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Fsrh guidelines quick starting contraception

the impact of COVID-19 pandemic on access to contraception while maintaining contraception despite face to face reduction consults the effectiveness and practicality of long-term reversible contraceptive methods, particularly during pandemics. Read this article on: GinP.co.uk/455670. article After reading this article, 'Test and reflect' on your updated knowledge with our most chosen questions. It is estimated that this activity will take you 30 minutes, namely 0.5 CPD credits. While I sit to write this article, I have a feeling of discomfort that this is calm before the storm. It is in mid-September 2020, the first wave of COVID-19 passed and the children returned to school, but new restrictions were just introduced,1 and there is almost certainly another increase in cases where to come and a rocky time ahead. This article talks about contraception in the COVID-19 era, considering how best to provide long-term reversible contraception (LARC) at the present time, and what to do if there is another wave and face-to-face appointments are further limited. It is important that we obtain this right — definitions of pregnancy have already increased since the beginning of pandemic,2 and if access to contraception is poor, then there is the potential for termination rates to increase even higher. 1. Always offer LARC to every patient looking contraception It is common for a patient to open a consultation saying 'I would like to go on the pill, Sometimes, this phrase does what it says on the box — the patient was on the pill first and is happy with it, or did their research and decided that the pill is the most suitable method for them. However, 'going on the pill' is often used as shorthand for contraception in general; if the patient's request is taken at a nominal value, the possibility of discussing LARC methods, which are much more reliable, can be lost. The plant and all intrauterine devices (IUDs) are more than 99% effective with the use of real life,3 and the injection of the deposit is about 94% effective.3 The methods that rely on the action of the user every day/week, such as contraceptive pill and patch, are only 91% effective in real life, 3 because people forget to use them. The use of male condoms as the only contraception method should generally be discouraged, because their effectiveness in real life is only 82%,3 and fertility monitoring, otherwise known as natural family planning, has the worst effectiveness of all at 76%.3 2. Know how long LARC methods can remain in force The amount of time LARC methods can be left in place varies between different products, and recommendations on how long they can stay have changed with COVID-19. Not every GP will be a LARC fitter, but each GP can have a basic knowledge of these methods and their duration of action. The Faculty of Sexual and reproductive hygiene (FSRH) now recommends that the 52 mg levonorgestrel (IUS) intrauterine system and systems can befor 1 year after their licence expiry — further information is provided in Box 1.4 note: for the off-licence of drugs, the prescribed person should follow a relevant professional guide, taking full responsibility for the decision. informed consent must be obtained and documented. see the good practice of the general medical advice in prescription and in the management of medicines and devices for further information.5 contraceptive plants fsrh recommends that the risk of pregnancy is 'how to be very low' in the fourth year of use4 this is based on observational studies where 783 patients have oated the plant for 4 years and 306 have oated it for 5 years, and no gravidance has been observed. at 52- mg ius has the risk of a pregnancy of only 0.25 years for the sixth year of use and 0.43-0.5 for the seventh year of use4,7,8 for 100 years of female age, and can therefore be safely used for a sixth year Mirena® (levonorgestrel; bayer plc, reading, uk) and Levosert® (levorgenorgenostrelof 45 years that are used for contraception may remain in force until the age of 55; this was the case before COVID-19.9,10 Cu-IUD 10 years old as the TCu380A can be used for 12 years with the minimum risk of pregnancy,11 but 5 years old devices must be modified when due to AVI-IUD with 300 mm2 or more of copper that is equipped to 40 years of IUS = intrauterine system; IUD= intrauterine apparatus; FSRH=Ease of sexual hygiene and reproductive; HRT = hormone replacement therapy; Cu-IUD=copper intrauterine device It is important to inform patients that the risk of pregnancy is very low when LARC is used in this extended way, but it is not zero, and that generally the numbers of patients enrolled in relevant studies are too small to calculate the exact effectiveness rates. Most patients who care to use LARC this way could be given a progestin-only pill (POP) to take on top of their LARC method until a change can be arranged. There are very few absolute contraindications for POP, with the remarkable exception of present breast cancer, but if uncertain, the medical eligibility criteria of the United Kingdom 2016 for contraceptive use should be consulted. 12 3. Many contraceptive methods can be prescribed remotely The Forum for Women's Health of Primary Care (PCWHF) hasa useful flow diagram to help with the online delivery of contraception (see figure 1).11 in general, almost any patient can be prescribed pop on the phone, unless they have an absolute or strong relative contraindication. Therefore, pop can be used as a “fall-back” method to provide contraceptives for people who, for any reason, cannot access or use their normal method during COVID-19. it is also good to prescribe the combined oral contraceptive (coc) on the phone; a history of contraindications can be aroused on the phone and documented in the notes. 13 It is necessary to have the body mass index and blood pressure measurements taken in the previous year, but if the patient cannot participate in surgery for this and is unable to perform these measurements at home, then it is safer to prescribe the pop. written information must be sent to the patient via text or email: good sources of advice include the site of family planning contraception choices association14 and university university london. 15 anecdotically, the injection of the deposit seems to have become less popular since the plant has become available. This is not too surprising, because attending the gp every 12–14 weeks for an intramuscular injection cannot be elevated on the list of priorities of a patient. Sayana® press (medroxyprogesterone acetate; pfizer limited, tadworth, uk) is the only subcutaneous injection of deposit contraceptives on the market, and can be safely self-administration at home. ›that someone else is present during the administration in case of anaphylaxis,16 although this is very rare and would seem common sense that, after the first injections, there is not unlikely to be such a serious reaction. Sayana® The print must be injected into the abdomen or the anterior thigh. The patient can be taught to use it by a health professional (as patients with diabetes are taught to inject), or they can watch an online video that teaches them how to do it. 17 The dosage range recommended by FSRH is 13 weeks for both Depo-Provera® intramuscular acetate (medroxyprogesterone; Pfizer Limited) and Sayana® printing, but can be administered up to 14 weeks without additional contraception. Patients who are late with their next injection (up to 16 weeks) can be reassured that the risk of pregnancy is less than 1% and that the guidance of the World Health Organization allows injection intervals up to 16 weeks, but the UK guide is more prudent. 16 Does the FSRH provide a clear guide to providing a deposit injection if more than 14 weeks have passed since the last injection, including considerations on the opportunity of unprotected sex and on the need for extra contraceptive precautions (see Table 1).16 Table 1: FSRH advice in relation to the contraceptive injections of end progestogeny-only 16 Inject Temptation UPS is successful? Is there a risk of pregnancy? Can the EC be offered? Can the injection be administered? Is a further licence required? It is required? up to 14 weeks from the last dmpa injection or up to 10 weeks from the last NET-EN injection Yes No N/A Yes no 14 weeks + 1 day or more from the last injection im or sc dmpa or 10 weeks + 1 day or more from the last injection NET-EN no (not sex or method of barrier oate) no N/A Yes (7 days after injection) no Yes, but only in the last 5 days (the sex that occurs until week 14 or week 10 is protected) Yes. Consider Cu-IUD or lng ec. the effectiveness of the ec supplement could theoretically be reduced by residual circular progestion.[A] Yes* (if the bridging method is not acceptable.) [a] * after lng ec injection can be given immediately. after upa ec, delay injection for 5 days. [a] Yes (up to 7 days after injection) Yes ≥3 weeks from the last episode of upsi Yes —many episodes 5 days ago Yes. The effectiveness of the ec up could theoretically be reduced by residual circular progestion.[A] Yes* (if the bridging method is not acceptable.) [a] * after lng ec injection can be given immediately. after upa ec, delay injection for 5 days. [a] Yes (up to 7 days after injection) Yes, before administering injection and ≥3 weeks from the last episode of upsi Yes — multiple episodes >5 days ago and ≤3 weeks ago Yes no Yes (if the method of bridging is not acceptable.) Yes (up to 7 days after injection) Yes, before administering injection and ≥3 weeks from the last episode of upsi Yes —many episodes >3 weeks ago Yes no perform a pregnancy test and if you administer negativeYes (up to 7 days after injection) Yes, before administering the injection [a] see the clinical guide fsrh: emergency contraception (www.fsrh.org/standards-and-guidance/documents/ceu-clinical-guidance-emergency-contraception-march-2017) FSRH=Faculty of sexual and reproductive health; upsi= unprotected sexual intercourse; EC=emergency contraception; DMPA=depot medroxyprogesterone; NET-EN=norethisterone enanthate; N/A=not applicable; IM=intramuscular; SC=subcutaneous; Cu-IUD=copper intrauterpano; lng= injectable contraception only progestin. londra: fsrh, 2014 (update 2020). available at: www.fsrh.org/standards-and-guidance/documents/cec-ceu-guidance-iniiettibill-dec-2014 reproduced with permission. internet is a valuable source of advice, but also allows easy propagation of myths; It is always useful to remind patients that those who are happy with their contraception form the silent majority who do not tend to go online and talk about it common myths and answers to them are listed in box 2. 'IUDs should not be used in adolescents or nulliparous people.' there is no lower age limit, and these devices can be easily mounted in nulliparous individuals or those who have delivered only from section cesarea. 18 All patients must have a chlamydia pad before mounting, the risk of pelvic infection is higher in the first weeks after iud assembly, but thethe risk remains low. The FSRH recommends taking a sexual history, and a screen offered to all patients who are identified as at risk of sexually transmitted infection,18 usually consists of a single swab for gonorrhea and clamydia. There is no need to shield for other organisms using a high vagina swamp. If the patient has no symptoms of pelvic infection, then the UD can be mounted before the results of the swamp are back until the patient can be contacted if necessary with the result of the swamp. 'IUDs cause ectopic/patient pregnancy with an earlier ectopic pregnancy should not have an IUD.' IUDs drastically reduce the number of pregnancies in the complex, and also reduce the number of ectopic pregnancies. If the UD fails and occurs a pregnancy, then the relative risk of this pregnancy being ectopic is greater than a patient without IUD, but the absolute risk of an ectopic pregnancy is still much lower than a patient who does not use contraception. 18 Past ectopic pregnancy is not a contraindication for the use of an IUD. 12 If my periods stop with the plant, I will not be able to conceive in the future. Some anovulator methods can cause amenorrhea. Patients can be reassured that this has no impact on their future fertility, and that ovulation quickly returns when a plant is removed. The only contraceptive method with a known delay in return for fertility is the injection of the deposit, with an average delay of 6-7 months until a maximum known delay of 1before the first ovulation,16 although patients should not rely on this for contraception after injection is stopped. IUD= intrauterine apparatus; FSRH=Faculty of sexual health and reproductive 6. Do not be afraid to start up LARC again Although there is still a need to reduce the fall of the feet in our interventions, this must be balanced with the risks for patients not to be able to access the appropriate contraception. This can be particularly important for those patients in abusive relationships — we know that domestic abuse has increased during pandemic19 — for which the contraception that their partner does not know about can be particularly important. It is reasonable to take some basic precautions when rebooting the LARC fittings. Do as much as possible on the phone to reduce face to face time—this may include full counseling and documentation of it, establishing where the patient is in their cycle and answering their questions. You can then send a sms or email to a leaflet for the patient to read before they enter. Wear appropriate personal protective equipment (gloves, aprons, surgical mask and visor)20 and make sure the patient knows in advance wearing a mask. The patient must attend alone unless there is a good reason to have a friend with them (irregion may include the patient being young, having learning difficulties, or need an interpreter), and must be confirmed on the day of appointment that they have no symptoms of COVID-19. After assembly was made,any surface that the patient touched with antiviral spray before seeing the next patient. A deep cleansing of the room among patients is impractical. More information is available on FSRH21 and PCWHF.22 websites If the application exceeds the offer of appointments, take into account the priority those who are vulnerable, for example those who are under the age of 18, are homeless, are sexual workers, have learning difficulties, or are known to be in abusive relationships. You may also want to give priority to those whose LARC methods are the most out of date, and in particular anyone who approaches 4 years for a plant or approaching 6 years for an IUS 52-mg. Remember that most LARC can be quick at any time in the cycle if 'it is reasonably certain that a woman is not pregnant or at risk of pregnancy from a recent unprotected sexual intercourse',23 using FSRH criteria in box 3. Although these criteria are not satisfied, the plant, COC, POP and the injection of the deposit can be started as long as the patient understands that there is a risk that can be in early pregnancy and undertakes to do a pregnancy test 3 weeks after the last episode of unprotected sex. Further details on the LARC quick start are in the FSRH guide on the topic. 23 Doctors can be reasonably certain that a patient is not currently pregnant if one or more of the following criteria are satisfied and there are no symptoms or signs of pregnancy: They haven't had sex since the beginning of pregnancy.patients who do not have an infection with infectious diseases (especially working-age patients) Faculty of sexual and reproductive education. Quick approach. London: FSRH, 2017. Available at: www.fsrh.org/standards-and-guidance/documents/fsrh-clinical-guidance-quick-starting-contraception-april-2017/ Reproduced with FSRH permission=Faculty of sexual and reproductive health; CG=umana gonadotropin corionica Termination rates increased during the block and it is vital that we continue to provide good access to contraception in the likely turbulent months in advance. This is it.discusses secure remote delivery of contraception, when a long-term method can be left for more time than its licensed usage period, and how to safely restart long-term contraception methods for those who have not yet restarted. Dr. Toni Hazell GP Part-time, London's Great Declaration of Interest Dr Hazell is on the Executive Committee of the Primary Care Women's Health Forum, a role that involves both paid and unpaid work. Read the relative Summary of the Guidelines After reading this article, 'Test and reflect' on your updated knowledge with our most chosen questions. It is estimated that this activity will take you 30 minutes, namely 0.5 CPD credits. References British Broadcasting Corporation. Coronavirus: social meetings higher than six bandits in England since September 14. www.bbc.co.uk/news/uk-54081131 (accessible 15 October 2020). DHSC. 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