UKMi North West

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A summary of prescribing recommendations from NICE guidance

Long-acting reversible contraception (update)

NICE CG30; 2014

This guideline gives recommendations on long-acting reversible contraception.

Definition of terms

LARC	long-acting reversible contraception
IUD	intrauterine device
IUS	intrauterine system
DMPA	depot medroxyprogesterone acetate
NET-EN	norethisterone enantate
COC	combined oral contraceptive
STI	sexually transmitted infection
NSAID	non-steroidal anti-inflammatory drug

See NICE pathway: LARC

Cost effectiveness

- LARC methods are more cost effective than the COC pill even at 1 year of use.
- IUDs, the IUS and the implant are more cost effective than injectable contraceptives.
- Increasing the use of LARC will reduce the number of unintended pregnancies.

Choice of LARC method

ALL LARC methods are suitable for women:
- who are nulliparous,
- who are breastfeeding,
- who have had an abortion,
- with migraine (with or without aura),
- with a contraindication to oestrogen,
- with HIV,
- with BMI >30,
- with diabetes

See: **Table 1** for considerations in different women.
Table 2 for counselling information.

IUD: when choosing consider:
- the licensed duration of use,*
- the most effective IUDs contain at least 380 mm^2 of copper and have banded copper on the arms.

Implant: not recommended for women taking enzyme-inducing drugs e.g. rifampicin, phenytoin, carbamazepine*

*See Summary of Product Characteristics (SPC) for full prescribing information.

Initiation of method

- Exclude pregnancy by menstrual and sexual history.

If it is reasonably certain that the woman is not pregnant, the LARC can be fitted/administered:

IUD/IUS (Mirena®)
- at any time during the menstrual cycle (**IUS****),
- immediately after first or second trimester abortion, or at any time afterwards,
- from 4 weeks post-partum, irrespective of the mode of delivery.

Progestogen-only injection (DMPA/ NET-EN)
- up to and including the fifth day of the menstrual cycle without the **need for additional contraceptives,**
- **at any other time in the cycle; use barrier contraception for 7 days after injection,**
- immediately after first or second trimester abortion, or at any time afterwards,
- at any time post-partum.

Implant (Nexplanon®)
- See Summary of Product Characteristics

**if the woman is amenorrhoeic or it is >5 days since menstrual bleeding started use barrier contraception for first 7 days.

Cautions and counselling

- For irregular/heavier/prolonged bleeding due to use of device:
  IUD: treat with NSAIDs and tranexamic acid, **OR** suggest changing to the IUS if bleeding is unacceptable.
  DMPA: treat with mefenamic acid or ethinylestradiol.
- If pregnancy occurs:
  IUD/IUS - remove before 12 weeks' gestation, whether or not the woman intends to continue the pregnancy.
  DMPA: there is no evidence of congenital malformation to the fetus if pregnancy occurs during use.
- For women using **DMPA:**
  - repeat injections may be given up to 2 weeks late without the need for additional contraceptives (unlicensed use),
  - for use beyond 2 years, carry out a clinical review, discuss the benefits and risks, and support the woman's choice.

Table 1: Choice of LARC method in different women

	IUD	IUS	Implant	DMPA
Adolescents	No specific restrictions		No specific restrictions	Care needed: only use if other methods unacceptable/unsuitable
Women aged > 40 years	No specific restrictions		No specific restrictions	Care needed: generally benefits outweigh risks
Women with epilepsy	• no specific contraindications • seizure risk may be increased at the time of fitting;have emergency drugs including anti-epileptic medication available.		• not recommended for women taking enzyme-inducing drugs e.g. phenytoin, carbamazepine*	• no specific contraindications • may be associated with reduced seizure frequency
Women at risk of STI	Tests may be needed before insertion		No specific contraindications	

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Contraceptive provision

- Women requiring contraception should be given information about and offered a choice of all methods including LARC.
- All healthcare professionals providing LARC methods need training in the relevant skills.
- If LARC is not provided within the practice/service a referral mechanism should be in place.

Table 2: Counselling – information for discussion with women choosing a LARC method

	IUD	IUS	Progestogen-only injection	Implant
How it works	By preventing fertilisation and inhibiting implantation	Mainly by preventing implantation; sometimes by preventing fertilisation	By preventing ovulation	By preventing ovulation
Duration of use	5 to 10 years for IUDs with 380 mm^2 copper – see SPC	5 years	Repeat injections every 12 weeks (DMPA) or every 8 weeks (NET-EN; maximum of 2 injections)	3 years
Failure rate	< 2 in 100 women over 5 years Expulsion in < 1 in 20 women in 5 years	< 1 in 100 women over 5 years Expulsion in < 1 in 20 women in 5 years	< 4 in 1000 women over 2 years Pregnancy rates lower for DMPA than NET-EN	< 1 in 1000 women over 3 years
Advice at time of fitting	♦ There may be pain and discomfort for a few hours and light bleeding for a few days ♦ Watch for symptoms of uterine perforation ♦ Follow-up visit after first menses or 3 to 6 weeks after insertion ♦ Return at any time if problems or if wish to change method ♦ Check for threads regularly ♦ Device may remain in place until contraception no longer needed even if this is beyond the duration specified by the UK Marketing Authorisation (see SPC) for the following women: **IUD**: Women aged ≥ 40 years at time IUD inserted, **IUS**: Women aged ≥ 45 years at time IUS inserted and are amenorrhoeic		♦ Return for next injection or if problems	See SPC for full prescribing information
Discontinuation rates	Up to 50% of women stop using IUDs within 5 years	Up to 60% of women stop using IUS within 5 years	Up to 50% of women stop using DMPA by 1 year	
Most common reason for discontinuation	Unacceptable vaginal bleeding and pain		Altered bleeding pattern such as persistent bleeding	
Risks	**Ectopic pregnancy:** ♦ Overall rates lower than with no contraception ♦ Risk 1 in 20 if a woman becomes pregnant with IUD/ IUS in situ – seek advice to exclude this **Pelvic inflammatory disease:** less than 1% for women at low risk of STI **Uterine perforation:** less than 1 in 1000 **Change in mood/libido:** may be a small effect; similar for IUD and IUS **Acne:** IUS - risk may be increased, but is an uncommon reason for stopping use **No evidence of an effect on:** weight gain		**DMPA** **Bone mineral density:** ♦ Associated with small loss, largely recovered when it is stopped ♦ No evidence that fracture risk increased **Weight gain:** may be up to 2 to 3 kg over a year **No evidence of an effect on:** depression, acne, headaches	Complications with insertion and removal are uncommon. See SPC for full prescribing information
Effect on menstruation	Heavier bleeding and/or dysmenorrhoea likely	♦ Irregular bleeding and spotting common in first 6 months ♦ Oligomenorrhoea or amenorrhoea likely by end of first year	♦ Amenorrhoea is common, but not harmful – more likely wth DMPA than NET-EN and with longer use ♦ Persistent bleeding may occur	♦ Changes in bleeding pattern which are likely to remain irregular ♦ Dysmenorrhoea may improve
Return to fertility	No evidence of delay		♦ Can take up to a year ♦ Women who do not want to get pregnant start a different contraceptive as soon as injections stop	No evidence of delay