Contraception: LARCs first?

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Care more particularly for the individual patient than for the special features of the disease.[1]

What is the best contraception available for most Australian women? It depends on whom you ask. Clinical guidelines recommend considering long-acting reversible contraceptives (LARCs) as they are highly effective and safe.[2] But Australian women, two-thirds of whom use, alter and stop contraceptives over a 30-year span, take into account a much broader array of factors.[3] General practitioners (GPs), who see their patients on an ongoing basis, handling experiences, expectations and diverse patient comorbidities, would say the question is challenging. The overall benefits of modern hormonal contraceptives are undisputable.[4] Reliable and affordable access to contraceptives must continue.

LARCs do offer several compelling advantages over oral contraceptives. The chief benefit is relief from the burden of daily pill-talking.[5] Around 38% of young women who become pregnant unintentionally do so on oral contraceptives, with medication compliance an important factor.[3] LARCs are also safe for women who are nulliparous, breastfeeding, avoiding oestrogen or perimenopausal.

Women's contraceptive choices, however, are much more nuanced and multifaceted.[6] Women are concerned about changes in mood, libido, effects of synthetic hormones and bleeding patterns. There is a range of attitudes to unplanned pregnancy. Preferences of male partners are taken into account. Some women are worried about the loss of bodily integrity, which they associate with a LARC-related procedure. Women also seek contraceptives for cycle control, acne management and menstrual pain relief.

For such a widely used class of pharmacotherapy, key questions that speak directly to women's concerns about hormonal contraceptives remain unanswered. Notably, mood effects and sexual satisfaction while using LARCs, as with other hormonal methods, are rarely measured in commonly reported trials.

Until the barriers and problems that remain around the real-world experience of LARCs are addressed, oral contraceptives will remain immensely popular. This includes breakthrough or irregular bleeding – a tricky but familiar management problem among women on hormonal contraceptives.[7] GPs, therefore, must be conversant with the myriad complex situations that might arise 'on the pill'.[7,8]

So what of the other alternatives to the combined oral contraceptive pill? Intrauterine devices (IUDs) and subcutaneous implants are widely accepted by women and clinicians in other developed countries.[9,10] Most women report that IUD insertion is painful, usually mild to moderate, but sometimes severe for days afterward.[6,11] There are gaps in the literature on painless IUD insertion techniques in nulliparous and young women.[11]

Emergency contraception is another essential option. Oral methods, including the newer ulipristal acetate,[12] are available through pharmacists. However, cost remains an issue in Australia as they are not subsidised by the Pharmaceutical Benefits Scheme. Interestingly, copper IUDs, widely available elsewhere for postcoital contraception, are not commonly used in Australia despite the documented efficacy and benefits.[9,12]

There will always need to be a range of contraceptive choices. Each woman or each couple will tend towards various options for different reasons at different times. A patient-centred contraceptive counselling approach shares decision-making between women and their GPs, and honours the principle that each woman will know what is right for her. GPs need the relevant skills, knowledge, networks and resources to help women maximise a trouble-free contraceptive experience.

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