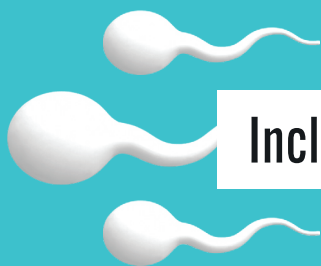
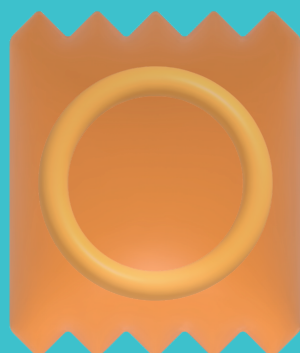
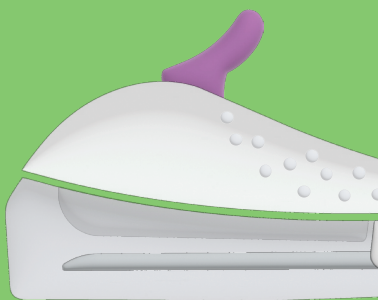


CONTRACEPTION MADE EASY

L. PERCY and D. MANSOUR

4th EDITION



Includes the 2025 UKMEC guidance



CONTRACEPTION **MADE EASY**

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4th EDITION

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Foreword to the fourth edition

I am delighted to write the foreword for this book. I share a geographical link with its two authors, Laura and Diana, as we are all based in the North-east of England. This has given me the opportunity to become familiar with their clinical work over many years and to witness first-hand the expertise, professionalism and passion they bring to women's health. They are highly respected clinicians, educators and advocates, and it has been a privilege to work alongside them.

Working in healthcare is both a privilege and a challenge. The privilege lies in the people we meet: our colleagues, whose knowledge and enthusiasm continually inspire us, and our patients, who place their trust in us at some of the most important moments in their lives. Throughout my career, I have been fortunate to work with exceptional clinicians, and Laura and Diana are undoubtedly among them. I have learnt a tremendous amount from their extensive experience, both through working together clinically and by attending the engaging educational sessions they have delivered. Watching experts teach with such clarity, enthusiasm and compassion has often inspired me to reflect, *"One day, I hope I can deliver a lecture as well as that"*.

The benefits of learning from experts extend far beyond professional development. Every new piece of knowledge, every practical tip and every evidence-based update ultimately benefits the people we care for. My patients have undoubtedly received better care because of what I have learnt from Laura and Diana over the years, and that is perhaps the greatest testament to the value of sharing expertise.

The challenge of working in healthcare is that knowledge never stands still. Advances in medicine, changing guidance and an ever-growing evidence base mean that continuous learning is no longer optional – it is an essential part of delivering safe, high-quality care. The era of 'doctor knows best' has rightly passed. Today's clinicians must combine the best available evidence with excellent consultation skills, shared decision-making and an understanding of each individual's values and preferences.

Alongside this, healthcare professionals must also navigate an increasingly complex information landscape. Patients arrive having accessed information from websites, podcasts and, inevitably, social media. While this has empowered many people to engage actively in their own healthcare, it has also contributed to the spread of myths and misconceptions. Our role is not simply to provide information but to interpret the evidence, address concerns with empathy and support informed, shared decisions.

This book provides exactly the kind of practical, evidence-based resource that clinicians need. Laura and Diana have created an accessible and comprehensive guide to modern contraception and sexual health service provision, written specifically with the primary care audience in mind. Each chapter focuses on a key topic, clearly identifying the essential learning points before exploring consultation skills and concluding with clinical cases that demonstrate how knowledge can be applied in everyday practice. This thoughtful structure makes the content both engaging and highly relevant to the realities of primary care.

Whether you are a pharmacist providing emergency contraception, a practice nurse supporting contraceptive choice, an advanced nurse practitioner managing more complex presentations, or a GP seeking an evidence-based approach to challenging consultations, this book offers practical guidance that will enhance confidence and improve patient care. It will also be a valuable resource for trainees and those developing a specialist interest in women's health.

I have no doubt that this book will become a trusted companion on the bookshelves, and increasingly the desks, of healthcare professionals across primary care. It is a resource that readers will return to time and again, not only to refresh their knowledge but also to support clinical decision-making and inspire best practice in contraception and sexual health.

I congratulate Laura and Diana on producing such an excellent and much-needed resource. I know it will make a meaningful contribution to the education of healthcare professionals and, ultimately, to the care of countless patients.

Most importantly, I hope you enjoy reading it and, above all, enjoy learning.

Dr Julie Oliver
Chair, The Primary Care Women's Health Society

About the authors

Dr Laura Percy qualified as a Consultant in Community Sexual and Reproductive Healthcare, and is currently an Associate Editor of *BMJ Sexual & Reproductive Health*. She was the winner of the inaugural Anne Szarewski Journal Memorial Award, and has published several articles on contraception and women's health. She completed her MBBS from the University of Newcastle upon Tyne in 2006 and began working in contraception in 2008. She has an MSc in Health Education and Health Promotion, and a BSc in Human Biology from King's College, London. Laura is a qualified psychosexual therapist and has a special interest in this area. She is also very interested in the provision of medical information to the public and professionals, with a particular emphasis on sexual health. Information provision and dissemination is currently the main focus of her work.

Dr Diana Mansour is a Consultant Gynaecologist in Newcastle upon Tyne, UK. She has been an Associate Clinical Lecturer at Newcastle University and a Visiting Professor at the University of Sunderland. She is a Clinical Appraiser for Newcastle Hospitals NHS Foundation Trust. In addition Dr Mansour was the Senior Vice President at the then Faculty of Sexual and Reproductive Healthcare in the UK and Past Chair of their Clinical Effectiveness Committee. She sits on the Steering Group and Guideline Development Group for the UK Medical Eligibility Criteria for Contraceptive Use.

Dr Mansour was the first accredited subspecialty trainee in Community Gynaecology and Reproductive Healthcare of the Royal College of Obstetricians and Gynaecologists.

She is first author to over 110 peer-reviewed publications. Her areas of expertise include acceptability of contraceptive methods, non-contraceptive benefits of contraception, development of long-term methods of contraception, changes in health service provision, medical management of heavy menstrual bleeding and management of the menopause.

Abbreviations

ART	antiretroviral therapy
BMD	bone mineral density
BMI	body mass index
<i>BNF</i>	<i>British National Formulary</i>
CHC	combined hormonal contraception
CIN	cervical intraepithelial neoplasia
COC	combined oral contraceptive
CoSRH	College of Sexual and Reproductive Healthcare
CTP	combined transdermal patch
Cu-IUD	copper intrauterine device
CVE	cardiovascular event
CVR	combined vaginal ring
DMPA	depot medroxyprogesterone acetate
DVT	deep vein thrombosis
EC	emergency contraception
EVA	electronic vacuum aspiration
FPA	Family Planning Association
FSH	follicle-stimulating hormone
GLP-1	glucagon-like peptide-1
hCG	human chorionic gonadotrophin
HFI	hormone-free interval
HMB	heavy menstrual bleeding
IBD	inflammatory bowel disease

IMB	intermenstrual bleeding
IMP	implant
IUC	intrauterine contraceptive
LNG-IUD	levonorgestrel intrauterine device
IVF	<i>in vitro</i> fertilization
LAM	lactational amenorrhoea method
LARC	long-acting reversible contraception
LH	luteinizing hormone
LNG	levonorgestrel
MI	myocardial infarction
MIV	minimally invasive vasectomy
MSM	men who are gay, bisexual or have sex with other men
MVA	manual vacuum aspiration
NET-EN	norethisterone enanthate
NICE	National Institute for Health and Care Excellence
NSAID	non-steroidal anti-inflammatory drug
NSV	no-scalpel vasectomy
PCB	post-coital bleeding
PE	pulmonary embolism
PEP	post-exposure prophylaxis
PID	pelvic inflammatory disease
POP	progestogen-only pill
PrEP	pre-exposure prophylaxis
RCOG	Royal College of Obstetricians and Gynaecologists
STI	sexually transmitted infection
UKMEC	UK Medical Eligibility Criteria
UPA	ulipristal acetate
UPSI	unprotected sexual intercourse
VTE	venous thromboembolism

Chapter 4

Combined hormonal contraception

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Although still common, rates of combined hormonal contraceptive (CHC) use have declined since 2020. An estimated 25% of UK women of reproductive age (16–49 years), about 3 million people, rely on the COC. Across Europe, the UK has the seventh-highest share of women using the pill as their main method of contraception.

Combined hormonal contraceptives contain both oestrogen and progestogen. There are three routes of administration: oral (pill), transdermal (combined transdermal patch, CTP) and vaginal (combined vaginal ring, CVR).

In addition to its contraceptive indication, CHCs are prescribed to help manage menstrual symptoms including dysmenorrhoea, premenstrual syndrome, heavy menstrual bleeding and acne. Only one product (Qlaira) has a licence for the treatment of heavy menstrual bleeding in those who desire contraception. Prescribing solely for a non-contraceptive benefit is seen as an off-licence indication.

4.1 Potential users

4.1.1 Most appropriate users

- CHCs can be used from menarche to the age of 50 years providing there are no contraindicating risk factors or medical conditions. For those over 50, healthcare professionals can use their clinical judgement; however, the risk generally outweighs the benefit.
- CHCs are an ideal choice for women who wish to have a regular bleed or to control when they have a withdrawal bleed.
- Individuals should choose whether they wish to use oral, transdermal or vaginal CHCs.

4.1.2 Not suitable for the following users

CHCs are not suitable for the following women:

- those who suffer from migraine with aura and those who develop migraine without aura while taking CHC
- those with current or recent breast cancer
- those with known genetic mutation associated with breast cancer
- those breastfeeding and less than 6 weeks post-partum
- those less than 6 weeks post-partum with other risk factors for VTE, such as immobility, transfusion at delivery, BMI ≥ 30 kg/m², post-partum haemorrhage, post-caesarean delivery, pre-eclampsia or smoking
- those with a BMI over 35 kg/m²
- those with hypertension; discontinuation of CHC in women with hypertension may improve BP control
- those over 35 years of age who currently smoke, including those who stopped smoking less than 1 year ago; given the unknown long-term cardiovascular risk in those using e-cigarettes, an alternative to CHC should be used
- those with multiple risk factors for arterial cardiovascular disease (such as smoking, diabetes, hypertension, obesity and dyslipidaemias)
- those with current or past VTE, or with VTE in a first-degree relative or a known thrombogenic mutation, or those with multiple risk factors for VTE such as cancer, high BMI, thrombotic or inflammatory disorders

- those with diabetes with retinopathy, nephropathy, neuropathy or other vascular disease
- those undergoing major surgery (surgery of greater than 30 minutes duration and all surgery on the legs)
- those taking COC who have had bariatric surgery, because contraceptive effectiveness may be reduced due to the type of surgery undertaken, or postoperative complications such as long-term diarrhoea and/or vomiting
- those experiencing prolonged immobility including following surgery, and individuals with multiple sclerosis associated with prolonged immobility
- those who have undergone organ transplantation with complications such as graft failure (acute or chronic), rejection, cardiac allograft vasculopathy, and those women with Budd-Chiari syndrome due to the increased risk of thrombosis and graft rejection
- those with acute or flare of viral hepatitis
- those with current and medically treated gallbladder disease
- those with past history of CHC-related cholestasis
- those with severe (decompensated) cirrhosis, hepatocellular adenoma or hepatocellular carcinoma
- those with complicated valvular and congenital heart disease such as pulmonary hypertension, or history of subacute bacterial endocarditis
- those with cardiomyopathy and impaired cardiac function
- those with atrial fibrillation
- those with current or history of ischaemic heart disease
- those with vascular disease including coronary heart disease presenting with angina, peripheral vascular disease presenting with intermittent claudication, hypertensive retinopathy, and transient ischaemic attack
- those with current or history of stroke
- those with positive antiphospholipid antibodies
- those with current or history of meningioma (Zoely only). Although the evidence does not relate directly to Zoely, but to preparations containing higher doses of norgestrel acetate, CoSRH suggests that Zoely users should be advised that it is possible that higher cumulative norgestrel acetate exposure resulting from prolonged use could increase risk of intracranial meningioma (although the absolute risk remains small); furthermore, any associated increase in risk would be expected to reduce towards baseline after stopping Zoely.

4.2 Available CHC in the UK

CHCs available in the UK are detailed in *Table 4.1*, along with associated costs and formulations. First-line choices are those containing ≤ 30 micrograms of ethinylestradiol and either levonorgestrel and norethisterone (highlighted in bold in table). There are currently no low ethinylestradiol dose and norethisterone-containing products on the UK market.

Table 4.1 CHCs available in the UK

Type of preparation	Trade name	Oestrogen and progestogen		Cost for 3 cycles Drug tariff price (NHS indicative price)	
Monophasic low strength	Bimizza	Ethinylestradiol 20 micrograms		£5.98 (£5.04)	
	Gedarel 20/150	Desogestrel 150 micrograms		£5.98 (£5.98)	
	Mercilon			£5.98 (£8.44)	
	Akizza 20/75	Ethinylestradiol 20 micrograms		£8.85 (£6.73)	
	Femodette	Gestodene 75 micrograms		£8.85 (£8.85)	
Monophasic standard strength	Millinette 20/75			£8.85 (£6.37)	
	Cimizt	Ethinylestradiol 30 micrograms		£4.93 (£3.80)	
	Gedarel 30/150	Desogestrel 150 micrograms		£4.93 (£4.93)	
	Marvelon			£4.93 (£7.10)	
	Dretine	Ethinylestradiol 30 micrograms		£14.70 (£8.34)	
	Lucette	Drospirenone 3 mg		£14.70 (£11.00)	
	Yacella			£14.70 (£8.30)	
	Yasmin			£14.70 (£14.70)	
	Akizza 30/75	Ethinylestradiol 30 micrograms		£6.73 (£8.85)	
	Femodene	Gestodene 75 micrograms		£6.73 (£6.73)	
	Millinette 30/75			£6.73 (£4.85)	
	Ambelina	Ethinylestradiol 30 micrograms		£2.82 (£2.60)	
Alternative monophasic options	Elevin	Levonorgestrel 150 micrograms		£2.82 (£29.25)	
	Levest			£2.82 (£1.80)	
	Maexeni			£2.82 (£1.88)	
Monophasic 28-day preparations	Microgynon 30			£2.82 (£2.82)	
	Ovranette			£2.82 (£2.20)	
	Rigevidon			£2.82 (£1.89)	
	Cilique	Ethinylestradiol 35 micrograms		£4.65 (£4.65)	
	Lizinna	Norgestimate 250 micrograms		£4.65 (£4.64)	
Phasic standard strength	Brevinor	Ethinylestradiol 35 micrograms		£1.99 (£1.99)	
	Norimin	Norethisterone 500 micrograms			
		Ethinylestradiol 35 micrograms		£2.28 (£2.28)	
		Norethisterone 1 mg			
Phasic standard strength	Drovelis	Estetrol 14.2 mg		£8.60 (£8.60)	
		Drospirenone 3 mg			
	Eloine	Ethinylestradiol 20 micrograms		£14.70 (£14.70)	
		Drospirenone 3 mg			
Phasic standard strength	Microgynon 30 ED	Ethinylestradiol 30 micrograms		£2.99	
		Levonorgestrel 150 micrograms			
	Zoely	Estradiol (as hemihydrate) 1.5 mg		£19.80 (£19.80)	
		Nomegestrol acetate 2.5 mg			
Phasic standard strength	Logynon	Ethinylestradiol 30 micrograms	Levonorgestrel 50 micrograms	6	£3.82
	TriRegol	Ethinylestradiol 30 micrograms	Levonorgestrel 75 micrograms	5	£2.87
		Ethinylestradiol 30 micrograms	Levonorgestrel 125 micrograms	10	
	Synphase	Ethinylestradiol 35 micrograms	Norethisterone 500 micrograms	7	£3.60
		Ethinylestradiol 35 micrograms	Norethisterone 1mg	9	
		Ethinylestradiol 35 micrograms	Norethisterone 500 micrograms	5	

Type of preparation	Trade name	Oestrogen and progestogen		Cost for 3 cycles Drug tariff price (NHS indicative price)	
Phasic standard strength every day	Logynon ED	Ethinylestradiol 30 micrograms	Levonorgestrel 50 micrograms	6	£4.00
		Ethinylestradiol 30 micrograms	Levonorgestrel 75 micrograms	5	
		Ethinylestradiol 30 micrograms	Levonorgestrel 125 micrograms	10	
Phasic every day, 26 active and 2 inactive	Qlaira	Estradiol valerate 3 mg	Dienogest 2 mg	2	£25.18
		Estradiol valerate 2 mg	Dienogest 2 mg	5	
		Estradiol valerate 2 mg	Dienogest 3 mg	17	
		Estradiol valerate 1 mg	Dienogest 3 mg	2	
Patch	Evra	Ethinylestradiol approx. 33.9 micrograms/24 hours Norelgestromin approx. 203 micrograms/24 hours		£19.51 (£19.51)	
Ring	NuvaRing	Ethinylestradiol approx. 15 micrograms/24 hours		£29.70 (£29.70)	
	SyreniRing	Etonogestrel approx. 120 micrograms/24 hours		£29.70 (£19.00)	

Data from BNF, 2026.

4.3 Mechanism of action

- The main mode of action is the prevention of ovulation through negative feedback on the pituitary gland, inhibiting the release of luteinizing hormone (LH) and follicle-stimulating hormone (FSH). In formulations with 21 days of active hormone, the first 7 days of CHC use results in ovulation inhibition and the next 14 days maintains anovulation.
- Cervical mucus is altered which inhibits penetration of spermatozoa.
- Endometrial growth is suppressed, reducing the likelihood of blastocyst implantation.

4.4 Efficacy of CHC

If used consistently and correctly the failure rate for CHC is 0.3% (in the first year of use 3 in 1000 women would become pregnant) but this increases to 7% with typical use. The efficacy of CHC is affected by drug interactions, and the efficacy of the CTP may be reduced in women weighing >90 kg. LARCs are more effective than CHCs.

4.5 Pros and cons of CHC

4.5.1 Advantages

- Effective, reversible, convenient.
- Under user's control and unrelated to sexual intercourse.
- Provides regular, predictable withdrawal bleeds.
- Reduces menstrual loss by at least 40% – recommended by NICE (NG88, 2018, updated 2021) for the treatment of heavy menstrual bleeding.
- Decreases dysmenorrhoea and relieves ovulation pain.

- Reduces acne.
- May improve premenstrual symptoms.
- Protects against ectopic pregnancy because it inhibits ovulation.
- Reduces incidence of benign breast disease.
- Reduces the risk of ovarian cancer. A recent meta-analysis determined a significant duration–response relationship, with a reduction in the incidence of ovarian cancer of more than 50% among women using the CHC for 10 years or more (Havrilesky, 2013). This protection continues for at least 30 years after discontinuation.
- Reduction in functional ovarian cysts and fibroid formation.
- Reduces risk of endometrial cancer; this risk reduction correlates with duration of use. After 10–15 years of use the risk is reduced by 50% and there is persistence of this protective effect for up to 30 years after cessation of use.
- It had been thought that CHC reduces the incidence of colorectal cancer, although there was no duration of use effect. A recent Danish study suggests there is no increase or decrease in the risk of colorectal cancer in CHC users.
- Continuous CHC use can improve the symptoms of endometriosis and can reduce risk of recurrence of endometriosis after surgical management.
- Helps to protect against pelvic inflammatory disease.
- Can be used for management of acne, hirsutism and menstrual irregularities associated with polyendocrine metabolic ovarian syndrome (previously polycystic ovary syndrome).
- Menopausal symptoms may be reduced. Extended use or a reduced pill-free interval may further improve symptom control.

4.5.2 Disadvantages

- These methods must be used correctly and consistently to be effective.
- Drug interactions reduce efficacy.
- Patches cause local skin reaction in up to 20% of users.
- Vaginal ring causes ‘vaginitis’ in 5–14% of women.
- CHC does not provide protection against STIs.
- There is a small increased risk of breast cancer in current CHC users. This risk may increase with duration of use. The risk declines gradually after stopping CHC use, returning to the same risk as never user of CHC by 5–10 years of non-use.
- After 5 years of use, these methods may be associated with an increase in the incidence of cervical intraepithelial neoplasia (CIN) and cancer of the cervix. The combined hormonal components appear to be a co-factor leading to persistence or repeated replication of oncogenic human papilloma virus. Those taking CHC should be advised to have regular cervical screening as indicated by the NHS cervical screening programme (NHSCSP). Women who have previously been treated for CIN may choose to take a CHC because the benefits outweigh the potential risks. They should be advised to continue cervical screening as indicated by the NHSCSP.
- There is an increased risk of MI in CHC users. The absolute risk from a Danish cohort study was 1.0 per 10 000 woman-years of use of hormonal contraception. This risk is increased in women who smoke (up to 20-fold increased risk) and in those with hypertension.
- There is a small increased risk of ischaemic stroke in current CHC users. The absolute risk from a Danish cohort study was 2.1 per 10 000 woman-years of use of hormonal contraception. The risk of ischaemic stroke is increased further in women who experience migraine with aura, from

an odds ratio of 2.7 with no CHC use to an odds ratio of 6.1 with CHC use. There is no increased risk of haemorrhagic stroke associated with CHC use.

- Current use of CHC is associated with increased risk of VTE from a baseline of approximately 2 in 10 000 to 5–12 in 10 000. This risk of VTE is highest in the months immediately after initiation or when restarting after a break of at least 1 month. The risk then reduces over the first year of use and thereafter remains stable. Some CHC formulations are associated with a greater risk of VTE than others (see *Table 4.2*); the various progestogens may modify the effect of oestrogen on hepatic clotting factors in different ways.
- A recent study suggests that when both CHC and non-aspirin NSAID are used, VTE risk is higher than with use of either alone. However, the number of events remains small; the additional number of VTE events during the first week of prescribed non-aspirin NSAID use is around 4 per 100 000 for non-users of CHC, 3 per 100 000 for users of POP, ENG-IMP and LNG-IUD, 11 per 100 000 for users of DMPA or lower risk CHCs, and 23 per 100 000 for users of higher risk CHC including the combined patch, ring and CHC containing higher risk progestogens. This study is observational and confounders maybe present, however, when discussing CHC-associated VTE risk, clinicians may consider advising users about potential small additional risk if non-aspirin NSAIDs are used alongside CHC.

Table 4.2 Risk of developing a VTE in a year

Women not using a combined hormonal pill/patch/ring and who are not pregnant	About 2 out of 10 000 women
Women who are pregnant or in the immediate post-partum period	About 29 out of 10 000 women
Women using a CHC containing levonorgestrel, norethisterone or norgestimate	About 5–7 out of 10 000 women
Women using a CHC containing etonogestrel or norelgestromin	About 6–12 out of 10 000 women
Women using a CHC containing drospirenone, gestodene or desogestrel	About 9–12 out of 10 000 women
Women using a CHC containing dienogest or nomegestrol acetate	*

Data from MHRA (2014); SPC for estradiol valerate and dienogest (2018) and SPC for estradiol hemihydrate and nomegestrol acetate (2019).

* Research suggests these combinations carry a significantly lower risk (roughly half the risk of traditional ethinylestradiol/levonorgestrel pills).

4.6 Using the CHC

- Prior to starting the CHC, medical eligibility needs to be determined from medical, drug (including over-the-counter preparations), family and lifestyle histories (see *Chapters 2 and 3*). Documentation of blood pressure and BMI is recommended.
- If medically eligible, a discussion of the effectiveness, benefits, risks, side-effects and advice regarding when to stop the CHC or seek medical review is advised. This discussion should be supplemented by the provision of written information or a trusted internet link (such as www.contraceptionchoices.org) to support CHC use.
- A good first-line CHC is one containing ≤ 30 micrograms ethinylestradiol in combination with levonorgestrel or norethisterone.
- Women wishing to use the CHC as their method of contraception should be provided with information about standard and tailored regimens, to enable them to make a decision about the most appropriate regimen for them.

- A prescription for up to a 12-month supply of CHC can be provided, whether initiating or continuing this method based on clinical assessment. For some women it may be of benefit to provide CHC for a shorter duration of 3 or 6 months between reviews. The Nuvaring CVR can only be prescribed 1 pack or three months at a time, therefore arrangements will be required for women to obtain repeat prescriptions without the need for 3-monthly medical review.

4.6.1 Standard use

- For most preparations the CHC is taken daily for 21 days followed by a 7 day pill-free or placebo pill interval, during which time a withdrawal bleed will occur. Apps are available to help users remember to take their pills. There are a small number of COCs with 24 active pills and 4 placebo pills.
- The CTP is changed every 7 days for 3 weeks followed by a patch-free week.
- The CVR is inserted into the vagina and remains in place for 3 weeks followed by a ring-free week.
- All of the methods have similar efficacy, but the CTP and CVR are advantageous for women who cannot remember a daily pill or who have gastrointestinal problems affecting pill absorption.
- The CHCs containing estradiol and norgestrel acetate or ethinyl estradiol and drospirenone include four placebo tablets in each 28 day cycle. Estradiol valerate and dienogest have a quadriphasic regimen including two placebo tablets in each 28 day cycle. The latter preparation has an oestrogenic step-down and progestogenic step-up dosing regimen, reducing the incidence of breakthrough bleeding associated with estradiol-containing pills. The estradiol/norgestrel and estradiol valerate/dienogest COCs are associated with a shorter withdrawal bleed (3–4 days for the former and 4 days for the latter) compared to other CHCs (typically 5 days). There is a higher likelihood of missing a withdrawal bleed (18–32% for estradiol/norgestrel compared to 5% with drospirenone-containing CHCs, and 19.4% for estradiol valerate/dienogest CHCs). A pregnancy test is advised if two withdrawal bleeds are missed.

4.6.2 Tailored use (off licence)

- There is no medical reason to have a monthly withdrawal bleed.

Tailored regimens can reduce the frequency of withdrawal bleeds and can reduce withdrawal symptoms such as headache, bloating, tiredness and menstrual pain, which can occur during the HFI. However, unscheduled bleeding is common. There are four options when it comes to tailoring:

- Shortened HFI – 21 days of active pills or 3 patches or 1 ring are used, followed by a 4-day interval.
- Extended use – wherein the CHC method is used for 9 weeks, i.e. 3 packets of pills, 9 patches or 3 rings. Following this a 7 day or 4 day method-free interval is taken, after which the method is recommenced.
- Flexible extended – the chosen CHC method can be used flexibly with continuous use for at least 21 days. Then if troublesome breakthrough bleeding occurs for 3–4 days the CHC can be stopped for an interval of 4 or 7 days. It is then recommended that the CHC is used for at least a further 21 days before another method-free interval is taken.
- Continuous use – when the CHC is used continuously with no HFI.
- Women should be advised that use of tailored CHC regimens is outside the manufacturer's licence but is supported by CoSRH.

Multiphasic COC should not be used in tailored regimens.

4.6.3 Vomiting and severe diarrhoea

- Efficacy of CHCs can be affected by vomiting and severe diarrhoea.
- If vomiting occurs within 3 hours of taking the CHC, another pill should be taken and no further action is needed.
- If the vomiting continues or severe diarrhoea occurs for more than 24 hours, it is advisable to follow the missed pills advice (see *Section 4.6.6*).

4.6.4 Drug interactions

- Non-enzyme inducing antibiotics such as amoxycillin do not affect the efficacy of CHCs.
- Hepatic cytochrome P450 inducing medications such as carbamazepine, phenytoin and topiramate increase the metabolism of both oestrogen and progestogen, thereby reducing the contraceptive efficacy of CHC (see *Chapter 2*). It may be more prudent to change the method of contraception provided for women who are using these medications long-term.
- Lamotrigine monotherapy with CHC use may result in a reduction in serum levels of lamotrigine. It could result in an increased seizure frequency during CHC use and toxicity risk during the CHC-free interval. Therefore concomitant use is not recommended as the potential risks outweigh the benefits.
- CHC users should wait 5 days after taking UPA-EC before commencing their CHC. During this time, and until the CHC has become effective, condoms or abstinence will be required.

4.6.5 Starting regimens

These are described in *Table 4.3* below.

Table 4.3 Starting regimens for CHCs

Circumstances	Start when?	Requirement for 7 days of additional contraceptive precautions (9 days for estradiol valerate/dienogest COC)?
Natural menstrual cycle	Up to and including day 5 At any other time if it is reasonably certain she is not pregnant and/or a high sensitivity urine pregnancy test (HSUPT) is negative	No Yes
Amenorrhoea	At any time if it is reasonably certain she is not pregnant and/or a HSUPT is negative	Yes
Quick starting	At any time if it is reasonably certain she is not pregnant or a HSUPT is negative (see <i>Chapter 2</i>)	Yes
Following childbirth		
• breastfeeding	From 6 weeks following childbirth	Yes
• not breastfeeding	Without additional risk factors* for VTE – from 3 weeks	Yes
	With additional risk factors* for VTE – from 6 weeks	Yes
Following abortion, miscarriage, ectopic pregnancy or gestational trophoblastic disease	Up to and including day 5 following treatment (day 1 for estradiol valerate/dienogest) After day 5 if reasonably certain she is not pregnant (day 1 for estradiol valerate/dienogest)	No Yes

(continued)

Table 4.3 *Continued*

Circumstances	Start when?	Requirement for 7 days of additional contraceptive precautions (9 days for estradiol valerate/dienogest COC)?
Following oral emergency contraception • after LNG-EC • after UPA- EC	Immediately No sooner than 5 days after taking UPA-EC	Yes Yes
Switching from another CHC	Start on day after last active COC, CVR or CTP or during weeks 2–3 or subsequent consecutive weeks of CHC if using extended regimen Week 1 or days 3–7 of HFI AND no UPSI since start of HFI Week 1 or days 3–7 of HFI AND UPSI since start of HFI	No Yes Continue CHC until 7 consecutive days taken, then advice as for week 2 or 3 If a HFI is taken, the need for additional precautions or emergency contraception should be individually assessed, taking account of correct use before the HFI
Switching from a traditional POP	Can be started immediately if the POP has been used consistently and correctly	Yes
Switching from progestogen-only anovulatory methods • desogestrel and DRSP POP pill • injectable • implant	Start on day after last desogestrel and DRSP POP Start any time up to when the repeat injection is due Start any time up to when the implant is due for removal	No CHC will have suppressed ovulation by the time the inhibitory effect of the previous method is lost
Switching from LNG-IUD	Start at any time	Yes if LNG-IUD removed on day of method changed, or No if LNG-IUD remains <i>in situ</i> for 7 (or 9) days until the CHC becomes effective If there has been any UPSI in the preceding 7 days the LNG-IUD should be left <i>in situ</i> for 7 days
Switching from Cu-IUD	Up to day 5 of menstrual cycle (day 1 estradiol COC) At any other time during the menstrual cycle	No Yes if Cu-IUD removed on day of method changed, or No if Cu-IUD remains <i>in situ</i> for 7 (or 9) days until the CHC becomes effective If there has been any UPSI in the preceding 7 days the Cu-IUD should be left <i>in situ</i> for 7 days

* Other risk factors for VTE: immobility, transfusion at delivery, BMI ≥ 30 kg/m², post-partum haemorrhage, immediately post-caesarean delivery, pre-eclampsia and smoking.

4.6.6 Advice about missed or late CHC

- A missed pill is one which is taken more than 24 hours after the pill was due but less than 48 hours late (48–72 hours since the last pill was taken).
- It is recommended that women consider alternative methods if they frequently miss pills or repeatedly make errors while using a patch or ring.
- If one pill is missed, it should be taken as soon as it is remembered and the rest of the pack should be continued. No further action is generally required.
- If two or more pills missed (i.e. more than 72 hours since last pill was taken or more than 48 hours late in restarting pill after pill-free interval) see *Table 4.4* for advice.

If a CHC containing estradiol and norgestrel is taken less than 24 hours late there is no reduction in contraceptive efficacy. If the pill is taken more than 24 hours late see *Table 4.5* for missed pills advice.

Table 4.4 Missed pills advice

Pills missed	Guidance
If two or more pills are missed in the first week or the HFI is extended (>7 days)	• Take most recent missed pill • Continue with the rest of the pack and use condoms or abstain for the next 7 days • If sexual intercourse occurred in the preceding 7 days, emergency contraception may be needed (see <i>Chapter 13</i>)
Two or more missed pills and more than 7 pills left in the packet	• Take the most recent missed pill • Continue with the rest of the pack and use condoms or abstain for the next 7 days • Finish packet and have the pill-free interval as usual
Two or more missed pills and less than 7 pills left in the packet	• Take the most recent missed pill • Continue with the rest of the pack and use condoms or abstain for the next 7 days • Omit the pill-free interval, finish the active tablets in the current packet and immediately start a new packet; do not take any of the inactive or placebo tablets
More than 7 consecutive pills missed in any week of pill taking	• Manage as new start contraception • Consider immediate pregnancy test • Quick start new COC packet (or consider other effective contraception) • Condoms should be used or sex avoided until pills have been taken for 7 consecutive days • Consider follow-up pregnancy test • Consider emergency contraception

Table 4.5 Missed pills advice – estradiol- and norgestrel-containing CHCs

When pills missed	Guidance
Day 1–7	• Take the pill when it is remembered, even if it means taking 2 tablets at the same time • Use barrier methods for next 7 days; consider EC
Day 8–17	• 1 tablet missed, take it when remembered, no condoms needed unless other pills have been missed earlier in the pack • >1 tablet missed, use condoms for next 7 days
Day 18–24	Option 1: skip placebo pills, no additional need for condom use providing no missed pills in the preceding 7 days; may get some menstrual spotting Option 2: stop taking active pills and take a maximum of 3 days of the placebo tablets so that not more than 4 active tablets are missed; then begin new pack

Table 4.6 Missed pills advice – estradiol valerate- and dienogest-containing CHCs

When pills missed	Guidance
Day 1–17	Take the missed pill as soon as possible, even if it means taking 2 pills at the same time Continue taking pills according normal use Use barrier method for 9 days
Day 18–24	Discard remaining pills, start new packet and take normally Use barrier method for 9 days
Day 25–26	Take the missed pill as soon as possible, even if it means taking 2 pills at the same time No barrier method needed
Day 27–28	Discard missed pill and continue taking the packet as normal; no barrier method needed

If one CHC pill containing estradiol valerate and dienogest, estetrol and drospirenone, or 20 mcg ethinylestradiol and drospirenone is taken more than 12 hours late, the missed pills advice in *Table 4.6* is recommended.

4.6.7 Advice regarding incorrect use of CTP and CVR

- If the HFI is increased to greater than 7 days, a new patch or ring should be applied or inserted as soon as possible. Additional contraception or abstinence is needed for 7 days. There may be a need for EC if sexual intercourse occurred in the HFI (see *Chapter 13*).
- If the CTP or CVR is detached or removed for less than 48 hours:
 - a new patch should be attached or a ring inserted
 - no additional contraception is required providing the method has been used correctly in the previous 7 days (or earlier in week 1 and in the 7 days prior to the HFI if detachment or removal occurs in week 1 after the HFI).
- If the CTP or CVR is detached or removed for more than 48 hours:
 - a new patch or ring should be attached or inserted as soon as possible and continued until scheduled change or removal day; additional contraception or abstinence is required for the following 7 days
 - if the removal or detachment occurs in week 1 following the HFI there may be a need for EC if sexual intercourse occurred in the HFI (see *Chapter 13*)
 - if unscheduled removal or detachment occurred in the week prior to a planned HFI, this interval should be omitted and additional contraception or abstinence used for 7 days.
- Continued use of CTP for more than 7 days:
 - if a patch is used for more than 7 but less than 9 days (i.e. up to 48 additional hours), no additional contraception or EC is required, providing that the method has been correctly used for the preceding 7 days or earlier in week 1, and for the week prior to the HFI if the detachment occurs in week 1.
 - if a patch is used for more than 9 days (i.e. more than 48 additional hours) women are advised to apply a new patch, omit the HFI (if within 7 days of the HFI) and use additional contraception or abstinence for the following 7 days.
- Continued use of the CVR for more than 3 weeks:
 - if a ring is used for more than 21 days but less than 28, women can either start their HFI and insert a new ring at the end of the HFI, or insert a new ring and miss the HFI; additional contraception or abstinence is not required, nor is EC, providing the ring was consistently *in situ* from day 21 to day 28

- if a ring is used for more than 4 weeks but less than 5, women are advised to omit the HFI and insert a new ring; additional contraception or abstinence is needed for 7 days but EC not required if the ring was consistently *in situ* from day 21 to 28 of use
- if a ring is used for more than 5 weeks, women are advised to omit the HFI and insert a new ring; additional contraception or abstinence is needed for 7 days. If unprotected sexual intercourse has occurred in week 5 or beyond, EC should be considered (see *Chapter 13*).

4.6.8 Indications that a medical review is needed

Symptoms that require an urgent medical review:

- Calf pain, swelling and/or redness
- Chest pain and/or breathlessness and/or coughing up blood
- Loss of motor or sensory function.

Symptoms that require a medical review:

- Breast lump, unilateral nipple discharge, new nipple inversion, change in breast skin
- New onset migraine
- New onset sensory or motor symptoms in the hour preceding onset of migraine
- Persistent unscheduled vaginal bleeding.

New medical diagnoses that require advice from contraceptive provider to determine the ongoing suitability of CHC:

- High blood pressure
- High body mass index ($>35 \text{ kg/m}^2$)
- Migraine, or migraine with aura
- Deep vein thrombosis or pulmonary embolism
- Blood clotting abnormality
- Antiphospholipid antibodies
- Angina, myocardial infarction, stroke or peripheral vascular disease
- Atrial fibrillation
- Cardiomyopathy
- Breast cancer or breast cancer gene mutation
- Liver tumour
- Symptomatic gallstones.

4.6.9 Surgery and immobility

- VTE risk in CHC users is further increased with prolonged immobility and following major surgery.
- Women should discuss discontinuing the CHC with their surgeon.
- It is normally advised that CHC should be stopped 4 weeks prior to major elective surgery, surgery to the lower limbs, and surgery which will result in prolonged immobility but not for minor or short duration surgery.
- Alternative contraceptive options should be discussed and commenced to avoid unplanned pregnancy. All progestogen-only methods are suitable in this situation.
- The CHC can be recommenced at least 2 weeks after full mobilization.

4.7 Routine follow-up

- Reassess medical eligibility and review current medication, method adherence and satisfaction. In addition, blood pressure and BMI are recorded or can be self-reported by women if consultations are online or by phone.
- Women are advised to return at any time if they have concerns or are experiencing troubling side-effects, have changes in their general health, commence new medication, wish to discontinue CHC, or to discuss alternative methods.
- CHCs can be used during the peri-menopause in non-smoking women with no other contraindications and may reduce menopausal symptoms, especially if the HFI is reduced.
- CHCs can be continued until the age of 50 after which an alternative method is advised. This should be continued until the age of 55 years by which time 98% of women will be at least 1 year past their last menstrual period (see *Chapter 2*).

4.8 Return to fertility

- There is no delay in return to fertility and increasing duration of use is not associated with reduced fertility.
- The earliest estimated date of ovulation following missed combined pills or cessation of CHC is 10 days. Typically, ovulation occurs within 1 month of stopping CHC use.
- Conception rate is 79.4–95.0% within 12 months of ceasing CHC use.

4.9 Managing side-effects

Unscheduled bleeding is one of the most common side-effects, reported by approximately 20% of CHC users. This generally resolves over the first 3 months of use.

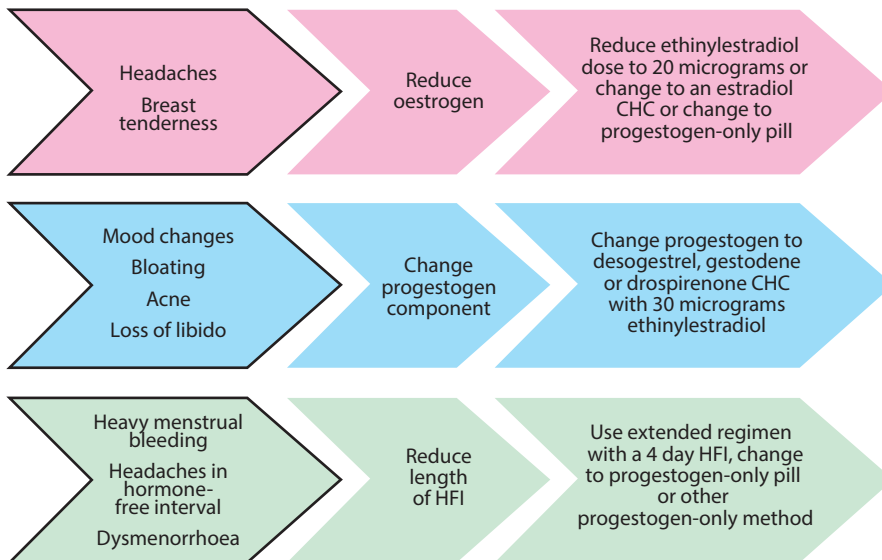


Figure 4.1 Side-effect management options.

If bleeding persists and other pathology known to cause IMB, such as STI, pregnancy, cervical pathology and missed pills, has been excluded, consider increasing the oestrogen dose to ≥ 30 micrograms or change to a more modern progestogen such as gestodene, desogestrel or drospirenone, or a trial of the CVR (increased bioavailability of the steroids via this route of administration). Explain that there is an element of trial and error to find the right choice for each woman.

Side-effects such as headaches, genital irritation, tiredness, bloating and menstrual pain may occur in the HFI rather than during active pill use. Extended, continuous use or shortening the pill-free interval may be beneficial.

Hormonally-associated side-effects include:

- **Nausea** – taking the pill at night or with food may improve symptoms; alternatively a CVR or CTP could also be tried.
- **Breast tenderness** – a support bra or evening primrose oil for cyclical pain may be tried prior to a change in CHC.
- **Chloasma** (skin discolouration) – the use of skin block is recommended in conjunction with stopping the CHC and changing to POP, although it may continue with POP.
- **Acne** – lifestyle, diet and skin care advice are an initial management approach. If acne continues, change progestogen to desogestrel, gestodene or drospirenone CHC with 30 micrograms ethinylestradiol. If it continues after 3 months add in topical or systemic acne treatment. If acne fails to improve after 6 months, change to cyproterone acetate and 35 micrograms ethinylestradiol.
- **Hirsutism** – change to a drospirenone with 30 micrograms ethinylestradiol CHC. If there is little response after 6 months, change to cyproterone acetate and 35 micrograms ethinylestradiol.
- **Mood changes and loss of libido** – in addition to considering a change in progestogen it is important to explore relationship and personal issues.

There is no clear, consistent evidence that CHC use causes depression; if negative mood changes are experienced but the CHC is still the desired method of contraception, different progestogens could be tried. In addition there is no clear evidence of an association between use of CHC containing ≥ 20 micrograms ethinylestradiol and libido.

CTP-specific side-effects include application site skin reaction in up to 20% of women. These reactions include irritation, redness, itch or rash. If they occur the patch should be removed and a new patch applied to another site. Skin reactions are an infrequent reason for discontinuation (2.6%).

CVR-specific side-effects include vaginitis (5.6%), change in vaginal discharge (4.8%) and awareness of the CVR during sexual intercourse (reported by 18% of women and 32% of partners). Foreign body sensation, coital problems and ring expulsion are less common, collectively affecting 4.4% of users.

4.10 Myths and misconceptions

- **CHCs should be stopped after 5 years of use** – there is no medical reason to support women taking a break. Women who take a break and remain sexually active increase their risk of pregnancy. Taking a break from the CHC for 1 month or more then re-starting increases the risk of IMB and more significantly VTE. Additionally, the CHC has a duration-related protective effect for ovarian and endometrial cancer which supports continuation.

- **CHCs cause weight gain** – there is no evidence that CHCs cause weight gain. Weight fluctuates naturally due to changes in age or life circumstance; women tend to gain weight as they age. In addition, most evidence suggests no association between weight/body mass index (BMI) and effectiveness of CHCs. However, there is limited evidence to suggest a possible reduction in patch effectiveness in women ≥ 90 kg.
- **CHCs reduce sexual desire and pleasure** – there is no evidence that CHCs affect a woman's sex drive.
- **CHCs cause acne** – although it is a common belief that CHCs cause acne, evidence suggests that CHCs may reduce acne lesions and those containing cyproterone acetate are licensed to treat severe acne.
- **CHCs must be stopped before air travel** – long-haul travel is a moderate risk factor for VTE. It is advisable that women keep well hydrated, avoid alcohol and undertake appropriate exercise to reduce immobility. Experts recommend that women who are spending more than one week at altitudes above 4500m should consider avoiding CHC. Below this altitude, use of CHC is likely to be safe in a healthy, non-smoking woman.

EXAMPLE

A 27 year old attends for review to discuss irregular bleeding with her combined pill. She has taken it for 9 months.

What questions do you ask her? What are her contraceptive options if she wishes to continue to use a CHC?

1. Check compliance, pregnancy risk, malabsorption, drug interactions and undertake an STI risk assessment.
2. Check she has had a cervical screen within the last 5 years.
3. The CVR provides the best cycle control, with irregular bleeding occurring in just 2% of users compared to 39% in pill users. If she wishes to continue with a pill then 30 micrograms ethinylestradiol and 75 micrograms gestodene, or 35 micrograms ethinylestradiol and 250 micrograms norgestimate would be good alternatives.
4. Alternatively she may wish to try a LARC.

References

British National Formulary, March 2026–September 2026.

CoSRH (2019, amended 2020) *Combined Hormonal Contraception*. Clinical Effectiveness Unit.
[www.cosrh.org/Common/Uploaded%20files/documents/fsrh-guideline-combined-hormonal-contraception-october-2023.pdf – accessed May 2026]

CoSRH (2020, amended 2021) *Recommended Actions after Incorrect Use of Combined Hormonal Contraception (e.g. late or missed pills, ring and patch)*. Clinical Effectiveness Unit.
[www.cosrh.org/Common/Uploaded%20files/documents/fsrh-ceu-recommended-actions-after-incorrect-use-of-chc-march-2020-amended-jul-2021-.pdf – accessed May 2026]

- EMC (2018) *Qlaira Film-Coated Tablets* (oestradiol valerate dienogest): Summary of product characteristics.
[www.medicines.org.uk/emc/product/6536/smpc – accessed March 2026]
- EMC (2019) *Zoely 2.5 mg/1.5 mg Film-Coated Tablets* (oestradiol hemihydrate nomegestrol acetate): Summary of product characteristics.
[www.medicines.org.uk/emc/product/3038/smpc – accessed March 2026]
- Fitzpatrick, D., Pirie, K., Reeves, G., Green, J. and Beral, V. (2023) Combined and progestagen-only hormonal contraceptives and breast cancer risk: a UK nested case-control study and meta-analysis. *PLoS Medicine* **20**(3): e1004188.
- Havrilesky, L.J. *et al.* (2013) Oral contraceptive pills as primary prevention for ovarian cancer: a systematic review and meta-analysis. *Obstetrics and Gynaecology*, **122** (1): 139–47.
- Lange, I.H. *et al.* (2026) Contemporary hormonal contraception and colorectal cancer in premenopausal women: nationwide cohort study. *BMJ*, **394**:e100065.
- Lidegaard, Ø., Løkkegaard, E., Jensen, A. *et al.* (2012) Thrombotic stroke and myocardial infarction with hormonal contraception. *New England Journal of Medicine*, **366**: 2257–66.
- Meaidi, A., Mascolo, A., Sessa, M., *et al.* (2023) Venous thromboembolism with use of hormonal contraception and non-steroidal anti-inflammatory drugs: nationwide cohort study. *BMJ*, **382**:e074450; doi:10.1136/bmj-2022-074450.
- MHRA (2014) Drug Safety Update: *Combined hormonal contraceptives and venous thromboembolism: review confirms risk is small*.
[www.gov.uk/drug-safety-update/combined-hormonal-contraceptives-and-venous-thromboembolism-review-confirms-risk-is-small – accessed March 2026]
- Tepper, N.K., Whiteman, M.K., Zapata, L.B. *et al.* (2016) Safety of hormonal contraceptives among women with migraine: a systematic review. *Contraception*, **94**: 630–40.
- UKMEC (2025) *UK Medical Eligibility Criteria for Contraceptive Use*
[www.cosrh.org/Common/Uploaded%20files/documents/UKMEC_2025.pdf – accessed March 2026]