Pennine GP Learning Group

Minutes of meeting

Date: 28th September 2016

Time: 7.30-9.30pm

Topic: Contraception Update Part 1

Members present: Dr Rukhsana Hussain, Dr Claire Stansfield and Dr Ainie Chaudhry

Apologies: Several members sent their apologies for cancellation at short notice due to unforeseen circumstances. Other members had already advised that they were unable to attend on this occasion but wanted to be kept informed of future meetings.

1. Dr Hussain welcomed and briefly explained the purpose of the group to Dr Chaudhry who was attending for the first time. She signposted her to the website and the rules of the group.

2. Dr Hussain and Dr Stansfield relayed some recent positive events in practice to remind us all why we love being GPs!

3. Dr Hussain presented a brief summary of "**contraceptive pill brands"** grouped according to their oestrogen and progesterone content. Members admitted that often when having to switch pills from one to another they would need to look through the BNF to ensure they didn't pick a brand that had the same ingredients as the current one!

Dr Hussain also noted when researching the topic that the BNF quoted prices for medications were from a few years prior to the publication date and so not up to date.

We all agreed that a quick reference summary would save time that was spent looking through the BNF as well as help us to remember recommended brands and their content.

4. Dr Stansfield presented a **comprehensive summary of the "FSRH guidelines on the management of problematic bleeding in women using hormonal contraception"**. Some of the recommendations included explaining expected bleeding patterns to patients and using the lowest oestrogen content pill that controls bleeding. We discussed the fact that our first line COCP would normally be a standard strength oestrogen and not a low strength one. We agreed that we would probably still start younger very fertile women on standard strength oestrogen pills but may consider lower oestrogen pills first line in women in their 30s for example.

We learned that urine testing is no longer recommended in STI screening in women and that a single self taken swab can suffice for testing for chlamydia and gonorrhoea by NAAT. We admitted that we would normally perform triple swabs as this was what we have been taught historically but may offer the option of a self taken swab more often now that we were aware of this guidance, as well as avoid urine testing.

We covered the indications for examination and visualisation of the cervix:

- persistent bleeding beyond the first 3 months of use
- for new symptoms or a change in bleeding after at least 3 months of use
- If a woman has not participated in the NHS cervical screening programme
- If requested by a woman
- After a failed trial of the limited medical management available
- If there are other symptoms such as pain, dyspareunia or postcoital bleeding (these would require bimanual examination also)

We learned that only a quarter of women are amenorrhoeic with the mirena coil at 3 years. We had expected the number to be greater and admitted that we would often tell patients that they would most likely have no periods or very light periods after the initial 6 months or so!

We learned that bleeding with the implant in the first 3 months is indicative of how it will continue and so we will inform patients of this. We would normally not remove the implant so early and had found anecdotally many women benefitted from concurrent use of the COCP or POP for a few months to settle the bleeding.

The guidelines outlined that bleeding pattern with one progesterone only method did not predict bleeding with another method and we agreed that we could use this information to reassure women when switching methods.

In women over 45 on the pill or hormonal contraception we need to consider investigating any change in bleeding pattern and not just assume it is peri-menopausal bleeding.

We discussed how we would apply these guidelines in practice.

5. Dr Hussain presented a summary of "**contraception after childbirth"**

We learned that fertility can return as early as 21 days after childbirth and so women need to be made aware of the need for contraception to avoid unwanted pregnancy. Dr Hussain informed the group of the various methods available to women and from what time from birth. The timing of use of some methods was related to whether the woman was

breastfeeding or not. Of note was the recent update in the UKMEC 2016 guidelines which advised that there was no evidence that the COCP had an adverse effect on milk supply in breastfeeding women or on the infant's growth and so recommended it can be used 6 weeks postpartum in fully or almost fully breastfeeding women. This was in contrast to the previous recommendation to use it after 6 months postpartum in these women. We discussed the implications of this and that probably in practice we would continue prescribing the POP unless women had particular concerns or problems with the POP or preferred the COCP.

Emergency contraception in the form of levornorgestrol can be used after 21 days and the IUD after 28 days. We learned that if using these methods a woman could breastfeed normally, but if EllaOne was used then the woman would have to express her breast milk and discard it for a week after.

Dr Hussain also mentioned regarding the use of contraception after miscarriage and abortion.

6. Dr Hussain discussed and highlighted the contents of a **recent MHRA alert regarding the use of the levonorgestrel emergency contraceptive pill** women taking enzyme inducing medicatiion including St Johns Wort. **MHRA alert levornogestrel**

Health professionals are advised to recommend the IUD first line in these women and if declined offer a double dose of the pill i.e 3mg instead of 1.5mg. EllaOne is NOT recommended for use in these women or women who have stopped using these drugs in the previous 4 weeks.

The session was closed by a general chat about work and discussion regarding plans for the next meeting. We agreed that a break from the topic of contraception was sensible and that part 2 of the update could be held in a few months' time depending on member preferences.

We decided that the next meeting would be "miscellaneous topics" and that each member could bring anything they wanted to discuss or present at the meeting for the benefit of the group.

Actions to be taken

1. Dr Hussain has booked the next meeting for the 19th October 2016 7-9 pm (earlier time due to feedback from the group)

2. Review FSRH guidelines in own time to consolidate learning. Research benefits of low vaginal swab vs triple swabs and local recommendations.