

From Choice to Care: Clinical Decision-Making in Contraception for Community Pharmacists

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Learning Outcomes

- Understand clinical & practical considerations in contraception.
- Apply UKMEC effectively in real-world pharmacy settings.
- Differentiate between combined, progestogen-only, LARC & EC.
- Recognise red flags, drug interactions, and patient-specific risks.
- Apply knowledge through real-life case studies.



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NHS Pharmacy Contraception Service (PCS)- Advanced Service

- Tier 1: POP initiation/continuation- April 2023
- Tier 2: COC initiation – Dec 2023

Useful links

<https://www.nhs.uk/nhs.uk/sites/default/files/2025-06/NHS%20Pharmacy%20Contraception%20Service%20v%203.0%20FINAL%20DRAFT.pdf>



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Why Contraception Service?

- Up to 45% of all pregnancies in the UK are unplanned.
- One in five pregnancies end in abortion every year
- The total number of abortions in England and Wales in 2021 was 214,256
- 62% of women attending for an abortion were using contraception when they became pregnant
- 40% of women attending for abortion had one or more previous abortions



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Inclusion criteria

To be eligible to access this service a person must:

- Be an individual of childbearing potential seeking a supply of oral EC only following confirmation of UPSI or where regular contraception has been compromised or used incorrectly
- Be an individual seeking to be initiated on an OC, or seeking to obtain a further supply of their ongoing OC for contraceptive purposes:

Combined Oral Contraceptive (COC)

from menarche up to and including 49 years of age;

Progestogen Only Pill (POP)

Norethisterone, Levonorgestrel and Desogestrel - from menarche up to and including 54 years.

Drospirenone only - from menarche up to and including 49 years.



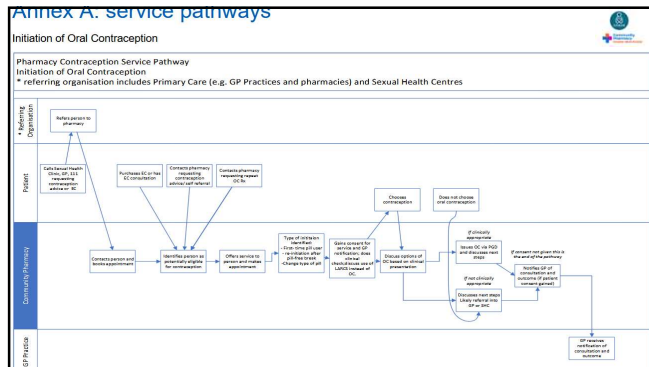
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Exclusion criteria

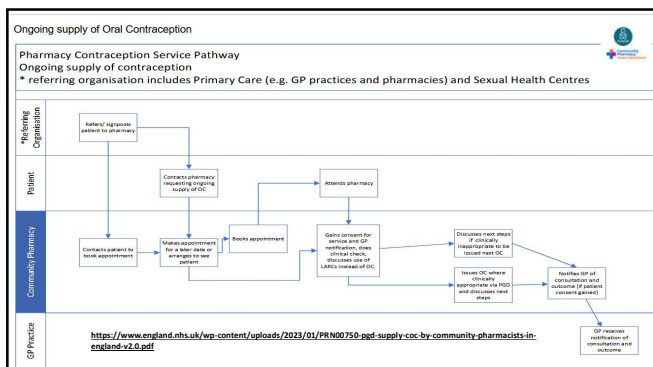
A person will not be eligible for this service if:

- They are considered clinically unsuitable, or are excluded for supply of oral EC or OC according to the relevant PGD protocols, including, but not limited to:
- Individuals under 16 years of age and assessed as not competent using Fraser Guidelines.
- Individuals 16 years of age and over and assessed as lacking capacity to consent.
- The service exclusions also include all advance supplies of oral EC

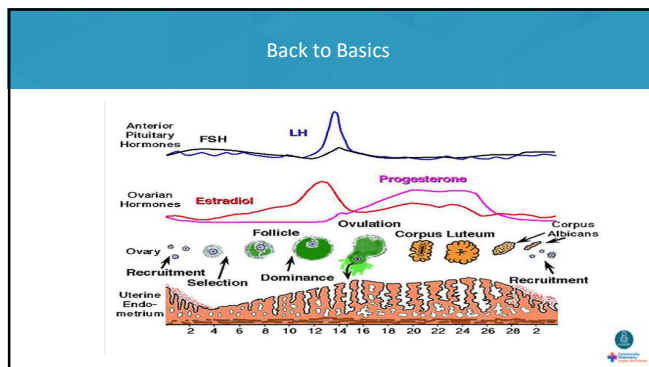
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Initial Consultation

- Age , Current contraception, Compliance
- Menstrual Hx – LMP, risk of pregnancy, need for EC, cycles/heaviness
- Medical and family history
- Drug history
- Allergies
- Lifestyle – smoking/ alcohol/ drug use
- Check BP, BMI

Always refer to UKMEC (UK Medical Eligibility Criteria for Contraceptive Use)

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What does she want from her contraceptive method?

- Low failure rate
- Regular periods/no periods/light periods
- Rapid Baseline Fertility reversibility
- **Convenience**
- Lack of hormonal influence

Contraception isn't one-size-fits-all

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Patient choice & Decision making

www.contraceptionchoices.org

SIMPLE APPROACH

Is the method right for the woman

Is she aware of her choices

Discuss advantages and disadvantages of contraceptive methods

Identify contra-indications (Refer to UKMEC 2016) Safety

<https://www.cosh.org/Common/Uploaded%20files/Standards-and-Guidance/fsrh-ukmec-full-book-2019.pdf>

UK MEDICAL ELIGIBILITY CRITERIA FOR CONTRACEPTIVE USE (REVISED SEPTEMBER 2016)

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UKMEC: UK Medical Eligibility Criteria for Contraceptive Use Definition of Categories

UKMEC	DEFINITION OF CATEGORY	WHAT THIS MEANS IN PRACTICE
Category 1	A condition for which there is no restriction for the use of the method	Use method in any circumstances
Category 2	condition where the advantages of using the method generally outweigh the theoretical or proven risks	Generally, use the method but higher-level judgement and more careful follow up required
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	Probably don't use (need expert judgement/specialist referral)
Category 4	A condition which represents an unacceptable health risk if the method is used	Do not Use

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Shared decision making (SDM)

- Shared decision making (SDM) ensures that individuals are supported to make decisions that are right for them. It is a collaborative process through which a clinician supports a patient to reach a decision about their treatment
- The conversation brings together: the clinician's expertise, treatment options, evidence, risks and benefits
- What the patient knows best: their preferences, personal circumstances, goals, values and beliefs

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Combined Hormonal Contraception (CHC)

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Types Combined Hormonal Contraception (CHC)

Contraceptive Method	Progestosterone	Oestrogen	Effectiveness (Typical Use)	Frequency of Change	Changes to Bleeding Pattern	Helps with Acne	Return to Baseline Fertility	Pros	Cons
Contraceptive Vaginal Ring (NuvaRing)	Etonogestrel 11.7 mg (releases 120 mcg/24h)	Ethinylestradiol 2.7 mg (releases 15 mcg/24h)	91%	Every 3 weeks	May cause spotting	Yes	After stopping	Can help reduce period pain	Requires self-insertion and removal
Contraceptive Pill (Combined Oral Contraceptive Pill)	Various combinations of progestogens	Ethinylestradiol (typically 20-35 mcg)	91%	Taken for 21 days, then a 7-day pill-free break	May cause spotting	Yes	After stopping	Can help with Endometriosis, PCOS, and menopause symptoms	Increased risk of venous thromboembolism (VTE)
Contraceptive Patch (Eura)	Norelgestromin 5 mg (releases 203 mcg/24h)	Ethinylestradiol 600 mcg (releases 34 mcg/24h)	91%	Changed once a week	May cause spotting	No	hormones from the patch are cleared within a week, ovulation resumes shortly thereafter	Oral route not tolerated Convenience	May cause sore breasts and skin irritation, slightly higher risk of blood clots

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Combined Hormonal Contraception (CHC) Is it safe?

Most contain Ethinyl Estradiol (EE) (20-35ug)



- Risk of significant adverse health events associated with CHC use is **small**, but... background risk of adverse health events –VTE risk increases significantly with age and comorbidities like HTN, Diabetes , Obesity , smoking and slight increase in Breast cancer risk, Cervical cancer
- Refer to UKMEC 2019 CHC updated recommendations

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Combined Hormonal Contraception (CHC)

What to consider (Exclusion criteria)

- Risk factors
- Cardiovascular disease
- Neurological Conditions
- Cancers
- Post-natal / breast feeding
- Side Effects
- standard or tailored regime


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Combined Hormonal Contraception (CHC)

UKMEC SUMMARY TABLE HORMONAL AND INTRAUTERINE CONTRACEPTION

CONDITION	Cu-IUD	LNG-IUS	IMP	DMPA	POP	CHC
I = Initiation, C = Continuation						
CARDIOVASCULAR DISEASE (CVD)						
Multiple risk factors for CVD (such as smoking, diabetes, hypertension, obesity and dyslipidaemias)	1	2	2	3	2	3
Hypertension						
a) Adequately controlled hypertension	1	1	1	2	1	3
b) Consistently elevated BP levels (properly taken measurements)						
(i) Systolic >140-159 mmHg or diastolic >90-99 mmHg	1	1	1	1	1	3
(ii) Systolic ≥160 mmHg or diastolic ≥100 mmHg	1	1	1	2	1	4
c) Vascular disease	1	2	2	3	2	4
History of high BP during pregnancy	1	1	1	1	1	2
Current and history of ischaemic heart disease	1	I	C	I	C	3
Stroke (history of cerebrovascular accident, including TIA)	1	I	C	I	C	3
Known dyslipidaemias	1	2	2	2	2	2

CVD Risk Thrombotic Risk!




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Combined Hormonal Contraception (CHC)

CVD Risk Thrombotic Risk!

UKMEC SUMMARY TABLE HORMONAL AND INTRAUTERINE CONTRACEPTION


CONDITION	Cu-IUD	LNG-IUS	IMP	DMPA	POP	CHC
I = Initiation, C = Continuation						
Venous thromboembolism (VTE)						
a) History of VTE	1	2	2	2	2	4
b) Current VTE (on anticoagulants)	1	2	2	2	2	4
c) Family history of VTE						
(i) First-degree relative age <45 years	1	1	1	1	1	3
(ii) First-degree relative age ≥45 years	1	1	1	1	1	2
d) Major surgery						
(i) With prolonged immobilisation	1	2	2	2	2	4
(ii) Without prolonged immobilisation	1	1	1	1	1	2
e) Minor surgery without immobilisation	1	1	1	1	1	1
f) Immobility (unrelated to surgery) (e.g. wheelchair use, debilitating illness)	1	1	1	1	1	3
Superficial venous thromboses						
a) Varicose veins	1	1	1	1	1	1
b) Superficial venous thrombosis	1	1	1	1	1	2
Known thrombotic mutations (e.g. factor V Leiden, prothrombin mutation, protein S, protein C and antithrombin deficiencies)						
	1	2	2	2	2	2



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Table 7: UK Medical Eligibility Criteria (UKMEC) categories for the use of combined hormonal contraception with cardiovascular risk factors²⁹



Condition	UKMEC Category ^a
Multiple risk factors for cardiovascular disease	3
Adequately controlled hypertension	3
Consistently elevated BP levels (properly taken measurements):	
Systolic >140-159 mmHg or diastolic >90-99 mmHg	3
Systolic ≥160 mmHg or diastolic ≥100 mmHg	4
Vascular disease	4
History of high BP during pregnancy	2
Current and history of ischaemic heart disease	4
Stroke (history of cerebrovascular accident, including transient ischaemic attack)	4
Known dyslipidaemias	2
Obesity	
BMI ≥30-34 kg/m ²	2
BMI ≥35 kg/m ²	3
Smoking	
Age <35 years	2
Age ≥35 years	
<15 cigarettes/day	3
≥15 cigarettes/day	4
Stopped smoking <1 year	3
Stopped smoking ≥1 year	2



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When NOT to Use Combined Hormonal Contraception


- Age over 50 years (switch to safer alternatives)
- Multiple risk factors for CVD
- Hypertension (≥140/90 mmHg), obesity (BMI ≥35 kg/m²)
- Migraine with aura.
- History of venous thromboembolism (DVT/PE), stroke, TIA, or ischemic heart disease.
- First degree relative with VTE which first occurred when they were under 45 years of age
- Age ≥35 AND currently smoking (especially ≥15 cigarettes/day).
- Age ≥35 AND stopped smoking < 1 year
- Less than 21 days postpartum (high clot risk).
- Severe liver disease (e.g., cirrhosis, liver tumors).
- Current breast cancer or past breast cancer

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When to Start CHC?

Situation	Additional Precautions?	Immediate Efficacy?
Start on day 1-5 of period	No	Yes
Start any other cycle time (inc. quick start) Always rule out pregnancy before quick start.	Yes – for 7 days	No
After levonorgestrel EC	Yes – for 7 days	No
After ulipristal acetate EC	Wait 5 days, then 7 days' extra cover	No



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Standard and tailored regimens for CHC

Type of regimen	Period of CHC use	HFI
Standard use	21 days (21 active pills or 1 ring, or 3 patches)	7 days
Tailored use		
Shortened hormone-free interval (HFI)	21 days (21 active pills or 1 ring, or 3 patches)	4 days
Extended use (tricycling)	9 weeks (3 x 21 active pills or 3 rings, or 9 patches used consecutively)	4 or 7 days
Flexible extended use	Continuous use (≥21 days) of active pills, patches or rings until breakthrough bleeding occurs for 3–4 days	4 days
Continuous use (no break)	Continuous use of active pills, patches or rings	None

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Which is first line Combined Oral Contraception (COCP) ?

- First line pill: Ethinyl estradiol(E.E.)<= 30 mcg
- Progestogen with Norethisterone (NET) or Levonorgestrel (2nd gen progestogens)
- 20 mcg pills have lower risk of VTE/CVD than 30 mcg pills
- Newer pills – Qlaira, Zoely, Drovelis use natural estrogens (estradiol or estetrol) may have lower estrogen-related
- Timing- Greatest VTE risk soon after starting, do not stop & start

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Monophasic COC products/regimens

VMP/AMP Name	VMP/AMP Name	VMP/AMP Name
Ethinylestradiol 20mcrogram / Desogestrel 150mcrogram tablets	Ethinylestradiol 20mcrogram / Drospirenone 3mg tablets	Ethinylestradiol 35mcrogram / Norethisterone 1mg tablets
Belinza 150mcrogram/20mcrogram tablets	Droneo 0.03mg/3mg tablets	Nonimis 1mg/25mcrogram tablets
Gedarel 20mcrogram/150mcrogram tablets	Elianelle 0.03mg/3mg tablets	Ethinylestradiol 35mcrogram / Norethisterone 500mcrogram tablets
Mecorin 20mcrogram/20mcrogram tablets	Lucette 0.03mg/3mg tablets	Brevinor 500mcrogram/35mcrogram tablets
Ethinylestradiol 20mcrogram / Gestodene 75mcrogram tablets	Yacella 0.03mg/3mg tablets	Ethinylestradiol 35mcrogram / Norgestimate 250mcrogram tablets
Akiza 75mcrogram/20mcrogram tablets	Yasmin tablets	Clioque 250mcrogram/35mcrogram tablets
Femodette tablets	Ethinylestradiol 20mcrogram / Gestodene 75mcrogram tablets	Lioina 250mcrogram/35mcrogram tablets
Milvete 20mcrogram/75mcrogram tablets	Akiza 75mcrogram/30mcrogram tablets	Mestranol 50mcrogram / Norethisterone 1mg tablets
Sarye 20/75 tablets	Femodene tablets	Norinyl-1 tablets
Ethinylestradiol 20mcrogram / Desogestrel 150mcrogram tablets	Kaisa 30/75 tablets	
Cinix 20mcrogram/150mcrogram tablets	Milivette 30mcrogram/75mcrogram tablets	
Gedarel 30mcrogram/150mcrogram tablets	Ethinylestradiol 35mcrogram / Levonorgestrel 250mcrogram tablets	
Marvelon tablets	Amelina 350mcrogram/30mcrogram tablets	
	Bisov 350mcrogram/30mcrogram tablets	
	Levest 150/90 tablets	
	Maaxeno 350mcrogram/30mcrogram tablets	
	Microgynon 30 tablets	
	Quarantele 350mcrogram/30mcrogram tablets	
	Trigynon tablets	

www.gmmmg.nhs.uk

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Phasic and phasic everyday COC products/regimens

VMP/AMP Name
Logynon tablets
TriRegol tablets
Synphase tablets

VMP/AMP Name
Logynon ED tablets
Qlaira tablets

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Monophasic everyday COC products/regimens

VMP/AMP Name
Drospirenone 3mg / Estetrol 14.2mg tablets
Drovelis 3mg/14.2mg tablets
Estradiol 1.5mg / Norgestrel 2.5mg tablets
Zoely 2.5mg/1.5mg tablets
Ethinylestradiol 20mcrogram / Drospirenone 3mg tablets
Eloine 0.02mg/3mg tablets
Femodene ED tablets
Microgynon 30 ED tablets

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Combined Oral contraception Pill(COCP)

Side effects
• Nausea
• Breast tenderness
• Mood disturbance
• Bleeding problems
• Headaches
• Libido reduction

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Combined Oral Contraception Pill (COCP)

Nausea, breast tender, headaches – reduce Ethinylestradiol.
Bleeding problems - increase Ethinylestradiol
Mood, bloating, weight gain, acne- change progestosterone.
Libido Issues - changing the progestogen to one with more androgenic activity (e.g. levonorgestrel, norethisterone).

Ethinylestradiol 20mcgs + Drospirenone Eloine	Ethinylestradiol 30mcgs + Drospirenone (For Acne) Yasmin/ Yasminelle	
Ethinylestradiol 20mcgs + Desogestrel/ Gestodene Marvelon / Gidarel / Femodette	Ethinylestradiol 30mcgs + Desogestrel/ Gestodene Marvelon / Gidarel / Femodene	Ethinylestradiol 35mcgs + Norgestimate/ Norethisterone Brevinor / Uchina / Clique / Norimin
	Ethinylestradiol 30mcgs + Levonorgestrel 150mcg (Can cause acne) Rigevidon / Microgynon / Lovest / Ovarlette	Cyproterone 2000mcgs + Ethinylestradiol 35mcgs Dianette

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Case Study 1

Age 43
 Partner 15 years
 No medical history/ medication
 Mother VTE at 50 years
 BMI: 32;
 BP: 139/85
 Ex smoker: stopped at 41 years

**Can she be given COC ?
 What would you offer?**

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Case Study 1

Age 43	UKMEC 2
Ex-smoker- stopped smoking at 41	UKMEC 2
BMI = 32	UKMEC 2
BP 139/85	UKMEC 2
Mother aged 50 with (VTE)	UKMEC 2

Consider COC with lowest risk Progestogen: NET/LNG Estrogen ≤30mcg
 Advise stopping COC at 50

<https://www.ukmec.co.uk/> UKMEC online calculator
 Disclaimer: To be used as an educational resource only. Not to be used alone to guide clinical decisions or patient care.

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Case Study 2

- Age 35 , in a new relationship was started on Microgynon 30 – 3 months back, attends for review
- Stopped smoking over 12 months ago (UKMEC 2)
- BMI = 24, BP 110/70
- Med Hx – on Thyroxine 50 mcg daily x 3 years
- No Family History of CVD
- Using condoms
- Problem: weight gain , low mood

What would you change her to and why?

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Case Study 2

Ethinylestradiol 20mcgs + Drospirenone Eloine	Ethinylestradiol 30mcgs + Drospirenone (For Acne) Yasmin/ Yasminelle	
Ethinylestradiol 20mcgs + Desogestrel/ Gestodene Marvelon / Gidarel / Femodette	Ethinylestradiol 30mcgs + Desogestrel/ Gestodene Marvelon / Gidarel / Femodene	Ethinylestradiol 35mcgs + Norgestimate/ Norethisterone Brevinor / Uchina / Clique / Norimin
	Ethinylestradiol 30mcgs + Levonorgestrel 150mcg (Can cause acne) Microgynon	Cyproterone 2000mcgs + Ethinylestradiol 35mcgs Dianette

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The Lowdown missed pill calculator

@get.the.lowdown the lowdown.

Missed a contraceptive pill?

Work out if you should use emergency contraception or extra contraception using The Lowdown's tool (based on UKC, Faculty of Sexual and Reproductive Health guidance)

Scan to use




You need The Lowdown's missed pill calculator!

<https://thelowdown.com/missed-pill-calculator>

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Progesterone Only Contraception

- Progesterone Oral Pill (POP)
- Long-Acting Reversible Contraceptives (LARCs)




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Progesterone Oral Pill (POP)

Norethisterone (NET) Age from menarche up to and including 54 years	Levonorgestrel (LNG) Age from menarche up to and including 54 years	Desogestrel (DSG) Age from menarche up to and including 54 years	Drospirenone (DSP) Age from menarche up to and including 49 years
UNPREDICTABLE BLEEDING with ALL POPs			

<https://www.england.nhs.uk/wp-content/uploads/2023/03/PRN00750-pgi-supply-pop-by-community-pharmacists-in-england-v2.0.pdf>



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FSRH
Clinical Effectiveness Unit

The Faculty of Sexual & Reproductive Healthcare of the Royal College of Obstetricians & Gynaecologists

FSRH CEU Quick Reference Guide: Progestogen-only Pills (August 2022, Amended July 2023)

Desogestrel 75 mcg



Norethisterone 350 mcg



Levonorgestrel 90 mcg



Drospirenone 4mg





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Norethisterone (NET)


Pros

- Breastfeeding safe
- Rapid Fertility reversibility

Cons

- Strict daily timing
- contraceptive efficacy may be reduced if taken more than 3 hours late

How to take
Taken daily within 3 hours
Day1-5 of period –no EP
Quick start – EP x 48 hours



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Levonorgestrel (LNG)


Pros

- Breastfeeding safe
- Rapid reversibility

Cons

- Strict daily timing
- contraceptive efficacy may be reduced if taken more than 3 hours late

How to take
Taken daily within 3 hours
Day 1-5 of period –no EP
Quick start –EP x 48 hours



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Desogestrel (DSG)


Pros

- 12-hour missed pill window improves adherence
- Safe in breastfeeding
- Very effective when taken correctly (99%)

Cons

- Efficacy may be reduced by certain medicines (enzyme inducers)
- Daily compliance required - typical failure rate 9%

How to take
Taken daily within 12 hours
Day1-5 of period –no EP
Quick start – EP x 48 hours



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Drospirenone (DSP)

Pros

- only POP in the UK with a 24-hour missed pill window
- anti-androgenic Properties (good for acne)

Cons

- Efficacy may be reduced by certain medicines (enzyme inducers)
- Daily compliance required - typical failure rate 9%

How to take
Taken daily with 24 hours missed pill rule
Day 1 -5 start – no EP
Quick start- EP x 1 week

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Table 1: Medical conditions that are UKMEC3 or UKMEC4 for use of the progestogen-only pill

Condition	UKMEC category	Comments
Current and history of ischaemic heart disease	UKMEC3 for continuation (UKMEC2 for initiation)	Duration of use of POP in relation to the onset of CVD should be carefully considered when deciding whether continuation of the method is appropriate (this is a precaution in case the POP somehow contributed to development of CVD)
History of stroke	UKMEC3 for continuation (UKMEC2 for initiation)	
Current breast cancer	UKMEC4	For individuals with a history of breast cancer, any decision to initiate hormonal contraception may be best made in consultation with their oncology team
Past breast cancer	UKMEC3	
Severe (decompensated) cirrhosis (associated with, eg, ascites, jaundice, encephalopathy or gastrointestinal haemorrhage)	UKMEC3	
Hepatocellular adenoma or carcinoma	UKMEC3	

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Long-Acting Reversible Contraceptives (LARCs) - Highly effective and low-maintenance

Contraceptive Method	Progestosterone	Effectiveness	Frequency of Change	Changes to Bleeding Pattern	Use in Breastfeeding	Return to Baseline Fertility	Pros	Cons
Implant (Nexplanon)	Etonogestrel 68 mg	99%	Every 3 years	Yes	No	After removal	Good for women who cannot take oestrogen	Can increase body weight; infections may occur; breast tenderness; red blood changes
Intrauterine Device (IUD-Copper Coil) (Para, T330, Biline, Para-T, Nova T)	-	99%	5-10 years (dependent on brand)	May cause heavier and more painful periods (often improve over time)	Yes	After removal	Hormone-free option	Risk of perforation and ectopic pregnancy
Intrauterine System (IUS-hormonal coil)	Levonorgestrel 52 mg (Mirena) / 13.8 mg (Liletta) / 20 mg (Savina)	99%	Mirena: 8 years / Liletta: 6 years / Savina: 5 years	Usually irregular bleeding in the first 6 months	Yes	After removal	Periods often become lighter	Can cause breast tenderness and mood changes
Contraceptive injection	Medroxyprogesterone (Depo-Provera 150mg/ml) / Savina Press 104mg / 0.65ml	94%	Depo: Every 12 weeks (+/- 5 days) / Savina Press: every 13 weeks	May cause irregular bleeding	Yes	Return to fertility may take 6-12 months	None directly due to oestrogen withdrawal	Possible mood and libido changes, can temporarily decrease bone density during use


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Case Study 3


25 yr old, on Yasmin stopped after 3 months due to migraines on COC (UKMEC 3)
 However, Yasmin did improve her acne
 No other risk factors for CVD, no risk factors for VTE
 BP 110/70 mmHg, BMI=26
 Has tried Desogestrel pill - made acne worse
 Worried about trying LNG/NET due to 3 hrs missed pill window period
 Not keen on LARC methods – Depo may worsen acne, doesn't like the idea of having something inside her – coil/implant feels not in control.
 What are her options?

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Emergency Contraception



Ulipristal pill- EllaOne (UPA-EC)
 delays ovulation → up to 5 days post UPSI (unprotected Sexual Intercourse)

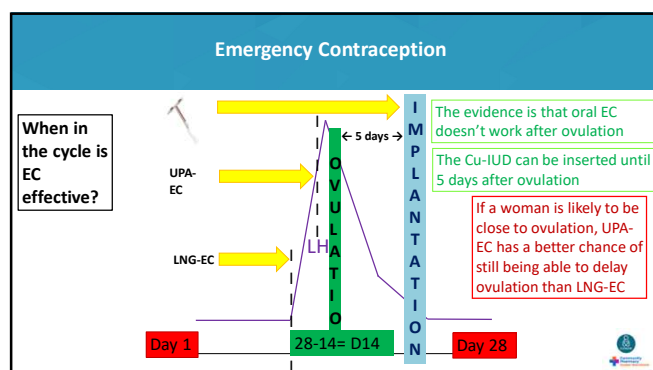


Levonorgestrel pill Levonelle (LNG-EC)
 delays ovulation → up to 3 days post UPSI



Copper IUD (CU-IUD)
 blocks fertilisation/implantation → most effective, up to 5 days post UPSI

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Emergency Contraception

UPA-EC has been demonstrated to be more effective than LNG-EC when taken less than 120 hours after UPSI....

shouldn't we always give UPA-EC all the time?


?



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Emergency Contraception

Scenario	Preferred Option	Comment
Most women presenting ≤ 120 h post UPSI, esp. pre-ovulation	UPA-EC (GIMMGG 1 st line)	Most effective oral EC
Needs immediate ongoing hormonal contraception	LNG-EC	UPA-EC requires 5-day delay before hormone quick start
On enzyme-inducing drugs	Double dose LNG-EC Cu-IUD	UPA-EC's effectiveness is reduced
High BMI	Cu-IUD	UPA-EC effectiveness may be reduced at BMI >30 kg/m ² OR weight >85 kg LNG-EC if BMI >26 kg/m ² or weight >70 kg- Double dose
Breastfeeding	LNG-EC Cu-IUD	with UPA-EC, passes into breast milk \rightarrow must express & discard milk for 1 week.
Severe asthma managed with oral steroids,	LNG-EC	UPA-EC's effectiveness is contra-indicated
Gastric pH-raising medications (e.g. antacids, PPIs, H2 antagonists)	LNG-EC Cu-IUD	UPA-EC efficacy may be reduced by these drugs

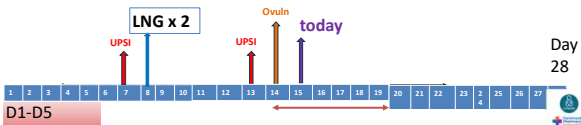



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Case Study 4

- Age 30, LMP (start date)- 15 days back, Cycle every 28-30 days
- BMI=27
- UPSI - 8 days back (on D7 of cycle)
- Took LNG -1500 (double dose) following day on D8
- Another UPSI 2 days on D13, attends on D15


Requests EC, what are her options?

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Repeat usage of EC


<p>Taken UPA-EC</p> <p>LNG-EC should not be taken in the following five days</p> <p>↓</p> <p>Cu-IUD UPA-EC</p>	<p>Taken LNG-EC</p> <p>UPA-EC could theoretically be less effective if taken in the following seven days</p> <p>↓</p> <p>Cu-IUD LNG-EC</p>
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When To Start Contraception after EC

After UPA-EC



5 days wait


Start

- CHC
- POP
- Nexplanon®
- (Depo)

7 days ---->
condoms
(2 days for POP)


After LNG-EC

- Start hormonal contraception immediately
- Advise condoms for 7 days (POP 2 days)



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What about Drug Interactions with Contraception?



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Interacting Medication	Contraceptive Choice
Carbamazepine, Phenytoin, Phenobarbitone, Primidone, oxcarbazepine, Topiramate, Lamotrigine, Modafinil, Griseofulvin, Rifampicin, St Johns Wort,	LNG-IUD Copper IUD Depo Provera/Sayana press
Sodium Valproate	LNG-IUD, Copper IUD, Implant If using CHC, POP, Depo Provera – advised to use condoms in addition
GLP1 Agonists (Mounjaro)	For Oral contraception-use a barrier method of contraception (e.g. condoms) in addition to the contraceptive pill for four weeks after starting Mounjaro, and for four weeks after any increase in dose. Or use non-oral method of contraception
UPA-EC	Initiation of hormonal contraception must be delayed for 5 days after UPA-EC

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Case Study 5

Age 40
She has tried various contraceptives in the past

- Copper IUD – heavy periods
- Desogestrel and traditional POP – NET, LNG- bleeding problems
- Not keen on Implant
- LMP – 3 weeks back, Periods regular not heavy , in a new relationship, using condoms

BP 110/70 mmHg, BMI=31, smoker
Can she have the Combined pill? What are her contraceptive options ?

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Case Study 5

	UKMEC
Smoker age 40	3
BMI=30	2
LNG-IUS/ Progesterone Injection	

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Case Study 6

20 yr old , in a new relationship wants to start combined pill for contraception
She has a history of heavy periods
She is on Lamotrigine for epilepsy for past 12 months
Can she be prescribed COC?

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Case Study 7

- Age 33, has no medical problems
- She is currently fully breastfeeding her 5-month-old baby
- She takes no medication
- She is not aware of any relevant family history
- She has never smoked
- Her BMI is 28 kg/m², BP 120/74 mmHg
- Previously on Gedarel, can she have this?

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Case Study 7

	UKMEC	CONDITION	Cu-IUD	LNG-IUS	IMP	IMPA	POP	OR
BMI is 28 kg/m ² ,	2							
BP 120/74 mmHg	<140/90							
Breastfeeding, 6 months post delivery	2							
She can have COC								

PERSONAL CHARACTERISTICS AND REPRODUCTIVE HISTORY	Cu-IUD	LNG-IUS	IMP	IMPA	POP	OR
Breastfeeding						
a) 0 to <6 weeks			1	2	1	4
b) 6 weeks to <6 months (primarily breastfeeding)	See below	1	1	1	2	
c) 6 months		1	1	1	1	1
Postpartum († non-breastfeeding women)						
a) 0 to <3 weeks			1	2	1	4
b) 3 to <6 weeks	See below	1	2	1	3	
c) 6 to <8 weeks		1	2	1	3	
d) 8 to <12 weeks	See below	1	1	1	2	
e) 12 to <18 weeks		1	1	1	1	1
Postpartum († breastfeeding or non-breastfeeding women, including postmenopausal women)						
a) 0 to <48 hours		1	1			
b) 48 hours to <4 weeks		3	3			
c) 4 weeks		1	1			
d) Postpartum sepsis		4	4			

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Summary

- No one-size-fits-all → tailor to age, risks & preferences.
- Use UKMEC to guide safe choices.
- CHC effective but avoid with age >50, migraine with aura, VTE/CVD, breast cancer, severe liver disease, or multiple risk factors. Refer to PGD
- POPS & LARCs are safer for many women; LARCs are most effective.
- Unpredictable bleeding patterns with all POPS
- EC: Cu-IUD best, UPA > LNG (unless recent hormones).
- Shared decision making is key.



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Thank You
Any Questions?



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