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GENERAL PRACTICE SUPERVISION AUSTRALIA

FAQ
FREQUENTLY ASKED QUESTIONS

PODCAST WEBINAR

Contraception: an update for GP supervisors

Since the renewal of the National Cervical Screening Programme, we have moved away from a two-yearly well women check. Widespread use of long-acting reversible contraception ("LARC") coupled with five-yearly screening has resulted in a substantial decrease in the frequency of Women's Health visits, making the contraception consult particularly important as a platform for opportunistic activity and reproductive health advice.

The Contraception Consultation

- Contraceptive history – identify any contraceptive failures, assess compliance if currently using non LARC method
- Medication history (enzyme inducers, teratogens)
- Significant medical history – identify any UKMEC C/I (eg migraine with aura), 1st degree relative VTE history
- VTE risk factors
- Current symptoms (abnormal bleeding, dyspareunia etc)
- Menstrual history
- Sexual History
- Reproductive/pregnancy history
- Smoking status

OPPORTUNISTIC SCREENING

- STI screening
  http://www.sti.guidelines.org.au/
- Cervical screening
  https://wiki.cancer.org.au/australia/Guidelines:Cervical_cancer/Screening
- Breast/bowel/CV/bones
- Reproductive – One Key Question: *Would you like to become pregnant in the next year?* If no, then adequate contraception should be offered; if yes, you can enable provision of adequate preconception care.
- Consider domestic violence / reproductive coercion

Self-collected cervical screening options are important for under-screened women. Supervisors should highlight guidelines for their registrars and mention the 2020 paper showing 37.2% had accessed screening options "never or rarely".

EXAMINATION

- BP & BMI
  BMI & BP are very important in informing any contraindications - COCP C/I in HTN & BMI over 35.
- Consider trial of speculum if planning IUD and never had a speculum examination
- Routine breast and pelvic exams not indicated and no longer recommended
- Always examine a symptomatic patient
  Eg – thrush and vulval cancer, discharge and retained tampon, PCB and large polyp / cervical lesion

UKMEC criteria to assess medical eligibility for contraceptives

MEC Category	Condition and example
MEC 1	A condition for which there is no restriction for the use of the contraceptive method. e.g. nulliparity & IUD use.
MEC 2	A condition where the advantages of using the method generally outweigh the theoretical or proven risks. e.g. previous VTE & progestogen-only method.
MEC 3	A condition where the theoretical or proven risks generally 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. e.g. smoking <15 cigarettes per day in a woman aged 35+ years & combined hormonal method.
MEC 4	A condition which represents unacceptable health risk if the contraceptive method is used. e.g. migraine with aura within 5 years and combined hormonal method.

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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) (eg. wheelchair use, debilitating illness)	1	1	1	1	1	3
Superficial venous thrombosis						
a) Varicose veins	1	1	1	1	1	1
b) Superfical venous thrombosis	1	1	1	1	1	2
Known thrombogenic mutations (eg. factor V Leiden, prothombin mutation, protein S, protein C and tntithrombin deficiencies)	1	2	2	2	2	4

Make sure your registrars know where to access this summary table: Source: https://www.fsrh.org/standards-and-guidance/documents/ukmec-2016-summary-sheets/

Current Resources

- Faculty of Sexual and Reproductive Healthcare
  https://www.fsrh.org/standards-and-guidance/fsrh-guidelines-and-statements/
  - This These are the key resources in this area of practice
  - Includes specific guidelines, e.g. contraception for women over 40, drug interactions, enzyme inducers etc
- Therapeutic Guidelines: Sexual & Reproductive Health
  https://tgldcdp.tg.org.au/etgAccess
  - Note that this replaces the Contraception Handbook which is no longer available to purchase (TG login required)
- FSRH Clinical Guidance: Drug Interactions with Hormonal Contraception
  https://www.fsrh.org/documents/ceu-clinical-guidance-drug-interactions-with-hormonal/
- FSRH Clinical Guideline: Contraception for Women Aged over 40 Years
  https://www.fsrh.org/standards-and-guidance/documents/fsrh-guidance-contraception-for-women-aged-over-40-years-2017/

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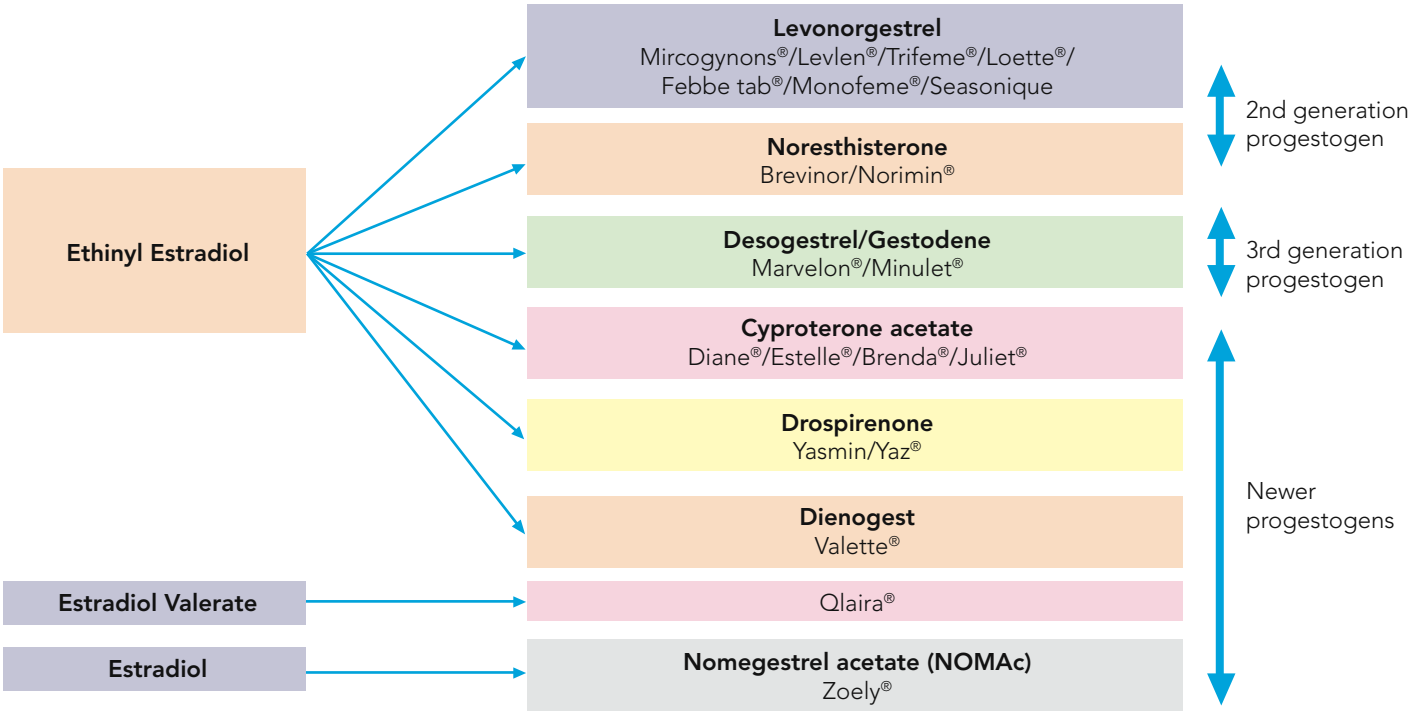
Combined Oral Contraception



Source: https://www.nps.org.au/australian-prescriber/articles/choosing-a-combined-oral-contraceptive-pill

WHY WOULD YOU SWITCH A WOMAN'S ORAL CONTRACEPTION?

- Nausea - reduce oestrogen
- Break through bleeding - more progestogenic pill
- PMS/PMDD - Zoely/Yasmin/Yaz

NB: There's really not much use for microgynon 50 – high VTE risk.

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New Oestrogens

Until 2010, all combined oral contraceptive pills contained ethinyl estradiol in varying doses as their oestrogen. Qlaira and Zoely were then devised with new formulations more in line with natural oestrogen – the goal being to minimise the impact that 2nd and 3rd generation oral contraceptives are seen to have on the body. The data to support this claim is pending.

A new product is coming to the market in 2022 - Estetrol (E4) -, the first NEST™ : Native Estrogen with Selective action in Tissues.

NEW OESTROGENS 'STRUCTURALLY IDENTICAL' OESTROGENS

New formulations replace ethinyl estradiol with:

- Estradiol valerate: Qlaira
- 17 – ß estradiol: Zoely
- Estretol (E4) – watch this space

Theoretically reduced effect on liver metabolism and clotting systems and a potential safety benefit in relation to VTE risk however evidence is pending so usual C/I apply.

Consider Zoely in BTB on other formulations, HMB, dysmenorrhea, PMS/PMDD.

Cypoterone

In a 2019 BMJ article (Turner, Tapley, Sweeney et al), it was revealed that between 2010 and 2017, the cypoterone-based pill was the second most common pill prescribed by GP registrars.

- 1737 registrars, 5382 problems/diagnoses involving women aged 12–55 years in which contraception was prescribed.
- 1356 (25%) involved LARC.

This is particularly concerning given pills like Diane are not licensed as contraceptives, and should be switched to another form of oral contraception as soon as the woman's acne is under control.

A PLACE FOR CYPROTERONE?

- Cyproterone containing pills can be used as described in the PI for severe androgenisation with regular review – consider switch after symptoms have settled.
- Cyproterone-based COCPs not licenced as contraceptives.
- Strong evidence for difference between COCs and acne lacking.
- Arowojolu AO et al Cochrance Database Syt Rev 2009

Contraception and women with VTE risk factors

Ban on "Diane" proposed by MP

- December 2017 Federal MP demanded ban on Diane (or tougher regulations) with a requirement for mandatory thrombophilia screening
- Daughter diagnosed with VTE after long haul flight
- Pill commenced 3 weeks prior, subsequently diagnosed as a Factor V Leiden carrier
- A negative screen cannot exclude risk of a VTE (50% cases no identified thrombophilia)
- Risk assessment based on family history (any cause VTE in 1st degree relative <45 is UK MEC 3 and risks outweigh the benefit)
- Follow MEC guidance and don't prescribe any combined hormonal contraceptive for any MEC 4 (or MEC 3) conditions

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It is crucial to keep the following fresh in your registrars' minds:

Contraception for women with VTE risk factors

	CHCs	PO methods
Past history or current VTE	MEC 4	MEC 2
Known thrombogenic mutation	MEC 4	MEC 2
1° relative < 45 yrs VTE	MEC 3	MEC 2
Obesity BMI > 35Kg/m2	MEC 3	MEC 1
Major surgery with prolonged immobilisation	MEC 4	MEC 2
Immobility unrelated to surgery	MEC 3	MEC 2
Post partum <21 days	MEC 3/4	MEC 1

New Oral Progesterone-Only option

"Slinda" is due to be on the market in Australia before the end of the year (2021), offering a good oral alternative for migraine with aura, and women at 50 (although won't be licenced as progesterone component of MHT).

- 24/4 4mg drosperinone regime
- Inhibits ovulation
- Phase 3 data showed comparable efficacy to combined hormonal contraceptives, more acceptable bleeding profiles than current available POPs
- Increased amenorrhoea and less unscheduled bleeding with more cycles used
- Safe in women with increased VTE risk (older age, higher BMI)

Emergency Contraception

- Most effective oral EC
- Linear efficacy 120hrs
- Efficacy reduced if BMI>30 (cf 26 for LNG EC)
- Prevents ovulation at later stage than LNG-EC
- Efficacy reduced if hormonal contraception 7 days prior or 5 days after
- Competes with steroid receptor– care if on oral steroid
- No need to interrupt breastfeeding. To avoid the highest infant exposure, breast milk can be expressed and discarded for 24 hours after taking ulipristal

LARC Contraceptive CHOICE project

A study conducted in the US between 2007 and 2016, with nearly 10,000 women aged 14-45 provided with free contraception if they were willing to start a new reversible method.

- 75% chose LARC
- Women using LARC had highest satisfaction
- Women who used non-LARC were 20 times more likely to have an unintended pregnancy than those who used LARC
- Continuation of IUD and implant is greater than the pill and DMPA

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Australian Contraceptive Choice Project (ACCORd) – Mazza et al

The Australian version of the American Contraceptive Choice project was conducted between April 2016 and January 2017 across 57 Melbourne practices and involved 740 women.

- Primary aim: to increase the uptake of LARC amongst Australian women
- Trialed a complex intervention that involved training GPs providing 'LARC First' structured contraceptive counselling and implementing rapid referral pathways to LARC insertion.
- Project involved a cluster randomised control trial with GPs who are randomly allocated to one of two trial arms:
  - Intervention Arm – GPs undertake 6 hr online training in efficacy based 'LARC First' structured contraceptive counselling. GPs also have rapid referral pathways available to a LARC insertion clinic for instances where the GP does not undertake insertions in their own rooms.
  - Control Arm – GPs provide usual contraceptive care.
- The results showed increased LARC uptake in the intervention group

LARC First

Comprehensive resources on LARC are available from Family Planning Alliance Australia

LARC is highly effective and safe for women across the reproductive life course, including younger women and those who have not had children.

- Nulliparity is not a C/I to IUD
- May need to consider insertion with GA for adolescents, but can be easily inserted in rooms any age and parity
- No increased rates of PID
- Cannot insert if current PID. Q re required screening prior to IUD: STI screening (CT/NG PCR) prior to insertion, CST if due. Investigate any symptoms eg USS if HMB, Co test if indicated for symptoms

Download a copy here

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What's new: Kyleena®

- 19.5mg LNG-IUS
- PBS listed March 2020
- Slightly smaller dimensions than the 52 mg LNG IUS (28 mm W x 30 mm H vs 32 mm W x 32 mm H) and a slightly narrower inserter tube (3.8mm vs 4.4mm)
- Slightly higher mean spotting days, less amenorrhoea compared to 52mg device
- No off licence extended use
- Less benign functional ovarian cysts compared to 52MG device
- Indicated for contraception only (not for HMB or progesterone component of MHT)

Mirena/Kyleena

Copper T

Copper Load

Extended LARC use advice since COVID-19

Summary of recommendations during the pandemic:

- All efforts should be made to continue access to insertion of LARCs during the pandemic, particularly for younger people, people with serious health conditions, and post-abortion.
- The etonogestrel implant (Implanon NXT) can be extended off-label for use up to **4 years**.
- The 52mg LNG IUD (Mirena) can be extended off-label for use up to **6 years**.
- The 19.5mg LNG IUD (Kyleena) cannot be extended beyond 5 years.
- Standard sized T shaped banded copper IUDs can be extended off-label for use up to **12 years**.

Download the complete advice here

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Registrar practices around LARC

Consider facilitating all registrars to seek further training and competency in LARC insertion and provision.

- LARC prescription more likely if registrar had post graduate training/qualification specific to RSH
- More LARC prescribed in regional and remote locations
- LARC more likely to be prescribed if there were learning goals around LARC and/or assistance was sought from supervisor
- LARC prescribed more to older women, and more often by female registrars

How to assist a registrar seeking LARC upskilling

- RANZCOG CWH
- Family Planning IUD and Implanon NXT insertion training
- RTP workshops
- Locally run courses
- Local supervision pathways to facilitate practice
- FPAA training standards

Resources

- GPSA Contraception Teaching Plan https://gpsupervisorsaustralia.org.au/download/2074/
- STi Management Guidelines: http://www.sti.guidelines.org.au/
- National Cervical Screening Program: Guidelines for the management of screen-detected abnormalities, screening in specific populations and investigation of abnormal vaginal bleeding https://wiki.cancer.org.au/australia/Guidelines:Cervical_cancer/Screening
- Faculty of Sexual and Reproductive Health (FSRH) Guidelines & Statements https://www.fsrh.org/standards-and-guidance/fsrh-guidelines-and-statements/
- Therapeutic Guidelines: Sexual & Reproductive Health (TG login required) https://tgldcdp.tg.org.au/etgAccess
- Choosing a combined oral contraceptive pill https://www.nps.org.au/australian-prescriber/articles/choosing-a-combined-oral-contraceptive-pill
- Long Acting Reversible Contraception (LARC) resources https://www.familyplanningallianceaustralia.org.au/long-acting-reversible-contraception.php
- Turner R, Tapley A, Sweeney S, Davey A, Holliday E, van Driel M, Henderson K, Ball J, Morgan S, Spike N, FitzGerald K, Magin P. Prevalence and associations of prescribing of long-acting reversible contraception by general practitioner registrars: a secondary analysis of ReCEnT data. BMJ Sex Reprod Health. 2020 Jul;46(3):218-225. doi: 10.1136/bmjsrh-2019-200309. Epub 2020 Jan 21. PMID: 31964777. https://srh.bmj.com/content/46/3/218
- Shopfront Youth Legal Centre https://c1bc707a-3498-4f06-bd4745dfeb83d84.filesusr.com/ugd/50007a_65e9be57bc5e4d6685584313db3b3164.pdf
- Contraception Resources https://www.true.org.au/factsheets/choose-a-topic/contraception

Does this resource need to be updated? Contact GPSA: P: 03 9607 8590, E: admin@gpsa.org.au, W: gpsa.org.au
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