Contraception in women with medical conditions

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Abstract

Pregnancy in women with certain medical conditions can result in significant fetal and maternal morbidity and mortality. It is therefore crucial that these women are able to plan and space their pregnancies appropriately through the use of contraception. Obstetricians and gynaecologists will often encounter these women in the inpatient and outpatient setting and be asked to give advice about the suitability of contraception. In this case-based learning article we will consider how to assess a woman seeking contraception. We will also discuss the medical eligibility, efficacy and acceptability of contraception as well as when contraception should be started after pregnancy and stopped at menopause.

Keywords contraception; medical eligibility criteria; pregnancy; safety

Introduction

Women with medical conditions are advised to plan their pregnancies carefully or in rarer situations avoid pregnancy altogether. Some medical conditions can deteriorate in pregnancy because of the change to maternal physiology and some medical conditions and their treatments increase the risk of maternal and fetal complications. The risks of pregnancy for most women are greater than the risks of contraception and reliable contraception should not be withheld unnecessarily.

Obstetricians and gynaecologists must be able to give sound contraceptive advice to these women and ensure that they have access to the safest and most reliable methods. It is useful to consider five questions when managing a woman with a medical condition who requires contraception.

- How safe would pregnancy be for her? If she has been advised not to conceive (for example, if she has pulmonary hypertension) then making sure she has a highly effective method is crucial. Knowing the risks of pregnancy also helps you to weight up the risks versus benefits of contraception.
- How safe is contraception?
- Will her medications interact with any methods of contraception?
- What methods of contraception are acceptable to her?
- What is the most effective method of contraception available to her?

These case studies aim to improve understanding of contraception in women with medical conditions by focusing on these five questions.

History and examination

The information you gather from your history and examination should guide your decision about the safety and suitability of contraception. Your history should be targeted. In most cases a blood pressure and BMI are all that is required for examination. Points to cover in the history and examination include:

- What methods she has tried already and if any problematic side effects occurred.
- Her personal beliefs and attitudes towards contraception.
- A detailed past medical history and drug history particularly focusing on migraine with aura, venous thromboembolism (VTE), hypertension and other cardiovascular disease, diabetes, breast cancer, liver disease, epilepsy, previous operations and enzyme inducing medications.
- Family history of VTE and Breast Cancer (BRCA) gene mutations.
- Reproductive history
  - It is useful to know her parity and mode of delivery when considering intrauterine contraception (IUC) and sterilisation (although young age and nulliparity are *not* necessarily contraindications to IUC).
  - A menstrual history may guide what contraceptive you advise. For example, the levonorgestrel intrauterine system (LNG − IUS) would be beneficial if she has heavy menstrual bleeding.
  - The date of her last menstrual period along with the sexual history will enable you to determine if emergency contraception is required or if pregnancy needs to be excluded.
  - Cervical smear history
- Sexual history. You should establish if there is a risk of sexually transmitted infections prior to IUC fitting and when investigating bleeding problems with contraception. Chlamydia and gonorrhoea can cause unscheduled bleeding. Sexual history will also allow you to determine to what extent she is at risk of pregnancy.
- Social history
  - Smoking status
  - Alcohol consumption
  - Other social factors that may influence contraceptive choice including domestic and/or sexual abuse, ability to access services etc.
- BMI, blood pressure

Contraception efficacy

You should have a good understanding of the most effective methods of contraception available and be able to convey this to your patient (Table 1). Long acting reversible contraception (LARC) (progestogen only implant, LNG-IUS, copper intrauterine device (Cu- IUD) and depo medroxyprogesterone acetate (DMPA)) have superior efficacy to pills or barrier methods and

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Mode of action and effectiveness of contraception

Method	Primary mode of action	Typical use failure (% of women experiencing an unintended pregnancy in the first year of use)	Perfect use failure (% of women experiencing an unintended pregnancy in the first year of use)
Progestogen only implant	Ovulation inhibition	0.05	0.05
Sterilisation			
Male	Division or occlusion vas deferens	0.15	0.15
Female	Tubal occlusion	0.5	0.5
Intrauterine contraception			
IUS	Changes to endometrium and cervical mucus prevent fertilization and implantation.	0.2	0.2
IUD	Copper toxic to sperm.	0.8	0.6
Depo-provera	Ovulation inhibition	6	0.2
Combined hormonal contraception (pills, patch, ring)	Ovulation inhibition	9	0.3
Progestogen only pill	Ovulation inhibition (desogestrel pills) Cervical mucus changes ('traditional' pills)	9	0.3
Diaphragm	Barrier	12	6
Condom			
Male	Barrier	18	2
Female	Barrier	21	5

Table 1

are also more cost effective. It is important that women with medical conditions avoid unplanned pregnancies and should be encouraged to use LARC methods. However, for a method to be effective it has to be used and a woman will only use a method if it is acceptable to her. You should listen to her ideas, concerns and past experiences and allow her to make her own informed choice.

Medical eligibility

You also need to consider the safety of the contraceptive method for that woman. The UK Medical Eligibility Criteria (UK MEC) gives professionals guidance on the safety of contraception in women with medical conditions and other characteristics. Categories 1 and 2 mean that it is generally safe to use that method in the condition and categories 3 and 4 mean that it is generally unsafe to use that method in the condition.

- UKMEC 1 = A condition for which there is no restriction for the use of the method.
- UKMEC 2 = A condition where the advantages of using the method generally outweigh the theoretical or proven risks.
- UKMEC 3 = A condition where the theoretical or proven risks usually 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.
- UKMEC 4 = A condition which represents an unacceptable health risk if the method is used.

It should be remembered that the UK MEC only gives advice pertaining to the use of the method for contraception. If the method is being used to manage a medical condition, such as heavy menstrual bleeding, then the benefits may outweigh the risks and an individual patient centred approach should be taken.

Case 1

A 29-year-old para 0 + 1 (1 previous miscarriage) attends your antenatal clinic because she has type 1 diabetes. Her diabetic control has always been poor but she has no known end organ damage and her blood pressure is within normal range. Other than her insulin she is on no other medication. She has no other past medical history and in particular no history of VTE. She does not smoke. She wishes to have more children in the future. She asks you what contraception would be safe for her to use and when it should be started after she has had her baby. What other information do you need? What do you need to consider? How would you answer her questions?

What information do you need from the history?

You should explore her thoughts and concerns around contraception and find out what methods she has used in the past. It would also be useful inquire about problems in the past with heavy or painful periods.

UK MEC categorization for women with neurological disease

Condition	Cu-IUD	LNG-IUS	IMP	DMPA	POP	CHC
Non-migrainous headache	1	1	1	1	1	I 1 C 2
Migraine without aura at any age	1	2	2	2	**I** 1	**C** 2 **I** 2 **C** 3
Migraine with aura at any age	1	2	2	2	2	4
History (>5 year ago) of migraine with aura at any age	1	2	2	2	2	3

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Cu-IUD = copper intrauterine device, LNG-IUS = levonorgestrel intrauterine system, IMP=implanon/nexplanon, DMPA=depo medroxyprogesterone acetate (IM and SC), POP = progestogen only pill, CHC = combined hormonal contraception, VTE = venous thromboembolism, I = initiation of a method, C = continuation of a method.

Table 2

Although we are told she has no other past medical history, women are unlikely to disclose history of migraine with aura unless they are asked directly about it. It is important to ask about migraine with aura in a contraceptive history because there is evidence the risk of ischaemic stoke increases if these women take combined hormonal contraception (CHC). The use of CHC in women with migraine with aura is therefore a UK MEC 4 (Table 2).

You should also enquire about a family history of VTE and BRCA mutations. The risk of VTE increases from around 2 per 10,000 women in 1 year to 5–12 per 10,000 women in 1 year in CHC users. Therefore CHC use with a personal history of VTE or a strong family history of VTE (a first degree relative <45 years old) would generally be not advised (see Table 3). We know that the risk of breast cancer is increased in current or recent users of CHC and so CHC should be avoided if there is a family history of BRCA mutations (see Table 3).

UK MEC categorization for VTE and BRCA family history

Condition	Cu-IUD	LNG-IUS	IMP	DMPA	POP	CHC
Family history of VTE						
(i) First degree relative <45 years	1	1	1	1	1	3
(ii) First degree relative >45 years	1	1	1	1	1	3
Family history of breast cancer	1	1	1	1	1	1
Carriers of known gene mutations associated with breast cancer (eg BRCA1/BRCA2)	1	2	2	2	2	3

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Table 3

UK MEC categorization for women with diabetes

Condition	Cu-IUD	LNG-IUS	IMP	DMPA	POP	CHC
History of gestational diabetes	1	1	1	1	1	1
Non vascular diabetes (insulin dependent and non-insulin dependent)	1	2	2	2	2	2
Diabetic nephropathy/ retinopathy/neuropathy	1	2	2	2	2	3
Diabetic vascular disease	1	2	2	2	2	3

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Table 4

What do you need to consider?

Safety of pregnancy: women with diabetes are at increased risk of miscarriage, congenital malformation, stillbirth and neonatal death. Therefore, women with diabetes are advised to plan their pregnancies and optimise diabetic control to reduce these risks. This makes contraception an extremely important part their care. Another consideration is the potential adverse pregnancy outcomes with short inter pregnancy intervals (higher risk of preterm delivery, neonatal death and stillbirth) and this is important for any postnatal woman to be aware of, not just those with medical conditions.

Safety of contraception: unless there are vascular complications of diabetes all methods of contraception are generally safe to use in women with diabetes. CHC increases thrombosis risk and can cause elevation in blood pressure and fluid retention. CHC should therefore be avoided if there are vascular complications. The UK MEC for diabetes is outlined in Table 4.

The safety of contraception in the postnatal period also needs to be considered. Other than CHC, all methods of contraception can be safely started immediately after delivery. Due to the increased risk of VTE in the postnatal period then, for women who are otherwise medically eligible for CHC (patch, ring, pill), this should be delayed until at least 6 weeks (if breast feeding) or 3 weeks (if not breastfeeding and no additional risk factors), see Table 5.

Timing: fertility can resume quickly after delivery and many women become pregnant shortly after giving birth. Although

UK MEC categorisation for contraception after pregnancy

Condition	Cu-IUD	LNG-IUS	IMP	DMPA	POP	CHC
Breastfeeding						
a) 0- to <6 weeks post partum	See below	See below	1	2	1	4
b) ≥6weeks to <6 months post partum (primarily breastfeeding)	See below	See below	1	1	1	2
c) ≥6 months post partum	See below	See below	1	1	1	1
Postpartum (in non breastfeeding women)						
a) 0 to <3 weeks						
(i) With other risk factors for VTE	See below	See below	1	2	1	4
(ii) Without other risk factors for VTE			1	2	1	3
b) 3 to <6 weeks						
(i) With other risk factors for VTE	See below	See below	1	2	1	3
(ii) Without other risk factors for VTE	See below	See below	1	1	1	2
c) ≥6 weeks	See below	See below	1	1	1	1
Postpartum (in breastfeeding or non breastfeeding women, including post caesarean section)						
a) 0 to <48 hours	1	1	See above	See above	See above	See above
b) 48 hours to <4 weeks	3	3	See above	See above	See above	See above
c) ≥4weeks	1	1	See above	See above	See above	See above
d) Postpartum sepsis	4	4	See above	See above	See above	See above

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Table 5

contraception is not needed before day 21, it should ideally be started immediately after delivery. This is because many women find it hard to return for routine contraception appointments when recovering from childbirth and caring for a newborn baby. All methods of contraception, with the exception of CHC (see above), can be safely commenced immediately after delivery. If the woman is fully breastfeeding, amenorrhoeic and less than 6 months postnatal then she can rely on the lactational amenorrhoeic method (LAM) for contraception.

Efficacy of contraception: LARC methods are superior in efficacy and women who wish to or need to avoid pregnancy should be encouraged to use them. However, not all women wish to use these methods and this should be respected. Insulin does not reduce the efficacy of any contraception.

Summary

In answer to this patient's questions, she should start contraception immediately after delivery (ideally within 21 days) and from what we know she can safely use any method of contraception. She can have an implant inserted immediately, receive the progestogen only injectable immediately or even have a postplacental IUC inserted at the time of caesarean section or after the delivery of the placenta or within 48 hours of a vaginal delivery. If she wishes to use a pill then she may start a progestogen only pill (POP) immediately. However, if she wishes to use CHC then this should be delayed. If she breastfeeds she may also be able to rely on LAM.

You may wish to take the opportunity to discuss the importance of planning a future pregnancy carefully in view of her diabetes and the importance of good diabetic control. She should be encouraged to use LARC methods as they are the most effective methods available.

Case 2

A 45-year-old woman attends the early pregnancy unit. She thought she was too old to conceive and was very surprised to find herself pregnant. She had heavy vaginal bleeding and an ultrasound and HCGs confirm a complete miscarriage. She developed dilated cardiomyopathy following myocarditis secondary to infection 2 years ago and is under the care of a cardiologist who she still sees every 6 months. She has impaired cardiac function and is on an ACE inhibitor and beta blocker. She is keen to start on a reliable method of contraception and wants to know what options are available to her. Her periods are generally regular and unproblematic. She also wants to know at what age she can stop using contraception.

What information do you need from the history?

A full medical and family history should be taken as discussed in case 1. You should explore what contraception she has used in the past and her thoughts about what she may wish to use now. More information about the severity of her cardiomyopathy may be required from her cardiologist.

Sexual history is often overlooked in older women. However, many older women enter into either casual or long term relationships and may be at risk of pregnancy and sexually transmitted infections.

UK MEC for women with cardiovascular disease

Condition	Cu-IUD		LNG-IUS		IMP		DMPA	POP		CHC
Multiple risk factors for cardiovascular disease (such as smoking, diabetes, hypertension, obesity and dyslipidaemias)	1		2		2		3	2		3
Adequately controlled hypertension Hypertension	1		1		1		2	1		3
Systolic >140–159 mmHg or diastolic >90–99 mmHg Hypertension	1		1		1		1	1		3
Systolic ≥160 mmHg or diastolic ≥100 mmHg	1		1		1		2	1		4
Vascular disease	1		2		2		3	2		4
Current and history of ischaemic heart disease	1		**I** 2	**C** 3	I 2	C 3	3	**I** 2	**C** 3	4
Stroke (history of cerebrovascular accident, including TIA)	1		2	3	2	3	3	2	3	4
Cardiomyopathy with normal cardiac function	1		1		1		1	1		2
Cardiomyopathy with impaired cardiac function	2		2		2		2	2		4
Atrial fibrillation	1		2		2		2	2		4
Known long QT syndrome	**I** 3	**C** 1	**I** 3	**C** 1	1		2	1		2
Uncomplicated valvular and congenital heart disease	1		1		1		1	1		2
Complicated valvular and congenital heart disease (eg pulmonary hypertension, history of subacute bacterial and endocarditis)	2		2		1		1	1		4

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Table 6

What do you need to consider?

Safety of pregnancy: cardiac disease is usually made worse by pregnancy and in the UK it is the leading cause of maternal death from indirect causes. Cardiac diseases and their treatments may also be harmful to the fetus. The risks associated with pregnancy range from mild (no increased risk of mortality) to severe (extremely high risk of mortality, in some situations 50%). In very high risk cases (for example, pulmonary hypertension) pregnancy would be contraindicated and termination would be discussed if she were to become pregnant.

Another consideration is age and safety of pregnancy. Maternal and fetal complications increase in women over the age of 40 with the maternal mortality rate being three times higher in women over 40 compared to women aged 20–24. Although fertility decreases with age, women in their 40s and 50s are still at risk of pregnancy. Some women choose to have children in their 40s but for many the pregnancy is unintended. Women in this age group have one of the highest ratios of abortion to live births.

Safety of contraception: the Faculty of Sexual and Reproductive Healthcare (FSRH) gives guidance on contraception in women with cardiac conditions (ischaemic, valvular, congenital, cardiomyopathy, arrhythmias). It can be difficult for clinicians out with Cardiology to assess the severity of individual cardiac conditions. The FSRH advise that women are likely to have low risk/uncomplicated cardiac conditions if they have been discharged from Cardiology follow up (or seen at intervals of 1 year or more), have normal oxygen saturations, are asymptomatic and are not on any cardiac medications including aspirin. However, if there are any doubts about the safety of contraception with her cardiac condition then you should speak to her cardiologist.

Cardiac conditions may be complicated by heart failure, arrhythmias and thrombus formation. CHC causes fluid retention, elevation in blood pressure and increases the risk of thrombosis. Therefore, CHC should be avoided if there is 'complicated' cardiac disease or a history of ischaemic disease (Table 6). It is thought that DMPA may increase the risk of atherosclerosis because it alters lipid metabolism. It is therefore given a UK MEC 3 for ischaemic conditions. The POP and subdermal implant are not thought to increase the risk of cardiovascular disease and can be safely used in women with cardiac conditions.

The LNG-IUS and Cu-IUD are safe to use in women with cardiac conditions. However, consideration should be given to the insertion process. Women can suffer vasovagal reactions,

bradycardias and other arrhythmias during IUC insertion due to cervical stimulation. This could be dangerous in women who have complex cardiac conditions, arrhythmias or who are on medication to control heart rate (e.g. Bisoprolol). These women should have their device fitted in hospital so there is immediate access to emergency care. We will discuss anticoagulants and IUC insertion in case 3. Antibiotic prophylaxis for infective endocarditis is not required for women with cardiac conditions undergoing IUC insertion but STI risk assessment and screening, if appropriate, is required.

Age and the safety of contraception is also a consideration in this case. The risks of cardiovascular disease, VTE, stroke, and breast cancer rise with increasing age and with CHC use. Therefore, women over the age of 50 are advised to avoid CHC. A 20 μg oestrogen containing pill would be preferable in women who wish to use CHC in their 40s. DMPA is known to reduce bone mineral density and so it should also be avoided in women over 50 as they are already at increased osteoporosis risk due to their age. There are no age restrictions for the use of the implant, POP, CU- IUD and LNG-IUS.

Timing: most women will ovulate within the first month after a miscarriage or ectopic pregnancy and so contraception should ideally be started as soon as possible. If the contraceptive method is started within the first 5 days after the miscarriage then no additional precautions are required (i.e. condoms/abstinence). All methods of contraception are safe to start immediately after miscarriage, including IUC, provided the pregnancy has been expelled and there are no signs of infection. If LARC cannot be provided immediately then a bridging method should be provided (i.e. POP or CHC), until the woman can access her chosen method.

Many perimenopausal women wish to know when they can stop using contraception. If the woman is aged over 50 contraception can be stopped 12 months after the last menstrual period. If she is under 50 contraception can be stopped 24 months after her last menstrual period. The difficulty usually arises when she is using a contraceptive method that itself can cause amenorrhoea such as the progestogen only methods. There are two options available to her. The simplest option is to advise her to continue the method and simply stop when she is 55 years old. Spontaneous conception over 55 is extremely rare. Alternatively FSH levels can be measured if she is over 50 and using a progestogen only method (levels are not accurate if she is using a product containing oestradiol). If she is over 50 years and the FSH is >30 IU/L then contraception can be stopped 12 months later.

Summary

Pregnancy in this patient would carry significant risk and so she requires effective contraception. This patient has a cardiomyopathy with cardiac failure and so CHC would be unsafe for her to use. However, all other methods of contraception would be safe to use. The subdermal implant, Cu-IUD or LNG-IUS should be offered first line to women with cardiac conditions as they are more efficacious than CHC and there are no concerns over safety. The POP is also safe but not as effective as LARC. You may wish to discuss her case in more depth with her cardiologist and if she opted for IUC she should have this fitted in hospital.

This case is also a reminder that women over 40 do become pregnant and assessment of pregnancy risk and need for contraception should not be overlooked in older women attending gynaecology services. As well as advising her about when she can stop contraception you should also emphasis to her that fertility resumes almost immediately after a miscarriage and that the immediate initiation of a LARC method (implant, LNG-IUS or Cu-IUD) would be the most effective option.

Case 3

A 37-year-old para 4 attends the gynaecology clinic with her husband requesting female sterilisation. She had a pulmonary embolus (PE) following a long-haul flight 6 months ago and is on Apixaban (a Direct Oral Anticoagulant (DOAC)). Her BMI is 40. Her periods are heavy but regular and she has had four vaginal deliveries. She used the POP and implant in the past but found they gave her unacceptable bleeding. She wants a sterilisation because she does not want any more children and feels sterilisation would be the best option.

What do you need to consider?

Safety of pregnancy: pregnancy increases the risk of VTE considerably. There is limited data on the teratogenicity of Apixaban but the summary of product characteristics advises against its use in pregnancy and breastfeeding. Therefore, pregnancy should planned where possible in a woman with a previous or recent VTE.

Safety of contraception: CHC should not be used in a woman who has had a PE. CHC would put her at unacceptable risk from further VTE and is a UK MEC 4. In addition, CHC should be avoided in a woman with a BMI ≥35 due to the increased risk of VTE (UK MEC 3). There is no association between progestogen only contraception and VTE and so it would be safe for her to use POP, DMPA, implant or LNG-IUS.

Laparoscopic female sterilisation is effective but there are surgical and anaesthetic risks. These risks would be considerably higher in a patient who has had a recent PE and has a BMI of 40. She would need to be counselled carefully about these risks and encouraged to consider safer options which are equally, if not more, effective such as LARC or male vasectomy. She should also be counselled about the risks of regret and the lack of reversibility of sterilisation.

The risk of serious bleeding during the insertion of IUC in a woman on Apixaban is not truly known but is thought to be low. Women on Apixaban can have their device fitted in the outpatient setting without stopping or withholding the Apixaban. Intramuscular injection with DMPA could cause haematoma formation in an anticoagulated woman and so the subcutaneous preparation Sayana Press should be used if DMPA is the preferred option.

Male sterilisation is often overlooked and yet it is one of the most effective methods of contraception available and carries very few risks. It is performed under local anaesthetic and so is quicker and safer. The main risks to mention are short term pain, bleeding/haematoma, infection, early failure, late failure and a small risk chronic pain. Reliable contraception must be continued until postoperative semen analysis shows low numbers of non-motile sperm (usually at 3 months post procedure).

Efficacy: women often believe female sterilisation is the most effective contraception available and whilst it is appropriate for some women, they should not be under the impression it is the most effective method available. It is essential that we explain female sterilisation efficacy in the context of all other methods. Male sterilisation and the subdermal implant are more effective. Anticoagulants do not reduce contraceptive efficacy.

Bleeding patterns: heavy menstrual bleeding can be a troublesome and unwanted side effect of anticoagulant use. It would firstly be important to stress that female sterilisation will not affect her periods.

The LNG-IUS is a first line treatment for heavy menstrual bleeding and is a very effective contraceptive with similar failure rates to female sterilisation. She should be warned that many women experience irregular bleeding in the initial 3–6 months. DMPA causes amenorrhoea in around 47% of women by 1 year and unscheduled bleeding is common in the initial months. The desogestrel POP (eg cerazette) causes anovulation, and so may improve heavy bleeding. The FSRH guidelines advise that half of desogestrel pill users are amenorrhoeic or have infrequent bleeds by 1 year and the remaining have either regular or frequent or prolonged bleeding. The progestogen only implant is not recognised as a management option for heavy menstrual bleeding, and may be associated with a similar unpredictable bleeding patterns (including amenorrhoea) to the POP. The copper IUD often makes periods heavier and more painful and so is not a good option for women with heavy menstrual bleeding.

Summary

The most difficult part of the consultation may be dispelling some of her misconceptions around sterilisation and hormonal contraception and encouraging her to opt for a safer, more effective methods of contraception. This case highlights the need to listen carefully to the woman's beliefs, preconceptions and concerns. She is unlikely to try the POP or implant again but it would still be worth discussing these as options. An IUS would treat her heavy menstrual bleeding, give her effective contraceptive cover and could be used as part of HRT in the future so long as it is changed every 5 years. She has a raised BMI and so the IUS would also protect her endometrium against the higher levels of unopposed oestrogen. Male sterilisation would also be safer and more effective than female sterilisation.

Conclusion

Contraception is usually safer than pregnancy in women with a medical condition. Fertility and sexual activity usually resume quickly after pregnancy and so contraception should be initiated as soon as possible to avoid unintended pregnancy. When faced with a woman with a medical condition you should take a throughout but relevant history to determine potential contraindications for contraceptive use and explore her beliefs about and experiences of contraception. The UK MEC gives guidance about the safety of contraception in medical conditions and advice can also be sought from local specialist contraceptive providers. LARC methods have been shown to be the most effective methods of contraception and all women should be encouraged to use them. However, women should be supported to use whichever method they find acceptable so long as it is safe and they have been appropriately counselled. ◆

FURTHER READING

Faculty for Sexual and Reproductive Healthcare. UK medical eligibility criteria for contraceptive use. Clinical effectiveness unit, 2016.

Faculty for Sexual and Reproductive Healthcare. Contraception for women aged over 40 years. Clinical effectiveness unit, 2017.

Faculty for Sexual and Reproductive Healthcare. Contraception after pregnancy, 2017.

Faculty of Sexual and Reproductive Health. Contraceptive choices for women with cardiac diseases, 2014.

FSRH CEU Statement. Management of women taking anticoagulants or antiplatelet medications who request intrauterine contraception or subdermal implants, 2017.

Practice points

- Contraception is safer than pregnancy for most women and effective methods should not be withheld unnecessarily.
- Pregnancies in women with medical conditions should ideally be planned. LARC methods are the most effective contraceptives available and women with medical conditions should be encouraged to use them.
- The UK MEC should be consulted when considering the safety of contraception in women with medical conditions.
- Consideration should be given to how the medical condition may affect the contraceptive and how the contraceptive may affect the medical condition.
- Women should be managed on an individual basis and and their experiences, preferences and concerns taken in to account when deciding on the most suitable method of contraception.
- Contraceptives can have other health related benefits such as reduction in menstrual blood flow and protection against some cancers.