CoSRH
Contraception Provision Course for Pharmacy Professionals.

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While we may often refer to women in today's discussions/the materials, this is done for brevity on the understanding that trans men and non-binary individuals assigned female at birth may also require access to the care and services discussed today/in these materials.

A simple approach

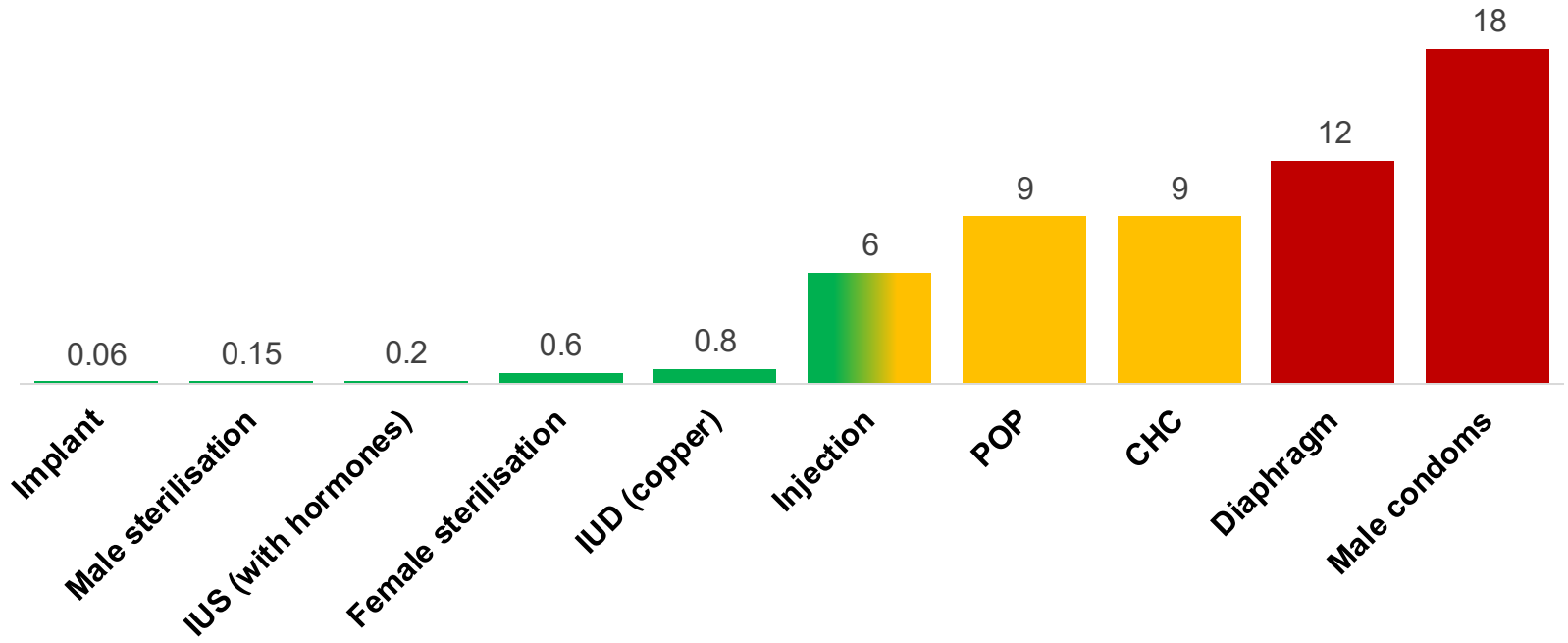
1. Is the method right for the individual?
   - Patient choice: advantages, side effects, ease of taking

2. Is the individual right for the method?
   - Safety: contraindications, concurrent drug interactions

An alphabetical list

Abstinence	Hormonal IUD	POP
Caps	Implant	Ring
COCP	Injection	Spermicide
Copper IUD	Lactational amenorrhoea	Sterilisation
Diaphragms	Male condoms	Vaginal sponge
Female condoms	Non-vaginal sex	Vasectomy
Fertility Awareness	Patch	Withdrawal

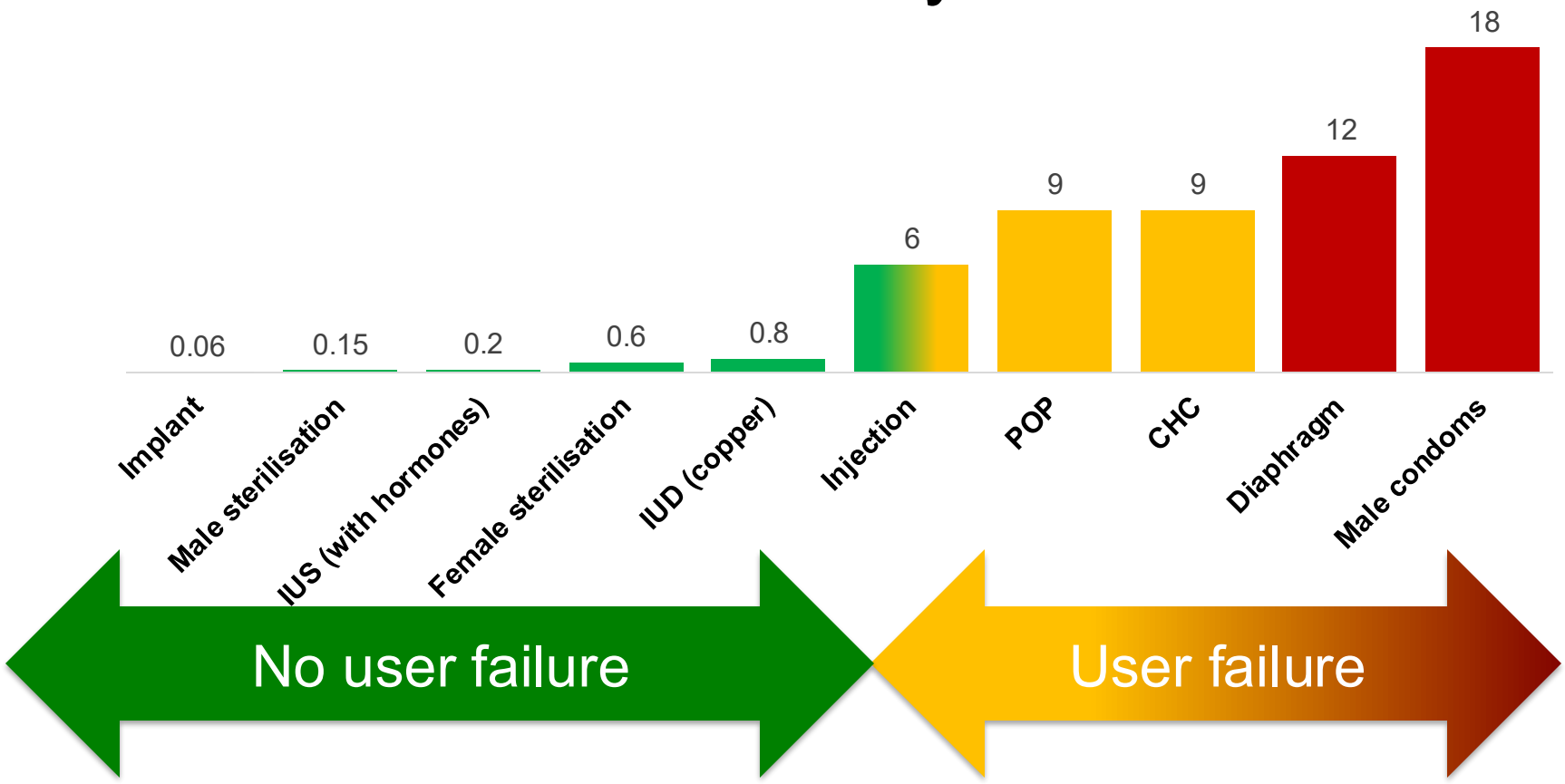
Failure rates with typical use per 100 individuals -years



Leaflets often quote 'perfect' use

Trussell J. In: Hatcher et al. (eds) *Contraceptive Technology* (20th Edition). New York, Ardent Media 2011

Failure rates with typical use per 100 individuals-years



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Lactational Amenorrhea Method (LAM)

Up to 98% effective if ALL THREE criteria met:

1. Fully breast feeding
2. No periods
3. ≤ 6 months postpartum

How clinicians tend to classify contraception

- **Irreversible methods**
  - Sterilisation
- **Long-acting reversible contraception (LARC)**
  - Hormonal IUD / Copper IUD / Implant / Injection
- **Short acting reversible methods**
  - COC / Patch / Ring / POP
- **Barrier methods**
  - condoms and diaphragms
- **Fertility awareness methods – incl FemTech**

How people using contraception tend to classify methods

- **Hormonal**
  - COC / Patch / Ring / POP / Hormonal IUD / Implant / Injection
- **Non-hormonal**
  - Barrier / **Copper IUD** / Fertility awareness methods
- **Sterilisation**

Side-effects

- Breast tenderness / enlargement / pain
- Nausea
- Bloating / weight gain
- Headache
- Mood swings
- Reduced sex drive
- Acne
- Greasy skin/hair
- Increased body and facial hair
- Vaginal dryness
- Increased vaginal discharge
- Irregular and/or prolonged bleeding
- Chloasma (skin pigmentation)

What is important to know about side-effects?

- Tell individuals:
  - hormonal side-effects likely to be **temporary** e.g. bloating, breast tenderness
  - if SE persist, switching pills/method may help

- Refer if side-effects persist
  - May not be related to contraceptive method
  - Chloasma: stop COC

How long do these long-acting methods last for?

- Implant **3 Years**
- Copper IUD **5 or 10 Years**
- Hormonal IUD **3, 5 or 8 Years**

Understanding medical risks

- There are risks associated with contraception BUT the risk is small for most individuals.
- These risks should have been assessed when contraception was first prescribed.
- When you are reissuing contraception, you need to check her risk has not changed and that it's still safe for the individual to continue with the method.

Risks fall into these categories

Personal characteristics

- Age
- Parity
- Breastfeeding
- Postpartum (non breast-feeding)
- Post abortion
- Past ectopic
- History of pelvic surgery
- Smoking
- Obesity
- History of bariatric surgery
- Organ transplant

Vascular disease

- Multiple risk factors
- Hypertension
- High blood pressure during pregnancy
- Ischaemic heart disease
- Stroke
- Dyslipidaemias
- VTE
- Superficial venous thrombos
- Known thrombogenic mutations
- Valvular and congr disease
- Cardiomyopa
- Cardiac

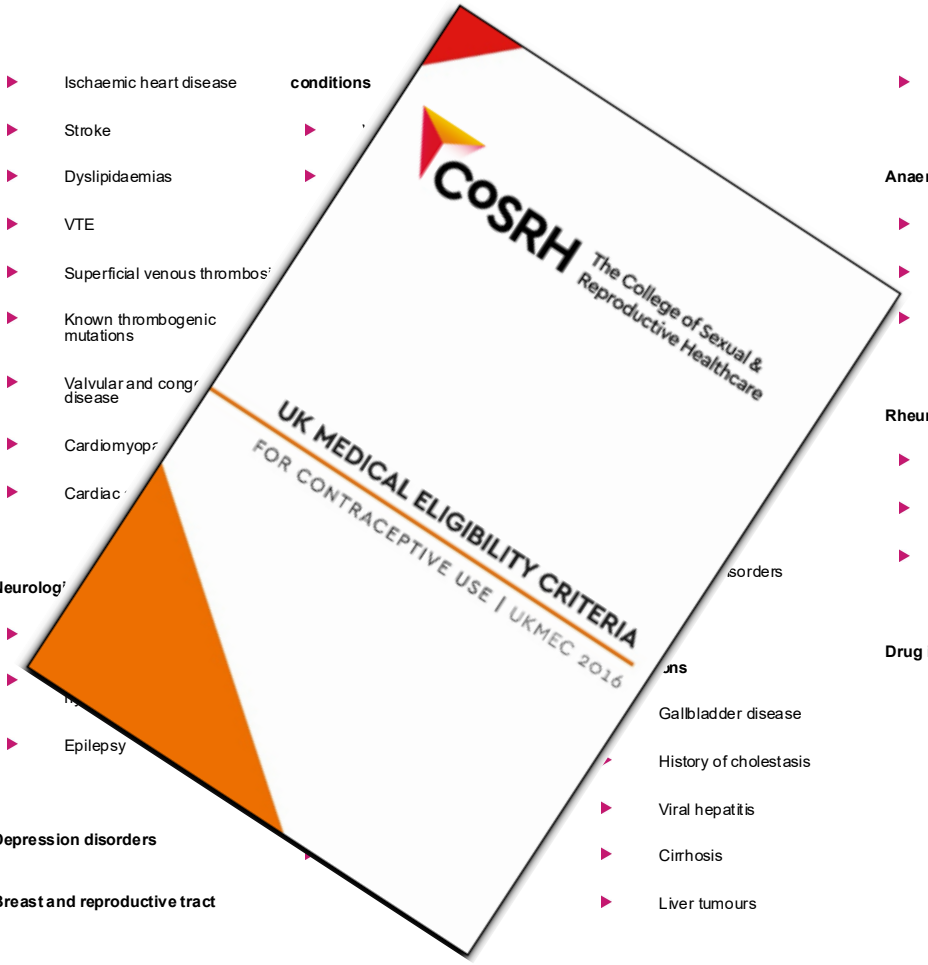
Neurolog

- Epilepsy

Depression disorders

Breast and reproductive tract

conditions



sorders

ons

- Gallbladder disease
- History of cholestasis
- Viral hepatitis
- Cirrhosis
- Liver tumours
- IBD

Anaemias

- Thalassemia
- Sickle cell disease
- Iron deficiency anaemia

Rheumatic diseases

- RA
- SLE
- Positive anti-phospholipids

Drug interactions

UKMEC 1

- No restrictions for use of the contraceptive method
- Go ahead!

UKMEC2

-Advantages of using the method generally outweigh risks
- Usually go ahead
- Consider discussing with colleague with relevant experience

UKMEC 3

- Risks generally outweigh advantages of using the method
- DO NOT reissue/initiate
- Refer to colleague with relevant experience

UKMEC 4

- Unacceptable health risk if contraceptive method if used
- NEVER reissue/initiate

Hormonal contraceptive red flags

- Cardiovascular and DVT/PE
  - Risk factors (Smoking, raised BMI, BP, family history, diabetes
  - Current or past disease
- Migraine with aura
- Breast cancer
- Liver disease / cancer
- Anti-phospholipid antibodies
- Post-natal / breast feeding
- Interacting medication

Types of Drug Interaction

Pharmacokinetic interactions:

- Occur when one drug alters the absorption, distribution, metabolism or excretion of another, changing its bioavailability

Pharmacodynamic interactions:

- Occur when the pharmacological effect of one drug influences the pharmacological effect of another by synergy or antagonism

Most drug interactions involving hormonal contraception are pharmacokinetic

Pharmacokinetic interactions: Reduced contraceptive effectiveness

- Interactions between hormonal contraceptives and drugs that induce hepatic CYP450 enzymes (i.e. enzyme inducers) → ↑ hepatic clearance of contraceptive hormones and potential ↓ effectiveness of…
  - combined hormonal contraceptive methods (i.e. combined oral contraceptive pills, vaginal ring, and patch) (CHC)
  - progestogen-only pills (POP)
  - contraceptive progestogen implants (ENG-IMP)
  - oral emergency contraception (EHC)

- A reliable contraceptive method that is unaffected by the enzyme inducer should be offered:
  - ✓ depot medroxyprogesterone acetate (DMPA) progestogen-only injectable (IM or SC)
  - ✓ levonorgestrel-releasing intrauterine device (LNG-IUD)
  - ✓ copper intrauterine device (Cu-IUD)

- **What if use of enzyme inducer is short term (<2 months)?**

- Other important pharmacokinetic drug interactions that could affect exposure to contraceptive hormones result from ↓ contraceptive absorption due to use of:
  - drugs that induce vomiting or severe diarrhoea
  - drugs that alter gut transit
  - chelating drugs
  - drugs that alter gastric pH.

What about use of antibiotics?

No additional contraceptive precaution is required during use of an antibiotic unless the antibiotic is an enzyme inducer (see later) or it (and/or the illness being treated) causes vomiting or diarrhoea

Pharmacokinetic interactions: Increased exposure to contraceptive hormones

- Concomitant use of drugs that inhibit cytochrome P450 with hormonal contraception could result in → ↑ exposure to contraceptive hormones and potentially ↑ adverse effects:
  - E.g. ethinylestradiol, elevated serum levels could theoretically result in increased risk of thrombosis.

Pharmacodynamic interactions: Example

- Drospirenone is an aldosterone antagonist with potassium-sparing properties:
  - Due to ↑ risk of hyperkalaemia, use of the drospirenone progestogen-only pill (DRSP POP) is not recommended during use of:
    - potassium-sparing diuretics or potassium supplements that also increase serum potassium.
    - ACE inhibitors and angiotensin II receptor antagonists

Contraception during use of teratogenic (or potentially teratogenic) drugs

- Individuals using known teratogenic drugs or drugs with potential teratogenic effects should be advised to use ‘highly effective contraception’ during use of the teratogen and for the recommended timeframe after discontinuation.
  - A pregnancy prevention plan should be in place to ensure there is no risk of conception.
  - Examples where a PPP is necessary: Valproate, Topiramate

If user-dependent forms of contraception used…

- i.e. pills, patches, vaginal rings or self-administered injectables
- two complementary forms of contraception including a barrier method e.g. condoms, should be used
- regular pregnancy testing considered

Non-enzyme-inducing teratogens eg valproate (and no other enzyme-inducing drug is being taken):

- Use of the implant, the copper IUD or a levonorgestrel-releasing IUD is recommended.

- If combined hormonal contraception, a progestogen-only pill or depot medroxyprogesterone acetate is used, condoms should be used reliably in addition.

Enzyme-inducing teratogens/potential enzyme-inducing teratogens eg topiramate (or if an enzyme-inducing drug is also being taken):

- Use of the copper IUD, a levonorgestrel-releasing IUD, or depot medroxyprogesterone acetate PLUS condoms is recommended.

- Use of combined hormonal contraception, progestogen-only pills and the etonogestrel implant is not recommended.

COC and POP regimes

	How often is it taken?	Breaks?	When is it late?
COC	One pill every day for a minimum of 21 days	4 or 7 days	24 hours
POP	One pill every day	No* * DRSP POP includes 4 inactive pills	Desogestrel: 12 hours Traditional: 3 hours DRSP POP: 24 hours

Tailored regimes (COC)

Types of regimen	Period of use	HFI
Standard use	21 days (21 active pills)	7 days
Tailored use		
Shortened hormone-free interval (HFI)	21 days (21 active pills)	4 days
Extended use (tricycling)	9 weeks (3 x 21 active pills)	4 or 7 days
Flexible extended use	Continuous use (≥21 days) of active pills until breakthrough bleeding occurs for 3 – 4 days	4 days
Continuous use	Continuous use of active pills	None

Benefits of tailored regimes

Higher CHC efficacy due to the:

- Reduction in likelihood of escape ovulation
- Reduction in late pills after HFI
- Reduction in missed pills after HFI

Other benefits:

- Reduction in breakthrough bleeding over time
- Reduction in HFI side effects e.g. headaches

Missed pills

- How long has it been since last active pill?
- How many pills have been missed?
- What week of pill taking were pill(s) missed - if HFI part of regime (COC/DRSP POP)?
- Is EC/Pregnancy testing required?
- Are additional contraceptive precautions required when re-starting?

- CoSRH provide guidelines on missed pill rules for POP and COC.

Initiating consultation

- Assess suitability of POP/COC for the individual
- Choose POP/COC or alternative method
- Discuss/offer alternative method
- Select formulation, regimen (COC) and duration of prescription
- Provide other essential information

Choosing formulation, regimen (COC) and duration of prescription

- Options for type and formulation (pill/patch/ring) – consider individual patient
- Prescription can be provided for up to 1 year
- Review annually

Quick-starting

- Starting contraception any time other than beginning of natural menstrual cycle
- Important to assess if pregnancy can be reasonably excluded.

Day 1 – 5 natural cycle (day 1 only for estraiol or estetrol COC and DRSP) [regardless of UPSI]	**CHC** 	**DSG/TRAD POP** 	**DRSP POP** 

- After day 5 of natural cycle*
- If pregnancy can be reasonably excluded and the patient has not recently been on hormonal contraception:

CHC	DSG/TRAD POP	DRSP POP
		
+7 days alternative contraceptive precautions	+ 2 days alternative contraceptive precautions	+ 7 days alternative contraceptive precautions

- After day 5 of natural cycle*
- If pregnancy cannot be reasonably excluded and the patient has not recently been on hormonal contraception:

CHC	DSG/TRAD POP	DRSP POP
✓	✓	✓
+7 days alternative contraceptive precautions	+ 2 days alternative contraceptive precautions	+ 7 days alternative contraceptive precautions

- Consider PT and EC

Quick-starting after EC

- What needs to be considered after EC?

Immediately after (**≤5 days after) UPA-EC**	**CHC** 	**DSG/TRAD POP** 	**DRSP POP** 
>5 days after UPA-EC OR Anytime after LNG-EC	**CHC**  + 7 days additional contraceptive precautions	**DSG/TRAD POP**  + 2 days additional contraceptive precautions	**DRSP POP**  + 7 days additional contraceptive precautions

Quick-starting after childbirth

< 21 days after childbirth	**CHC** 	**DSG/TRAD POP** 	**DRSP POP** 
≥ 21 days after childbirth	**CHC**** *  **+7 days additional contraception precaution***	**DSG/TRAD POP**  **+2 days additional contraception precaution**	**DRSP POP**  **+7 days additional contraception precaution**

Follow up

- Patients should be reviewed at least annually

- At follow up:
  - Check medical eligibility
  - Discuss compliance and satisfaction
  - Address concerns/side effects
  - Discuss LARC

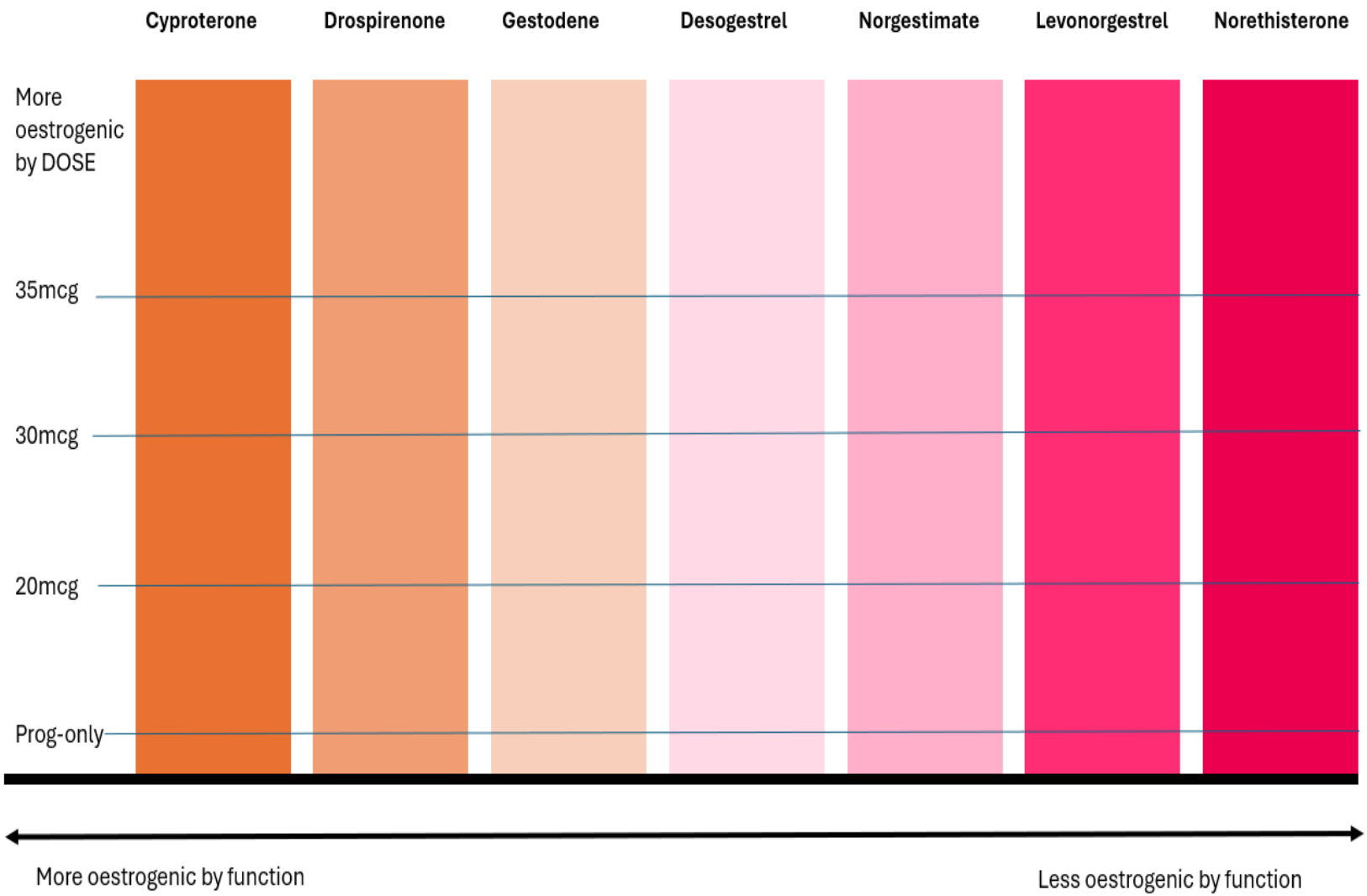
Switching oral contraception

- Switching oral contraception
- Re-issuing
- Legal and ethical considerations
- Consultation skills
- Scenarios

Side effects

- **Estrogen effects**
- Menorrhagia
- Cervical Ectopy
- Nausea
- Dizziness
- Vaginal discharge
- Breast Fullness
- Low libido, especially if not related to low mood
- Headaches / migraine

- **Progestogen effects**
- Acne
- Hirsutism
- Vaginal dryness
- Sustained weight gain
- Low mood
- Low libido especially if associated with low mood
- Breast tenderness.
- Dull non migraine headache
- Breakthrough bleeding
- Bloating and cyclical weight gain/ fluid retention
- Tiredness / irritability


Cyproterone
Drospirenone
Gestodene
Desogestrel
Norgestimate
Levonorgestrel
Norethisterone
More oestrogenic by DOSE
35mcg
30mcg
20mcg
Prog-only
More oestrogenic by function
Less oestrogenic by function

Reissuing contraception

Problems

Risks

Changes

Examination

Problems

Medical Adherence

- Are they remembering to take the pill correctly?
- Which regime are they following?
- Have they missed any pills?

Method Satisfaction

- Are they happy on the pill?
- Are they experiencing any unwanted side effects?
- Are any side-effects tolerable or do they wish to switch?

Risks

- Pregnancy
- STI

Changes

Medical eligibility

- Any changes in medical history
- New diagnoses or new health event
- New family history since last visit
- Smoking and age

Drug history

- Any new medications started (including herbal remedies)

Examination

- BMI
- Blood Pressure

Fraser Guidelines -UPPSI

The young person understan-ds the advice being given.

The young person cannot be persuaded to inform their parents or carers that they are seeking this advice or treatment (or to allow the practitioner to inform their parents or carers).

The young person's physical or mental health or both are likely to suffer unless they receive the advice or treatment.

The young person is very likely to continue having sex with or without contracept-ive treatment.

It is in the young person's best interests to receive the advice, treatment or both without their parents' or carers' consent.

Red flags when assessing a young person under the age of 16 years

- Child sexual exploitation
- Children who have been groomed
- Sexual activity with a child under 13 years old
- Repeatedly presenting for Emergency Contraception
- Previous concerns

Consultations for patients with specialist needs

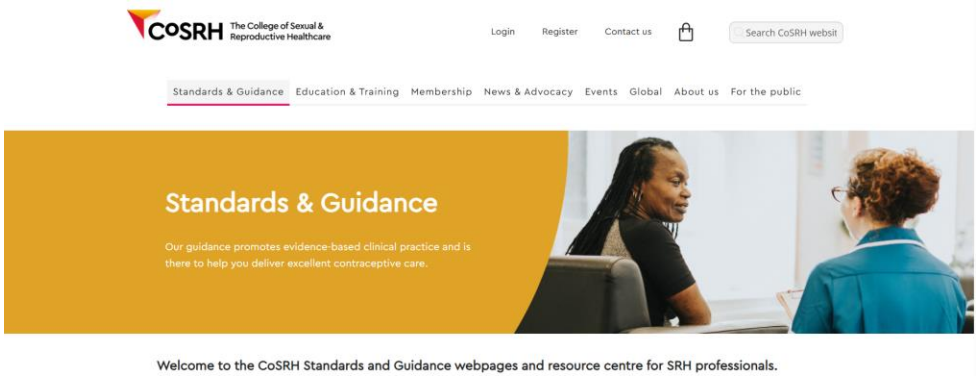
- Additional time
- Provisions – e.g. access to buildings, suitable consultation rooms, appropriate communication methods.
- Communication and referral for sexual assault.
- Translation services

Top Tips

- Introduce yourself
- Ask the person what they would like to be known as, incl pronouns
- Explain limits of confidentiality at the START of the consultation
- Use open questions, patient-focused, establish shared agenda
- Provide options including LARC
- Consider level of detail – risks and side effects
- Safety net

Useful Resources

- Contraception Choices website



- CoSRH Standards and Guidelines

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