Contraceptive Side-effects & Non-contraceptive benefits

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Overview

- Unwanted side effects
- Beneficial side effects
- Licensing issues
Pluses and minuses

- No method is 100% effective and with 0% side effects
- What are ‘nuisance’ side effects v medically concerning ones?
- Are there ways to control side effects?
- Can contraception methods be used to alleviate other medical problems?
SPC and PIL–don’t frighten women!!

- Commonly occurring side effects (1-10%)
- Rarely reported commonly occurring effects except on Black Triangle drugs and during trials
- Will patient reporting on Yellow Cards increase awareness?
- Placebo v nocebo effect
Hormonal methods side effects

- Skin changes (but can get better!)
- Unscheduled bleeding ?and > BV
- ?non-understanding of what is a ‘period’
- Mood swings
- Breast tenderness
- Headaches
- Loss of libido
- Vaginal dryness
Estrogenic v progestogenic effects

- Not cut and dried
- COC- distinguish between pill taking and pill free days
- Tricyclic pills with varying balance of hormones to try to mimic ovarian cycle
Contraception is good for your health!

- Reduction in blood loss (COC, IUS)
- Protection against cancers (COC, IUD, IUS)
- Reduction in acne (COC)
- Relief of painful periods (COC, IUS)
- Protection re pelvic inflammation (COC)
- Possibility to reduce menstrual convulsions, migraines (COC tricyclcing)
- Reduction in sickle cell crises (DPMA)
- Improvement in PMS (continuous COC)
Reduction in mortality

- Ever-use of COC resulted in 12% reduction in all-cause mortality
- No increased cancer risk overall

- Hannaford. Cohort evidence from RCGP Oral contraception Study. *BMJ* 2010
Reduction in cancer

- IUS to protect against thickening effects with tamoxifen

- COC (and ring and patch) reduce Ca uterus, ovary and colorectum
COC and cancer reduction

- 20% reduction ovarian Ca* per 5 yrs use
- 50% reduction endometrial Ca** per 5 yrs use
- Effects persists for decades after cessation*,**
- Colorectal Ca reduction with current or recent use**

*Collaborative Group Lancet 2008; 371:303-314
**Jick Obstet Gynecol 1993; 82:931-5
Use outside product licence

- GMC Good Practice in Prescribing and managing medicines and devices 2013
  - Must be satisfied there is sufficient evidence or experience of using the medicine to demonstrate its safety and efficacy
  - Take responsibility for prescribing the medication and oversee the patient’s care, monitoring and follow up, or arrange for another suitable doctor to do so
Menorrhagia (HMB)

- IUS: Licensed 1st line* indication for HMB
- COC: 2nd line* (and Qlaira licensed for this)
  - 2009 Cochrane Review: insufficient evidence
  - Small prospective studies and one RCT show benefit
  - Less hospital referrals for HMB in women on COC
- DPMA 3rd line*

*NICE guideline HMB 2007
Dysmenorrhoea

- COC Cochrane review
- Desogestrel POP if less bleeding days and thus reduced prostaglandin release
- Implant
- IUS
Endometriosis

- IUS RCOG green top guideline 24 (2006)
- COC Cochrane review
- Oral and implantable progestogens-no published evidence yet
Stabilisation of endometrium

- COC improves bleeding pattern with P-O methods
- Use cyclically or continuously
- Improvement may persist or decrease on cessation of COC

- CEU guideline  Management of unscheduled bleeding 2009

FSRH CEU Management of unscheduled bleeding in women using hormonal contraception 2009
Acne

- Cochrane review 2012
- Compared to placebo, COC improves facial acne, reduces severity.
- No clear differences in which type of COC was used, except drospirenone (Yasmin) and CPA (Dianette).
(Fibroids)

- UPA 5mg (Esmya) daily for 3/12 to reduce size, bleeding and pain pre-operatively
- Note this different dose and formulation (non-ionised) to EllaOne for EHC
Menstrual migraine

- Tricycle COCs (if no aura) to remove estrogen-withdrawal onset
- Cerazette or implant
- DPMA if achieves amenorrhoea and thus reduced prostaglandin levels
Menstrual Migraine

- IUS – not good if sensitive to estrogen-withdrawal – majority continue to ovulate
  - National Migraine Centre Information Sheet
- Your experiences??
STI protection

- Male latex + non-latex condoms good evidence of prevention of STIs with vaginal and anal sex
- Female condoms evidence for vaginal sex
- Diaphragms and caps – little evidence of protection

CEU guidance Barrier Methods 2012
Reduction in sickle crises

- DPMA – Cochrane review 2007
- One RCT with 25 patients (DPMA v placebo)
- 3 monthly injections with 6 month washout and cross over
- Improves the blood picture
- Reduces painful crises
Add back oestrogen at perimenopause

- COC is UK MEC – category 2 from age 40+ if non-smoker, but usual to stop at age 50.
- Natural oestrogen levels falling
- Bone protection and prevention of menopausal oestrogen-lowering symptoms
Any questions?