Katrina Allen

Contraception

Common issues and practical suggestions

Background

General practitioners are usually the first point-of-contact for young people seeking sexual health and contraceptive advice. Although the combined oral contraceptive pill is still the most common choice for contraception by Australian women, there is an increasing drive to encourage the consideration and use of long acting reversible contraception.

Objective

This article focuses on common issues that may complicate contraceptive management and provides some practical suggestions for effectively managing the use of different contraceptive methods, particularly in young women.

Discussion

If presented with information about the range of contraceptive choices, including long acting reversible contraception, young women will commonly choose a longer acting method. Good counselling is important before advocating either implant or depot injections as irregular bleeding can occur and is likely to be of particular concern to younger women.

Clinicians are increasingly considering intrauterine devices in nulliparous women and in women aged less than 25 years. It is uncommon for women to have complications with intrauterine device insertion, the most significant potential problem being pelvic infection.

The key to minimising problems in contraceptive practice is the consideration of sustainability (cost, efficiency, duration of action and suitability), making a careful choice and then counselling the patient well.

Keywords

contraception; women's health

CPD

The fundamentals of contraception have been well covered in a recent review article[1] and in World Health Organization guidelines.[2] This article focuses on common issues that may complicate contraceptive management and provides some practical suggestions for dealing with these problems and for facilitating good contraceptive choices for young women.

Although the combined oral contraceptive pill (COCP) is still the most common choice for contraception by Australian women,[3] there is an increasing drive to encourage the consideration and use of long acting reversible contraception (LARC), also called 'set and forget' (in the United Kingdom) or 'get it and forget it' (in the United States).

Long acting reversible contraception

General practitioners are usually the first point-of-contact for young people seeking sexual health and contraceptive advice, especially in rural areas where specialist sexual health services are not common. It is important to be aware of the safety and efficiency of the common long acting methods, such as the contraceptive implant (Implanon NXT®) and the depot injectable contraception (Depo-Provera® and Depo-Ralovera®), as a contraceptive choice for young women. There is evidence that, if presented with information about a range of choices, including the LARCs, young women will commonly choose a longer acting method.[4] In practice, I facilitate this by utilising resources such as the 'Choices in Contraception' leaflet from the Sexual Health information networking & education SA (SHine SA) website (see *Resources*).[5] Information about cost is worth adding, as this is often a crucial piece of information in the decision making process.

Contraceptive implant/injection

Recently, the inserting device for the contraceptive implant has been made simpler and less likely to result in deep insertions. The new device has been described as analogous to a 'stapler' rather than the old 'horse needle' – a change generally welcomed by patients.

The implant itself has had barium added so that it is visible on X-ray. In practice, this change will not often be useful, as an X-ray can only confirm the presence of the implant not its detailed position. An impalpably deep implant will still need to be extracted under direct ultrasound vision.

Young women may be agitated by irregular bleeding, so good counselling is important before advocating either the implant or depot. Injectable contraception has a high incidence of amenorrhoea, which is generally acceptable, but possible weight gain is a real concern for most women. The theoretical concern about altered bone mineral density in

teenagers is no longer regarded as a clinically significant risk if the depot injection is otherwise a good choice.[6]

Intrauterine devices

A significant minority of nulliparous women and women aged less than 25 years, are also keen to use the levonorgestrol intrauterine device (IUD, Mirena®) or the copper IUD, and increasingly clinicians are considering IUDs as a contraceptive choice in this group of patients.

Insertion of IUDs is returning to the domain of general practice and many group practices will have one or two GPs who have this skill. By being the 'practice inserters', these GPs also continue to perform the 10 or more insertions per annum that are likely to maintain their skill level. Insertion in young women and nulliparous women is not automatically more difficult, though it does need careful counselling about the process of insertion as well as the device as contraception. Despite conflicting evidence regarding its effectiveness, in practice, I counsel women to use nonsteroidal anti-inflammatory drugs (NSAIDs) before insertion to minimise the cramping that occurs during the insertion. It may be that the introduction of the 'mini-Mirena' in the near future will further increase the use of IUDs for young and/or nulliparous women.

Fortunately, it is uncommon for women to have any complications with IUD insertion. The most significant problem is pelvic infection. At SHine SA, we check that the Pap test is normal and current, and do a high vaginal swab and chlamydia screen. Bacterial vaginosis and any other infections are treated before the insertion. All GPs these days would have basic skills in diagnosing and treating pelvic infection immediately after IUD insertion. Signs of infection in the first 20 days after insertion – unexplained fever, malodorous vaginal discharge, lower abdominal pain/cramps, cervical excitation – should be treated vigorously with antibiotics, usually doxycycline and metronidazole for 10–14 days; checking local guidelines for treatment of pelvic inflammatory disease (PID) would be sensible. The IUD does not need to be removed, but review is important to ensure the infection is resolving. After the first 20 days, the woman's risk of PID resolves to the background population risk.[7]

Similarly, GPs can expect to utilise their skills in retrieving IUD strings, as many women choose this as their preferred method of contraception and/or menstrual control (the levonorgestrol IUD is available on the Pharmaceutical Benefits Scheme [PBS] for both reasons). The 'perfect' patient will check the presence of her own IUD strings regularly, but on sympathetic questioning I find a surprisingly large number of women either don't try or don't feel confident when they do try. Routine recording of the presence of the strings when performing a Pap smear and other internal examinations is very helpful and can assist if the strings are unable to be localised at a subsequent examination.

If the strings are missing, retrieval can be attempted with a cytobrush twirled in the external cervical canal or narrow sponge forceps introduced to the internal os. Alternatively, special IUD string retrievers are available. If retrieval fails, contraception can no longer be guaranteed, so alternative methods should be advised and an ultrasound for localisation should be ordered. If the ultrasound fails to uncover the IUD, do remember the possibility of migration as well as expulsion – an abdominal X-ray is essential to exclude IUDs nestling in the abdominal omentum.

Combined oral contraceptive pill

One of the most common problems with the COCP is discontinuation of use, therefore careful counselling before commencement is important. Women should understand that irregular bleeding is common in the first few months, and in the presence of daily pill-taking irregular bleeding, does not imply lack of contraceptive effect. If the COCP is continued, this problem will usually correct itself in time.

Research suggests that encouraging linked behaviours can reinforce pill taking. For example, 'If I am in the bathroom after brushing my teeth … then I will take my contraceptive pill'.[8]

Some common initial side effects, such as nausea, can be eased by taking the pill at night time for the first 2 months. Scheduling an early review when initiating the COCP enables monitoring and provides the opportunity to give encouragement and dispel any common myths about the effects of the COCP.

A well recognised problem with the COCP is unscheduled bleeding. One possible response is to advise extended active pill regimens; although careful questioning often uncovers continuous active pill taking that has been initiated by the woman. Again, good counselling at the time of the first prescription has been shown to be an effective tool to correct COCP use. If the woman (or her doctor) has advised extended active pill taking (tri-cycling or longer) then is it important to recognise that this may be associated with a longer duration of unscheduled bleeding (although no withdrawal bleeds). Current practice around extended active pill taking is evolving. It is suggested that a 4 day pill free interval with an associated withdrawal bleed but minimal chance of diminished contraceptive cover, may be the most effective way to deal with disruptive unscheduled bleeding. Persistent unscheduled bleeding in the presence of correct use needs to be investigated for cervical and other pathology.[9]

Finally, beware the product information (PI)! Particularly in relation to the COCP, the PI is often out-of-date with current practice. All combined oral contraceptives will work immediately if an active pill is taken in the first 5 days of the menstrual cycle, where 'day one' is the first day of bleeding.[5] Some COCP packaging does not support this and still advises starting in the red section, which coincides with five inactive pills. Again, good counselling is imperative, as is having your trusty swatch of samples to demonstrate with and a good pamphlet to give to the patient that reinforces your message.

Information about drug interactions with the COCP has also changed since the various PI were written. Antibiotics that are not liver enzyme inducers, ie. all of the commonly used antibiotics such as amoxicillin, doxycycline and the cephalosporins, do not interfere with the contraceptive effect of the COCP[9] – despite what the Medical Director prescribing prompt says! Only the anti-tuberculous antibiotic treatments, such as rifampicin, will inactivate the COCP. Other liver enzyme inducers including carbamazepine, which can be used as a mood stabiliser as well as a treatment for epilepsy, do reduce efficacy of the COCP. This

can be countered by the use of a higher dose pill (eg. Microgynon 50®) containing 50 µg of ethinyl oestradiol), depot injectable contraception or levonorgestrol IUD LARC.

Choices in contraception

When discussing contraceptive options with patients, it is vital to consider cost. In South Australia the average age of a woman having her first baby is now 29 years, so sustainability is an important aspect of choosing a form of contraception. Obviously, the LARCs are generally cost effective in this scenario, but choosing a PBS subsidised pill initially is essential, however attractive it might seem to give one or two 'free' samples of an unsubsidised agent as a starter. There is little evidence for particular changes in pill composition consistently affecting response, so experimenting with the subsidised levonorgestrol and norethisterone containing COCPs is sensible to maximise the likelihood of maintaining long term affordability.

A useful source of information for current best practice can be found in the UK Medical Eligibility Criteria for Contraceptive Use. These were initially developed by the World Health Organization and modified by the Royal College of Obstetricians and Gynaecologists Faculty of Sexual and Reproductive Healthcare.[10] They are now also available, combined with considered Australian practical advice, in the Australian Contraceptive Handbook.[6] For situations where women have complicated medical conditions and need contraception, these tables offer unrivalled clarity about choice and risks (*Table 1*).

Table 1. UK Medical Eligibility Criteria for Contraceptive Use categories[10]

Category	Hormonal contraception, intrauterine devices, emergency contraception and barrier methods	Example of contraception and condition in this category
1	A condition for which there is no restriction for the use of the contraceptive method	Copper IUD and migraine with aura
2	A condition where the advantages of using the method generally outweigh the theoretical or proven risks	COCP and body mass index of 30–34 kg/m^2
3	A condition where the theoretical or proven risks generally outweigh the advantages of using the method. The provision of the method requires expert clinical judgement and/or referral to a specialist contraceptive provider, since the use of the method is not usually recommended unless other more appropriate methods are not available or not acceptable	Progestogen-only pill (POP) and past history of breast cancer and no evidence of current disease for 5 years
4	A condition which represents an unacceptable risk if the contraceptive method is used	COCP and age ≥35 years and smokes ≥15 cigarettes daily

Summary

The key to minimising problems in contraceptive practice is considering sustainability, including cost, efficiency, duration of action and suitability, making a careful choice and then counselling the patient well. State based family planning organisations can provide information to both GPs and their patients to maximise correct and trouble-free contraceptive practice.

Resources

State based family planning organisations:

- Family Planning NSW: www.fpnsw.org.au
- Family Planning Queensland: www.fpq.com.au
- Family Planning Tasmania: www.fpt.asn.au
- Family Planning Victoria: www.fpv.org.au
- Family Planning Welfare Association of the Northern Territory: www.fpnwt.com.au
- FPWA Sexual Health Services: www.fpwa.org.au
- Sexual Health and Family Planning ACT: www.shfpa.org.au
- Sexual Health information networking & education SA: www.shinesa.org.au.

Author

Katrina Allen FRACGP, FAChSHM, is a general practitioner and Medical Education Coordinator, SHine, Adelaide, South Australia. katrina.allen@health.sa.gov.au.

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correspondence **afp@racgp.org.au**