

## Tips for GP trainees working in family planning

### INTRODUCTION

A family planning post offers a unique and valuable opportunity to build confidence, knowledge, and skills that are essential during a career in general practice. Doctors may be expected to answer complicated queries about contraceptives and this can be challenging if experience of family planning is limited.

Unfortunately gaining practical experience can be difficult. Contacting local faculty registered trainers and the regional family planning consultant is a sensible starting point when organising training.

### THE BASICS

1. Always take a full medical history, blood pressure, and calculate body mass index. Offer chlamydia screening, condoms, and give advice about attending the local sexual health clinic if appropriate. Ensure cervical screening is up to date.
2. The UK medical eligibility for contraceptive use (UKMEC)<sup>1</sup> offers guidance on prescribing different methods of contraception in a variety of clinical situations.

The four categories that relate to safe prescribing of contraception:

- UKMEC 1 'unrestricted use'
- UKMEC 2 'benefits outweigh risks'
- UKMEC 3 'risks outweigh benefits'
- UKMEC 4 'unacceptable health risk'

It is important to take a holistic approach when multiple risk factors are combined. For example if an individual has several UKMEC2s, a doctor may consider that the risks outweigh the benefits when prescribing the combined contraceptive pill (that is, manage the patient as per UKMEC3 and above). In such cases it may be safer to prescribe a progestogen-only form of contraception.

3. Ensure patients are not pregnant before

commencing contraception.

4. Doctors who hold moral reservations about any contraceptive method are still encouraged to undertake family planning training. Termination of pregnancy is separate from the regular provision of contraception and doctors can refer to colleagues if they are unable to provide care relating to a termination.
5. When prescribing contraception, use a prompt to ensure all the necessary information is appropriately given and documented. The FPA leaflets provide information on common problems (for example, diarrhoea, vomiting, missed pills, drug interactions and the mode of action of contraceptives).
6. The Faculty of Sexual and Reproductive Healthcare (FSRH)<sup>1</sup> offers excellent information on all contraceptive issues. The clinical effectiveness unit provides a free enquiry service that summarises up-to-date evidence in relation to particular medical conditions and contraception.

### THE PATIENTS

7. Be sensitive. There may be emotional elements in any consultation involving contraception, relationships, and obstetric and gynaecological history. A non-judgemental approach will help to ensure the best outcome for the patient.
8. There are a plethora of individual health beliefs regarding contraception, menstruation, and fertility. It is essential to explore these ideas and concerns to achieve an effective consultation.
9. Women are often concerned about the association between some types of contraception and weight gain. Developing a patient-centred approach to consultation may enhance compliance more than just quoting evidence from the latest research.

**J Gallagher**, BSc (Hons), DRCOG, DFSRH, GP Registrar, Langley House Surgery Chichester, West Sussex, UK. **V Beattie**, BSc (Hons), MRCGP, DRCOG, DFSRH, GP Partner and Family Planning Trainer; **J Vrahimides**, BSc (Hons), MRCGP, GP, Maywood Surgery, Bognor Regis, West Sussex, UK.

#### Address for correspondence

**Julia Gallagher**, Langley House Surgery  
27 West Street, Chichester, PO19 1RW, UK.

**E-mail:** juliagallagher@doctors.org.uk

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10. Young and vulnerable patients (both under and over 16 years of age) may present for contraception and this can be an opportunity to explore any issues they may have. Become familiar with local referral pathways for child protection and ensure Fraser guidelines are appropriately followed and documented.
11. There has been a rise in the number of women having terminations in their 40s over the last decade.<sup>2</sup> Women in this age group are often surprised when they become pregnant and it is essential to explore their health beliefs and discuss contraceptive choices.
12. Pill scares:<sup>3</sup> naturally patients will respond to media hype regarding pill use. The current scare regards co-cyprindiol (Dianette®, Bayer) which is licensed as a second-line treatment for women with acne who require contraception. It contains the progesterone cyproterone acetate and increases the risk of venous thromboembolism. However, the increased risk is still less than that of pregnancy.<sup>1</sup>

#### **METHOD SPECIFIC GUIDANCE: SOME HANDY HINTS**

##### **Combined contraceptive pill**

13. The combined pill contains synthetic oestrogen and progesterone (except Qlaira®, Bayer) which inhibit release of follicle stimulating hormone (FSH) and luteinising hormone (LH) from the pituitary and prevent ovulation.
14. There are many contraceptive pills on the market. The *BNF* has a comprehensive table for reference and can help guide choice when oestrogen/progesterone side effects are troublesome.<sup>4</sup>
15. Missed pill advice:<sup>1</sup> become familiar with missed pill guidelines. It is essential to ascertain exactly when the omission occurred in order to give the correct advice. For example, extending the pill-free interval (and missing a pill in week one) has been associated with increased risk of ovulation, and emergency contraception is often advised.
16. Antibiotics: additional precautions are not required when using non enzyme-inducing antibiotics,<sup>1</sup> although extra precautions are recommended if the antibiotics cause diarrhoea or vomiting.
17. Combined contraception is also available as a transdermal patch and vaginal ring. They avoid first pass metabolism and can be useful in women with conditions such as inflammatory bowel disease.

##### **Progestogen only pill (POP)**

18. Cerazette® (Organon) (contains desogestrel 75 µg) has revolutionised the market in progestogen-only contraception. It is the POP most likely to prevent ovulation (in about 97% of cycles) and unlike other POPs (that need to be taken within 3 hours of the same time every day), it has a 12-hour window period.
19. The POP has few contraindications and can be used much more widely than the combined contraceptive pill.
20. The most common side effect of the POP is irregular bleeding. This can be distressing and cause non-compliance.
21. Missed pill advice: if a traditional POP is taken more than 3 hours late or Cerazette is taken more than 12 hours late the current advice is:
  - Take the missed/late pill now and continue pill taking as normal.
  - Use extra precautions for the next 48 hours.<sup>1</sup>
22. It is important to obtain a full medical history because enzyme-inducing drugs and contraceptive pills can reduce the efficacy of each other. They should be used with caution in patients with HIV, epilepsy, and tuberculosis.

##### **LONG-ACTING REVERSIBLE CONTRACEPTION (LARC)**

##### **Progestogen-only injectables**

23. Depo-Provera® (Pharmacia) (150mg in 1ml) is the most widely-used injectable. It is given every 12 weeks and inhibits ovulation.
24. Depo-Provera has all the advantages of the POP but major disadvantages include a delay in return to fertility and patients needing to return every 12 weeks (maximum 14 weeks) for repeat injection.
25. It is good practice to review this contraceptive choice regularly as use of Depo-Provera is associated with a loss of bone mineral density. This is an important concern in young women (who have not reached their peak bone mass) and women approaching the menopause (when bone loss will occur).
26. Late injections (>14 weeks and 1 day): emergency contraception, alternative contraception, and pregnancy testing (at least 21 days following unprotected sexual intercourse) may be required but must be assessed on an individual basis.

##### **Implants**

27. Nexplanon® (Organon) has replaced

Implanon® as the only subdermal implant available in the UK. It gives effective, reversible, progestogen-only contraception for 3 years.

28. The most common reason for patients not tolerating an implant is erratic bleeding. A trial of Cerazette prior to implant insertion may help avoid early removal but women should be informed it is not a reliable predictor of future bleeding pattern.
29. NICE guidance recommends that Nexplanon needs to be used for contraception for a year to be cost-effective.<sup>5</sup>
30. Insertion is much easier with the new device and should help decrease problems with deep insertions and difficult removals. Training and a letter of competence are required before it is possible to fit the device unsupervised.

#### Intrauterine device/intrauterine system

31. These are a popular, effective, safe, reliable, and reversible method of long-term contraception for 5 years. The copper IUD works primarily by prevention of fertilisation. The Mirena® IUS works by thinning the endometrium and thickening cervical mucus.
32. It is good practice to complete a sexual health screen and ensure microbiology results are available before fitting. This should minimise the risk of pelvic infection.
33. Remember to explain the three risks of the procedure when gaining consent that is, expulsion, perforation, and pelvic infection. Above all ensure the patient is not pregnant and explain the importance of the 6 week follow-up; which should be used to exclude infection, perforation, and expulsion.
34. Prepare the patient for the problematic side effects and explain irregular bleeding will settle with the Mirena as the endometrium thins.
35. If you have the experience and practical training to meet the requirements for a letter of competence it is a good idea to develop a proforma to ensure valid consent is obtained.

#### Emergency contraception

36. Three options are available:
  - Levonelle® 1500, which is licensed for use up to 72 hours following unprotected sexual intercourse (UPSI).
  - Ulipristal acetate (EllaOne®. HRA Pharma): licensed for use up to

120 hours following UPSI, but not for use more than once in a cycle.

- Copper intrauterine device, this can be inserted up to 5 days after the earliest expected date of ovulation (day 19 of a regular cycle)
37. Don't forget to address the issue of effective regular contraception to avoid the need for emergency contraception in the future. If starting a new form of contraception immediately (in addition to giving emergency contraception), ensure the patient returns for a pregnancy test at least 3 weeks following the episode of UPSI.

#### FINALLY

38. Enjoy your family planning experience. Make the most of the advice and support obtained from your consultant and colleagues; this will be invaluable in your future career as a GP.

#### PDP POINTERS

At the start of your family planning placement consider your specific learning objectives. These can be documented in your personal development plan and discussed with your clinical supervisor. Some relevant examples are given below:

- Learn the advantages, mode of action, side effects and failure rate of each type of contraception available.
- Become competent and confident in counselling for individual contraceptive choices considering both patient preference and relevant medical history.
- Improve knowledge of STI counselling and testing and ensure chlamydia screening is offered. If possible organise a complementary placement in the local GUM (genitourinary medicine) clinic.
- Complete modules on sexual and reproductive health on the e-learning for healthcare website (<http://www.e-lfh.org.uk/projects/general-practitioners/>).
- Complement training with a diploma from the FSRH. This promotes an excellent foundation for further practical training and professional development.

#### Provenance

Freely submitted; externally peer reviewed.

#### Discuss this article

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