Worcestershire Area Prescribing Committee
Prepared by Dr Melanie Mann; Consultant in Contraception and Reproductive Health

PATHWAY FOR HORMONAL CONTRACEPTION DECISION MAKING

Woman requests contraception

Discussion of all methods, including emphasis on the efficacy of **Long acting reversible contraception (LARC)** methods. Review and offer at least annually Standard LARC Options: **Depot Progestogen, Implant, Intrauterine System (IUS), Intrauterine Device (IUD)**: All can be offered to all women regardless of parity and age but side effects and fitting techniques may mean some women are not keen to try.

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LARC declined (Many women have tried LARC and have found issues or have concerns about having an IUD) and an oral contraceptive method is chosen.

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Would the woman prefer a **Progestogen-Only Pill (POP)** or are there any contraindications to COC; e.g. migraine, drug interactions, personal or family history of venous or arterial thrombosis, smoker, high BMI, high BP?

Please refer to https://www.fsrh.org/standards-and-guidance/documents/ukmec-2016-summary-sheets/

If so offer choice and discuss side effects of POPs, e.g. irregular bleeding.

PATHWAY FOR COMBINED HORMONAL CONTRACEPTIVES

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Chooses **Combined Oral Contraceptive (COC)** [Faculty guidance is to use a levonorgestrel (LNG) COC first]

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Is she over 40 years of age?: Consider a 20 mcg pill
Please refer to: https://www.fsrh.org/standards-and-guidance/documents/fsrh-guidance-contraception-for-women-aged-over-40-years-2017/

- Combined oral contraception (COC) with LNG or norethisterone should be considered first-line COC preparations for women over 40 due to the potentially lower VTE risk compared to formulations containing other progestogens.
- COC with ≤30 mcg ethinylestradiol should be considered first-line COC preparations for women over 40 due to the potentially lower risks of VTE, cardiovascular disease and stroke compared to formulations containing higher doses of oestrogen.

Would an everyday pill suit better?; e.g. young person, busy lifestyle.

NO

try **ethinylestradiol 30 micrograms, levonorgestrel 150 micrograms (LNG) x 3/12**
e.g. Rigevidon®
Microgynon 30®
(Other brands are available on the Worcestershire formulary)

YES

try **ethinylestradiol 30 micrograms**, **levonorgestrel** plus 7 placebo tablets **x 3/12**
e.g. Microgynon 30 ED®

Acne problems? (See next page)

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Acne problems on previous pills

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Try **ethinylestradiol 30 micrograms, desogestrel 150 micrograms, e.g. Gedarel® 30/150, Marvelon®, Cimizt®** (with discussion regarding slightly increased risk of venous thromboembolism VTE compared to LNG COC.)

OR

ethinylestradiol 35 micrograms, norgestimate 250 micrograms, e.g. Cilest®, Lizinna®

Manage any other COC problems on an individual basis. Try several COCs as different preparations suit different women.

Concern about concordance with COC and declines standard LARC

OR

Tried and unable to tolerate side-effects of LARC and has concordance issues with COC.

Discussion about ways to help remember such e.g. mobile phone alarm setting, fixing pill taking regime to lifestyle.

(Young people may be a higher risk group and fall into this category)

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Consider **Transdermal patch**

Full discussion with woman about possibility of increased risk of venous thromboembolism (VTE) compared to LNG COC. Woman's individual risks assessed with regard to family history and BMI, as in all CHC prescribing.

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Concerns/ issues with patch

e.g. Forgets to change patch, patch falls off frequently (up to 4%), repeat discussion around LARC to encourage use. May consider ring if would like to further persist with CHC method

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Consider **CH Vaginal Ring**

Explanation of possible increased vaginal symptoms, e.g. discharge

Please refer to www.fsrh.org for guidance on all methods and also NICE Clinical Guideline 30 long-acting reversible contraception guidance 2014.

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