Some Prescribing Pearls[3] and Links

- Medical and drug history should be conducted to determine medical eligibility for chosen contraceptive method. See Appendix 3
- The CDC Medical Eligibility Criteria consider smoker > 35 years, uncontrolled hypertension, migraine with aura at any age an **unacceptable health risk** for use of combined hormonal contraception.[18] See Appendix 3 for these and others.
- Clinically exclude pregnancy. See Appendix 1
- Enhanced **counseling** on appropriate use and adverse effects may **improve compliance** and reduce method discontinuation. The discontinuation rate in trials is approximately 45%.
- Give the chosen contraceptive a reasonable trial; often side effects will be overcome within approximately 3 to 6 months.
- Consistent and correct use of male latex condoms are required to reduce the risk of STDs including HIV.
- Emergency contraception can be considered in addition to any method of contraception in situations where it is considered appropriate.
- **Removing unnecessary barriers** can help patients access and be successful with their contraception.[3]
- Benefits of starting contraception may outweigh risks (except insertion of an IUD) when it is reasonably certain that the woman is not pregnant; contraception can be started and a pregnancy test done in 2-4 weeks.[3]
- The "quick-start" method for CHC, (first pill is started on the day of office visit, provided she is not pregnant), may also be used. A back-up method of contraception is required for the first 7 days unless the first day of last menstrual period was ≤ 5 days ago. This method may increase adherence, with no associated increase in breakthrough bleeding or other side effects.[13]
- There is no increased risk for adverse outcomes to infants exposed to combined oral contraceptives or depot medroxyprogesterone acetate in utero.[3]
- The risk of VTE is higher with CHC; however, the absolute risk is low and substantially less than during pregnancy or the postpartum period.
- The **Academic Detailing Service** agrees with recommendations that, given the uncertainty, it seems reasonable to prescribe COCs containing progestins with potentially lower risk of VTE such as levonorgestrel or norethindrone as first choice.
- Progestin only contraception carries no apparent increased risk of VTE or stroke.[13]

LINKS

1. Medical eligibility http://reproductive-health-access-project-store.myshopify.com/products/medical-eligibility-for-initiating-contraception
2. CDC Selected Practice Recommendations http://www.cdc.gov/mmwr/pdf/rr/rr6205.pdf
3. Sexuality and You resources http://www.sexualityandu.ca/
4. Society of Obstetricians and Gynecologists of Canada http://sogc.org/clinical-practice-guidelines/