Contraception Today
Fourth edition

John Guillebaud

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Preface

Family planning could bring more benefits to more people at less cost than any other single ‘technology’ now available to the human race.

UNICEF

Recalling that every new birth in the UK is likely in its lifetime to do as much damage to the environment as 30–200 births in Burundi or Bangladesh will ever have the chance to do, this quote applies worldwide. So I welcome the opportunity to produce this pocketbook for general practitioners on the subject of contraception.

I write as one who is proud to have worked in general practice, as a locum in places as diverse as Barnsley, Cambridge, Luton and South London, and is hence able to appreciate some of the constraints of that role.

March 2000
General practitioners (GPs) are often well placed to offer good contraceptive advice because they already know the patient’s health and circumstances. Some practices are excellent; others provide little beyond oral contraception and devote insufficient time and skill to counselling. Ideally there should be at least one dedicated family planning session each week to deal with first visits and methods such as intrauterine devices (IUDs) or systems (IUSs) and implants. Women raising more complex contraceptive problems may be asked to reattend, after the surgery. Much can, indeed should, be delegated to a practice nurse fully trained in family planning, usually with a gain rather than a loss in standards. The following may be appropriately delegated to her:

- Taking sexual and medical history, discussion of choices
- Cap fitting, checking, teaching
- Pill teaching
- Pill reissuing, and emergency pill issuing against an agreed protocol. (At present UK law does not permit appropriately trained nurses to prescribe contraceptive hormones, but hopefully this will change)
- Pill monitoring in the absence of risk factors
- IUD and IUS checking
- Cervical smear taking

The practice nurse should also be taught to detect, and then always seek advice for, the simple but important sign of cervical excitation tenderness.
Formal training is also desirable for doctors* and should include both theoretical and ‘apprenticeship’ training, as well as discussion of the often complex psychosexual and emotional factors involved in the use of contraception. All clinicians should be sensitive to hidden signals in this area.

Doctors should back their counselling with good literature. Although some manufacturers have improved their package labelling, the latest UK Family Planning Association leaflets are better—‘user-friendly’, yet accurate and comprehensive. Your Guide to Contraception tabulates all the important methods, both reversible and permanent, and is ideal for reading in the waiting room before counselling. The leaflets on individual methods, especially Choosing and Using the Combined Pill, should be given with advice to ‘read, and keep long term for further reference’. Its month and date of publication should be recorded in the patient’s notes. Follow-up patients may need a replacement. Together with accurate contemporary records, these leaflets provide strong medicolegal back-up for practitioners who may be asked to justify their actions in the event of litigation. They are an essential supplement to—but by no means a replacement for—time spent with the doctor and/or nurse.

**Choice of method**

Most women who seek contraception are healthy and young, and present fewer problems than the over-35s, teenagers and those with intercurrent disease. There is an increasing tendency for sterilization procedures to be demanded at too early an age. This is partly because the pill is too often seen as synonymous with contraception,

* In the UK, the Faculty of Family Planning and Reproductive Health Care offers, through agencies such as the Margaret Pyke Centre (MPC), educational courses leading to their Diploma (DFFP) and Membership (MFFP), as well as a range of Letters of Competence. The Institute of Psychosexual Medicine offers relevant seminar training.
and we as providers have not been informing women about the many new or improved reversible alternatives to the pill and condom, about which there is still much ignorance and mythology. I refer particularly to the levonorgestrel intrauterine system (LNG IUS), the GyneT380, the GyneFix, injectables and the latest implants.

**The very young**

Although early cycles after the menarche are assumed to be anovulatory, very early conceptions are increasingly reported, and surveys show that around half the total female population aged 16 years or under have had intercourse. Easier access to emergency contraception is an obvious priority. As they may often ‘get away with it’ in one or more cycles, however, all too often the young do not seek advice until they have already conceived. Education must therefore promote (as in The Netherlands) the societal norm that sex may be a feature of a good relationship only when and if adequate contraception exists. In this age group we still await as first-line more ‘forgettable’ methods in which (in contrast to pills) non-pregnancy is the ‘default state’. Injectables and implants are preferable to copper IUDs, because they provide some protection against pelvic infection, although IUDs are only relatively contraindicated (the GyneFix or LNG IUS may be appropriate).

In spite of not having the ideal ‘default state’, for many young women the most suitable initial method currently remains a modern, low-oestrogen, combined oral contraceptive (COC), backed by good counselling. Once periods have been established there appear to be no special medical problems of the pill for teenagers, as compared with women in their early 20s.

With patients under 16 the GP should, merely as part of good medical practice—so long as it is done opportually, non-judgementally and in a non-patronizing way—present
the emotional, physical and legal advantages of delaying intercourse (and then of mutual loyalty). But the ‘best’ must not become the enemy of the ‘good’, a category that surely includes contraception (with age-appropriate sexual health education) when the foregoing is rejected. Involvement of at least one parent is vastly preferable, yet it can be good practice to prescribe the pill without it (see Box). At all times the young woman must be assured of confidentiality.

There is a useful mnemonic for the UK Memorandum of Guidance (DHSS HC(FP)86), issued after the Gillick case:

**Mnemonic: UnProtected SSsexual InterCourse. The doctor:**

- **U** - Must ensure the young person **UNDERSTANDS** the potential risks and benefits of the treatment/advice given
- **P** - Is legally obliged to discuss the value of **PARENTAL** support, yet the client must know that confidentiality is respected whether or not this is given
- **S** - Should assess whether the client is likely to have **SEXUAL INTERCOURSE** without contraception
- **S** - Should assess whether the young person’s physical/mental health may **SUFFER** if not given contraceptive advice or supplies
- **I** - Must consider if it is in the client’s best **INTERESTS** to give contraception without parental consent
- **C** - Must respect the duty of **CONFIDENTIALITY** that should be given to a person under 16, and which is as great as that owed to any other person

**HIV and other sexually transmitted infections**

No opportunity should be missed to advise the sexually active of all ages on minimizing their risk of sexually transmitted infections (STIs), including the human immunodeficiency virus (HIV). Besides ‘selling’ monogamy—on medical grounds—it is essential to promote the condom as an addition to the selected contraceptive whenever infection risk exists: the so-called Double Dutch approach.
Relative effectiveness of available methods

Good results depend on a couple-based, individualized approach—contraception is very much about choosing ‘horses for courses’, iatrogenic pregnancies can frequently be caused by omissions and errors on the part of service providers—and these are by definition avoidable. Table 1 outlines the comparative efficacy of most current methods.

Unwanted effects of contraceptives: contraindications

These are obviously important issues, but risks must be impartially evaluated (a failing of the mass media) and then rationally applied as contraindications (a failing often of doctors, who tend to introduce unnecessary medical barriers to contraceptive use).

An important general principle is summation, discussed on p. 36. Also important is the WHO system for classifying contraindications, which is applied in this book (to the best of my judgement). It is evidence-based, where evidence exists, but also tries to give the best interim guidance when we have to make a decision (in consultation with the woman/couple), in the frustrating absence of good evidence. This scheme (which I had a hand in devising at a WHO meeting in Atlanta, 1994) is more fully described in a 1996 WHO document on medical eligibility criteria (WHO/FRH/FPP96.9).
Table 1
First-year user-failure rates/100 women for different methods of contraception.

<table>
<thead>
<tr>
<th>Method of contraception</th>
<th>Range in the world literature*</th>
<th>Oxford/FPA study (Lancet report in 1982; all women married and aged above 25)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Age 25–34 (≤2 years’ use)</td>
</tr>
<tr>
<td>Sterilization</td>
<td></td>
<td>0–0.05</td>
</tr>
<tr>
<td>Male (after azoospermia)</td>
<td></td>
<td>0–0.5</td>
</tr>
<tr>
<td>Female</td>
<td></td>
<td>0–0.07</td>
</tr>
<tr>
<td>Subcutaneous implant</td>
<td></td>
<td>0.1–3</td>
</tr>
<tr>
<td>Implanon</td>
<td></td>
<td>0.2–3</td>
</tr>
<tr>
<td>Injectable (DMPA)</td>
<td></td>
<td>0.3–4</td>
</tr>
<tr>
<td>Combined pills</td>
<td></td>
<td>1–2</td>
</tr>
<tr>
<td>50 µg oestrogen</td>
<td></td>
<td>0.2–1</td>
</tr>
<tr>
<td>&lt;50 µg oestrogen</td>
<td></td>
<td>0.1–0.2</td>
</tr>
<tr>
<td>Progestogen-only pill</td>
<td></td>
<td>4–20</td>
</tr>
<tr>
<td>IUD</td>
<td></td>
<td>2–15</td>
</tr>
<tr>
<td>Nova-T</td>
<td></td>
<td>5–15</td>
</tr>
<tr>
<td>Nova-T380</td>
<td></td>
<td>6–17</td>
</tr>
<tr>
<td>Multiload Cu 375</td>
<td></td>
<td>4–25</td>
</tr>
<tr>
<td>Gyne T380</td>
<td></td>
<td>2–25</td>
</tr>
<tr>
<td>Levonorgestrel IUS</td>
<td></td>
<td>6–?</td>
</tr>
<tr>
<td>Diaphragm</td>
<td></td>
<td>80–90</td>
</tr>
<tr>
<td>(Male) condom</td>
<td></td>
<td>40–50</td>
</tr>
<tr>
<td>Female condom</td>
<td></td>
<td>10–20</td>
</tr>
<tr>
<td>Coitus interruptus</td>
<td></td>
<td>0–5</td>
</tr>
<tr>
<td>Spermicides alone</td>
<td></td>
<td>–</td>
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<tr>
<td>Fertility awareness</td>
<td></td>
<td>–</td>
</tr>
<tr>
<td>‘Persona’</td>
<td></td>
<td>–</td>
</tr>
<tr>
<td>No method, young women</td>
<td></td>
<td>–</td>
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<tr>
<td>No method at age 40</td>
<td></td>
<td>–</td>
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<tr>
<td>No method at age 45</td>
<td></td>
<td>–</td>
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<tr>
<td>No method at age 50</td>
<td></td>
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</tr>
</tbody>
</table>

*Excludes atypical studies and all extended use studies. For sterilization, rates in first column are estimated lifetime failure rates.

Note:  
1. First figure of range in first column gives a rough measure of ‘perfect use’ (but is not the same)  
2. Influence of age, all the rates in the fourth column being lower than those in the third column. Lower rates still may be expected above age 45  
3. Much better results also obtainable in other states of relative infertility, such as lactation  
4. Oxford/FPA users were established users as recruitment—greatly improving results especially for barrier methods.
There are now four categories of contraindication:

**WHO Classification of contraindications**

1. A condition for which there is no restriction for the use of the contraceptive method ‘A’ is for **ALWAYS USABLE**
2. A condition where the advantages of the method generally outweigh the theoretical or proven risks ‘B’ is for **BROADLY USABLE**
3. A condition where the theoretical or proven risks usually outweigh the advantages. But—respecting the patient/client’s autonomy—if she accepts the risks and rejects or should not use relevant alternatives, the method can be used with caution/additional care—as a ‘method of last choice’ ‘C’ is for **CAUTION/COUNSELLING**, if used at all
4. A condition which represents an unacceptable health risk ‘D’ is for **DO NOT USE**, at all

* My A–B–C–D additions are just aide-mémoires. WHO 1–2–3–4 numbering is used in the book, to avoid confusion.

The most useful new feature of the classification is the separation into two categories of **RELATIVE contraindication** (categories 2 and 3).

Clinical judgement is required in consultation with the contraceptive user when deciding whether to use the method, especially in all category 3 conditions, or if more than one category 3 or 2 condition applies (usually then signifies 4, ‘Do not use’).
**Mechanism of action**

Aside from secondary contraceptive effects on the cervical mucus and to impede implantation, COCs primarily prevent ovulation. They therefore ‘remove’ the normal menstrual cycle and replace it with a cycle which is user-produced and based only on the end-organ, the endometrium. So the withdrawal bleeding has minimal medical significance, can be deliberately postponed or made infrequent as in tricycling (see below), and if it fails to occur, once pregnancy is excluded, poses ‘no problem’. The pill-free time is the contraception-deficient time, which has great relevance to maintenance of the COC’s efficacy (see below).

**Benefits versus risks**

COCs can provide virtually 100% protection from unwanted pregnancy. They can be taken at a time unconnected with intercourse and provide enormous reassurance by the regular, short, light and usually painless withdrawal bleeding at the end of each pack. Most of the discussion here concerns possible risks*, but the positive aspects should not be forgotten.