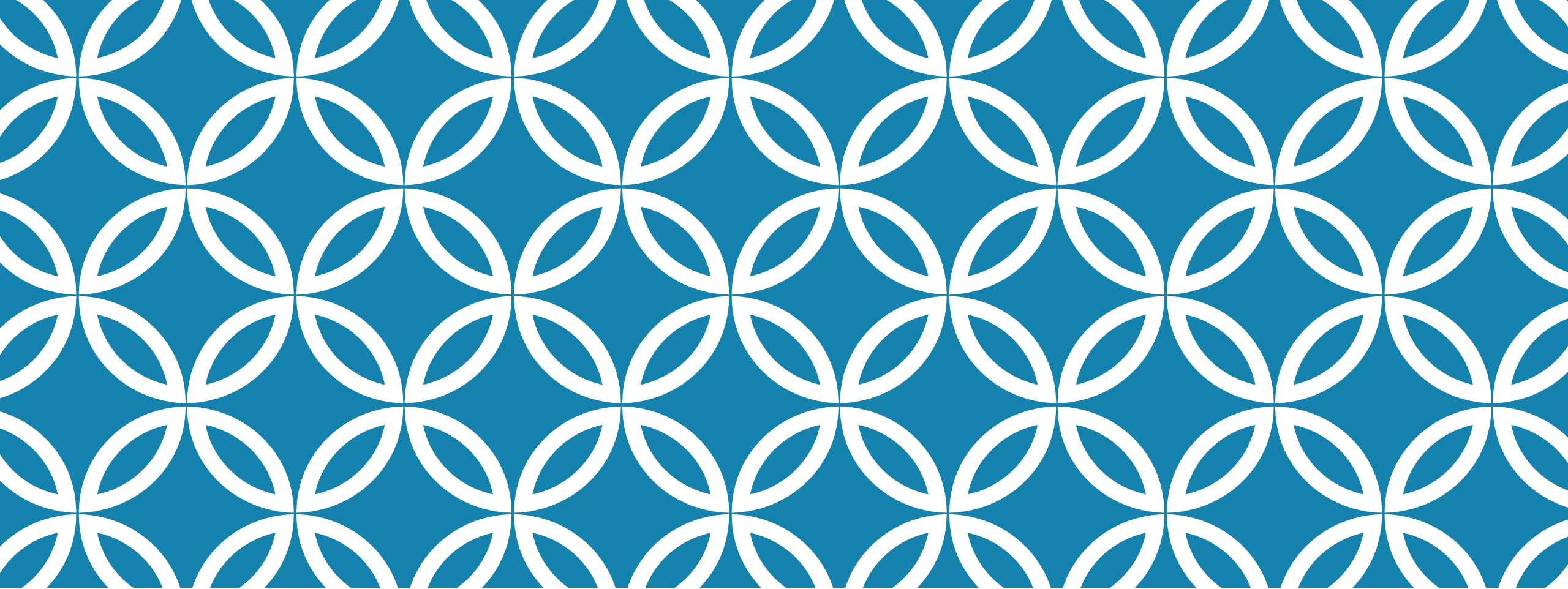




UKMEC UPDATE

Dr Rachel Westwick

NEW CONDITIONS

Multiple sclerosis

- Higher risk of venous thromboembolism (VTE)
- Due mostly to immobility.
- Have a 1.2-fold increased risk of any fracture.

Chronic kidney disease

- Increased risk of venous thromboembolism
- CHC CI
- DMPA – caution due to VTE risk and negative impact on bone health.

Sickle cell trait

- Small increase in the risk of VTE with sickle cell trait – “alternatives to CHC should be prioritized”

MS

UKMEC SUMMARY TABLE HORMONAL AND INTRAUTERINE CONTRACEPTION Cu-IUD = Copper intrauterine device; LNG-IUD = Levonorgestrel-releasing intrauterine device. IMP = Progestogen-only implant. DMPA = Progestogen-only injectable: depot medroxyprogesterone acetate. POP = Progestogen-only pill; CHC = Combined hormonal contraception						
CONDITION	Cu-IUD	LNG-IUD	IMP	DMPA	POP	CHC
*See additional comments at end of section	I = Initiation, C = Continuation					

Multiple sclerosis (MS)						
a) MS with prolonged immobility	1	1	1	2	1	3
b) MS without prolonged immobility	1	1	1	2	1	1

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CONDITION	Cu-IUD	LNG-IUD	IMP	DMPA	POP	CHC
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Chronic kidney disease						
a) Current nephrotic syndrome	2	2	2	3	2*	4
b) Haemodialysis	2	2	2	3	2*	4
c) Peritoneal dialysis	2	2	2	3	2*	4

*POP: excluding drospirenone (DRSP), which should not be used in individuals with severe renal insufficiency or acute renal failure and should be used with caution in individuals at risk of hyperkalaemia.¹⁸
See FSRH Clinical Guideline: Progestogen-only pills.¹⁹

SICKLE CELL TRAIT

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CONDITION	Cu-IUD	LNG-IUD	IMP	DMPA	POP	CHC
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ANAEMIAS						
Thalassaemia	2	1	1	1	1	1
Sickle cell disease	2	1	1	2	1	2
Sickle cell trait (SCT)	There is insufficient evidence to give MEC ratings for SCT. There is a small increase in the risk of VTE with SCT, therefore alternatives to CHC should be prioritised.					
Iron deficiency anaemia	2	1	1	1	1	1

TOPIC KEY EVIDENCE/CLARIFICATION

Multiple sclerosis:

Some evidence exists that individuals with multiple sclerosis (MS) are at higher risk of venous thromboembolism (VTE) than those without MS.

This is likely due mostly to immobility.

There is therefore the need to differentiate individuals with MS with prolonged immobility from those without.

MS patients have a 1.2-fold increased risk of any fracture.

Chronic kidney disease:

All severities of kidney disease appear to be associated with an increased risk of venous thromboembolism, therefore combined hormonal contraceptives (CHC) are not a suitable option.

Use of depot medroxyprogesterone acetate (DMPA) should be carefully considered due to the negative impact on bone health in this population.

Sickle cell trait:

There is a small increase in the risk of VTE with sickle cell trait, therefore alternatives to CHC should be prioritised.

UPDATED: PO INJECTION — INCREASED VTE RISK

Condition	Previous category DMPA	New category DMPA
Postpartum with other risk factors for VTE	2	3
BMI > 35	1	2
Superficial venous thrombosis	1	2
Known thrombogenic mutations	2	3
Ovarian cancer	1	2
Endometrial cancer	1	2
Inflammatory bowel disease	1	2
Sickle cell disease	1	2
Positive antiphospholipid antibodies	2	3

DMPA AND VTE

Five observational studies found evidence of a small increased risk of VTE with DMPA use compared to no hormonal contraception.

The overall risk remains low and is likely to be lower than the risk of VTE with combined hormonal contraception.

Conditions and characteristics that also increase a person's risk of VTE have been reviewed throughout the UKMEC and categories have been upgraded

‘Multiple risk factors for VTE’ has also been added.

MULTIPLE RISK FACTORS FOR VTE

CONDITION	Cu-IUD	LNG-IUD	IMP	DMPA	POP	CHC
*See additional comments at end of section	I = Initiation, C = Continuation					
Venous thromboembolism (VTE)						
History of VTE or current VTE (on anticoagulants)	1	2	2	3	2	4
Risk factors for VTE						
a) Family history of VTE (first degree relative)	1	1	1	2	1	3
b) Major surgery	1	1	2	I 3	C 2	4
c) Immobility (e.g. wheelchair use, chronic conditions)	1	1	1	2	1	3
Multiple risk factors for VTE (additional examples include cancer, high BMI, thrombotic or inflammatory disorders) Where more than one risk factor is present, clinical judgement must be applied	1	1	1	3	1	4
Superficial venous thrombosis						
a) Varicose veins	1	1	1	1	1	1
b) Superficial venous thrombosis	1	1	1	2	1	2
Known thrombogenic mutations (e.g. factor V Leiden, prothrombin mutation, protein S, protein C and antithrombin deficiencies)	1	2	2	3	2	4

MULTIPLE RISK FACTORS FOR CVD

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CONDITION	Cu-IUD	LNG-IUD	IMP	DMPA	POP	CHC
*See additional comments at end of section	I = Initiation, C = Continuation					
CARDIOVASCULAR DISEASE (CVD)						
Multiple risk factors for CVD (e.g., smoking, diabetes, hypertension, obesity, dyslipidemias) Where more than one risk factor is present, clinical judgement must be applied.	1	2	2	3	2	3

HOW SHOULD WE MANAGE PATIENTS REQUESTING PO INJECTION WITH MORE THEN ONE RISK FACTOR FOR CVD OR VTE?

Q: Is the patient already using PO injection or do they want to start PO Injection?

Q: Is the patient using PO injection for contraception only or gynaecological problems?

Q: If using PO injection to manage gynaecological reasons consider what these are and if there are safer ways to manage gynaecological problems?

Q: Weight and BMI and BP- check them at each visit and document them.

Q: What risk factors does the patient have for venous thrombo embolic disease (VTE) or cardiovascular disease (CVD)?

Age > 45, smoker or ex smoker (including vaping), raised BMI, hypertension, raised cholesterol, DM, personal and family history of VTE and CVD, significant immobility, postnatal (< 6 weeks), cancer, thrombotic disorders, antiphospholipid syndrome, inflammatory disorders (e.g. Crohns or UC)

HOW SHOULD WE MANAGE PATIENTS REQUESTING PO INJECTION WITH MORE THEN ONE RISK FACTOR FOR CVD OR VTE?

Q: What methods of contraception has patient used in the past and did they experience any problems?

Q: Document discussion with patient if more than one risk factor for CVD (cardiovascular disease) or VTE (venous thrombo embolic disease) = UKMEC 3 for PO injection

Q: Document discussion with patient regarding alternative safer methods of contraception (and if they are acceptable to the patient):

Q: Document lifestyle discussion and any onward referrals (consider referral to GP for help re weight loss, smoking session & optimisation of health problems e.g. High BP & DM)

Q: Document discussion with contraception specialist (e.g. GPwSI or Consultant / Specialist Dr in SRH)

- **Deep vein thrombosis (DVT) is more likely to occur in people with continuing or intrinsic risk factors, such as:**
 - A history of DVT.
 - Cancer (known or undiagnosed).
 - Age over 60 years.
 - Being overweight or obese.
 - Male sex.
 - Heart failure.
 - Medical illness, for example, acute infection.
 - Acquired or familial thrombophilia.
 - Inflammatory disorders (for example, vasculitis, inflammatory bowel disease).
 - Varicose veins.
 - Smoking.
- **Risk factors that temporarily raise the likelihood of DVT include:**
 - Recent major surgery.
 - Recent hospitalization.
 - Recent trauma.
 - Chemotherapy.
 - Significant immobility (bedbound, unable to walk unaided, or likely to spend a substantial portion of the day in bed or a chair).
 - Prolonged travel (for more than 4 hours).
 - Significant or direct trauma to a vein (for example, intravenous catheter).
 - Hormone treatment (oestrogen-containing contraception or hormone replacement therapy).
 - Pregnancy and the postpartum period.
 - Dehydration.

CASE - GINA

Gina is 44 – she turns 45 in 2 months

She comes to clinic today for her repeat injection – it was last given 11 weeks ago.

She has been using the PO injection for 10 years and loves it!

She doesn't bleed at all and as she used to have awful periods which meant time off work every month the injection has been "a real life saver"

She has 3 children (aged 14, 12 and 10) – all born by LSCS.

However...

She smokes 15 cigarettes a day

Her weight has steadily been increasing since she started the po injection and now her BMI is 36 and her BP is 145/95 today when you check it

What would you ask Gina?

What would you discuss with Gina?

GINA — WHAT SHOULD YOU ASK?

Any other risk factors for VTE and CVD?

She has a history of Ulcerative Colitis and has intermittent flare ups with significant diarrhoea

What methods of contraception has she tried?

She used to take the POP but conceived her 3rd child when taking this — the midwife told her she might not have been absorbing it properly when she had a flare up of her UC.

After her 2nd child she had a Mirena fitted when she was 6 weeks postnatal, but she found this really painful and she experienced a perforation and this has put her off trying this method again.

GINA — WHAT SHOULD YOU DISCUSS?

You should explain and document that Gina has the following risk factors for VTE:

- Age – almost 45 years
- Raised BMI = 36 (BMI > 35 – quadruples risk of VTE)
- Smoking
- UC

You should explain and document that Gina has the following risk factors for CVD:

- Age
- Smoking
- Raised BMI
- Raised BP

The above means that the risks of the injection outweigh the benefits and that there are safer alternative methods for contraception

The following are modifiable risk factors – weight and smoking – offer Gina support to reduce these risks.

GINA — WHAT SHOULD YOU DISCUSS?

You should explain and document:

- PO injection might increase risk of VTE
- PO injection might increase risk of CVD

You should discuss alternative safer methods of contraception (that may also help manage heavy periods):

1. LNG – IUD:

- Risk of perforation is very low (1-2 / 1000) & could consider insertion in specialist service.
- If fitted after 45th birthday can be used for contraception until aged 55 (when contraception no longer required)

2. PO implant (now licensed for contraception for 5 years)

Consider referral to specialist service for further discussion.

UPDATED: STROKE AND LNG-IUD

No evidence of increased risk of stroke with LNG-IUD.

Three observational studies found no evidence of increased risk of stroke with LNG-IUD

UKMEC 3 for continuation (i.e. ongoing use) has been removed.

STROKE AND TIA

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POP = Progestogen-only pill; CHC = Combined hormonal contraception								
CONDITION	Cu-IUD	LNG-IUD	IMP		DMPA	POP		CHC
*See additional comments at end of section	I = Initiation, C = Continuation							
Stroke and transient ischemic attack* (includes arterial thrombosis, venous thrombosis and intracerebral haemorrhage)	1	2	I	C	3	I	C	4
			2	3		2	3	

UPDATE: ANXIETY AND MOOD DISORDERS (HAS REPLACED DEPRESSION)

Statement:

“There is not consistent evidence that hormonal contraceptives (HCs) worsen or improve anxiety or mood (affective) disorders in those with pre-existing conditions. When starting hormonal contraception, clinicians should provide individualised counselling and advise patients to monitor their mood, seeking follow up with their healthcare provider if they notice a deterioration.”

OTHER CHANGES

E-cigarettes: clarification added around use of e-cigarettes.

Hypertension: updated to reflect NICE classification of blood pressure.

Cervical intraepithelial neoplasia (CIN): now includes high-risk human papillomavirus (HPV).

Definitions for past/current breast cancer have been updated.

Sexually transmitted infections (STI): updated to include M Gen and simplify classifications.

HIV: shift towards person-centred language.

E CIGARETTES

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Smoking	UKMEC does not include use of e-cigarettes as there is insufficient evidence to establish associated risks. However, given the unknown long term cardiovascular risks with e-cigarettes alternatives to CHC should be prioritised.					
a) Age <35 years	1	1	1	1	1	2
b) Age ≥35 years						
(i) <15 cigarettes/day	1	1	1	1	1	3
(ii) ≥15 cigarettes/day	1	1	1	1	1	4
(iii) Stopped smoking <1 year	1	1	1	1	1	3
(iv) Stopped smoking ≥1 year	1	1	1	1	1	2

HYPERTENSION

CONDITION	Cu-IUD	LNG-IUD	IMP	DMPA	POP	CHC
*See additional comments at end of section	I = Initiation, C = Continuation					
CARDIOVASCULAR DISEASE (CVD)						
Multiple risk factors for CVD (e.g., smoking, diabetes, hypertension, obesity, dyslipidemias) Where more than one risk factor is present, clinical judgement must be applied.	1	2	2	3	2	3
Hypertension						
a) Controlled hypertension	1	1	1	2	1	3
b) Consistently elevated blood pressure (BP) levels (properly taken measurements)						
(i) Stage 1 hypertension <u>Clinic</u> Systolic 140 – 159 and/or Diastolic 90 – 99 <u>Home</u> Systolic 135 – 149 and/or Diastolic 85 – 94	1	1	1	2	1	3
(ii) Stage 2 or 3 hypertension <u>Clinic</u> Systolic ≥ 160 and/or Diastolic ≥ 100 <u>Home</u> Systolic ≥ 150 and/or Diastolic ≥ 95	1	1	1	2	1	4
c) Vascular disease	1	2	2	3	2	4

CIN

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CONDITION	Cu-IUD	LNG-IUD	IMP	DMPA	POP	CHC
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Cervical ectropion	1	1	1	1	1	1
Cervical intraepithelial neoplasia (CIN) Includes individuals with high-risk human papillomavirus (HR-HPV)	1	2	1	2	1	2
Cervical cancer						
a) Awaiting treatment	I 4	C 2	I 4	C 2	2	2
b) Radical trachelectomy	3	3	2	2	1	2

BREAST CANCER

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CONDITION	Cu-IUD	LNG-IUD	IMP	DMPA	POP	CHC
*See additional comments at end of section	I = Initiation, C = Continuation					
c) Family history of breast cancer	1	1	1	1	1	1
d) Carriers of high-risk gene mutations associated with breast cancer (e.g. BRCA1/BRCA2)	1	2	2	2	2	3
e) Breast cancer						
(i) Currently being treated for breast cancer	1	4	4	4	4	4
(ii) Completed treatment for breast cancer	1	3	3	3	3	3

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CONDITION	Cu-IUD	LNG-IUD	IMP	DMPA	POP	CHC
*See additional comments at end of section	I = Initiation, C = Continuation					

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CONDITION	Cu-IUD	LNG-IUD	IMP	DMPA	POP	CHC	
*See additional comments at end of section	I = Initiation, C = Continuation						
infection							
b) Other current STIs (excluding HIV & hepatitis)	2	2	1	1	1	1	
c) Current vaginitis, including trichomonas vaginalis (TV) and bacterial vaginosis (BV)	2	2	1	1	1	1	

*M Gen testing is only recommended in certain circumstances, see BASHH guidelines.¹⁶

**Clinical symptoms and signs of infection include cervicitis, purulent discharge, lower abdominal pain, post-coital bleeding and/or systemic manifestations. PID is covered above.

HIV

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Human Immunodeficiency Virus (HIV)											
a)	High risk for HIV	1		1		1		1		1	
b)	Living with HIV										
	(i) Living with HIV Clinically well, on treatment	2		2		1		1		1	
	(ii) Living with HIV Clinically unwell and not on treatment	I	C	I	C	1	1	1	1		
		3	2	3	2						
c)	Taking HIV medications (for treatment or prophylaxis)	Certain HIV drugs have the potential to affect the bioavailability of steroid hormones in hormonal contraception. Drug interactions are not presented in the UKMEC as MEC categories relate to safety of contraceptive use, not effectiveness. For current recommendations, clinicians should refer to the FSRH Clinical Effectiveness Unit (CEU) Guidance: Drug Interactions Between HIV Antiretroviral Therapy and Contraception¹⁷ and the University of Liverpool HIV Drug Interactions Checker.¹¹ Note, there may be specific bone mineral density considerations around coadministration of tenofovir disoproxil (TDF) when used for HIV pre-exposure prophylaxis (PrEP) or treatment and DMPA.									



QUESTIONS?