7.1 Contraceptives

The Fraser Guidelines should be followed when prescribing contraception for women less than 16 years**.** The faculty of sexual and reproductive healthcare provides this and other useful information and guidance www.fsrh.org

Review patients on hormonal contraceptives at least **annually** for changes in risk factors, personal and family medical history.

Full counselling, backed by the appropriate FPA leaflet, should be provided.
NICE Clinical Guideline 30 recommends:

- women requiring contraception should be given information about and offered a choice of all methods, including long-acting reversible contraception (LARC) methods;
- contraceptive service providers should be aware that:
  - All currently available LARC methods (intrauterine devices [IUDs], the intrauterine system [IUS], injectable contraceptives and implants) are more cost effective than the combined oral contraceptive pill even at 1 year of use.
  - IUDs, the IUS and implants are more cost effective than the injectable contraceptives
  - increasing the uptake of LARC methods will reduce the numbers of unintended pregnancies

For advice on interactions between hormonal contraception and other drugs see FSRH guidance.

7.1.1 Combined hormonal contraceptives (CHC)

1st line option Ethinyloestradiol 30 micrograms			
Brand Name	**Contraceptive formulation**	**Use**	**Comments and alternative equivalent brands* for information**
rigevidon	Ethinyloestradiol30mcg levonorgestrel 150mcg	A first line option in new users	Same formulation as Levest/Ovranette/ Microgynon 30/Maexeni/Eribelle/Elevin Review patients at 35 years of age Useful if require a more progestogen dominant pill
Loestrin 30	Ethinyloestradiol 30mcg northisterone acetate 1.5mg	Second line option in this class	
Millinette 30/75	Ethinyloestradiol 20mcg gestodene 75mcg	Third line option in this class	Same formulation as femodene, katya/ **Aidulan/ Sofiperla**
Gedarel **30/150**	Ethinyloestradiol 30mcg desogestrel 150mcg	Fourth line option in this class	Same formulation as Marvelon/Cimizt/ Alenvona/Munalea/ l **Lestramyl** 30/150
If suffering progestogenic effects of products above try products below:			
2nd line option- Ethinyloestradiol 20 micrograms			
Gedarel **20/150**	Ethinyloestradiol 20mcg desogestrel 150mcg	First line in this class	Same formulation as Bimizza//Mercilon**/L**estramyl

Millinette 20/75	Ethinyloestradiol 20mcg gestodene 75mcg	2nd line option in this class	Same formulation as Femodette/Sunya
Loestrin 20	Ethinyloestradiol 20mcg norethisterone acetate 1mg	Existing patients only	NO new initiations due to breakthrough bleeding sexual health team are phasing out
Ethinyloestradiol 35micrograms			
Norimin	Ethinyloestradiol 35mcg Norethisterone 1mg		

N.B. products are selected by both cost-effectiveness but also based on keeping a consistent product choice to enable easier ordering for local pharmacies.
****New brands of oral contraceptives are constantly being launched and prescribers may find this information helpful in selecting formulary equivalents***

1. Appropriate for women up to 50 years of age if no risk factors for CVD, provided a CHC is otherwise suitable. Caution re: risk of VTE with BMI ≥30 (contraindicated with BMI ≥35). Avoid in women aged over 50. Avoid in smokers aged 35 years and over.

2. There is an increased risk of venous thromboembolic disease in users of combined hormonal contraceptives particularly during the first year and possibly after restarting combined hormonal contraceptives following a break of four weeks or more. This risk is considerably smaller than that associated with pregnancy (about 60 cases of venous thromboembolic disease per 100,000 pregnancies). (BNF online). The MHRA in February 2014 confirmed the small VTE risk of CHCs and recommended that prescribers consider risk factors and remain vigilant for signs and symptoms. A prescribing checklist is available in the annex of the CAS letter sent to prescribers.

3. The MHRA in March 2014 advised **St John's Wort interacts with hormonal contraceptives** including implants. This interaction reduces the effectiveness of these contraceptives and increases the risk of unplanned pregnancy

4. CHCs containing both oestrogen and progestogen are the most effective. A low hormone content pill should be tried initially and the patient maintained on a preparation with the lowest oestrogen and progestogen content consistent with good cycle control and minimal side effects. Preparations containing the older progestogens levonorgestrel and norethisterone are to be preferred.

5. **Phased preparations** are available but they are more complicated to use. They may help to improve cycle control with a lower dose increase in some women, where this is inadequate with a recommended (monophasic) preparation above. These are reserved for women who either do not have withdrawal bleeding or who have breakthrough bleeding with monophasic. As these are extremely expensive this should be used on specialist recommendation only so are classified as amber 1.The formulary preparation logynon ED.

6. Ethinylestradiol 30mcg/drospirenone 3mg e.g. Lucette (preferred choice), Dretine and Yasmin is a 3rd line choice. However the patient should have already tried at least two other CHC's including a third generation one –i.e. containing either Gestodene or Desogestrel e.g Gedrael of femodette.

7. Evra patch is 2nd line to oral formulary CHC. Reserved for women who have demonstrated or are deemed to be at substantial risk of poor compliance with oral CHC. It is significantly more expensive than oral CHC.

8. NuvaRing is not used frequently but is green for Gp initaiton though it is a last line contraception.

7.1.2 Progestogen only contraceptives:

Oral progestogen only contraceptives			
Desogestrel			
Brand Name	**Progestogen**	**Use**	**Comments and alternative equivalent brands* for information**
cerelle	75mcg	1st line	Prescribe generically as caused some confusion due to supply availabiltiy Brands include Aizea/Cerzette/Cerelle/ Desomono/Desorex/Nacrez/Zelleta
Levonorgesterel			
Norgeston	30mcg	2nd line	
Norethisterone			
Noriday	350mcg		
Parenteral progestogen only contraceptives			
Etonogestrel			
Nexplanon	68mg		Subdermal implant
Norethisterone			
Noristerat	200mg		Deep intramuscular injection
Medroxyprogesterone acetate			
Depo-Provera	150mg/ml		• Deep intramuscular injection • See notes below
Sayana Press	104mg/0.65ml		• Subcutaneous injection whereby patients may self-administered by the patent at 13 week intervals after appropriate training .
Intra-uterine progestogen only system ***N.b. the health professional should be fully trained in the technique and should provide full counselling backed by the patient information leaflet***			

Levonorgestrel These should always be prescribed by brand name because products have different indication, duration of use and introducers. MHRA Jan 2016			
Mirena	20mcg/24hours	Duration 5 years and licensed for menorrhagia	• Not to be prescribed to be purchased and used as per the SLA agreement
Jaydess	13.5mg	Duration 3 years , not licensed for menorrhagia	• Not to be prescribed to be purchased and used as per the SLA agreement

**New brands of oral contraceptives are constantly being launched and prescribers may find this information helpful in selecting formulary equivalents*

1. Levosert (levonorgestrel 20micrograms/24 hours) is currently non formulary.

Medroxyprogesterone acetate

Full counselling, backed by manufacturer's approved leaflet, required before administration.

1. In women aged under 18 years progestogen-only injectable contraception can be used after consideration of alternative methods.
2. Women using DMPA who wish to continue use should be reviewed every 2 years to assess individual situations, and to discuss the benefits and potential risks.
3. In women with risk factors for osteoporosis, a method of contraception other than medroxyprogesterone acetate should be considered.

7.1.3 Spermicidal contraceptives

No recommendations for this section

7.1.4 Contraceptive devices

The most effective intra-uterine devices have at least 380mm² of copper and have banded copper on the arms. On the formulary are the TT-380 slim line and the Nova-T 380.

Levonorgestrel 52mg (Mirena Coil) Levonorgestrel 13.5mg (Jaydess Coil) are progestone only coils on the formulary. For menorrhagia only the mirena coil is licensed.

Please note: These devices should be purchased and supplied as part of the SLA with public health. They should not be prescribed on FP10.

7.1.5 Emergency contraception- See decision aid

All women seeking emergency contraception should be advised that a copper IUD is more effective than EHC. "A copper IUD (or advice on how to obtain one) should be offered to all women attending for emergency contraception, even if they present within 72 hours of unprotected sexual intercourse" (FSRH 2017) .

Women should be advised that if they have already ovulated there is no evidence that hormonal emergency contraception has any effect.

Levonorgestrel 1.5mg (Upostelle)

Ulipristal acetate 30mg (EllaOne) – second line when patient presents more then 72 hours after coitus but less then 120 hours, also more effective in those of higher weight (see point 3)

1. Do not prescribe as 'Levonelle One Step' as this is the OTC preparation and more expensive.

2. Women using liver enzyme-inducing drugs should be advised that an IUD is the preferred option for Emergency Contraception (Grade A). Women who are using liver enzyme-inducing drugs who are given. 1.5 mg tablets of levonorgestrel should be advised to take a total of 3 mg (two tablets) as a single dose, as soon as possible and within 72 hours of unprotected sexual intercourse. This use is outside the product license.
3. Women who are over 70 kg or have a bmi of 26 or more should also receive a higher off label dose of 3 mg (two tablets of levonorgestrel or take the second line option ulipristal (Ellaone®)
4. . MHRA September 20163. For missed pills levonorgestrel is the preferred option.

Quick starting contraception includes:

- Starting contraception at a time other than the beginning of the menstrual cycle, but it is reasonably certain that there is **no risk of pregnancy.**
- Starting contraception at a time other than the beginning of the menstrual cycle **and there is a potential risk of very early pregnancy from recent UPSI** (but it is too early to exclude pregnancy using a high- sensitivity pregnancy test). Quick starting in this situation is appropriate if a woman considers it likely that she will continue to be at risk of pregnancy or if she wishes to avoid delaying commencement of contraception.

After oral emergency contraception, further episodes of unprotected intercourse in the same cycle put women at risk of pregnancy therefore quick starting method is advised.

- After **levonorgestrel** EC administration, CHC, POP, IMP (and DMPA) can be quick started **immediately**.
- After **ulipristal acetate** EC administration, they should **wait 5 days** before quick starting suitable hormonal contraception.

Number of days for abstinence or barrier methods after oral emergency contraception dose:

Type of HC	Quick start after ulipristal after 5 day delay	Quick start after levonorgestrel
Combined oral contraceptive pill (except Qlaira®)	5 day delay+7 days	+7 days
Qlaira® - combined oral contraceptive pill	5 day delay +9 days	+9 days
Combined vaginal ring/ transdermal	5 day delay +7 days	+7 days
Progestogen-only pill	5 day delay +2 days	+2 days
Progestogen-only implant or injectable	5 day delay +7 days	+7 days

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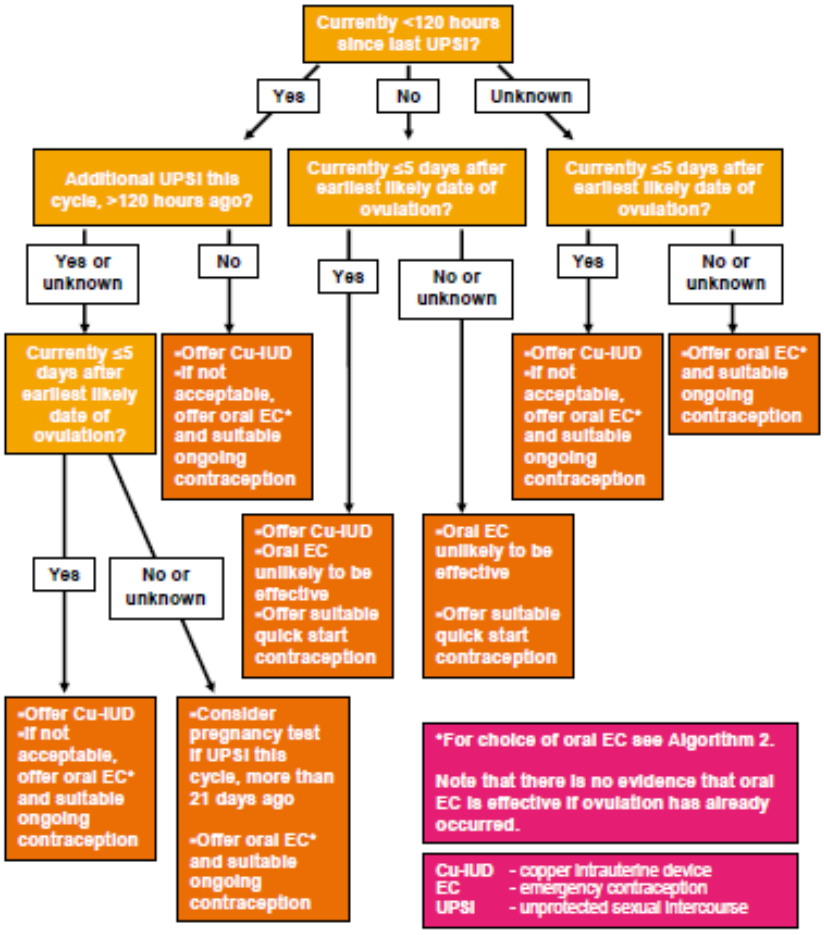
Decision-making Algorithms for Emergency Contraception

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



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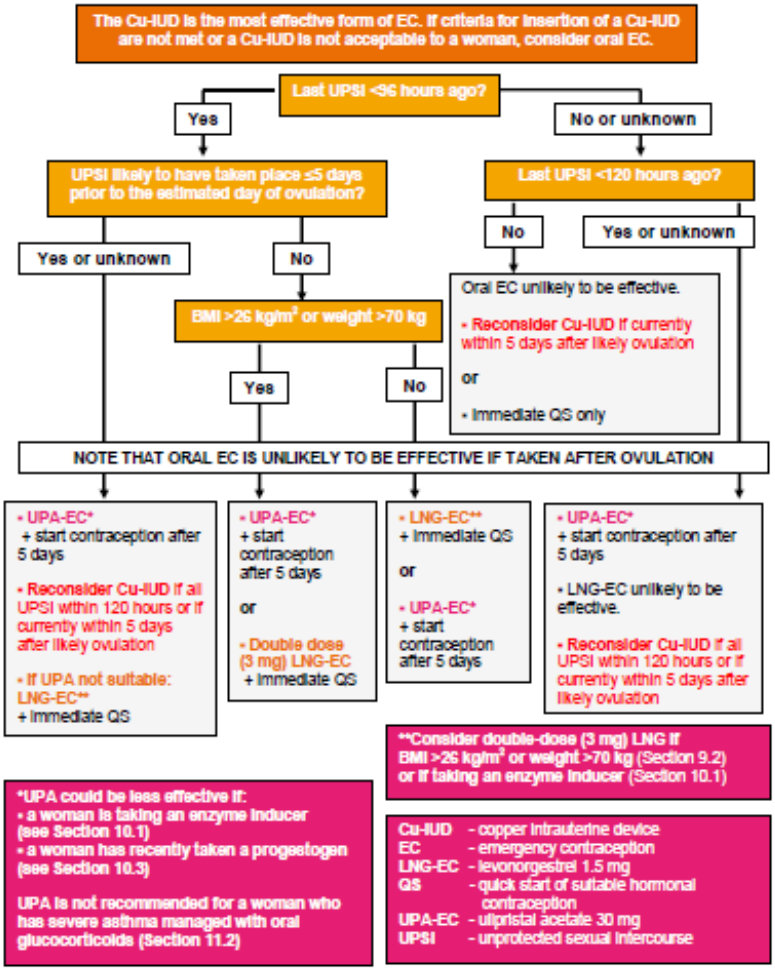
Algorithm 2: Decision-making Algorithm for Oral Emergency Contraception (EC): Levonorgestrel EC (LNG-EC) vs Ulipristal Acetate EC (UPA-EC)



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