CLINICAL GUIDELINE

Contraceptive Prescribing in Primary Care

A guideline is intended to assist healthcare professionals in the choice of disease-specific treatments.

Clinical judgement should be exercised on the applicability of any guideline, influenced by individual patient characteristics. Clinicians should be mindful of the potential for harmful polypharmacy and increased susceptibility to adverse drug reactions in patients with multiple morbidities or frailty.

If, after discussion with the patient or carer, there are good reasons for not following a guideline, it is good practice to record these and communicate them to others involved in the care of the patient.

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Important Note:

The Intranet version of this document is the only version that is maintained.
Any printed copies should therefore be viewed as 'Uncontrolled' and as such, may not necessarily contain the latest updates and amendments.

CONTRACEPTIVE PRESCRIBING IN PRIMARY CARE

NHS Greater Glasgow and Clyde

Patient requests contraception

- Check BP and smear status
- Consider STI screening
- Consider aspects such as whether patient is taking sodium valproate or other enzyme-inducing medicines
- Discuss contraceptive choices taking into account the above, patient preference and medical and sexual history

Consider long-acting reversible contraception (LARC) as first line option as this is the most effective way to avoid pregnancy

Consider appropriateness of COC or POP taking into account patients age, medical history, risk factors and patient preferences

POP appropriate

Noriday
Should be considered 1st line POPs

Should the 1st line POPs or Norgeston® be unsuitable then a desogestrel-containing POP (e.g. Cerelle®) should be considered in women who cannot tolerate or have contraindications to oestrogen, or where there is a history of poor compliance

COC appropriate

- The 1st line choice COC is Rigevidon®
- If patient suffers from acne, consider a third generation combined pill

Adverse effects, poor cycle control or poor compliance may dictate further options, which may include tailored pill-taking (off-label use)

Condom use should always be promoted in addition to chosen contraceptive m to help prevent the spread of STIs

COVID-19: The FSRH has issued guidance to support the ongoing provision of effective contraception during COVID-19 restrictions in face to face contact with patients, - CLICK HERE

LONG-ACTING REVERSIBLE CONTRACEPTION (LARC)

See Nice CG30 (Oct 2005)

- Progesterone-only implant (Nexplanon®) - Lasts 3 years
- Copper IUD (TT380 Slimline®) - Lasts 10 years
- Progestogen-only IUS (useful if menorrhagia present): Levosert® , Kyleena® and Mirena® all last for 5 years
- Progestogen-only injectable (Depo-Provera® and Sayana Press®) – 14 weekly
- NB: The effectiveness of LARC preparations containing hormones, such as Nexplanon® may be affected by interacting medicines. Refer to individual SPC or BNF for guidance

CONTRAINDICATIONS AND RISKS FOR COMMENCING COMBINED HORMONAL CONTRACEPTIVES

(List is not exhaustive - see BNF, UKMEC and individual product SPC)

CONTRAINDICATIONS (UKMEC Category 4 – unacceptable health risk)

- Severe or multiple risk factors for arterial disease or venous thromboembolism (VTE)
- Migraine with aura
- Smoker ≥15 CPD and ≥35 years of age

RISK FACTORS (UKMEC Category 3 – risks outweigh benefits)

- 1st degree relative <45yrs with history of VTE or arterial disease
- BMI ≥35
- Smoker <15 CPD or stopped in last year and ≥35years of age
- Symptomatic gall bladder disease
- Adequately controlled hypertension
- Diabetes without complications and >20 years duration
- >50years of age

RISK FACTORS TO CONSIDER AT INITIATION (UKMEC Category 2 – benefits outweigh risks)

- Smoker of <35 years of age
- BMI ≥30-34
- Migraine without aura at any age
- Asymptomatic gallbladder disease
- Diabetes without complications
- Primarily breastfeeding between 6 weeks and 6 months post partum

All patients should be reviewed on an annual basis which should include checking for changes to risk factors which may affect their eligibility (e.g. measure BP, BMI, smoking status, STI and cervical screening as appropriate).
Please refer to UKMEC if any new medical conditions present whilst the patient is receiving contraception, as this may alter the patient's risk factors.
Prescribers should also be aware of the risk of interactions between hormonal contraceptives (including some LARC methods) and other medicines.
The BNF, Stockley's Drug Interactions and Summary of Product Characteristics for the individual preparations can be used for advice and information

CONTRACEPTIVE PRESCRIBING IN PRIMARY CARE

NHSGGC PREFERRED LIST CONTRACEPTIVES AND EFFECTIVENESS*

NB: An effectiveness rate of 92% means that if 100 women used this form of contraception for one year, 8 women would fall pregnant. The effectiveness rate should be explained to the patient when considering what form of contraception to use and typical effectiveness rates may be more appropriate.

COMBINED ORAL CONTRACEPTIVES

*Effectiveness is >99% when used perfectly, but typical use has an associated effectiveness of 92%**

Monophasic standard-strength: **Rigevidon®**
Monophasic low-strength: **Gedarel 20/150®**
Millinette 20/75®

ORAL PROGESTOGEN-ONLY CONTRACEPTIVES

*Effectiveness when used perfectly is 97.5% for the first year of use and in women under the age of 35 prescribed standard POPs Effectiveness is 99.5% for women >35 years of age when used perfectly. Typical use has an associated effectiveness of approximately 92%**

Noriday®

LONG-ACTING REVERSIBLE CONTRACEPTION

Depo-Provera® (Medroxyprogesterone acetate)
Sayana Press® (Medroxyprogesterone acetate)
*Effectiveness with perfect use is >99% and 97% with typical use**
Nexplanon®
Effectiveness with perfect and typical use is >99%
Levosert®
Mirena®
Kyleena®
Effectiveness with perfect and typical use is >99%
TT380 Slimline®
Nova-T 380®
*Effectiveness with perfect and typical use is 98-99%**

EMERGENCY HORMONAL CONTRACEPTION

Levonorgestrel (Upostelle®) for up to 72 hours post-intercourse. Between 72 – 120 hours, when a copper IUD is not acceptable or suitable, ulipristal acetate (EllaOne®) can be considered (see GGC Formulary for full restrictions). Further guidance relating to EHC may be found in the Faculty of Sexual and Reproductive Healthcare Guideline on Emergency contraception (March 2017).

CONDOMS

Effectiveness is 98% in the first year when condoms are used perfectly, but typical use has an associated effectiveness of 85%

*Typical use effectiveness reference: Trussell J. Contraceptive failure in the United States. Contraception 2004;70:89-96

Further Advice and Information

- UKMEC (UK Medical Eligibility Criteria for Contraceptive Use 2009) is available on the Faculty of Sexual and Reproductive Healthcare Website: *www.ffprhc.org.uk*
- Advice on all matters of contraception is available from the Sandyford professional helpline, available 9am - 4.30 pm Tel: (0141) 211 8646
- NICE Clinical Guideline 30: Long-acting Reversible Contraception: *www.nice.org.uk*
- NHS Greater Glasgow and Clyde Formulary: *www.ggcmedicines.org.uk*
- For up to date information about medicine shortages and how to manage, see the Current Medicines Supply Problem and Shortages page on StaffNet.

NHS Greater Glasgow and Clyde

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