectopic pregnancy should tubal occlusion fail, and the need to seek medical advice if she thinks she might be pregnant, or if she has abnormal abdominal pain or vaginal bleeding.

- After the operation, women should be advised of the method of tubal occlusion actually used, and of any complications that occurred during the procedure

Contraception - Management

View full scenario

CKS safe practical clinical answers - *fast*

What natural family planning methods are recommended for use in the UK?

- Natural family planning methods (techniques to avoid conception) that are recommended fall into two categories: fertility awareness–based methods (which involves abstinence), and the lactational amenorrhoea method (that does not involve abstinence).
- **Fertility awareness–based methods** monitor changes in one or more indicators of fertility such as basal body temperature, cervical secretions, hormone levels, and/or estimating the fertile days of the menstrual cycle.
- **The lactational amenorrhoea method** can be used provided:
  - Complete amenorrhoea, *and*
  - Fully or very nearly fully breastfeeding, *and*
  - No longer than 6 months since birth of the baby.

In depth

How do I assess a woman who is planning to use a fertility awareness-based method?

- Assessment should include answers to the following questions:
  - Does she have a medical condition that would make pregnancy especially dangerous?
  - Is her menstrual cycle sufficiently regular to reliably estimate the fertile time?
  - Does she have a chronic condition that could affect fertility signs, making fertility awareness–based methods hard to use?

- Does she have a temporary condition that could affect fertility signs, making fertility awareness–based methods hard to use?
- Does she take any drug that affects cervical mucus, making fertility awareness–based methods hard to use?
- Is she at increased risk for sexually transmitted infection?

In depth

What advice and information should I give a woman who is considering using a fertility awareness-based method?

- Give advice and information about:
  - The need for her to receive counselling, training, and ongoing support from a family planning specialist.
  - The advantages, disadvantages and risks of the method.
  - Alternative methods of contraception, taking into account her personal, cultural, and religious sensitivities.
  - Where to purchase or seek accurate information about fertility predictors (e.g. Persona®).
- The fpa (Family Planning Association) has information both about natural family planning methods and where women can find teachers of natural planning methods. Visit the fpa website www.fpa.org.uk, or phone their helpline on 0845 122 8690.

In depth

How do I assess a woman who is planning to use the lactational amenorrhoea method?

- Assessment should include answers to the following questions:
  - Can she use the lactational amenorrhoea method?
  - Does she have a condition in which breastfeeding is not advisable?

In depth

What advice and information should I give a woman who is considering using the lactational amenorrhoea method?

- Give advice and information about:
  - The advantages, disadvantages and risks of the method.
  - The conditions for it to be reliable:
    - Complete amenorrhoea, *and*
    - Fully or very nearly fully breastfeeding, *and*
    - No longer than 6 months since birth of the baby.
  - Alternative methods of contraception for when the lactational amenorrhoea method becomes unreliable or for now if she wants additional protection, taking into account her personal, cultural, and religious sensitivities.