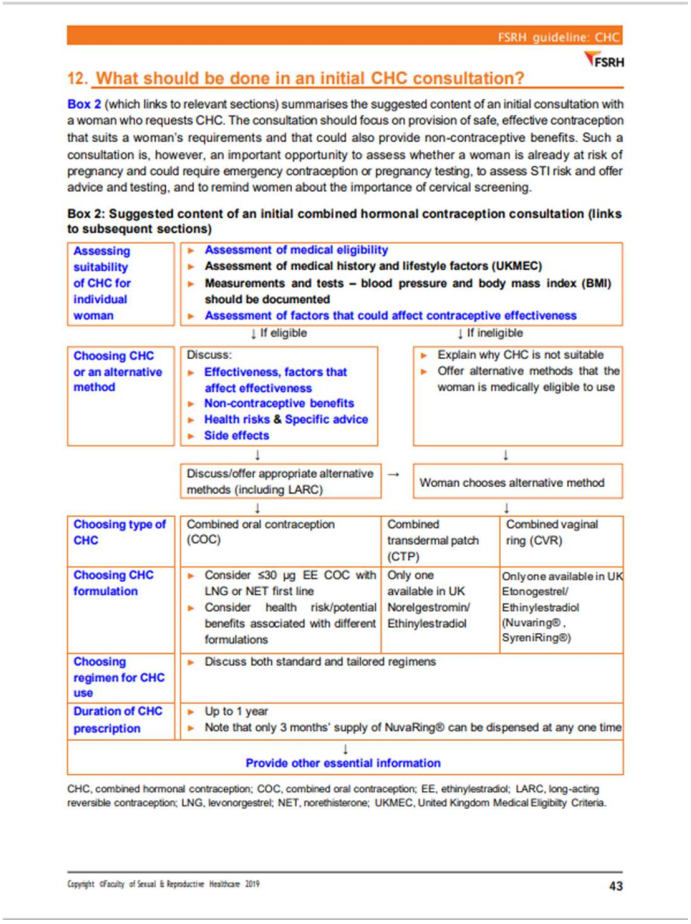
Learning Summary – CHC and VTE – supplementary information

Detailed information on the FSRH UK MEC and method-specific information can be found:

Standards and Guidelines | FSRH

For FSRH members, there is an excellent Quick Reference Summary of Clinical Guidance on Combined Hormonal Contraception 2019, which practice teams may find helpful to discuss together if they have access.

Alternatively, there is a table contained within the FSRH Combined Hormonal Contraception guideline 2019 that is linked to the relevant sections of the guideline that colleagues may find helpful:



FSRH guideline: CHC

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## 12. What should be done in an initial CHC consultation?

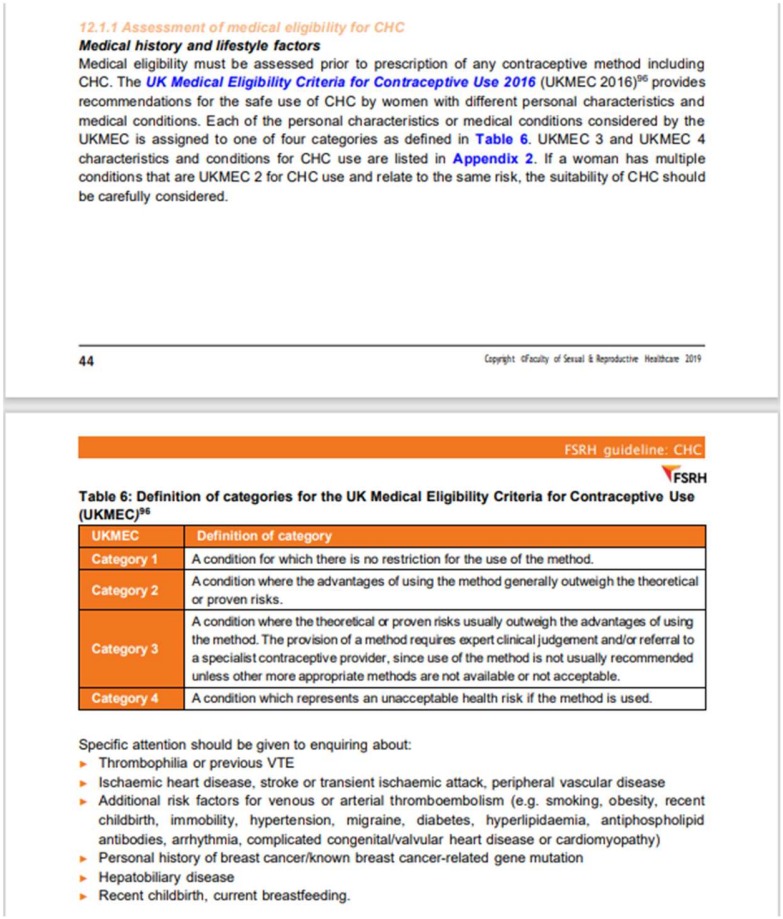
**Box 2** (which links to relevant sections) summarises the suggested content of an initial consultation with a woman who requests CHC. The consultation should focus on provision of safe, effective contraception that suits a woman's requirements and that could also provide non-contraceptive benefits. Such a consultation is, however, an important opportunity to assess whether a woman is already at risk of pregnancy and could require emergency contraception or pregnancy testing, to assess STI risk and offer advice and testing, and to remind women about the importance of cervical screening.

**Box 2: Suggested content of an initial combined hormonal contraception consultation (links to subsequent sections)**

| | | | |
|---|---|---|---|
| **Assessing suitability of CHC for individual woman** | ▸ **Assessment of medical eligibility**<br>▸ **Assessment of medical history and lifestyle factors (UKMEC)**<br>▸ **Measurements and tests – blood pressure and body mass index (BMI) should be documented**<br>▸ **Assessment of factors that could affect contraceptive effectiveness** | | |
| | ↓ If eligible | ↓ If ineligible | |
| **Choosing CHC or an alternative method** | Discuss:<br>▸ **Effectiveness, factors that affect effectiveness**<br>▸ **Non-contraceptive benefits**<br>▸ **Health risks & Specific advice**<br>▸ **Side effects** | ▸ Explain why CHC is not suitable<br>▸ Offer alternative methods that the woman is medically eligible to use | |
| | ↓ | ↓ | |
| | Discuss/offer appropriate alternative methods (including LARC) → | Woman chooses alternative method | |
| | ↓ | ↓ | |
| **Choosing type of CHC** | Combined oral contraception (COC) | Combined transdermal patch (CTP) | Combined vaginal ring (CVR) |
| **Choosing CHC formulation** | ▸ Consider ≤30 µg EE COC with LNG or NET first line<br>▸ Consider health risk/potential benefits associated with different formulations | Only one available in UK<br>Norelgestromin/ Ethinylestradiol | Only one available in UK<br>Etonogestrel/ Ethinylestradiol (Nuvaring®, SyreniRing®) |
| **Choosing regimen for CHC use** | ▸ Discuss both standard and tailored regimens | | |
| **Duration of CHC prescription** | ▸ Up to 1 year<br>▸ Note that only 3 months' supply of NuvaRing® can be dispensed at any one time | | |
| | ↓ | | |
| | **Provide other essential information** | | |

CHC, combined hormonal contraception; COC, combined oral contraception; EE, ethinylestradiol; LARC, long-acting reversible contraception; LNG, levonorgestrel; NET, norethisterone; UKMEC, United Kingdom Medical Eligibilty Criteria.

Assessment of suitability of combined hormonal contraception (CHC) for an individual woman is the recommended first step:



12.1.1 Assessment of medical eligibility for CHC

**Medical history and lifestyle factors**

Medical eligibility must be assessed prior to prescription of any contraceptive method including CHC. The ***UK Medical Eligibility Criteria for Contraceptive Use 2016*** (UKMEC 2016)[96] provides recommendations for the safe use of CHC by women with different personal characteristics and medical conditions. Each of the personal characteristics or medical conditions considered by the UKMEC is assigned to one of four categories as defined in **Table 6**. UKMEC 3 and UKMEC 4 characteristics and conditions for CHC use are listed in **Appendix 2**. If a woman has multiple conditions that are UKMEC 2 for CHC use and relate to the same risk, the suitability of CHC should be carefully considered.






**Table 6: Definition of categories for the UK Medical Eligibility Criteria for Contraceptive Use (UKMEC)[96]**

| UKMEC | Definition of category |
|---|---|
| Category 1 | A condition for which there is no restriction for the use of the method. |
| Category 2 | A condition where the advantages of using the method generally outweigh the theoretical or proven risks. |
| Category 3 | A condition where the theoretical or proven risks usually outweigh the advantages of using the method. The provision of a method requires expert clinical judgement and/or referral to a specialist contraceptive provider, since use of the method is not usually recommended unless other more appropriate methods are not available or not acceptable. |
| Category 4 | A condition which represents an unacceptable health risk if the method is used. |

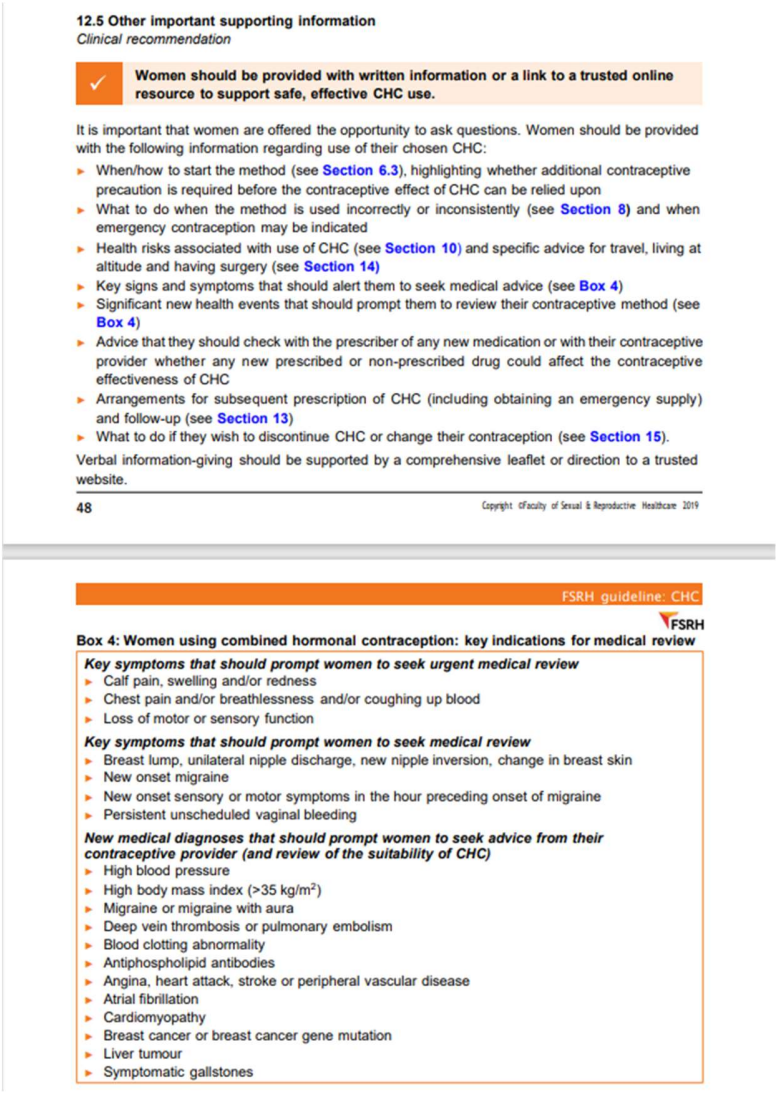
Specific attention should be given to enquiring about:

- Thrombophilia or previous VTE
- Ischaemic heart disease, stroke or transient ischaemic attack, peripheral vascular disease
- Additional risk factors for venous or arterial thromboembolism (e.g. smoking, obesity, recent childbirth, immobility, hypertension, migraine, diabetes, hyperlipidaemia, antiphospholipid antibodies, arrhythmia, complicated congenital/valvular heart disease or cardiomyopathy)
- Personal history of breast cancer/known breast cancer-related gene mutation
- Hepatobiliary disease
- Recent childbirth, current breastfeeding.

FSRH recommend that blood pressure and BMI are documented before prescribing.

Drug interactions and the potential for malabsorption are further considerations.

FSRH further recommend:



**12.5 Other important supporting information**

*Clinical recommendation*

✓ **Women should be provided with written information or a link to a trusted online resource to support safe, effective CHC use.**

It is important that women are offered the opportunity to ask questions. Women should be provided with the following information regarding use of their chosen CHC:

- When/how to start the method (see **Section 6.3**), highlighting whether additional contraceptive precaution is required before the contraceptive effect of CHC can be relied upon
- What to do when the method is used incorrectly or inconsistently (see **Section 8**) and when emergency contraception may be indicated
- Health risks associated with use of CHC (see **Section 10**) and specific advice for travel, living at altitude and having surgery (see **Section 14**)
- Key signs and symptoms that should alert them to seek medical advice (see **Box 4**)
- Significant new health events that should prompt them to review their contraceptive method (see **Box 4**)
- Advice that they should check with the prescriber of any new medication or with their contraceptive provider whether any new prescribed or non-prescribed drug could affect the contraceptive effectiveness of CHC
- Arrangements for subsequent prescription of CHC (including obtaining an emergency supply) and follow-up (see **Section 13**)
- What to do if they wish to discontinue CHC or change their contraception (see **Section 15**).

Verbal information-giving should be supported by a comprehensive leaflet or direction to a trusted website.

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**Box 4: Women using combined hormonal contraception: key indications for medical review**

***Key symptoms that should prompt women to seek urgent medical review***

- Calf pain, swelling and/or redness
- Chest pain and/or breathlessness and/or coughing up blood
- Loss of motor or sensory function

***Key symptoms that should prompt women to seek medical review***

- Breast lump, unilateral nipple discharge, new nipple inversion, change in breast skin
- New onset migraine
- New onset sensory or motor symptoms in the hour preceding onset of migraine
- Persistent unscheduled vaginal bleeding

***New medical diagnoses that should prompt women to seek advice from their contraceptive provider (and review of the suitability of CHC)***

- High blood pressure
- High body mass index (>35 kg/m$^2$)
- Migraine or migraine with aura
- Deep vein thrombosis or pulmonary embolism
- Blood clotting abnormality
- Antiphospholipid antibodies
- Angina, heart attack, stroke or peripheral vascular disease
- Atrial fibrillation
- Cardiomyopathy
- Breast cancer or breast cancer gene mutation
- Liver tumour
- Symptomatic gallstones

FSRH recommend women should be provided with written information or a link to a trusted online resource to support safe, effective CHC use.  Women can be signposted to further information about CHC:

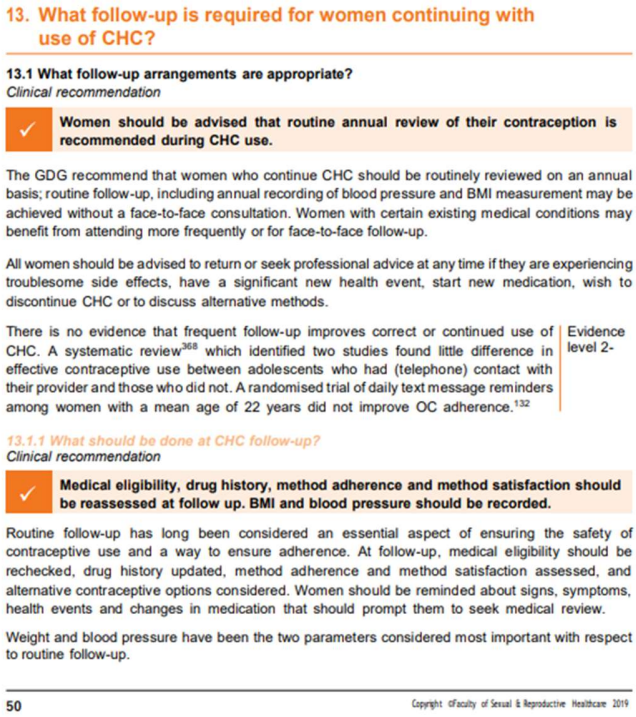
NHS Inform: Contraception | NHS inform

Contraception choices: Contraception Choices

The West of Scotland Sexual Health MCN also has helpful patient information and clinical guidance:

WOS Sexual Health MCN – Managed Clinical Network for Sexual Health in the West of Scotland

Annual review is recommended by FSRH, including blood pressure and BMI. It is acceptable for this to be achieved without a face-to-face consultation if GMC guidance on safe prescribing for doctors is met.



## 13. What follow-up is required for women continuing with use of CHC?

**13.1 What follow-up arrangements are appropriate?**
*Clinical recommendation*

✓ **Women should be advised that routine annual review of their contraception is recommended during CHC use.**

The GDG recommend that women who continue CHC should be routinely reviewed on an annual basis; routine follow-up, including annual recording of blood pressure and BMI measurement may be achieved without a face-to-face consultation. Women with certain existing medical conditions may benefit from attending more frequently or for face-to-face follow-up.

All women should be advised to return or seek professional advice at any time if they are experiencing troublesome side effects, have a significant new health event, start new medication, wish to discontinue CHC or to discuss alternative methods.

There is no evidence that frequent follow-up improves correct or continued use of CHC. A systematic review[368] which identified two studies found little difference in effective contraceptive use between adolescents who had (telephone) contact with their provider and those who did not. A randomised trial of daily text message reminders among women with a mean age of 22 years did not improve OC adherence.[132] | Evidence level 2-

*13.1.1 What should be done at CHC follow-up?*
*Clinical recommendation*

✓ **Medical eligibility, drug history, method adherence and method satisfaction should be reassessed at follow up. BMI and blood pressure should be recorded.**

Routine follow-up has long been considered an essential aspect of ensuring the safety of contraceptive use and a way to ensure adherence. At follow-up, medical eligibility should be rechecked, drug history updated, method adherence and method satisfaction assessed, and alternative contraceptive options considered. Women should be reminded about signs, symptoms, health events and changes in medication that should prompt them to seek medical review.

Weight and blood pressure have been the two parameters considered most important with respect to routine follow-up.




It is also recommended that a discussion about LARC is offered at CHC review.

A local Ayrshire and Arran CHC review protocol and template have been prepared to support practice teams and primary care pharmacists with CHC reviews.

<u>Prescribing – Higher risk VTE pills</u>

FSRH recommend:

**C** **HCP can prescribe up to 12 months' supply of CHC for women who are initiating or continuing CHC.**

and

✓ **COC containing ≤30 µg EE in combination with levonorgestrel or norethisterone is a reasonable first-line choice of CHC to minimise cardiovascular risk.**

In January 2014, health care professionals received communication from the MHRA through the Central Alerting System, advising of difference in risks of thromboembolism between Combined Hormonal Contraceptive products. Data included in the MHRA safety alert documents risk:

***CHC use and Risk of VTE***

| | Risk of VTE per 10,000 women years |
|---|---|
| Non contraceptive users and not pregnant | 2 |
| CHC containing ethinylestradiol plus levonorgestel, norgestimate or norethisterone | 5-7 |
| CHC containing etonogestrel (ring) or norelgestromin (patch) | 6-12 |
| CHC containing ethinylestradiol plus gestodene, desogestrel or drospirenone | 9-12 |
| Pregnancy | 29 |
| Immediate Postpartum period | 300-400 |

(taken from WoS MCN CHC guidance as table clearer)

West-of-Scotland-CHC-Guideline-Final-9-.1-Jan-24.pdf

Formulary choices for COC prescribing in NHS Ayrshire and Arran can be accessed easily using the synonym: **.OC-COC**

There are many different pill brands available, and we understand it can be difficult keeping track of names. This table is accurate in January 2024:

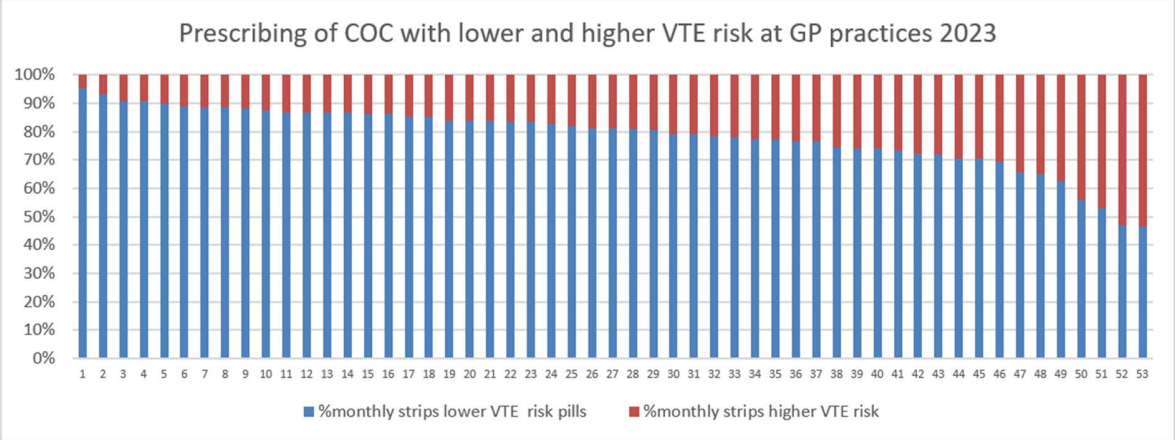
West-of-Scotland-CHC-Guideline-Final-9-.1-Jan-24.pdf

**Table: CHC Preparations**

| Monophasic preparations Grouped by progestogen type and generation | Oestrogen dose | Brand names |
|---|---|---|
| Norethisterone (1st) | 35 micrograms EE | Brevinor®<br>Norimin® |
| Levonorgestrel (2nd) | 30mcg EE | Microgynon 30®<br>Ovranette®<br>Rigevidon®<br>Levest®<br>Maexeni®<br>Ambelina®<br>Leandra® |
| Desogestrel (3rd) | 30 mcg EE<br><br>20 mcg EE | Marvelon®<br>Gedarel 30/150®<br>Cimizt®<br>Mercilon®<br>Gedarel 20/150®<br>Bimizza® |
| Gestodene (3rd) | 30 mcg EE<br><br><br>20 mcg EE | Femodene®<br>Katya®<br>Akizza®<br>Millinette 30/75®<br>Femodette®<br>Sunya®<br>Millinette 20/75® |
| Cyproterone (equivalent to 3rd) | 35 mcg EE | Co-cyprindiol<br>Dianette®<br>Clairette®<br>Teragezza® |
| Norgestimate (3rd) | 35 mcg EE | Cilique®<br>Lizinna® |
| Drospirenone (4th) | 20 mcg EE<br><br>30 mcg EE | Eloine®<br>Daylette®<br>Yasmin®<br>Lucette®<br>Yacella®<br>Dretine®<br>Yiznell®<br>Dretine® |
| Triphasic pills with varied progestogens | 30 – 40 mcg EE | TriRegol®<br>Triadene® |
| Phasic with Dienogest (4th) | 1 – 3 mg Estradiol valerate | Qlaira® |
| Nomegestrel acetate (4th) | 1.5mg Estradiol hemihydrate | Zoely® |
| Low Dose Patch with norelgestromin | 20 mcg EE | Evra® |
| Intravaginal ring with etonogestrel | 15 mcg EE | Nuvaring®<br>SyreniRing® |

**Prices vary between health boards and between Primary and Secondary Care. First choice preparation will be guided by the stock arrangements/availability within each service.**

2023 Local Ayrshire and Arran prescribing data has shown the following distribution curve, with 2 practices prescribing >50% higher VTE risk pills:




the % of higher VTE risk COC being between 5% and 53% (R Holman)

Quality Improvement suggestions for practices to consider:

- Review of Combined Oral Contraceptive Pill prescribing and discussion with women to review risk and choice, where levonorgestrel or norethisterone containing pills are not being prescribed
- Information given to women at initiation of CHC, including flexible use
- Practice processes for CHC annual reviews
- Uploading, promoting within the team and using the A+A EMIS templates to support CHC reviews
- Text shortcuts to support documentation of information discussed
- Systems for providing women with detailed information about contraceptive choices – poster with QR codes has been prepared by Public Health
- Prescribing of contraceptives on repeat lists so easily visible
- Documentation and coding of family history of venous thromboembolism – where a diagnosis has been made, has this been coded in relative's records?