Update on LARC methods –
(and a little about Emergency Contraception)

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“LARC” - NICE Guidelines, October 2005:

Long **A**cting **R**eversible **C**ontraception

“Long Acting” = lasting longer than one month

Aims of this session

- How to assess / advise patients appropriately: which LARC method for which woman?
- How to help her keep it - irregular bleeding
- To update on the BNSSG LARC training scheme
- Emergency Contraception – when should you consider EllaOne or an emergency IUD?
- CASH service appointments for emergency IUD fittings

LARC METHODS

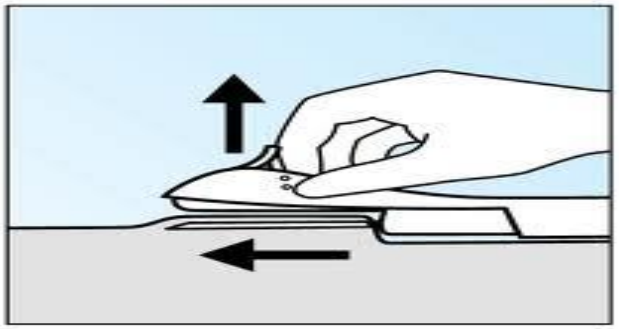
IUS – now 2 types: Jaydess Mirena

IUD

LARC

DEPO PROVERA

IMPLANTS

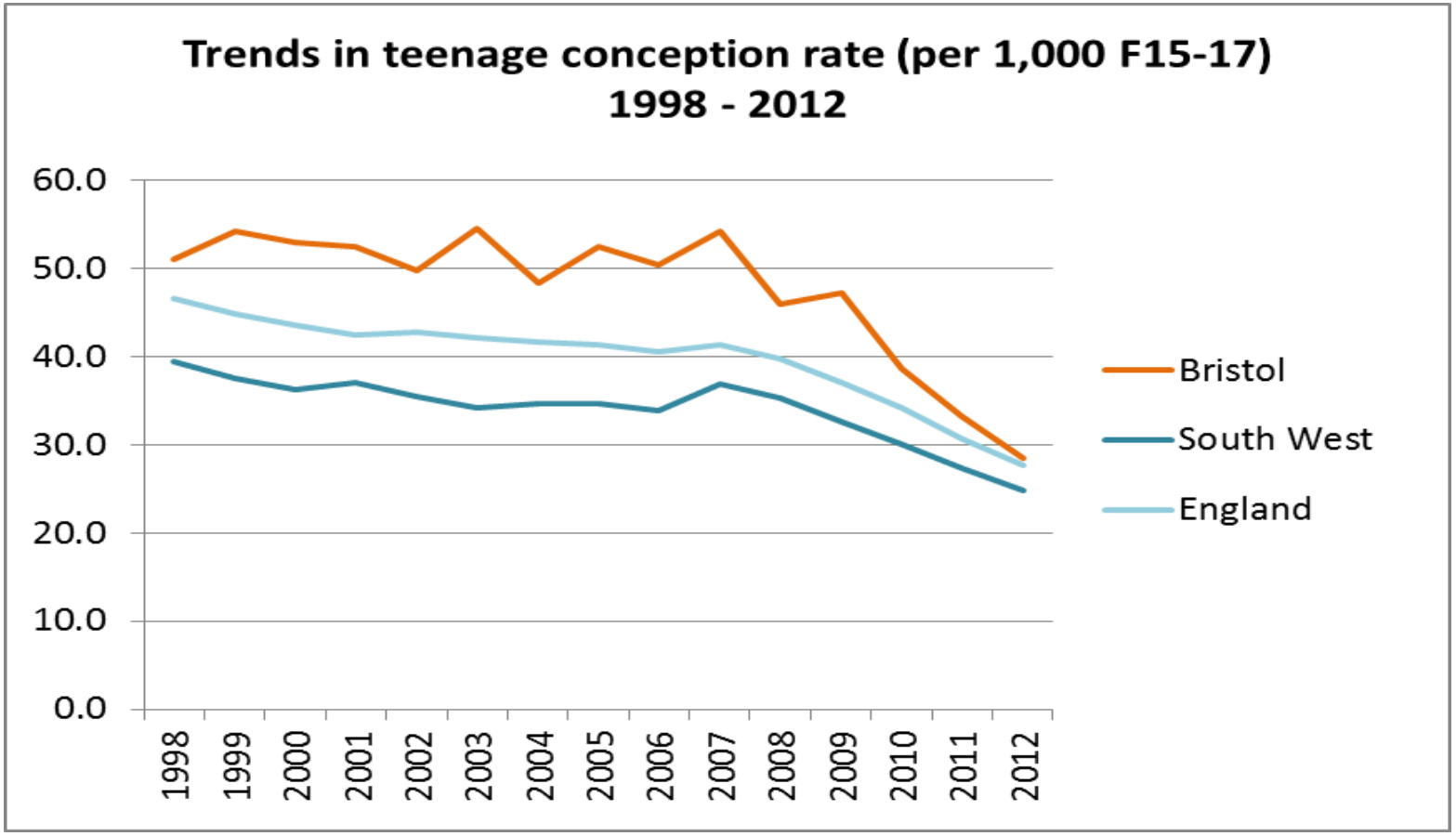


Why the push for women to use these methods?

- Prevent unplanned pregnancies
- IUD, IUS and Implants are very, very reliable:
- < one pregnancy /100 woman-yrs
- Cost effective

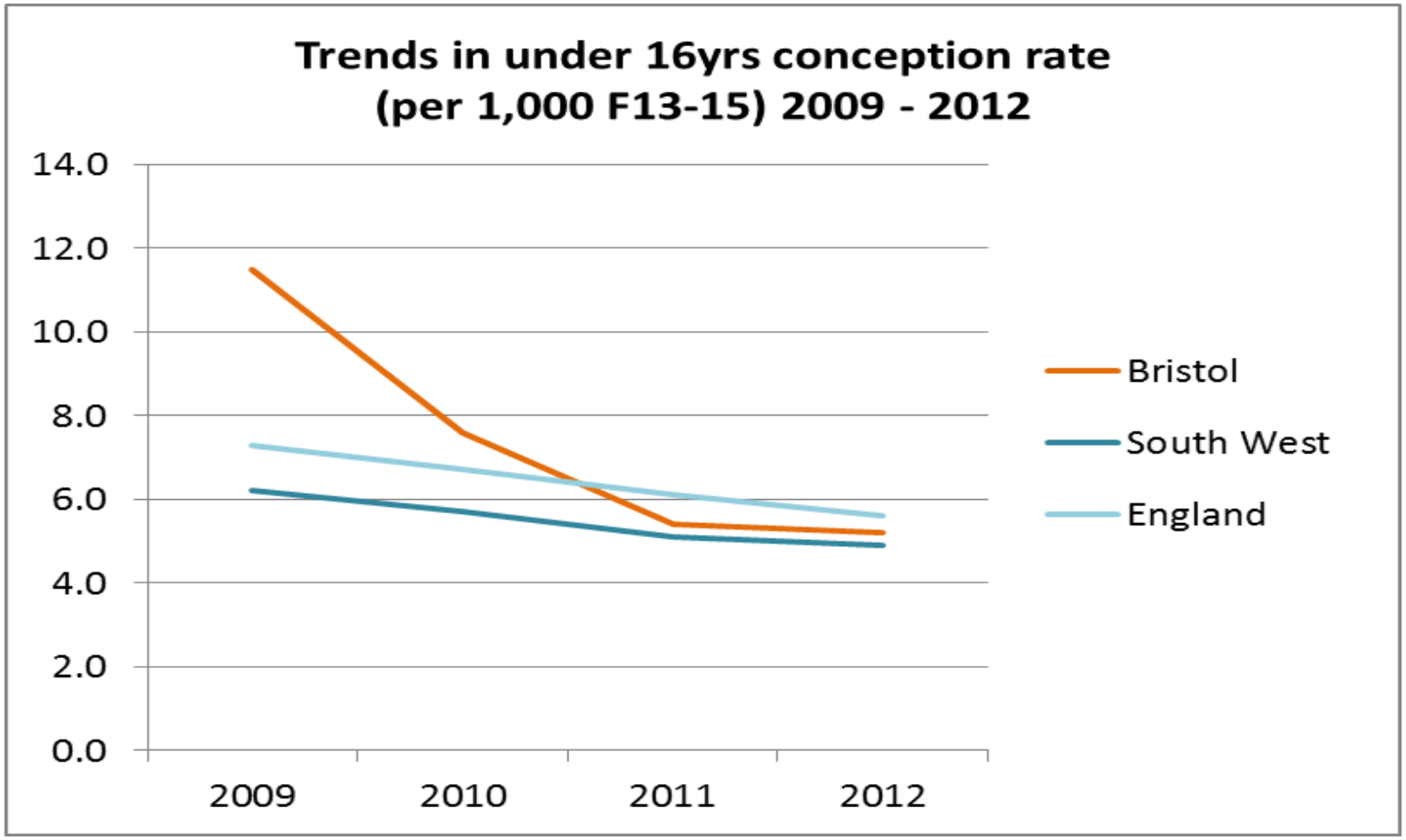
Teenage pregnancy rates are falling

Stats from the Office for National Statistics & Public Health Bristol

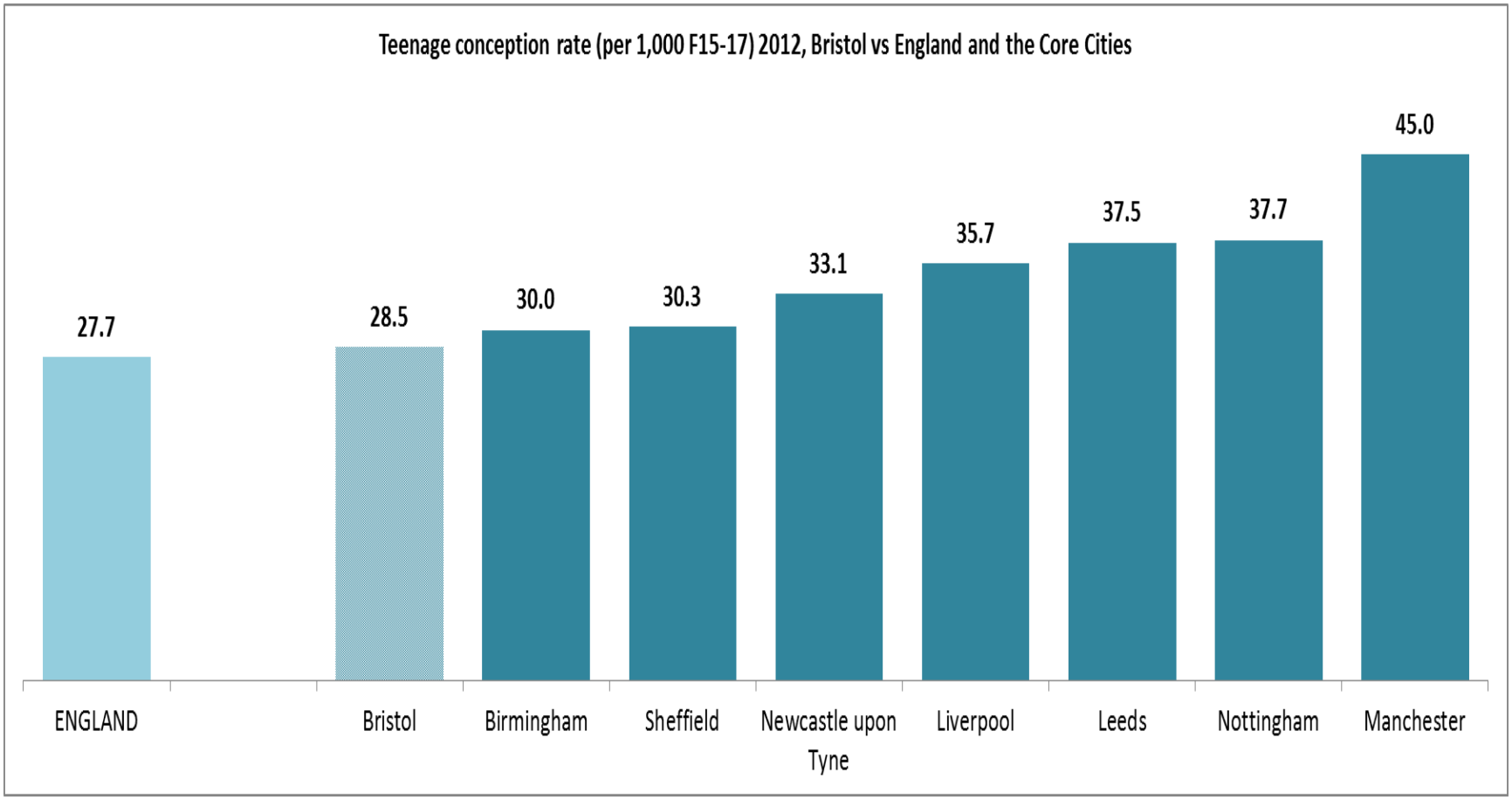


Under 16 years since 2009

Stats from the Office for National Statistics & Public Health Bristol



Bristol compared to other core cities

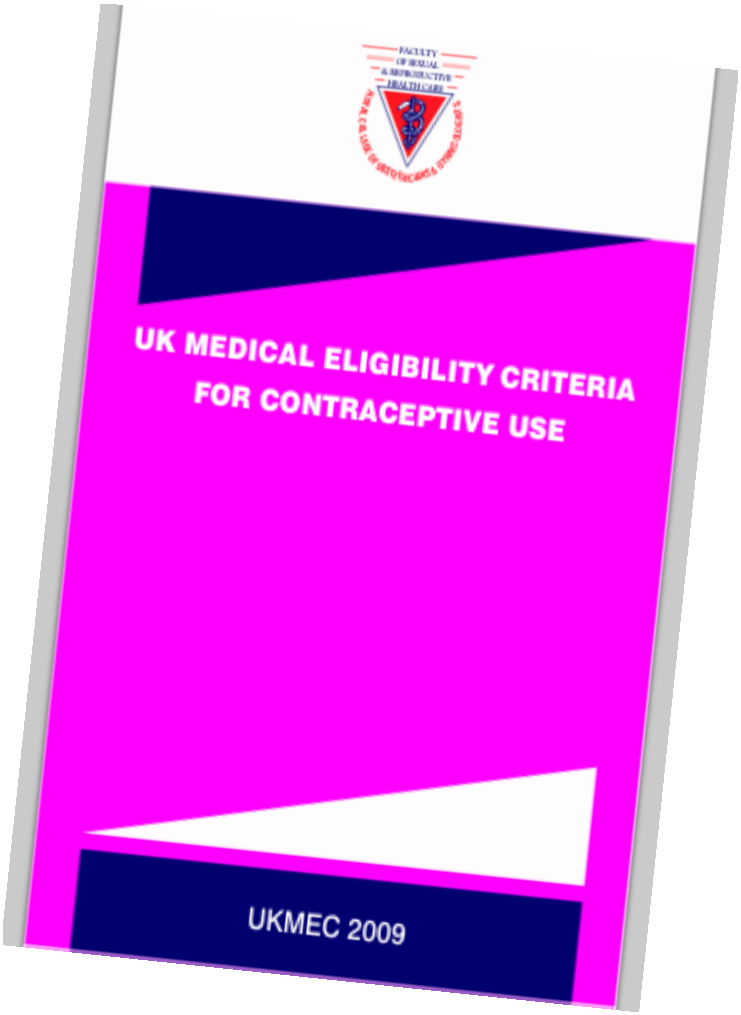


Cost Effectiveness: 2005 NICE Guidelines

- LARC methods are more cost effective than the COC or male condom, even at only 1 year of use
- Up to 2 years, Depo is cheapest LARC – but also the least effective
- IUDs, IUS and Implants are more cost effective than Depo Provera
- Female sterilisation has a higher failure rate than IUDs, IUS or Implants
- Sterilisation (male and female) only become more cost effective after 15 years of use

Which LARC method for which women?

- **Brief medical hx**
  - Any conditions requiring liver enzyme inducers?
- **Brief gynae / sexual hx – eg:**
  - Vaginal deliveries vs C-sections
  - Menorrhagia / dysmenorrhoea
  - Risk of STI
- **What has she used before ?**
  - Her attitude to “hormones” and whether she wants a regular period – or not
  - She’ll tell you what she’s heard / what her friends use
  - She’ll tell you if conceived after coil expelled etc
- **What are her thoughts about any future pregnancy ?**
  - Is she spacing children or thinking of longer term contraception ?
  - Consider Depo Provera’s risk of delayed return to fertility


FACULTY
OF SEXUAL
& REPRODUCTIVE
HEALTHCARE
UK MEDICAL ELIGIBILITY CRITERIA
FOR CONTRACEPTIVE USE
UKMEC 2009

What problems do women complain of?

IUD / IUS

- Bleeding
- Pain
- Bleeding and Pain
- Worried it has fallen out
- Systemic symptoms possible but very rare
- Fantasies about “foreign body” etc

Implants

- Bleeding
- “Pill”-type side effects
- Sometimes – period-type pains
- Discomfort at site of implant
- Acne
- Fantasies about “foreign body” etc

UKMEC for IUD/IUS

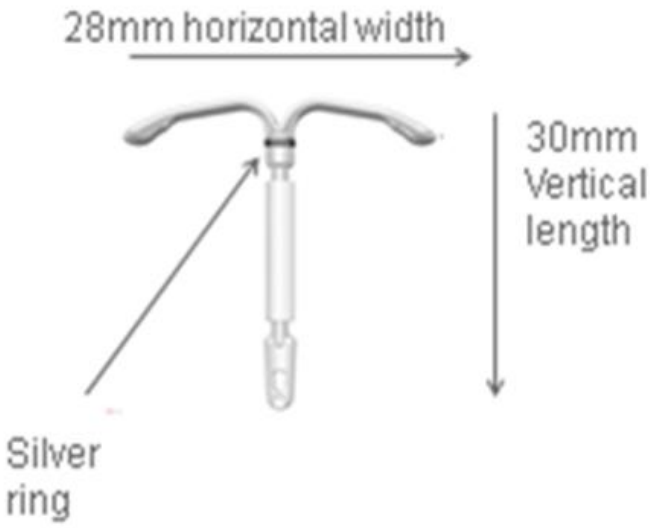
- Uterine fibroids
- Uterine Fibroids with distortion of cavity
- Cervical abnormalities / stenosis
- PMH PID
- Current PID
- HIV Positive

- UK MEC 1
- UKMEC 3
- UKMEC 2
- UKMEC 1
- UKMEC 4
- UKMEC 2

What is Jaydess®?

Jaydess® is:

- The world's smallest IUS (28x30mm)
- Placed using the smallest diameter insertion tube for an IUS (3.8 mm)
- The lowest average daily dose of LNG-IUS available (6 µg levonorgestrel)[1]
- Licensed for contraception for up to 3 years[1]



Jaydess®

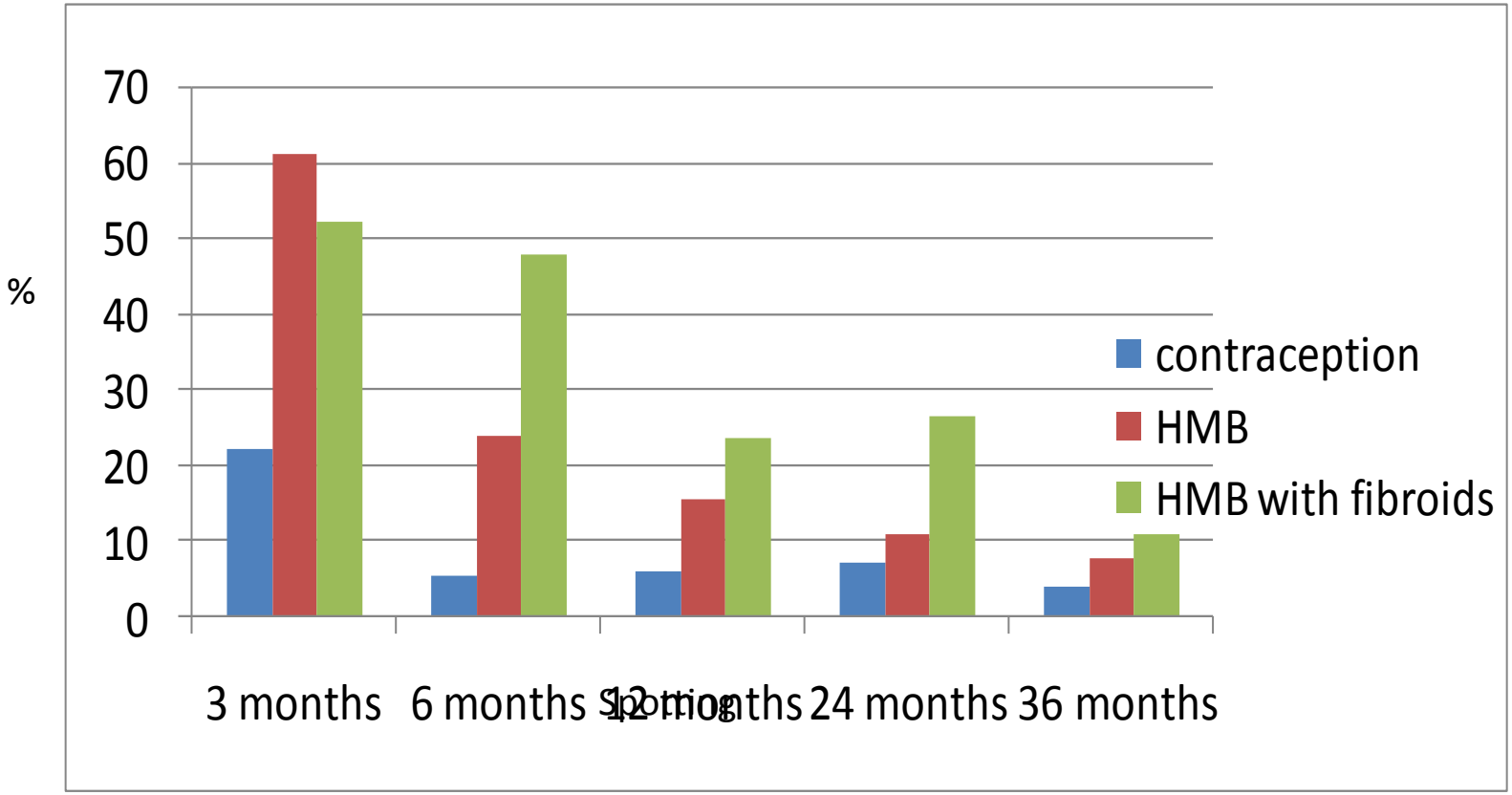
IUS, intrauterine system.

1. Jaydess® Summary of Product Characteristics, Bayer plc

IUD / IUS - bleeding

- IUD users:
  - Will probably have more prolonged periods, especially compared to withdrawal bleeds with COP – usually 6-8 days
  - May have heavier periods with clots / flooding / dysmenorrhoea on Day 1 or 2
    - Mefenamic Acid for 24 -48 hours before period starts may help reduce bleeding
- Mirena:
  - Periods usually much lighter – so licensed for HMB
  - Spotting in between periods is common for first 3 – 6 months
  - Amenorrhoea with Mirena:
    - some women ask to have IUS removed because they want a regular period - so pre-counselling crucial
- Jaydess: most likely cyclical bleeding +/- some BTB

Bleeding patterns with Mirena



Magalhaes et al. Contraception 2007

IUD / IUS – Causes of Pain:

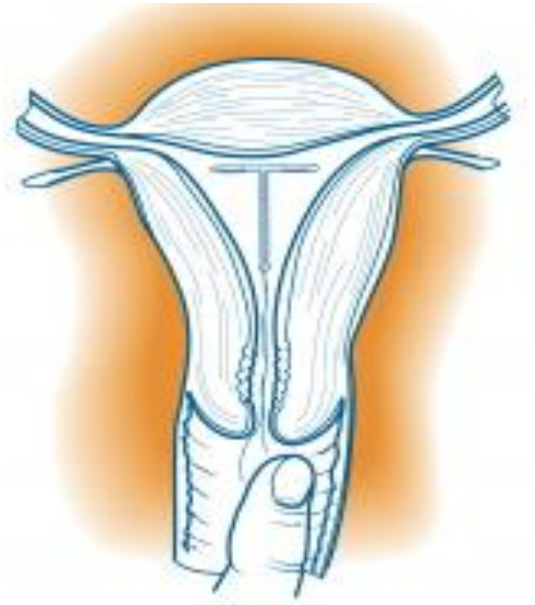
- **P**elvic Infection (PID)
- **P**artial Expulsion
- **P**regnancy (?? Ectopic)
- Other gynae causes
- Non-gynae causes

Pelvic Infection

An intrauterine device does not ***cause*** PID

- Risk is higher than the background risk only in the three weeks following insertion
- Careful sexual history and pre-insertion NAAT swab reduces this risk
- Give Azithromycin at the time of fitting if high risk of chlamydia
- Advice concerning future STI risks should be given
- Nullips can have an IUD/S – the main reason for concern is their risk of acquiring future infection – so explain

IUD / IUS



If the woman can't feel the threads:

- Have a look

If you can't see the threads:

- ? Pregnant
- **or at risk of pregnancy until proven otherwise**:

- So: Pregnancy Test
  - Advise extra contraception
  - USS
  - ?expelled
  - ?perforated

Implants

Don’t give the data sheet!

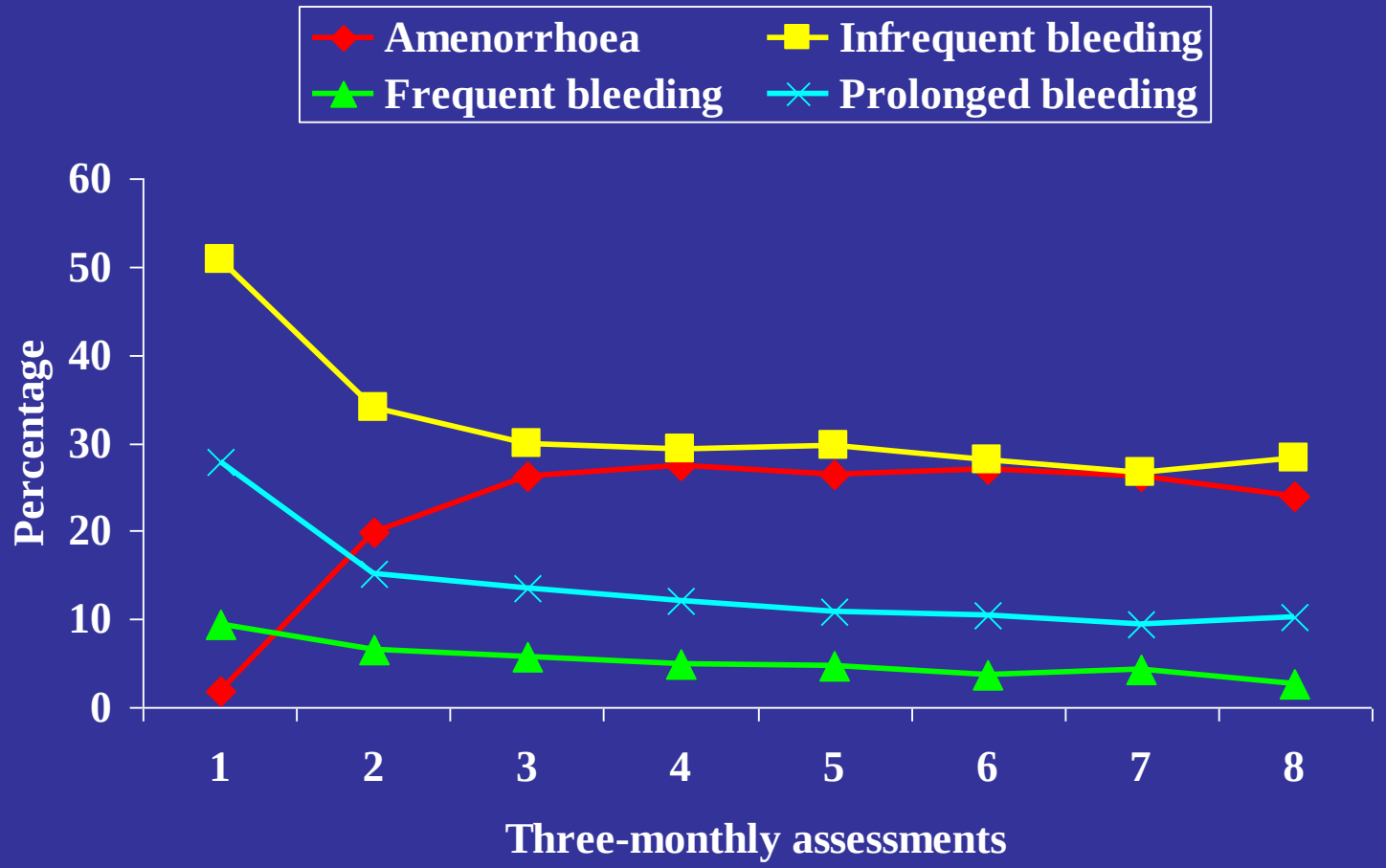
Discomfort at site of implant:

- Have a look
- If it looks infected (very rare) – treat.

Don’t play with it!

Allergic reaction is “never” seen

Bleeding patterns with Implants



Bleeding patterns with Implants

- Amenorrhoea – 25-30%

- Infrequent – ie normally acceptable irregular bleeding: 25-30%

- Up to 50% can have frequent or prolonged bleeding intially
  - Many women find prolonged bleeding /spotting improves over the first 6/12

  BUT
  - 10% have >14 days of bleeding / spotting each month at 1 year

- So:
- Warn women that it is NORMAL to have irregular bleeding with implants
- Ask her to keep a diary of her bleeding pattern / other symptoms

- Never recommend an implant to help a woman to “control” her bleeding

Mechanism of unscheduled bleeding with progestogen-only LARC methods

- Leaky tight junctions between endothelial cells of endometrium
- Altered clotting cascade
- High dose progestogen needed to precipitate complete atrophy
- Small events (eg SI, BO) perceived as trauma, and then bleeding persists

Management of unscheduled bleeding with progestogen-only LARC (1)

Ask her to keep a bleeding / symptom diary:

Purpose of treatment is to EITHER

- Stop a bleeding episode by interrupting the vicious cycle of bleeding
- OR
- Atrophy the endometrium

Management of irregular bleeding with any contraceptive method – consider:

- Pregnancy
- Infection (Chlamydia)
- Drug interactions (eg: liver enzyme inducers with implants)
- IUD/S - ? Partial expulsion – check threads, consider USS
- Cervical ectropion / polyp
- Endometrial pathology (polyps etc)
- Foreign body in vagina

Management of unscheduled bleeding with progestogen-only LARC (2)

Whenever she has bled for more than 7 or 8 consecutive days:

- Ethinyl estradiol as combined pill (if eligible) – one or two cycles (not "back to back") and review….
- **OR**
- Mefenamic acid – 500mg 2x daily for up to 5 days

- a POP: eg Cerazette

- Progestogens: eg Norethisterone 5mg up to 3x daily for 21 days (NOT included in FSRH guidance)

- Consider Depo Provera – can be useful for some women (NOT in FSRH guidance)

Repeat if needesd

How do you manage bleeding problems with LARC in your practice?

How do you manage requests for removal in your practice?

How do you manage requests for new fittings in your practice?

2014: LARC Training changed

- The FSRH Letters of Competence (LoCs) are now stand-alone qualifications – you no longer require DFSRH first
  - Need to do eKA and e-SRH module 17 or 18
- Faculty membership is open to nurses for both diploma and LoCs
- 5 yearly reaccreditation

The BNSSG LARC Training Scheme
started 2011 – currently “on hold”

- In addition to existing training scheme via the Contraception service
- DOH funding: “Improving Access to Contraception”
- Funded originally via PCTs - Public Health commissioners for each area: identify practices which require training in LARC methods, targeting “areas of greatest need
- Faculty trainers come to your practice for practical training sessions
- Two Routes to qualification:
  - National accreditation = the Faculty LoCs
  - Local LoCs
- But:
  - Since the Faculty changes in 2014 most areas have stopped awarding local LoCs
  - Because local authorities are uncomfortable with the responsibilities of clinical governance and reaccreditation issues

Current options for LARC training in BNSSG

- Via the contraception service:
  - DFSRHtraining@UHBristol.nhs.uk
- UWE – integrated sexual health course includes implant fitting
  - University accredited, not Faculty
  - Reaccreditation pathway not clear
- The drug companies:
  - Implants: MSD
  - IUD / IUS – Bayer
  - Both of these will only offer training for FSRH Letters of Competence.

BNSSG / Public Health - 2015 Audit of LARC Provision in general practice

- Plan is to do a “mapping” exercise this summer of current LARC provision within general practice
- Part of this will include a survey of LARC fitter’s qualifications and their views about the relevance the Local Letters of Competence
- Part will be “sharing best practice” – useful templates, READ codes etc

Remember - C&SH clinics can only fit Mirena or Nexplanon:

- If the woman is registered with a practice that does not fit either coils or implants
- If she's resident in BNSSG but not registered with a local GP
- Under 18 years old
- If she's not using effective contraception
  - ie: Condoms only, withdrawal or no contraception
- If there's a "complex long-term medical condition"
  - Includes learning difficulties & significant mental health issues
- The GP supplied the IUS or Implant
  - (without being requested to do so)
- There is a GP referral – letter or phone call

Emergency contraception

	Approx failure rates
Levonelle	1 in 50
EllaOne	1 in 100
Copper IUD	1 in 1000

The woman should be warned of the need for a pregnancy test if her next period does not start on time

Woman needing emergency contraception

- <u>Assess:</u>
- Time since UPSI, in hours
- Current day of cycle
- Any other risk of pregnancy this cycle
- Any UPSI > 120 hours ago
  - So not suitable for UPA

- <u>Record:</u>
- Shortest cycle length (= L)

  so:
- Earliest predicted ovulation day = L – 14 days
- Therefore calculate, with the patient:
  - **Her earliest possible date of ovulation**
  - **Day of Ovulation + 5 days is the latest an emergency IUD can be fitted**

<u>An Emergency IUD can be fitted:</u>

Either:

up to 120 hours after a single episode or the earliest episode of UPSI at any time in the cycle

OR:

After multiple episodes: up to 120 hours after the earliest predicted ovulation.

So offer all women an emergency IUD – the most effective method.

- An IUD could last 10 years –-or post-menopause when fitted in a woman > 40

- Central Health clinic and Brook both have one appointment available each day for emergency IUD fittings – referral form on BSHS website

If patient declines an IUD:

- **If 0 -72 hours**
  - **and not within 48 hours of predicted ovulation**:
  - **Levonorgestrel 1500mg**
- **If > 120 hours:**
  - **Not for UPA**
  - **Not for LNG**
  - **Proactive follow-up with pregnancy test and consider starting contraception immediately**

UPA can be given if:

- **If 0- 120 hours,** especially if within 48 hour period before expected ovulation:
  - No exclusion criteria
  - **Ulipristal acetate 30mg**
- **If >72 – 120 hours,**
  - No other previous UPSI this cycle,
  - No exclusion criteria:
  - **Ulipristal acetate 30mg**

Remember most common exclusion criteria for UPA:

No UPSI > 120 hours ago or any other possible risk of pregnancy

No previous UPA use this cycle

Or – if uncertain and nothing else to offer: Levonorgestrel 1500mg

Ulipristal acetate (EllaOne)

- A progesterone receptor modulator
- Primary mechanism of action is to inhibit or delay ovulation
- Usually well tolerated, but could have usual hormonal SEs
- Dose 30mg – may repeat if patient vomits within 3 hours, so long as she's still within 120 hours UPSI

Ulipristal - BNSSG clinical guidance, April 2013

- Indications:

- Women who present between 72 and 120 hours post UPSI for whom emergency IUD is unacceptable or awaited

- Women who present in the 48 hours before predicted ovulation

- Women allergic to Levonorgestrel

- Exclusion criteria:

- UPSI > 120 hours (5d) ago / women in whom pregnancy can't be excluded
- Unexplained or unusual vaginal bleeding
- Severe liver disease
- Severe asthma – not controlled by steroids
- Women who have already taken Levonelle for the same episode UPSI or who have taken EllaOne earlier this cycle.
- Breastfeeding women – would need to stop for 7 days.
- Potential drug interactions:
  - **PPIs, Antacids, H2 agonists**
  - **Liver enzyme inducers or inhibitors**
  - **May reduce the effectiveness of her usual hormonal contraception**

Key messages

- **Use the FSRH on-line guidance:**
- **Become an advocate for copper IUDs and use the emergency appt system….!**
- **For LARC: consider "quick-starting" a LARC method if appropriate:**
- **Use an interim method whilst waiting to fit LARC:**
  - **Could reception staff offer telephone call from clinician - to assess pregnancy risk**
- **IUS: use the non-contraceptive benefits:**
- **To reduce the risk of early removal:**
  - **Explain fully about bleeding patterns, including what can be done to help, if troublesome.**
  - **Encourage women to use bleeding diaries – it helps them to feel more in control**

- **www.fsrh.org.uk**
- **But ideally also give oral emergency contraception when patient first seen**
- **You may start a hormonal method, or fit an implant, IUD/S immediately, if a woman has been using condoms "consistently & correctly"**
- **Desogestrel POP is the most useful – especially after oral emergency contraception**
- **eg: for menorrhagia or as the progestogen component of HRT**
- **Irregular bleeding is better tolerated if she knows it's not abnormal**
- **Remember some women don't want amenorrhoea**