

BMJ Masterclasses

BMJ Masterclass for GPs
General Update
 Using the latest evidence to make better decisions

WOMEN'S HEALTH
23.10.09
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Declaration of interests

- I regularly receive sponsorship for educational meetings from Schering Plough, Bayer Schering, NovoNordisk, Mates, 3Ms, Ely Lilly
- I have previously received research grants for Organon, Schering, Novartis
- I lecture on a regular basis for Schering Plough, Bayer Schering and NovoNordisk and receive remuneration for this

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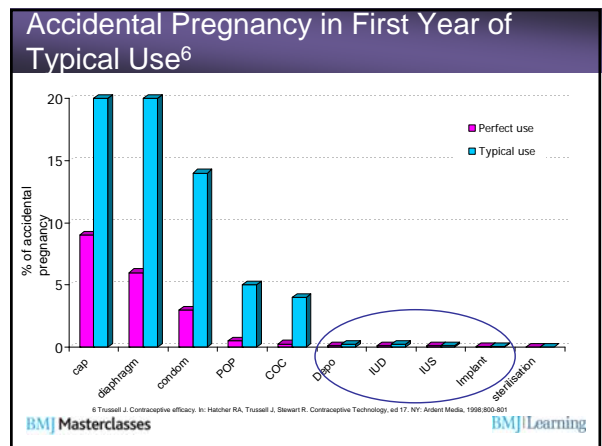
Learning objectives

- Management of common problems relating to hormonal contraception (including new contraceptive methods and Quickstart)
- STIs in Primary Care
- Diagnosis and management of PCOS in Primary Care

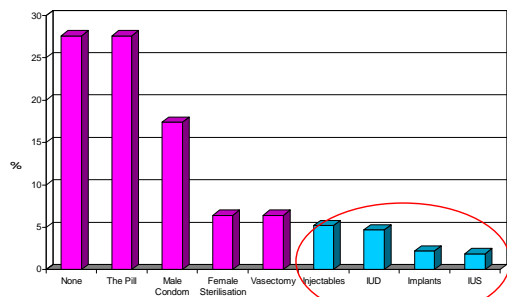
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UK teenage pregnancy rates are the highest in Europe (p149)

Country	Teenage birth rate (per 1,000 women aged 15-19)	Country	Teenage birth rate (per 1,000 women aged 15-19)
Korea	2.9	Germany	13.1
Japan	4.6	Austria	14.0
Switzerland	5.5	Czech Republic	16.4
Netherlands	6.2	Australia	18.4
Sweden	6.5	Ireland	18.7
Italy	6.6	Poland	18.7
Spain	7.9	Canada	20.2
Denmark	8.1	Portugal	21.2
Finland	9.2	Iceland	24.7
France	9.3	Hungary	26.5
Luxembourg	9.7	Slovak Republic	26.9
Belgium	9.9	New Zealand	29.8
Greece	11.8	United Kingdom	30.8
Norway	12.4	USA	52.1



However Current LARC Usage is Low⁵



5. S. Bohning Data on File, 2006, WOMEN AGED 16 TO 44

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Helping you to Talk Choice

- Information pads
- Counselling cards
- Reading pattern diaries for patients
- Reminder cards directing patients to the Talk Choice website

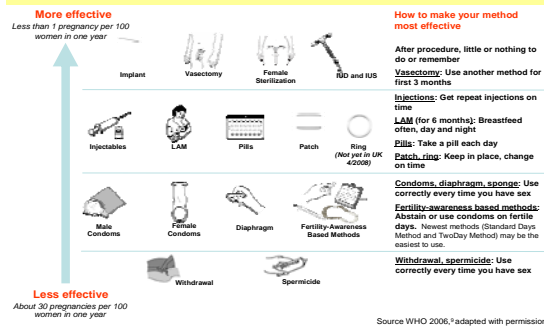


Information and advice on all contraceptive options is available online at:
www.talkchoice.co.uk

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Figure 3-1 Comparing typical effectiveness of contraceptive methods



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Quick Start

- Starting a contraceptive method later in the cycle than the licence allows
- When you are “reasonably sure” that the woman is not pregnant – endorsed by CEU
- Straight after POEC
- Six month data available shows non-significant decrease in pregnancy rate

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Common problems on COC

- Headaches and migraine
- Break through bleeding

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Headaches and Migraine (151)

- Are they migraine headaches?**
 - Cannot continue with normal activities
 - Accompanied by nausea/vomiting or sensitivity to light or both
- Are they accompanied by aura?**
 - Focal symptoms commencing prior to headache and lasting up to 1h
 - Usually visual: bright coloured partial loss of vision on one side of field, gradually increasing in size, with scintillating edges
 - Other variants: unilateral paraesthesia and/or numbness; unilateral weakness; speech disorder; basilar symptoms (vertigo, ataxia, LOC)

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HEADACHES AND MIGRAINE

- Headaches common, often occur during hormone free interval
- Can tricycle (off licence use) or take Qlaira
- Headaches on pill days ,switch to 20mcg preparation e.g. Ethinylestradiol/Desogestrel (Mercilon), Ethinylestradiol/Gestodene (Femodette)
- Switch to POP

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- Client has current focal migraine – UKMEC 4, can't have CHC - absolute CI
- Client develops focal migraine while on CHC, stop immediately, UKMEC4 – CI
- Any sort of migraine+ >35yrs = UKMEC 3, risks outweigh benefits – review and agree alternative contraception

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Interactive Question

A 23yr old lady attends your practice for repeat levonorgestrel 150 mcg/ethinylestradiol 30 mcg (Microgynon 30/Ovranette). For 2yrs she has had a regular withdrawal bleed but recently she has had some intermenstrual and postcoital bleeding. Would you:

- 7% 1. Change her pill to a more oestrogen dominant pill
- 36% 2. Offer cervical cytology
- 57% 3. Neither of the above

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Correct answer No. 3

- On method >3 months
- Check compliance, general history, drug interactions including OTCs
- Sexual health history, other symptoms
- Pregnancy test
- Cytology history if >25yr
- 45yr+ consider further assessment e.g. USS hysteroscopy

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The Contraceptive ring (NuvaRing)

- **Regimen**
 - Lasts 3 weeks with 1 ring-free week
- **Daily release**
 - 15 µg ethinylestradiol
 - 120 µg etonogestrel (active metabolite of desogestrel)
- **Cycle control**
 - Better than 30mgEE/LNG pill and EE/drospirenone (Yasmin)
 - no associated weight gain

p150



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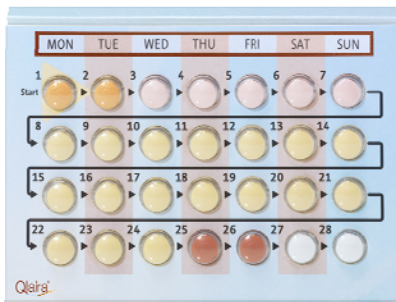
MARC!

- Hormones absorbed through vaginal epithelium directly into the blood stream. Low incidence of expulsion.
- Same UKMEC guidelines as COC
- 15 mcg of EE & 120mcg ETN/24 hours
- Less oestrogen than COC or patch
- Efficacy unaffected by GI upsets
- Efficacy comparable to COC
- Good cycle control
- Costs £9 per month

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The Qlaira pill pack



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Qlaira

- New COC released in May 2009 costs £8.39 per month
- Contains:
 - Oestradiol valerate – natural oestrogen used in HRT, metabolised to oestradiol
 - Dienogest – new progestogen, progesterone receptor specific, anti androgenic and endometrial specific so good cycle control
- Efficacy PI 0.42 for ages 18-50yr

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Pharmacokinetics and dynamics

- EV rapidly absorbed and hydrolysed to 17B oestradiol
- Stable levels achieved within normal follicular range of cycle (180pmol/l)
- Regime allows for stable levels of 17BE throughout the cycle with no “oestrogen withdrawal” in placebo phase, suggesting endogenous production of oestrogen
- This may prevent hormone withdrawal symptoms e.g. headache

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Who can have Qlaira?

- Not for women >35 yrs with CV risk factors or CI to EE e.g. diabetic microvascular disease
- Same UKMEC 3s and 4s as other CHC
 - Appears to have less metabolic effects than current COCs
 - May be better for women over 35yrs or with uncomplicated diabetes
 - Women who want “natural” hormones
 - Women who get oestrogen withdrawal symptoms in PFI

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New EC ellaOne (p150)

- Launched on Oct 1st
- Ulipristal acetate 30mg
- One tablet taken within 5 days of UPI/accident
- Progesterone receptor modulator, same family as Mifepristone
- Works by delaying or inhibiting ovulation.
- Not recommended to breast feed within 36hrs of taking it
- Not recommended in severe asthmatics
- Concomitant use with a LNG containing contraceptive not recommended
- May reduce efficacy of regular hormonal contraception? No quick start

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- In clinical trials at least as effective as Levonorgestrel 1.5mg (Levonelle)
- Menstrual disorder common
- Should not be given if pregnancy is suspected
- Limited data re toxicity in pregnancy but no evidence of increased miscarriage or birth defects in the small no of pregnancies that have so far been exposed

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PROGESTOGEN ONLY PILL

Used by 5% of women aged 16-50 yrs

- **Benefits**
- Safe, very few absolute contraindications
- Only UKMEC 4 is current breast cancer
- Breast feeding
- Desogestrel (Cerazette) more effective and with 12 hr window
- **Risks/Problems**
- Requires meticulous pill taking
- Older pills less effective in younger women
- Irregular bleeding

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Interactive Question

The efficacy of the Progestogen only pill is reduced by broad spectrum antibiotics

20% 1. True

80% 2. False

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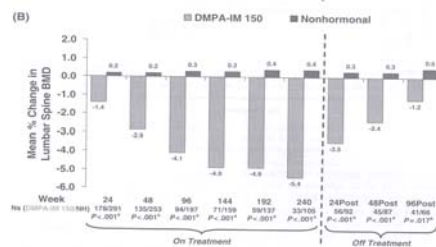
Medroxyprogesterone acetate (Depoprovera) (p155)

- Effect on bone density
- Management of late injections
- Depo and adolescents

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Cohort of women aged 25-35 using DMPA for 5 years



Kaunitz et al Contraception 2006

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Statement on MHRA Guidance on DMPA from 2004

Key points:

- DMPA may be used as first line contraception in adolescents, but only after other methods have been discussed and considered to be unsuitable or unacceptable
- In women of all ages, careful re-evaluation of the risks and benefits of treatment should be carried out in those who wish to continue use for more than 2 years
- In women with significant life style and /or medical risk factors for osteoporosis, other methods of contraception should be considered.

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- Women most likely to have other risk factors for OP e.g. smoking, poor diet are often depo users.
- UKMEC 2 for <18s. LARC same as MHRA
- UKMEC 2 benefits >risks for women >45yr
- if other risk factors should consider other options for contraception
- Women in mid reproductive life no real concerns as bone density recovers quickly

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Late injections (P155)

DMPA is only effective if given within 12 weeks and 5 days of previous injection

31% 1. True

69% 2. False

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Management of late injection

- LARC says – women attending up to 2 weeks late for repeat injection may be given it without the need for additional contraceptive cover i.e. can be given up to 14 weeks from last injection
- CEU – gives the same advise and states that for injections >2 weeks late, local protocols should be developed

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DH Department of Health

You're Welcome quality criteria
Making health services young people friendly

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STIs (p161)

- Chlamydia is the most common sexually transmitted infection (STI)
 - Affects an estimated one in ten sexually active young women
- Other infections are also increasing
 - 715,000 STI diagnoses in GUM clinics (2006)
 - Increasing rates of STIs in older women who do not perceive themselves to be at risk
 - Large increase in women accessing community contraceptive services and Primary Care with symptoms of STI over the last 5 years

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Improving access to STI screening(p165)

STI testing

- NAATS testing for Chlamydia and gonorrhoea on urine samples or self taken vulvo vaginal swabs removes the need for examination in asymptomatics
- Postal kits can be provided by pharmacies and in “serve yourself bins” in health centres, GP surgeries and colleges etc

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CASPHER: chlamydia screening programme for under 25s (p164)



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Overlap between Contraception, STIs and other pathologies

- Clinical history
- Method and compliance
- OTC remedies
- Sexual health history
- Cytology history
- Risk assessment STI v other pathology

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Vaginal discharge

- Women call everything “Thrush”
- Need to assess risk factors
- Need to take a sexual health history

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Risk factors for STI

- Under 25yr
- Recent change of sexual partner
- More than 1 partner in last 12 months
- Presenting for emergency contraception
- Symptoms of upper genital tract problems

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Management of vaginal discharge if low risk for STI

- Empirical treatment based on clinical history
- Non offensive white discharge with itch
Clotrimazole
- Offensive discharge without itch
Metronidazole

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Who needs to be investigated/examined?

- High risk STI
- Upper genital tract symptoms
- Post partum, TOP or miscarriage
- Recurrent infections
- Failed treatment

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What tests to do in Primary Care

- pH
- HVS
- Endocervical M C and S
- Endocervical chlamydia
- PV

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Interactive Question

What is the commonest cause of vaginal discharge in young women?

- 5% 1. Chlamydia
- 84% 2. Physiological
- 9% 3. Candida
- 2% 4. Trichomonas vaginalis

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Polycystic ovary syndrome (p169)

- Is present in up to 30% of women presenting with secondary amenorrhoea
- Can only be diagnosed when other causes of oligo/amenorrhoea have been excluded
- Exclude:
Pregnancy, thyroid dysfunction, menopause, hyperprolactinaemia, Cushing's syndrome, congenital adrenal hyperplasia, adrenal secreting tumours

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Interactive Question

Raised LH/FSH is a useful diagnostic criterion for PCOS?

- 40% 1. True
- 60% 2. False

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- False
- Inconsistently raised in PCOS
- Basic screening includes
- TFTs, Prolactin, FAI, Pregnancy test, FSH and LH (premature menopause)

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PCOS

- Rotterdam criteria 2 out of 3 of following
- Hyperandrogenism
- Oligo/amenorrhoea
- Polycystic ovaries on ultrasound

- 50 % are obese with increased risk of CVD
- Increased risk of diabetes
- Endometrial hyperplasia/ malignancy
- Infertility

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Management of PCOS

- Effective treatment depends on specific goals
- May include
- Weight management
- Fertility
- Acne and hirsutism
- Regulation of menstrual cycle
- Prevention of long term consequences

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Management

- COC EE/drospirenone (Yasmin) and co-cyprindiol (Dianette) help with hyperandrogenism and protect endometrium (need 4 bleeds per year) but issues with BMI and VTE
- Metformin unlicensed for PCOS and not always helpful for obese women but loss of 5% body weight results in resumption of ovulation, increased SHBG and decreased insulin levels
- Refer if :
 - Testosterone >5nmol/l
 - Irregular bleeding /concerns re endometrial pathology
 - Fertility issues
 - Diagnosis/management not clear

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Summary

- Management of common problems on hormonal contraception
- New methods of CHC and EC
- Assessment of STIs in Primary Care
- Management of PCOs

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The future!

- Touch screen for access to Sexual Health Partnership website, drugs and alcohol information, PPI, access to goods, possibly recruitment for research programmes
- To contain chlamydia testing kits, condoms with lube.....



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References

- FFPRHC Guidance 2005, The use of contraception outside the product licence. JFP and RHC 2005;31(3):225-242
- NICE Clinical Guideline 30 on LARC 2005
- FFPRHC Clinical guidance on Progestogen only injectables CEU Nov 2008
- FFPRHC Clinical guidance on Progestogen only pills CEU Nov 2008
- FFPRHC guidance on First prescription of combined hormonal contraception CEU
- FFPRHC Clinical guidance on Progestogen only implants CEU April 2008
- FFPRHC and BASHH guidance on Management of Women of reproductive age attending non GUM settings complaining of Vaginal discharge JFP and RHC 2006;32(1): 33-42
- RCOG Green top Guideline 33 Dec 2007 Long term consequences of Polycystic ovary syndrome
- Management of PCOS. Trends in Urol, Gynae and Sexual Health Nov 08 p 14-19

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