REAL PATIENT CASE
32y female

Endometrial hyperplasia without atypia.
Likely will return to normal without any treatment.
Pelvic US shows 8mm EM
Progesterone (Mirena coil) ↓ likelihood of endometrium normalising if used for 12 months.
Pt is aware of the endometrial changes usually struggle to conceive so would be better if these changes return to normal before getting pregnant.
Pt is aware of endometrial cancer risk, but not risk of deeximally progressing towards cancer.

I will do ffu and repeat biopsy.

Rx'ed metformin MR 500mg BD to aid wt loss.
Rx'ed Provera to Rx'ed Medroxyprogesterone 10mg OD for 12 months.

MedCorrt Oct 2018
Dr Kulisum Jaffar

The leaflets talk about 99% effective, but thats theoretical, if taken properly.
they contrl bleeding, so pills are chosen for this reason.

Migraine is an independent risk factor for ischaemic stroke.
In all migraineurs RR 2.16.
RR of 2 = doubling of stroke.

COC is thought to be an independent risk fraactor for stroke in old studies. more recent stuies did not show increase risk with lower dose new pills.
so still conflicting evidence. probably low dose modern ones are not.

all POP do not have increased risk of stroke. because its the oestrogie which makes the blood more clotty.

Tutor

ulerac 1-year on then size if you do it on your own, in primary care your advicel to get
backup of a specialist. otherwise the lesions love it.

Non migraiousa e.g. tension headache.
if already migraine without aura., then would be acceptable (2), so start COC. however,
if you put on COC and then she develops migraine without aura., then it not safe to continue (3).

POP pills = 1 or 2 so ok to use.

failure rate for oral pills = 9 per 100 in reality, rather than 99% theoretial.

Cornillient health algorithm

if irregular lifestyle think about a patch or ring, or even better LARC.
Every2day preparations are better in some women.

at 3 months review + the shelf life of the ring is only 3 months. so do not giv more on prescription.

unscheduled bleeding. at the 3 months review. we should check for disease e.g. chlamydia / STI
if persistent bleeding, check for polyps.
cervical cancer. so have to look at the cervix.
missed pills therefore the hormone slevels going down and irregular sheeding of the endometrium
other meds might be interacting and decreasing the hormone levls and causing bleeding.

can change it, or say wait a further 3 months.

the hormone is not maintaing the endometrium. we ant to give something to sustain the endometrium
so its not shed. so can give higher dose of oestrogen OR changing the progestiron.
if bleeding persists despite changing the pill, see if mentins the endometrium. if that
does nto work, then change the progestogen.

triphasic pills. not any better than others. should be outlawed ! only a last resort.

irrespective if during pil or the pill free period, and aura migraine, then COC is contra indicated.
but if no aura, then COC is ok.
headache can occur during withdrawing hormo (in the break) or during due to increasing hormone
levels when starting after the pill free break.
if have a bad headache during the hormone content if non nuing headache. e.g drop from 30 to 20 oestrogen.
might have same break through bleeding, but hopefully should settle down after a few months. this risk of
bleeding will be there.

breast tenderness is oestrogenic effect and progestogen. so can change these hormones.
mood changes = less androgenic pill. e.g 3rd generation.
wt gain = no studies that COC increases wt. generally bloated feel is form progestogen.

acne =progestogen effect. generally COCs(increased SGBH, which then attaches to testosterone so shoul mo
give rise to acne. but we all know in the 2nd generation pills they have acne, so in these cases switch to 3rd generation.

diarrette is not a contraception, but is used as one. it is out of product licence. it means if any sck or risks, the
company will not take responsibility.
sexual health experts = if started fix acne , then stop after sneldon has settled. then change to different contraception.
Depo provera = bone density issues, but reversible after stopping.
the company said long term use wouz cause liver derangement, but now the company has given details that the
dose was ok higher in rats, but now more robust data and the long term data does nto suggest adverse effect
Nexplanon = compared to other COC.
some
dermatologist are seeing evere acne. diarrette might be the only thing that controls it. if are gave to slights spots
and the pt is concerned about taking the pill in the pill free rule, you trial oral 3rd generation or drospirenone pill, if still bad
then use diarrette for the resume length of tie.

Nausea = chane he timing, take with milk at night, or decrease orstrogen. switch to patch. or ring.

Ella One is option for case 1. 10y . refuses coul. if days ago UPSI.
if ulipristal acetate (Ella One) taken within 5 days of UPSI, then the LNG alternative is has UPSI. cant start hormonal
contraception for 5 days. so you have to take the risk of that 5 days period.
could give levonorgestrel, but can start any hormonal contraception. o not have to wait. can start at same time.
rather than not have anything for 5 days and the risk of getting pregnant again.

She is using more and more of the Levonelle to allow quick starting of a regular pill.

1. no
2. patch less effective if over 90kg.
3. Ella One is not a contraceptive, just not pregnant.
4. if desogestrel main mode of action = anovulation method, so a CHC which is another anovulation method.
if etoxrdar POP where anovulation is not the main mode of action , then has to use 7 days of pl protection.
5. no
7. better not to start, do not tell women to take a break after 3 months. those were old dose of 50mcg. no
need to have a break. highest risk when firs starting.
8. no
9. yes
10. no weight gain.

pregnancy test if no iut if unsre 3 weeks of UPSI.
can fit coil up to day 15 of last COC pill she took. can have Ella one if wanted, but generally is safe.

Aug 2015, MedCorrt lecture
Dr Kulsum Jaffar, 5 stages of using nexaplon.
ensure not pregnant, test for chlamydia...and can give back to back COC or cerazette (3 packs = 9 weeks)
you can use both the pill and the nexaplon for 3 years max use !

if it keeps happening...ask the question = is it cervical Ca?

- if high risk of chlamydia and about to put coil in, can test and treat and then fit it.
or else just test for chlamydia and fit if not high risk.

- if given microgynon and not suited to it...give marvelone or femedone (dont use ovranete because its the same !)

if tpotly patient + use Yasmin as its skin friendly.

- depo injection can be given every 14 weeks (but call them back at 12 anyway, as they will might be late booking)

- should use HRT for 3 yrs minimum.

- heavy menstrual bleeding = do FBC. clotting screen only if always had it (which might show the congenital cause in coagulation e.g. VW disease).

- tranexamic acid use a decent dose = 1g QDS. use it as soon as start bleeding.
start it even if your waiting for aan USS or referral.

- do CaU3 when not having period (as it is a marker for peritoneal irritation).

- ovarian reserve = FSH on day 2-4.
day 23 progesterone (but this has to be 7 days before her nexy cycle, so cant do if has irregular periods).

- Provera is better than norethisterone, 5-7 days course. can use it if been 3 months since the last period, to shed the endometrial lining.
Dose = 10mg BD. not OD. Can even use TDS.

- probably not pregnant when whitles in 7 days of LMP.

- quick starting is not wise using yasmin, dianette, mirena.
so bridge instead with something else and then you can later on quickstart with the above.

- and caution with depo as cant be removed (in case pregnant when you give it), so better to bridge first.

- coc mg of DVT is due to oestrogen, so if pt insists (even if mec 3) give the one with lowest oestrogen e.g. microgynon....bit other pilot are not massively different.

- BMI > 30 = class this as class 3 caution, even though WHO says BMI<35.

- use zoeley or qlaira if WHO 3 (or above 45y with no risk factors.
Zoely is better as simpler dosing.

- nexaplexon can cause bleeding for 6 months. if still bleeding after that, its probably not gogo to settle.

- to increase the chance of amenorrhoea can reduce the injection to 10 weeks rather than 12 (is this for depo or sunpress or both???).

- can leave mirena inside if fitted after 45y until reaches menopause

- copper once can be left in for 15 yrs

- coc menas you not longer have a normal cycle, your periods are not periods. .your ovaries are asleep, they only wake up when your not on it.

- levetrin20 or microgynon 30 = can take every single day of the yr (un licenced but legitimate). if unacceptable bleeding just do a 3-4 day pill free interval to shed the endometrial lining.

- use cerelle instead of cerazette (cheaper).
in real world sonce take everyday, and no FPC and 12 hour window, ob is probably better than a COC.

- if worried about possibility of pregnancy and want to give LARC , simply give cerazette bridge for 3 week, do a preg test, and then give the LARC.

- last age of potential fertility = 56, after 56 simply stop contraception.

CONTRACEPTION

MEDIMAPS.CO.UK | 24TH MAR 2024

DRAFT

Contraception

Disclaimer:
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References:
1. NICE CG30 guidelines
2. Cornillient Health Patient Decision Tree
3. FSRH
4. British Journal of Family Medicine Vol 5 Issue 6 Nov 2017

Post pregnancy contraception

- Technically is not required for 21 days post delivery, as impossible to get pregnant.

Regular contraception

- Intrauterine contraception
  - Can be inserted immediately post delivery
  - Within the first 48 hrs after uncomplicated cesarean section or vaginal birth.
  - However, after 48 hrs, insertion should be delayed until 28/7 post delivery.
- Progestogen-only implants (IMP)
  - Any time post delivery.
- Progestogen-only injectable (POI)
  - Any time post delivery.
- Progestogen-only pills (POP)
  - Any time post delivery.
- Combined Hormonal Contraception
  - assess for risk factors for VTE
    - Smoking.
    - BMI ≥30.
    - Thrombophilia.
    - Immobility.
    - Prescriptopis.
    - Varicose.
    - Postpartum haemorrhage.
    - Transfusion at delivery.
    - If no risk factors and breast feeding = wait until 6/52 post delivery before starting CHC.
    - If no risk factors and not breast feeding = wait until 21/7 post delivery before starting CHC.
    - If any risk factors (regardless of breast feeding) = wait until 6/52 post delivery before starting CHC.

Additional precautions

- Additional contraceptive precautions (e.g. barrier method/abstinence) is required if hormonal contraception started 21/7 or more post delivery.
- Not required if initiated immediately or within 21/7 post delivery.

Emergency contraception

- Emergency contraception is not required for the first 21 days post delivery. OR
- Levonorgestrel 1.5 mg.
- OR
- Ulipristal acetate 30 mg.
- OR
- Copper intrauterine device.
  - No adverse effects on breastfeeding or on their infants.
  - Stop breast feeding.
    - Express and discard milk for a week after taking.
  - From 28 days post delivery.

Lactational amenorrhoea method (LAM)

- Highly effective if:
  - EBFD12
  - AND
  - Amenorrhoeic.
  - AND
  - Fully breast feeding.
- Be aware
  - Risk of pregnancy is increased if:
    - Frequency of breastfeeding decreases.
    - OR
    - When menstruation returns.
    - OR
    - When more than 6/12 post delivery.
  - Stopping night feeds.
    - Introducing complementary supplementary feeding.
    - Expressing milk.
    - Using dummies.

Implant

- Persistent spotting post implant insertion
- This is due to instability of the endometrial lining.
- Investigations
  - Speculum.
  - STI screen if appropriate.
  - Pregnancy test if recent insertion.
  - Examine cervix for pathology.
- Management - additional treatments to stabalise endometrium
  - CHC.
    - High dose progestogen for 21/7 then 7/7 break.
    - POP.
    - Mirena.
    - PO, patch, ring.
    - Medroxyprogesterone OR Norethisterone.
      - ???10mg TDS.
  - USS.
  - Refer to gynaecologist.

COC

- Headache
  - Tension headache.
    - No change needed.
    - Treated with analgesics.
  - Migraine with aura.
    - Stop.
    - Consider alternative method of contraception.
  - Migraine without aura.
    - during active pills
      - Breast tenderness
        - Bra support.
        - Evening primrose oil.
        - If fails after 3/12
          - ↓ oestrogen
            - Gedarel 20/150
            - Millinette 20/75
            - Cerelle
      - Nausea
        - Take with/after food.
        - Take at night.
        - If fails after 3/12
          - ↓ oestrogen
      - Mood change
        - Reassure.
        - Should settle by 3/12.
        - If fails change progestogen component
      - Loss of labido
        - Reassure.
        - Should settle by 3/12.
        - If fails change progestogen component
          - Gedarel 30/150
          - Millinette 30/75
          - Lucette
      - Acne
        - Reassure.
        - Should settle by 3/12.
        - If fails change progestogen component
          - Dianette (Cyproterone acetate/ethinylestradiol)
          - If fails after 3/12
      - Weight gain
        - Do not switch to alternative COC or POP.
        - Explore alternative methods of contraception.
    - during pill free week
      - Cerelle.
      - Consider alternative method of contraception.
  - Heavy withdrawal bleeding.
    - Qlaira (Estradiol/dienogest)
    - OR
    - LARC.
  - Unscheduled bleeding
    - Cilique
    - Millinette 30/75
    - If fails after 3/12
      - Consider specialist advice.
- Risks
  - Protects against:
    - Osteoporosis.
    - Ovarian cancer.
    - Endometrial Ca.
  - Increases risk of:
    - Breast Ca (but this disappears after 10y of stopping CHC).
    - VTE.
    - CVD.
    - Stroke.

Adolescent

- If high dose COC 50mcg can close epiphyseal plates early, so use 20mcg versions which are safe.
- Or just use a POP.

> 40 y

- Combined Hormonal Contraception
  - Can be used until 50y if no other risk factors.
  - Risks outweigh benefit after 50y, so need to switch to alternative.
  - Use preparations with ≤ 35mcg ethinyl estradiol, as lower VTE risk.
  - Useful at perimenopause as it provides similar benefits to HRT.
- Progestogen-only implants (IMP)
  - Can use until 55y.
  - Change every 3 yrs.
  - Can be used while using HRT (but be aware it does count as the progestogenic component for HRT).
- Progestogen-only injectable (POI)
  - Can use until 50y.
  - Can be used in use over this age if patient informed of potential risk of ↓ bone mineral density, so should be avoided if other risk factors of osteoporosis.
- Progestogen-only pills (POP)
  - Can use until 55y.
  - Can cause irregular bleeding.
- Intrauterine system (Mirena)
  - If fitted > 45y can be kept as contraception until 55y.
  - Remove after 55yr age is reached.
  - If fitted < 45y can be continued to 55yr if being used as endometrial protection e.g. as part of HRT regime.
- Intrauterine device (copper coil)
  - If fitted > 45y can be kept as contraception until no longer required i.e. 1yr after the menopause if ≥ 55y, or 2yr after the menopause if < 55y.
  - Can make menorrhagia worse.

Stopping contraception

- > 50y:
  - Can assume menopause if two FSH readings, taken 6/52 apart, are > 30.
  - Note: Cannot rely on FSH if using depot or CHC.
- < 50y:
  - Can assume menopause if one FSH reading > 30. Only need to use contraception for 1yr.
  - If FSH < 30, repeat 6/52 later.
  - Note: Cannot rely on FSH if using depot or CHC. Can be relied upon if using progestogen contraception.
- Can cease contraception in women when reach 50y age, even if experiencing menstrual bleeding. If she is worried, can prescribe.
- ??? depot is progestogen contraception !!!

HRT

- Continuous HRT
  - Can be assumed to be contraceptive, as a constant dose of hormone suppresses ovulation.
  - Do not assume when stable on this type of HRT, she is sufficiently menopausal for contraceptive benefit to be assumed.
- Sequential HRT
  - Must use additional appropriate contraception.
  - Sequential HRT does not provide contraception.
- Intra uterine system
  - The intra uterine system (Mirena, Jaydess, Levosert) provides both endometrial protection and also provides contraception.
  - So only estrogen HRT is required (not combined) as the IUS is providing the progestogen to protect the endometrium.