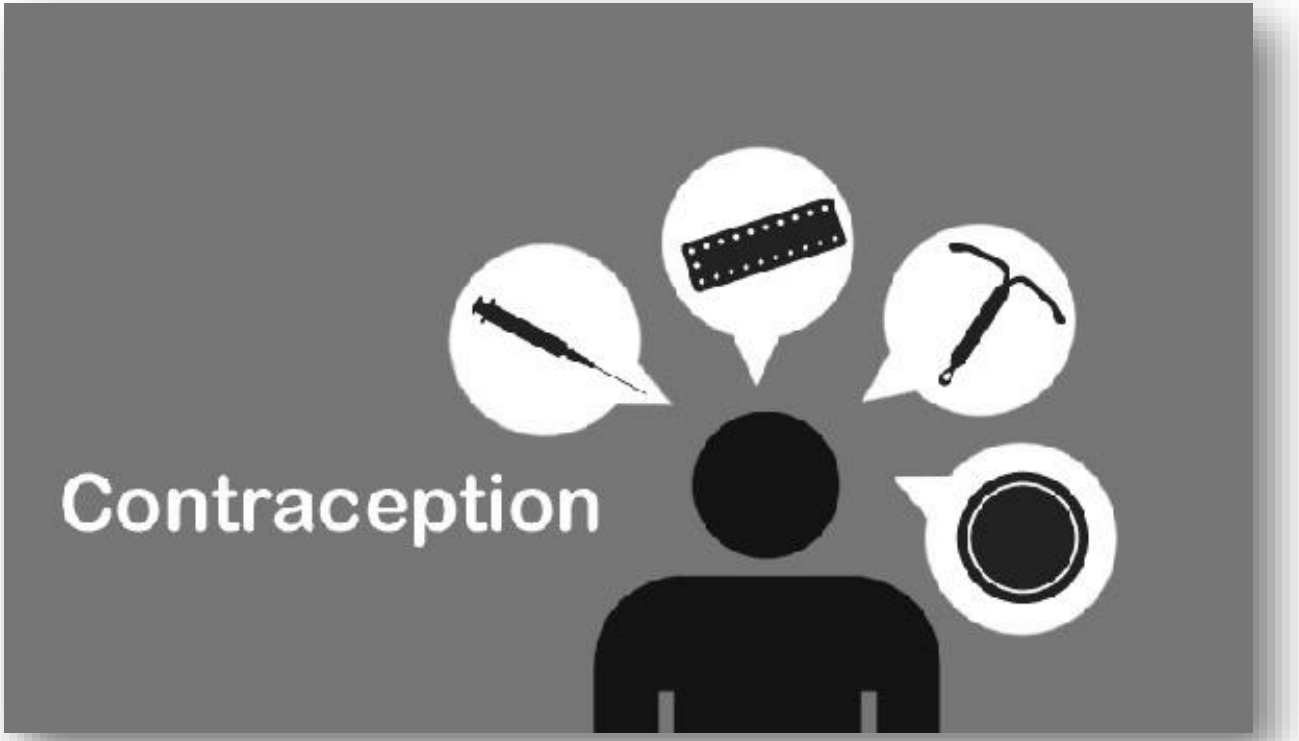
NHS Tayside Hormonal Contraception Guide:

NHS Tayside formulary, pharmacological content and other characteristics



Tayside Sexual & Reproductive Health Service (TSRHS)
(Latest update: 10/24)

General overview over contraceptive methods available in the UK

Method	Pregnancy prevention (1st year + typical use)	Use (or fit) and forget	STI prevention	Reduced PV bleeding (at one year)	Reduced pain if PV bleeding	Acne control	Hormone types and systemic levels
Permanent method							
Tubal ligation (female sterilisation)	+++ Approx. 99%	+++ (permanent)	0	0	0	0	0
LARC (long acting reversible contraception)							
Nexplanon® (SDI)	+++ **Approx. 99.6%**	+++ (lasts 3 years)	0	+/- (variable, random bleeding- might not settle) 50% ameno	++	+/-	P only Medium Steady
Hormone coil (LNG IUD) 52 mg LNG- Mirena®/Benilexa® 19.5 mg LNG- Kyleena® 13.5 mg LNG- Jaydess®	+++ Approx. 99%	+++ lasts 6-8 years lasts 5 years lasts 3 years	- (at insertion)/ 0	Tends to settle over time; might restart near licence limit ++/+++ (51% ameno) + /++ (38% ameno) +/- (25% ameno)	+++ ? ?	- / 0 (might ↓ with time)	P only Low Steady
Copper coil (Cu IUD)	+++ Approx. 99%	+++ (lasts 5 or 10 years)	- (at insertion)/ 0	- / 0	- / 0	0	0
DMPA injection SayanaPress® (subcut) DepoProvera® (im)	++/+++ Approx. 94%	++ (lasts 13 weeks; SayanaPress® can be self-administered)	- / 0 (↑ HIV risk?)	++/+++ Tends to settle with time 58% ameno	++/+++	- / 0	P only High
Non LARC hormonal methods							
Combined oral contraception (COC)	++ Approx 91%	0 (used daily: 24 hrs window)	0	+/+++ (esp. when used continuously- off license)	++	++/+++ (depends on P type)	P + EE or E Medium
Combined vaginal ring NuvaRing® /SyreniRing® (CVR)	++ Approx 91%	++ (used three weekly)	0	+/+++ (esp. when used continuously- off license)	++	+++ (low EE- 15 mcg)	P + EE Medium
Combined transdermal patch Evra® (CTP)	++ Approx 91%	+ (used weekly)	0	+/+++ (esp. when used continuously- off license)	++	+++ (high EE- 34 mcg)	P +- EE Medium
Progestogen only pill (POP)	++ Approx 91%	0 (used daily: 3, 12 or 24 hrs window, depending on P type)	0	+/- (variable- might not settle, ≈ type) 50% ameno	++	- / 0 (+ with DRSP POP?)	P only Medium
Barrier methods and others							
Condoms (external or internal)	+ Approx 80%	0 (used PRN)	++	0	0	0	0
Diaphragm (plus spermicide)	+ Approx 88%	0 (used PRN)	0	0	0	0	0
Natural Family Planning Methods	+ Approx 80%	0 (daily input required)	0	0	0	0	0

ABBREVIATIONS:

ameno	amenorrhoea (or infrequent spotting or bleeding)
approx.	approximately
COC	combined oral contraceptive/contraception
Cu IUD	copper intrauterine contraception
CTP	combined transdermal patch
CVR	combined vaginal ring
DRSP	drospirenone
DMPA	depot medroxyprogesterone acetate
E	estradiol
EE	ethinylestradiol
Esp	especially
hrs	hours
im	intramuscular
IUD	intrauterine contraception
LARC	long acting reversible contraception
LNG	levonorgestrel
LNG-IUD	levonorgestrel intrauterine contraception
P	progestogen
POP	progestogen only pill
PRN	pro re nata (as needed)
Subcut	subcutaneous

SYMBOLS

0	No change or effect
-	negative change
+, ++ or +++	positive change or increase
?	unknown
+/-	variable
≈	depends on

Combined hormonal contraception (CHC): pharmacological content

(NHS Tayside Formulary contraceptives are in bright green, "first choice" COC is in grass green, currently most cost-effective brands on TAF are in bold, COC not licensed for contraception in yellow, prices are from 11/23 and for a 3/12 supply)

Oestrogen	Progestogen						
	First generation	Second generation	Third generation			Newer generation	17 OHP[4]
Ethinyl-estradiol (EE)*	Norethisterone (NE)	Levonorgestrel (LNG)	Gestodene (GSD)	Norgestimate[1] (NGM)/ Norelgestromin[2] (NGMN)	Desogestrel (DSG)/ Etonorgestrel[3] (ENG)	Drospirenone (DRSP)/ Dienogest (DNG)/ Nomegestrol (NOM)	Cyproterone acetate (CPA)
15 mcg					NuvaRing® (£29.70) **~ SyreniRing®(£23.76)** (15 mcg EE/ 120 mcg ENG/24h)		
20 mcg	*Loestrin 20®- (discontinued) (NE 1mg)*		Femodette® (£8.85) ~ Millinette 20/75® (£6.37) ~ Sunya® (£6.62) (GSD 75 mcg)		Mercilon® (£8.44) ~ Gedarel 20/150® (£5.98) **~ Bimizza® (£5.04)** (DSG 150 mcg)	Eloine® (3 mg) (£14.70) (DRSP 3 mg)	
30 mcg	*Loestrin 30® (discontinued) (NE 1.5 mg)*	Microgynon 30® (£2.82) Microgynon 30® ED[5] (£2.99) **~ Levest® (£1.80)** ~ Maexeni® (£1.88) ~ Rigevidon® (£1.89) (LNG 150 mcg)	Femodene® (£6.73) Femodene® ED[5] (£7.10) ~ Millinette 30/75® (£4.85) ~ Katya® (£5.03) (GSD 75 mcg)		Marvelon® (£7.10) ~ Gedarel 30/150® (£4.93) **~ Cimizt® (£3.80)** (DSG 150 mcg)	Yasmin® (£14.70) **~ Yacella® (£8.30)** ~ Dretine® (£8.34) (DRSP 3 mg)	
35 mcg	Bevinor® (£1.99) (NE 0.5 mg) Norimin® (£2.28) (NE 1 mg) Synphase® (triphasic)[7] (£3.60) (NE 0.5/1/0.5 mcg) *BiNovum® (biphasic) (discontinued) (NE 0.5 mg/1 mg)* *TriNovum® triphasic) (discontinued) (NE 0.5/0.75/1 mg)*	Logynon® (£3.82) ~ TriRegol® (£2.43) Logynon® ED[5] (£4.00) (triphasic)[7] (EE 30/40 mcg) (LNG 50/75/125 mcg)		*(Cilest®- discontinued)* *(Cilique®- discontinued)* Lizinna® (£4.64) (250 mcg NGM) **Evra® (patch) (£19.51)** (33.9 mcg EE/ 203 mcg NGMN/24h)			Dianette®[6] (£7.71) Clairette (£5.90) **~ Co-cyprindiol (£10.78)** **(Scottish Drug Tariff price)** (CPA 2mg)

Combined hormonal contraception (CHC): pharmacological content (cont.)

Oestrogen	Progestogen						
	First generation	Second generation	Third generation			Newer generation	17 OHP[4]
	Norethisterone (NE)	Levonorgestrel (LNG)	Gestodene (GSD)	Norgestimate[1] (NGM)/ Norelgestromin[2] (NGMN)	Desogestrel (DSG)/ Etonorgestrel[3] (ENG)	Drospirenone (DRSP)/ Dienogest (DNG)/ Nomegestrol (NOM)	Cyproterone acetate (CPA)
Mestranol							
50 mcg	Norinyl-1® (NE 1 mg) (£2.19)						
Estradiol Valerate (EV)							
1-3 mg						Qlaira® (DNG 0- 3 mg, EV 0-3 mg) (26d/2d) (quadriphasic ED[5] tablet)[7] (£*25.18*)	
Estradiol Hemihydrate (EH)							
1.5 mg						Zoely® (NOM 2.5 mg/ EH 1.5 mg) (24d/4d) (monophasic ED[5] tablet) (£19.80)	
Estetrol (E4)							
14.2 mg						Drovelis® (DRSP 3mg) (24d/4d) (monophasic ED[5] tablet) (£25.80)	

Check BNF and MIMS for other brands and the latest availability and price of non-proprietary tablets

* VTE and CVD risks increase with increasing EE doses

[1] Norgestimate: levonorgestrel is one of its metabolites

[2] Norelgestromin: metabolite of norgestimate

[3] Etonogestrel: active metabolite of the inactive prodrug desogestrel

[4] 17 OHP: 17α hydroxyprogesterone

[5] ED: every day (28-day) preparations can be considered for patients with compliance issues who do not want to use the COC continuously (unlicensed) and decline LARC

[6] Cyproterone acetate products are not licensed for oral contraception but for hormone treatment of moderate or severe acne

[7] There are few if any reasons to prefer a tri- or quadriphasic preparation to a monophasic preparation as they carry a higher risk of hormonal side effects.

Venous Thromboembolism risk (VTE) with combined hormonal contraception (CHC)

Situation	VTE risk per 10,000 healthy patients per year
Non contraceptive user, not pregnant	2
During pregnancy	29
During postpartum period	300- 400
COC containing norethisterone, levonorgestrel or norgestimate (mainly first and second generation progestogens)	5-7
CHC containing etonorgestrel or norelgestromin (combined vaginal ring or transdermal patch)	6-12
CHC containing gestodene, desogestrel, drospirenone or cyproterone acetate (third and newer generation progestogens)	9-12

- Current use of CHC is associated with increased risk of VTE, with some CHC formulations being associated with a greater risk of VTE than others, dependent on progestogen type and estrogen dose. Higher EE dose being associated with greater VTE risk.
- New progestogens ("newer generation progestogens") and oestrogens are being incorporated into new combined oral contraception (COC) products such as estradiol valerate/dienogest (Qlaira®), estradiol hemihydrate/nomegestrol acetate (Zoely®) or estetrol/drospirenone (Drovelis®). Long-term safety data for these new formulations is still limited but their VTE risk might be comparable with COCs containing levonorgestrel.
- **Cardiovascular risk:** current use of CHC is associated with a very small increased risk of myocardial infarction (MI) and ischaemic stroke that appears to be greater with higher doses of estrogen in COC but not dependent on the progestogen type.

Reference: FSRH- FSRH Guideline Combined Hormonal Contraception (2019, amended 10/23)

Prescribable oestrogen types used in the UK

Oestrogen	Type	Products
EE: Ethinylestradiol	Synthetic, "potent"	Most CHC products, including vaginal ring and patch
E2: Estradiol	Natural, dominant during reproductive time	Qlaira® COC (with dienogest) Zoely® COC (with nomegestrol) Most systemic HRT products Some topical /vaginal tx products (menopause)
E3: Estriol	Natural, dominant during pregnancy	Some topical /vaginal tx products (menopause)
E4: Estetrol	Natural, only during pregnancy, produced by fetal liver and found in maternal blood	Drovelis® COC (with drospirenone)

Main progestogen types used in combined hormonal contraception (UK)

Progestogen	Products	EE	Androgenic	Anti-androgenic	Anti-mineral-corticoid	VTE risk*
Levonorgestrel (LNG)	Microgynon®≈ Levest®≈ Rigevidon® ≈ Maexeni®	30 mcg	+	-	-	5-7
Norgestimate	(Cilest®)≈ Cilique®	35 mcg	+	-	-	5-7
Etonorgestrel	SyreniRing® ≈ NuvaRing®	15 mcg/d	-/+	-	-	6-12
Norelgestromin	Evra Patch®	34 mcg/d	-/+	-	-	6-12
Gestodene	Femodette® Femodene® Millinette®	20 mcg 30 mcg 20 or 30 mcg	+	-	-	9-12
Desogestrel (DSG)	Mercilon® Marvelon® Gedarel®	20 mcg 30 mcg 20 or 30 mcg	+	-	-	9-12
Drospirenone	Eloine® Yasmin® ≈ Yacella® Drovelis®	20 mcg 30 mcg na – estetrol	-	+	+	9-12
Nomegestrol	Zoely®	na- estradiol	-	+/-	-	na
Dienogest	Qlaira®	na- estradiol	-	+	-	na
Cyproterone acetate**	Dianette®≈ Co-cyprindiol®	35 mcg	-	++	-	9-12

* VTE risk per 10,000 healthy patients per year
** not licensed for contraception

Progestogen-only contraception: pharmacological content (excluding emergency contraception)

(NHS Tayside Formulary contraceptives are in green, the currently most cost-effective POP is in bold, "first choice" DMPA method is in grass green, prices are from 11/23 per item or for a 3/12 supply)

Via	First generation	Second generation	Third generation	Newer generation	17 OHP
	Norethisterone (NE)	**Levonorgestrel (LNG)**	**Desogestrel (DSG)/ Etonorgestrel (ENG)**	**Drospirenone (DRSP)**	**Depot medroxy-progesterone acetate (DMPA)**
Oral	*Micronor®* *(discontinued)* ~ Noriday® (£2.10) (NE 350 mcg)	Norgeston® (LNG 30 mcg) (£2.21)	**DSG 75 mcg (generic brand) (£3.26) (Scottish Drug Tariff price)** ~ Cerazette® (£9.55) ~ Cerelle® (£4.30)	Slynd® (DRSP 4 mg-monophasic ED tablet) (£14.70)	
Intrauterine (contraception)		**Mirena® LNG-IUD (£88.00)** (LNG 52 mg) (8 years) **Benilexa® LNG-IUD (£71.00)** (LNG 52 mg) (8 years) **Levosert® LNG-IUD (£66.00)** (LNG 52 mg) (8 years) **Kyleena® LNG-IUD (£76.00)** (LNG 19.5 mg) (5 years) Jaydess® LNG-IUD (£69.22) (LNG 13.5 mg) (3 years)			
Subdermal			**Nexplanon® (£83.43)** (68 mg Etonogestrel) (3 years)		
Intramuscular					DepoProvera® (£6.01) (DMPA 150 mg) (every 13 weeks)
Subcutaneous					**SayanaPress® (£6.90)** (DMPA 104 mg) (every 13 weeks)

Ovulation suppression and estrogens

Method	Ovulation suppression	Estrogenic benefits (& risks)
CHC- cyclical use (7 day hormone free interval)	+	+
CHC- continuous use (off license)	++	++
Depo Medroxyprogesterone Acetate (DepoProvera® or SayanaPress®)	++	- -
LNG-IUD Mirena®, Levosert®, Benilexa® (52 mg LNG)	- or +/- (not long-term)	-
LNG-IUD Kyleena® (19.5 mg LNG)	-	-
LNG-IUD Jaydess® (13.5 mg LNG)	-	-
POP (second generation: NE, LNG)	- or +/-	-
POP (third and new generation: DSG, DRSP)	++	-
SDI (Nexplanon®)	++	-

Scale:	
– –	negative effect
–	no effect
+/-	variable effect
+	good effect
++	very good effect

CHC: combined hormonal contraception (combined pill, patch or vaginal ring)
DRSP: drospirenone
DSG: desogestrel
NE: norethisterone
LNG: levonorgestrel
LNG-IUD: levonorgestrel containing intrauterine device, previously known as intrauterine system (IUS)
POP: progestogen-only pill
SDI: subdermal contraceptive implant

Ovulation suppression: benefits patients with endometriosis, recurrent ovarian cysts, menstrual migraine, epilepsy and other medical conditions affected by fluctuating hormones, ovulation pain and PMS/PMDD (together with estradiol)

Estrogen: benefits patients with hirsutism, acne, hormone-related (reproductive) depression, PMS/PMDD and premature ovarian insufficiency

Combined Hormonal Contraception: tailored regimes (unlicensed)

Regimen	Details	Purpose
Shortened hormone-free interval (HFI)	HFI of only 4 days	More forgiving of late restart, increased efficacy.
Extended use	E.g. tricycling- 3 cycles back to back (3 packets, 3 rings or 9 patches)	See below
Flexible extended use or continuous use	Method used continuously (≥ 21 days; HFI omitted) until breakthrough bleeding occurs for 3–4 days, then, if used at least for 2 weeks, HFI of 4 days before restarting again	Reduced or no vaginal bleeding and pain, reduced headaches/migraines, fewer perimenopausal symptoms, fewer mood swings, improved compliance- increased efficacy, choice, convenience, saving money (pain killers, sanitary products, washing power/electricity).

Patients should be given information about both standard and tailored CHC regimens to broaden contraceptive choice (FSRH recommendation) and optimize non contraceptive benefits.

Please consider giving your patient the patient information leaflet "Different Ways to take the Combined Pill" (LN0238) (on Staffnet).

Please check out the FSRH Guideline "Combined Hormonal Contraception" (2019/23) for more info: www.fsrh.org/standards-and-guidance/documents/combined-hormonal-contraception/

Possible side effects of hormonal contraceptive methods: classification according to hormone class

Side effect	Estrogenic	Progestogenic
Acne +/- seborrhoea	-	+ (especially "older" generation progestogens)
Anxiety	-	+
Bloating	+	+
Breast swelling	+	+/-
Breast tenderness	+	+/-
Decreased sex drive	+ (via increase of SHBG)	+/- (assoc. with low mood etc.)
Depression	-	+
Growth of ectropion	+	-
Growth of uterine fibroids	++	+
Headaches	+	+
Hirsutism	-	+
Irregular bleeding	+/-	+
Mood swings	+/-	+
Nausea/vomiting	+	-
Raised BP	+	-
Vaginal discharge (no infection)	+	-
Vaginal dryness	-	+
Weight gain	+/- (water retention: cyclical gain)	+/- (increased appetite → sustained gain- mainly DMPA)

Possible side effects on combined hormonal contraception (CHC): advice and treatment options

Clinical problem	Suggestions
Acne/ hirsutism	Take history and exclude pathology. Consider checking FAI levels. Give lifestyle, skin care and dietary advice. Treat condition(s). Encourage perseverance for 3/12. Change progestogen to less androgenic third generation progestogen. Omit hormone-free interval (unlicensed). Increase estrogen content* unless higher VTE/CVD/breast ca risk. Change to an EE/cyproterone acetate COC (Dianette®/ Co-Cyprindiol®) (licensed only for acne treatment). Change to non-hormonal method. Consider new DRSP POP.
Bloating	Take history, give lifestyle and diet advice. Exclude GI and ovarian pathology. Encourage perseverance for 3/12. Change progestogen. Change to progestogen-only or non-hormonal method. Reduce estrogen content** if due to water retention. Consider new DRSP POP.
Breast tenderness (bilateral)	Exclude pathology. Improve bra support. Encourage perseverance for 3/12. Add evening primrose oil. Reduce estrogen content**. Change to progestogen-only or non-hormonal method.
Headache	General advice: take a history and exclude other pathology. Check BP and eyesight. Give lifestyle advice (including hydration) and suggest suitable analgesia. Avoid codeine. Also think external "hormones"- ?puberty, ?perimenopause Complicated migraine (new onset): confirm dx, stop CHC and change to progestogen-only or non-hormonal method. CHC now contraindicated (UKMEC 4) Classical migraine (new onset or worsening of chronic migraine): confirm dx, might want to continue after adjustment and with caution but CHC now relatively contraindicated (UKMEC 3). Omit hormone-free interval or reduce hormone-free interval to 4 days only (unlicensed). Reduce estrogen content**. Vaginal ring leads to more stable oestrogen levels. Change to progestogen-only or non-hormonal method. Other headaches: make dx, encourage perseverance for 3/12. Omit hormone-free interval (unlicensed). Reduce estrogen content* or change progestogen. Change to progestogen-only or non-hormonal method.
Heavy withdrawal bleeding in hormone-free interval	Take history, screen for STIs. Exclude pregnancy. Do pelvic exam +/- arrange pelvic USS. Consider FBC, TFT and haemophilia screen. Add mefenamic +/- tranexamic acid. Encourage perseverance for 3/12. Omit hormonel-free interval (unlicensed). Change progestogen. Change to estradiol/dienogest COC (Qlaira®) (not recommended by the SMC) which is licensed for treatment of HMB. Change to a progestogen-only (especially recommended: Mirena® LNG-IUD) or non-hormonal method.
Loss of sexual desire	Encourage perseverance for 3/12. Take medical and psychosexual history, explore relationship issues including GBV. Consider referral to Sexual Problems Clinic. Change progestogen to a more androgenic second generation progestogen (norethisterone/ levonorgestrel). Reduce estrogen content** to reduce effect on SHBG. Change to a progestogen-only or non-hormonal method.
Mood changes (depression, anxiety +/- irritability)	Take a history (previous sensitivity to progestogens?, history of PMS/PMDD or postnatal depression?). Exclude suicidal ideation. Explore and treat other causes or signpost to other agencies. Encourage perseverance for 3/12. Omit hormone-free interval when on CHC (unlicensed). Change progestogen (consider use of drospirenone). Avoid using biphasic or triphasic COCs. Might try progestogen-only method (but avoid DMPA injections as irreversible for >> 3/12) with close monitoring of mood, or non-hormonal method. Consider PMS/PMDD treatment according to RCOG guideline (if applicable). Discuss referral to computerized CBT programme, counselor or mental health services.
Nausea	Take a history and exclude other causes. Do a pregnancy test. Encourage perseverance for 3/12. Take tablet at night. Take tablet with food. Reduce estrogen content**. Change to a progestogen-only or non-hormonal method.
Unscheduled bleeding	Check history (before and after starting CHC), compliance and drug interactions (including OTC drugs like St John's Wort). Exclude pregnancy. Screen for STIs. Check smear history. Inspect cervix and do VE. Add Mefenamic acid. Encourage perseverance for 3/12. Change progestogen. Increase estrogen content* or change to vaginal ring (more expensive option but increased bioavailability). Change to Mirena® or similar LNG-IUD, DMPA injections or non-hormonal method. See FSRH CEU Guideline "Unscheduled bleeding on hormonal contraception" for more info.
Water retention	Take history, exclude any pathology, give lifestyle and diet advice. Encourage perseverance for 3/12. If evidence of water retention: reduce estrogen content** or change to EE/drospirenone COC (Yasmin®/ Yacella®) with anti-mineralcorticoid activity. Change to a progestogen-only or non-hormonal method. Consider new DRSP POP if on-going.
Weight gain	Take history, give lifestyle and diet advice. Refer to dietician. Consider checking TFT. Encourage perseverance for 3/12. If proven weight gain: change to an LNG-IUD or non-hormonal method. Might try different progestogen or progestogen-only method. Avoid DepoProvera® and SayanaPress®.

*Increase estrogen content: reconsider underlying VTE/CVD/breast risks to make sure that this is appropriate, then change to 35 mcg EE combined oral contraceptive pill like Cilique® or to the combined transdermal patch (Evra®) which leads to approximately 34 mcg/24 hours systemic EE levels (but at higher costs).

**Reduce estrogen content: change to a 20 mcg EE combined oral contraceptive pill or to the combined vaginal ring (NuvaRing®) which leads to approximately 15 mcg/24 hours systemic EE levels (but has a much higher cost).

Suggestions modified from: FSRH guidance and Mansour D, Searle S, Smith D at al: Rational Prescribing of Oral Contraceptives. CH-OCS-0005-01/2016.

Perimenopausal Contraception – Basics I

Perimenopausal Contraception BASICS

Age < 40: premature insufficiency of ovaries (POI) might be transitional- continue with contraception unless ovaries removed

Age 40 -49: contraception can be stopped:

- 2 years after last "natural" menstrual period (and not on hormonal contraception, no IUS in situ, no hx of endometrial ablation etc) or
- 2 years after 2nd result of FSH* of > 30 IU/l, taken at least 4-6 weeks apart

Age ≥ 50: contraception can be stopped:

- 1 year after last "natural" menstrual (and not on hormonal contraception, no IUS in situ, no hx of endometrial ablation etc) or
- 1 year after result of a single FSH* > 30 IU/l

Age ≥ 55:

- contraception could be stopped even if still having periods- pregnancy very unlikely due to poor oocyte quality
- Might consider continuing contraception for another year or two if periods troublesome (non-contraceptive indication)

** If FSH normal- consider repeating in a year if wanting to stop contraception before the age of 55*

Perimenopausal Contraception BASICS

- Amenorrhoea in patients on any hormonal contraception or who had an endometrial ablation is not an indicator of (peri)menopause/POI
- Amenorrhoea after radio- or chemotherapy might be transitional and not an indicator of an iatrogenic (peri)menopause/POI
- FSH might be indicated in women ≥ 51 on hormonal contraception who wish to stop contraception
- FSH measurements are unreliable when being taken while on combined hormonal contraception or HRT, for up to 6 weeks after stopping
- Stopping and restarting CHC or HRT increases the VTE risk
- FSH might be suppressed by DMPA (DepoProvera/SayanaPress) injections (false-negative)- best to be taken shortly before the next injection is due
- FSH measurements are not affected by the POP, SDI (implant) or any IUS type

Please be aware that there remains a very low pregnancy risk in patients aged 40- 49 despite 2 “menopausal” FSH and waiting 2 years according to the FSRH. They might therefore prefer to continue contraception until the age of 50 and have their FSH levels rechecked then, or stop contraception at 55.

Contraception and the (peri)menopause: When to stop contraception

Method used	40- 49 years	≥ 50 years
Combined hormonal contraception, Depo-Provera® or SayanaPress®	Continue if satisfied with method & no CI	Stop & switch method
Condoms, diaphragms and Cu-IUD*	Stop /remove two years after LMP	Stop/remove)one year after LMP or at the age of 55
POP, Nexplanon® or IUS**	Continue if happy with method or stop two years after two FSH levels >30 IU/L (least 6 weeks apart)	Stop one year after one FSH level >30 IU/L or at the age of 55; if FSH premenopausal could repeat after a year

• Any IUD with ≥ 380mm² of copper inserted at the age of ≥40 can be used extendedly (Nova-T, T-Safe etc) (unlicensed)

***** The FSRH now recommends the extended use of any 52 mg LNG-IUD (IUS) (Mirena®, Benilexa®, Levosert®) up to the age of 55 when inserted at the age of ≥ 45 and used for contraception (not endometrial protection as part of HRT).***

Please be aware that there remains a very low pregnancy risk in patients aged 40-49 despite 2 "menopausal" FSH and waiting 2 years according to the FSRH. They might therefore prefer to continue contraception until the age of 50 and have their FSH levels rechecked then, or stop contraception at 55.

Levonorgestrel IUDs (LNG-IUD) used for contraception: devices available in the UK

Method	Mirena® LNG-IUD	Benilexa® LNG-IUD	Levosert® LNG-IUD	Kyleena® LNG-IUD	Jaydess® LNG-IUD
Total LNG content	52 mg	52 mg	52 mg	19.5 mg	13.5 mg
Licensed duration	8 years (contraception)	8 years (contraception)	8 years (contraception)	5 years (contraception)	3 years (contraception)
Licensed indication(s)	Contraception HMB part of HRT	Contraception HMB	Contraception HMB	Contraception	Contraception
Menstrual reduction	++	++	++	+	+
Amenorrhoea (at 3 years)	23.6%	"like Mirena® LNG-IUD"	"like Mirena® LNG-IUD"	18.9%	12.7%
Ovulation suppression (first year only)	+/- < 25%	?	?	None or minimal	None or minimal
Inserter diameter & type	4.4 mm EvoInserter® (one handed)	4.8 mm One handed device Longer inserter	4.8 mm Two handed device	3.8 mm EvoInserter® (one handed)	3.8 mm EvoInserter® (one handed)
Extended use for contraception recommended when inserted aged ≥ 45 (unlicensed) until age 55	Yes (FSRH 03/23)	Yes (FSRH 03/23)	Yes (FSRH 03/23)	No	No
Size	Width 32 mm Length 32 mm	Width 32 mm Length 32 mm	Width 32 mm Length 32 mm	Width 28 mm Length 30 mm	Width 28 mm Length 30 mm
Price per unit & licensed year (contraception) (01/24)	£88 (£11/year)	£71 (£9/year)	£66 (£8/year)	£76 (£15/year)	£69 (£23/year)
Comments	"Gold standard" LNG IUD. FSRH recommended extensions (unlicensed): can be kept until the age of 55 if inserted in patients aged 45 or over when used for contraception +/- bleeding prob-lems. As part of HRT licensed for 4 years. FSRH recommends use up to 5 years.	Inserter larger, longer and stiffer than Mirena® inserter. FSRH recommends its use as part of HRT (unlicensed) for up to 5 years. Ongoing clinical trials- license for contra-ception likely extended in the future. Same FSRH extended conceptive use recommendation as for Mirena® LNG-IUD.	**Cheapest option.** Inserter larger and stiffer than Mirena® inserter: two-handed and challenging to load. FSRH recommends its use as part of HRT (un-licensed) for up to 5 years. Ongoing clinical trials-license for contraception likely extended in the future. Same FSRH extended conceptive use recommendation as for Mirena® LNG-IUD.	Easier and less painful insertion; prolonged irregular bleeding can be an issue	Easier and less painful insertion; prolonged irregular bleeding can be an issue

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