Progestogen Only Pills

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Progestogen Only Contraception

- Implant
- Pills
- Injectables

POC

- No restrictions to use based purely on age
- Can be used during lactation
- Suitable for women with contraindications to estrogen containing contraceptives
- No restrictions to use based purely on smoking history

POP

POPs can be divided into two categories:

- Those that work primarily by a cervical mucus effect
- Those that work primarily by inhibiting ovulation

POP

POPs That Work Primarily by a Cervical Mucus Effect:

- primary mode of action is to cause thickening of cervical mucus, inhibiting sperm penetration into the upper reproductive tract
- contain either norethisterone 350 µg (Micronor™, Noriday™) or levonorgestrel 30 µg (Norgeston™)
- referred to as traditional POPs
- must be taken within three hours of the same time every day

POP

POPs That Work Primarily by Inhibiting Ovulation:

- Desogestrel (DSG)-containing POPs work predominantly by suppressing ovulation
- more effective than traditional POPs and may be less likely to be associated with follicular cysts and ectopic pregnancy
- should be noted that ectopic pregnancy risk is lower with any type of POP than when using no contraception at all
- appropriate for use for younger women or those with a history of symptomatic simple ovarian cysts
- must be taken within 12 hours of the same time every day

POP

How effective??

- With consistent and correct use (i.e. 'perfect' use) the failure rate is <1%. However, 'typical' use gives a much higher failure rate of 8%.
- No need for 2 pills for heavy women

POP

Suitability:

As with all contraceptives, the clinician should take a full medical history to identify any conditions that fall within the UKMEC categories 3 or 4. For example:

- UKMEC 4 - current breast cancer
- UKMEC 3 - history of breast cancer, active viral hepatitis, severe cirrhosis, malignant and some benign liver tumours, use of liver enzyme-inducing drugs, systemic lupus erythematosus with positive or unknown antiphospholipid antibodies, continuing the method if newly diagnosed with ischaemic heart disease or stroke

POP – What to check when starting

- Medical History
- Previous contraception used: were there any problems?
- LMP and menstrual history
- Gynaecological history, obstetric history
- Medication
- Allergies
- Sexual history

POP – Drug Interactions

Enzyme-inducing drugs:

- increase the metabolism of POPs
- need to change to an alternative contraceptive method that is unaffected by liver enzyme-inducing drugs recommended for both short and long term use

Ulipristal Acetate (UPA):

- POPs may reduce the efficacy of UPA
- women using UPA for emergency contraception are advised not to start a hormonal method of contraception for at least five days and to use barrier methods or to abstain from sex until effective hormonal contraceptive cover has been achieved - this takes two days with POPs

Not affected by antibiotics

POP - Issues

Bleeding Patterns:

As a guide, of those using DSG-containing POPs after one year of use, approximately:

- 5 in 10 can expect amenorrhoea or infrequent bleeding
- 4 in 10 can expect regular bleeding
- 1 in 10 can expect frequent bleeding

Traditional POPs = frequent and irregular bleeding common + prolonged bleeding and amenorrhoea less likely

Mood Changes and Other Side Effects:

- mood change can occur
- acne and breast tenderness have been reported

POP - Starting

General:

- started up to and including day five of the menstrual cycle without any additional contraception with immediate effectiveness
- can be started on any day of the cycle, provided it is reasonably certain that the woman is not pregnant - additional contraception needed for 48 hours

Postnatal:

- started up to day 21 without additional contraception
- after day 21, additional contraception must be used for 48 hours

Post Miscarriage/Abortion:

- Following day five, extra precautions are needed for 48 hours

POP - Starting

Following oral emergency contraception (EC) administration:

- can 'quick start' the POP if the woman is likely to continue to be at risk of pregnancy or unlikely to return
- additional contraception is advised for 48 hours following levonorgestrel EHC
- women using UPA for EHC are advised not to start a hormonal method of contraception for at least five days and to also use additional contraception precautions for 2 days

POP – Changing from another method

if a method has been used consistently and correctly, POPs can be started as soon as the previous method is ceased and are effective immediately EXCEPT:

Combined hormonal contraception (CHC)

- within 7 days of use, there is a need to use extra precautions for 48 hours
- if unprotected sexual intercourse has occurred in the hormone free interval or week one, continue CHC for at least seven consecutive days before switching to POP
- if CHC cannot be continued, switch to POP immediately and consider the need for EC and pregnancy test

AND…….

POP – Changing from another method

Intrauterine contraception (intrauterine devices and systems):

- extra precautions are needed for 48 hours (start pills 2 days before removing device)
- if an IUD/IUS is removed during the first five days of the menstrual cycle, no additional precautions are required

POP - Checks

- 1st review of the method at three months
- yearly review is sufficient in the absence of any special problems

POP – Missed Pills

If a traditional POP is >3 hours late (or >12 hours late if a DSG-containing POP), the woman should:

- Take the late or missed pill immediately
- Continue pill taking as usual (even if this means two pills in one day)
- Use condoms or abstain from sex for 48 hours after the pill is taken
- If unprotected sexual intercourse (UPSI) does occur during this interval, emergency contraception may be required

Poorly Absorbed Pills - vomiting or severe diarrhoea occur within two hours of pill taking, another pill should be taken as soon as possible

POP – Stopping?

- POP should be stopped at the age of 55
- POP does not suppress FSH (Follicle Stimulating Hormone) levels, enabling them to be used to diagnose the menopause if required (see NICE guidance 2015)