Cheshire & Merseyside
sexualhealthnetwork

**CMSHN Draft Protocol** **September 2012**

# DEPO PROVERA CONTRACEPTION

Depo Provera is an injectable form of progestogen only contraceptive and contains Medroxprogesterone acetate 150mg per 1ml as a micro crystalline suspension. The primary mode of action is to prevent ovulation, supplemented by contraceptive actions at the endometrial and cervical mucus level. It is suitable for sexually active women requesting long acting reversible contraception. Current practice is for the patient to re-attend at 12 week intervals although depo maybe administered up to 14 weeks since the last injection.

## Efficacy

Failure rate is <4 in 1000 over 2 years.

## Common Side Effects

- Change in menstrual pattern
- Delay in return of fertility. (Mean time to ovulation is 5.3 months following the preceding injection i.e.: 2 – 3 months following cessation of therapy).
- Weight gain.

## Less Common Adverse Effects

- Prolonged or very heavy bleeding – history and examination must be taken to exclude gynaecology pathology (e.g.: pelvic infection, miscarriage).
- Anaphylaxis.
- Galactorrhoea.
- Possible small increased relative risk of breast cancer.

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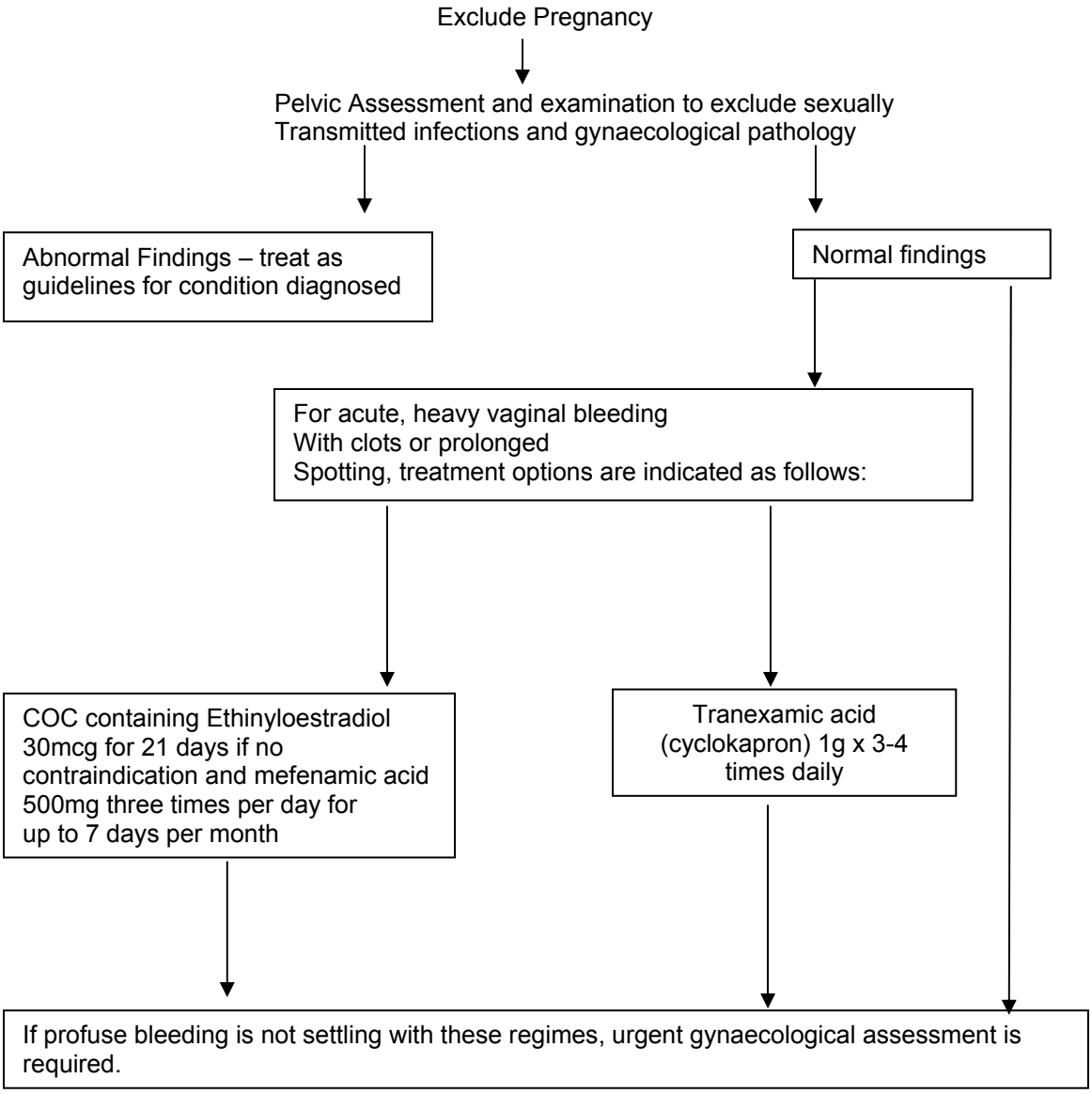
# Action for Persistent Bleeding




There is no evidence that reducing the injection interval improves bleeding.

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## Assessment of Client Suitability

### History

• Clinical history taking and examination allow an assessment of medical eligibility for DMPA use. In this context the history should include: relevant social and sexual history (to assess risk of sexually transmitted infections – STIs), medical, family and drug history as well as details of reproductive health and previous contraceptive use.
• Risk factors for osteoporosis should be assessed and alternative contraceptive choices discussed as appropriate.

### Examination

• Blood pressure and BMI should be noted prior to commencement of Depo Provera.
• Pelvic examination and cervical cytology if indicated.

### Documentation

• The full visit history should be completed or updated as required.
• Written method information including contact number is given to client.
• Prescription is recorded and dated.
• Site of injection, batch number and expiry date of medication recorded.
• Record date when injection is next due.
• Nurse supplying where appropriate under patient group direction.
• GP notified of prescription, if permission is given for correspondence.

### Drug Interactions

**Women should be informed that the efficacy of progestogen-only injectable contraception is not reduced with concurrent use of medication (including antibiotics and liver enzyme-inducing drugs) and the injection intervals do not need to be reduced.**

### Management & Timing Of First Injection

| | |
|---|---|
| General initiation | Ideally, first injection should occur between Days 1–5 (inclusive) of a normal menstrual cycle. No additional contraception is required.<br>Injections may also be initiated at any other time in the menstrual cycle if the clinician is reasonably certain that the woman is not pregnant and that there is no risk of conception.<br>Additional contraception (barrier method or abstinence) should be advised for 7 days after initiation.<br>If the woman is amenorrhoeic, the clinician must be reasonably certain that the woman is not pregnant and there is no risk of conception. Additional contraception should be used for 7 days. |
| Post-partum | Progestogen-only injectables may be initiated up to Day 21 postpartum with immediate contraceptive cover. If initiated after Day 21 then condoms or abstinence is advised for 7 days. Depo-Provera is safe to use during breast- |

| | |
|---|---|
| | feeding |
| Following miscarriage or termination | Initiate on day of surgical or second part of medical abortion or immediately following miscarriage:<br>no additional contraception is required. If started >5 days after abortion or miscarriage, additional contraception is required for 7 days. |
| Switching from CHC | Can be initiated immediately if method has been used consistently and correctly or if the clinician is reasonably certain that the woman is not pregnant and that there has been no risk of conception.<br>No additional contraception is needed. |
| Switching from PO implant or POP | Can be initiated immediately if method has been used consistently and correctly or if the clinician is reasonably certain that the woman is not pregnant and that there has been no risk of conception.<br>Additional contraception for 7 days is needed. |
| Switching from PO injectable | If the woman's previous method was another injectable, she should have the injection before or at the time the next injection was due. No additional contraception is needed. |
| Switching from IUS | Can be initiated immediately if the LNG-IUS was used consistently and correctly or if the clinician is reasonably sure that the woman is not pregnant. As bleeding with the LNG-IUS may not reflect ovarian activity, the LNG-IUS should be continued for at least 7 days. |
| Switching from IUD | Can be initiated immediately if the IUD was used consistently and correctly or if the clinician is reasonably sure that the woman is not pregnant. The IUD should be continued for at least 7 days unless the first injection occurs between Days 1–5 (inclusive) of a normal menstrual cycle. |
| Switching from barrier method | Can be initiated immediately if barrier method has been used consistently and correctly or if the clinician is reasonably certain that the woman is not pregnant and that there is no risk of conception. If the woman is amenorrhoeic or it has been more than 5 days since menstrual bleeding started; additional contraception should be continued for 7 days. |

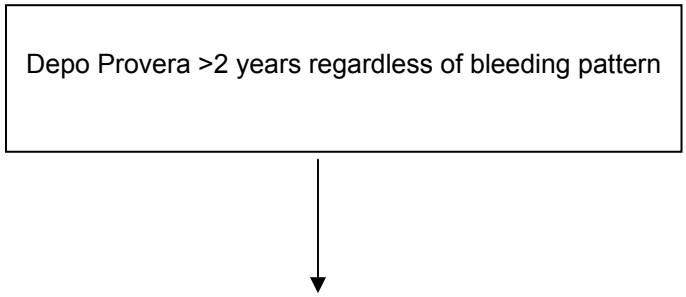
## Depo Provera and Bone Mineral Density

Women using Depo Provera contraception have a small reduction in bone mineral density (BMD) while using this method of contraception, which may be at least partly reversible on discontinuation. It is not known whether this increases the risk of osteoporosis in later life. The effect on BMD may be most marked in adolescents, who have yet to achieve their peak bone mass. For adolescent women, the MRHA recommends that Depo Provera is prescribed as first line contraception only after other methods have been discussed and deemed unsuitable or unacceptable.

Whilst further clarification of this is awaited, suggested management in women who wish to continue with this method of contraception follows (see flow chart).

Gonadotrophin checks or oestrogen replacement are not advised. Bone density measurements are not required.

## Long Term Use Of Depo Provera > 2 Years



- Discuss effects of DMPA on bone density and uncertainty about risk of later osteoporosis/fracture
- Review risk factors for osteoporosis: alcohol, exercise, diet, smoking, family history, medical conditions, e.g. Crohn's or drug use, e.g. steroids
- Discuss alternative forms of contraception.
- Document discussion and client's choice in notes

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Continue client contraceptive method of choice

Review indications, risk factors, alternatives every 2 years

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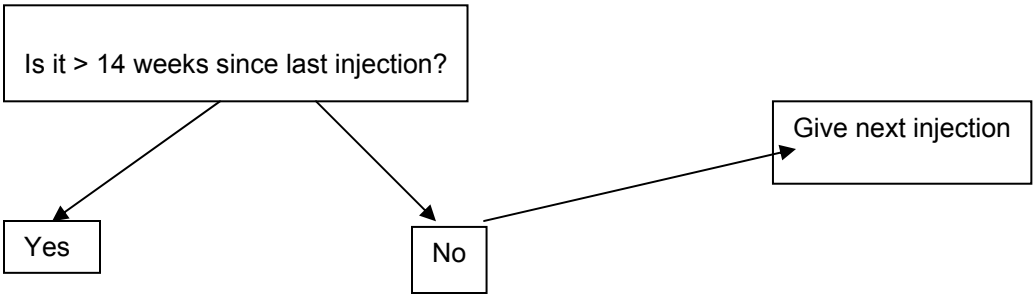
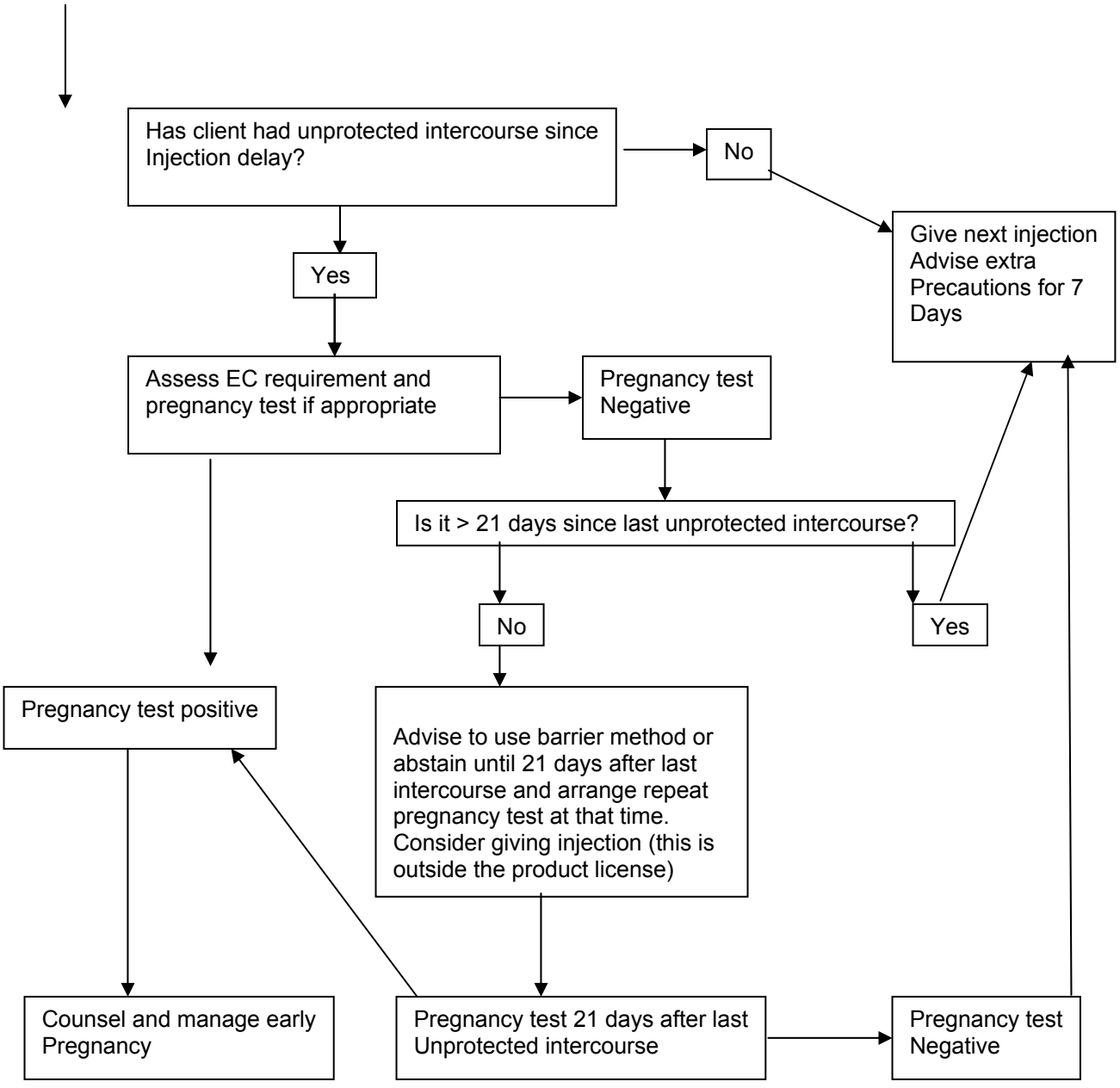
## Delayed Follow Up Visit > 12 weeks






| UKMEC | DEFINITION OF CATEGORY |
|---|---|
| Category 1 | A condition for which there is no restriction for the use of the contraceptive method. |
| Category 2 | A condition where the advantages of using the method generally outweigh the theoretical or proven risks. |
| Category 3 | A condition where the theoretical or proven risks usually outweigh the advantages |

| | |
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| | of using the method. |
| Category 4 | A condition which represents an unacceptable health risk if the contraceptive method is used. |

| **UKMEC TABLE – DMPA/NET-EN**<br><br>**COMMON REVERSIBLE METHODS**<br>**I = Initiation, C = Continuation** | |
|---|---|
| | |
| **PREGNANCY** | n/a |
| **AGE** | |
| **PARITY** | |
| a) Nulliparous | 1 |
| b) Parous | 1 |
| **BREASTFEEDING** | |
| a) <6 weeks postpartum | 2 |
| b) 6 weeks to <6 months (fully or almost fully breastfeeding) | 1 |
| c) ≥6 weeks to 6 months postpartum (partial breastfeeding medium to low) | 1 |
| d) ≥ 6 months postpartum | 1 |
| **POSTPARTUM** (non breastfeeding women) | |
| a) < 21 days | 1 |
| b) ≥ 21 days | 1 |
| **POSTPARTUM** (breastfeeding or non breastfeeding women, including post-caesarean section) | |
| a) 48 hours to < 4 weeks | |
| b) ≥ 4 weeks | |
| c) Puerperal sepsis | |
| **POST ABORTION** | |
| a) First trimester | 1 |
| b) Second trimester | 1 |
| c) Immediate post septic abortion | 1 |
| **POST ECTOPIC PREGNANCY** | 1 |
| **HISTORY OF PELVIC SURGERY** (including caesarean section) (see also postpartum section) | 1 |
| **SMOKING** | |
| a) Age < 35 years | 1 |
| b) Age ≥ 35 years | |
| i. <15 cigarettes per day | 1 |
| ii. ≥ 15 cigarettes per day | 1 |
| iii. Stopped smoking < 1 year ago. | 1 |
| iv. Stopped smoking ≥ 1 year ago | 1 |
| **OBESITY** | |
| a) Body mass index ≥ 30 – 34 kg/ m2 | 1 |
| b) Body mass index ≥ 35 kg/m2 | 1 |
| | |
| **MULTIPLE RISK FACTORS FOR ARTERIAL CARDIOVASCULAR DISEASE** (such as older age, smoking, diabetes and hypertension) | 3 |
| **HYPERTENSION** | |
| a) Adequately controlled hypertension | 2 |
| b) Consistently elevated blood pressure levels (properly taken measurements) | |
| i. systolic >140 to 159mmHg or diastolic > 90 to 94 mmHg | 1 |
| ii. systolic ≥160 or diastolic ≥ 95mmHg | 2 |

| | | |
|---|---|---|
| c) Vascular disease | 3 | |
| **HISTORY OF HIGH BLOOD PRESSURE DURING PREGNANCY** (where current blood pressure is normal) | 1 | |
| **VENOUS THROMBO-EMBOLISM (VTE)** (including deep vein thrombosis and pulmonary embolism) | | |
| a) History of VTE | 2 | |
| b) Current VTE (on anticoagulants) | 2 | |
| c) Family history of VTE | | |
| i. First degree relative aged <45 years. | 1 | |
| ii. First degree relative aged ≥45 years | 1 | |
| d) Major surgery | | |
| i. *With* prolonged immobilisation | 2 | |
| ii. Without prolonged immobilisation | 1 | |
| e) Minor surgery without immobilisation | 1 | |
| f) Immobility (unrelated to surgery) e.g.: wheelchair use, debilitating illness) | 1 | |
| KNOWN THROMBOGENIC MUTATIONS (e.g.: Factor V Leiden; Prothrombin mutation; Protein S, Protein C and Antithrombin deficiencies) | 2 | |
| **SUPERFICIAL VENOUS THROMBOSIS** | | |
| a) Varicose veins | 1 | |
| b) Superfical thrombophlebitis | 1 | |
| **CURRENT AND HISTORY OF ISCHAEMIC HEART DISEASE** | 3 | |
| **STROKE** (history of cerebrovascular accident) | 3 | |
| **KNOWN HYPERLIPIDAEMIAS** (screening is NOT necessary for safe use of contraceptive methods) | 2 | |
| **VALVULAR AND CONGENITAL HEART DISEASE** | | |
| a) Uncomplicated | 1 | |
| b) Complicated (e.g.: with pulmonary hypertension, artial fibrillation, or a history of subacute bacterial endocarditis) | 1 | |
| | | |
| **HEADACHES** | | |
| a) Non migrainous (mild or severe) | I 1 | C 1 |
| b) Migraine | | |
| i. without aura, at any age | I 2 | C 2 |
| iii. with aura, at any age | I 2 | C 2 |
| c) Past history (> 5 years ago) of migraine with aura at any age. | 2 | |
| **EPILEPSY** | 1 | |
| | | |
| **DEPRESSIVE DISORDERS** | 1 | |
| | | |
| **VAGINAL BLEEDING PATTERNS** | | |
| a) Irregular pattern *without* heavy bleeding | 2 | |
| b) Heavy or prolonged bleeding (includes regular and irregular patterns) | 2 | |
| **UNEXPLAINED VAGINAL BLEEDING (suspicious for serious condition) Before evaluation** | 3 | |
| **ENDOMETRIOSIS** | 1 | |
| **BENIGN OVARIAN TUMOURS (including cysts)** | 1 | |
| **SEVERE DYSMENORRHOAE** | 1 | |
| **GESTATIONAL TROPHOBLASTIC NEOPLASIA (GTN) (includes hydatidiform mole, invasive mole, placental site trophoblastic tumour)** | | |
| a) Decreasing or undetectable β-hCG levels | 1 | |
| b) Persistently elevated β-hCG levels or malignant disease | 1 | |
| **CERVICAL ECTROPION** | 1 | |
| **CERVICAL INTRAEPITHELIAL NEOPLASIA (CIN)** | 2 | |

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| | |
|---|---|
| **CERVICAL CANCER (awaiting treatment)** | 2 |
| **BREAST DISEASE** | |
| a) Undiagnosed mass | 2 |
| b) Benign breast disease | 1 |
| c) Family history of cancer | 1 |
| d) Carriers of known gene mutations associated with breast cancer (e.g.: BRCA1) | 2 |
| e) Breast cancer | |
| i. Current | 4 |
| ii. Past and no evidence of current disease for 5 years | 3 |
| **ENDOMETRIAL CANCER** | 1 |
| **OVARIAN CANCER** | 1 |
| **UTERINE FIBROIDS** | |
| a) Without distortion of the uterine cavity. | 1 |
| b) With distortion of the urine cavity | 1 |
| **ANATOMICAL ABNORMALITIES** | |
| a) Distorted uterine cavity (any congenital or acquired uterine abnormality distorting the uterine cavity in a manner that is incompatible with IUD insertion) | 1 |
| b) Other abnormalities (including cervical stenosis or cervical laceration) not distorting the uterine cavity or interfering with IUD insertion. | 1 |
| **PELVIC INFLAMMATORY DISEASE** | |
| a) Past PID (assuming no current risk factor of STIs) | |
| i. With subsequent pregnancy. | 1 |
| ii. Without subsequent pregnancy | 1 |
| b) PID – current | 1 |
| **STIs** | |
| a) Current purulent cervicitis or Chlamydial infection or gonorrhea. | 1 |
| b) Other STIs (excluding HIV and hepatitis) | 1 |
| c) Vaginitis (including trichomonas vaginalis and bacterial vaginosis) | 1 |
| d) Increased risk of STIs | 1 |
| | |
| **HIGH RISK OF HIV** | 1 |
| **HIV INFECTED** | |
| a) Not using anti-retroviral therapy | 1 |
| b) Using anti-retroviral therapy | 1-2 |
| **AIDS** | 2 |
| | |
| **SCHISTOSOMIASIS** | |
| a) Uncomplicated | 1 |
| b) Fibrosis of the liver | 1 |
| **TUBERCULOSIS** | |
| a) Non pelvic | 1 |
| b) Known pelvic | 1 |
| **MALARIA** | 1 |
| | |
| **DIABETES** | |
| a) History of gestational disease | 1 |
| b) Non vascular disease | |
| i. non insulin dependent | 2 |
| ii. insulin dependent | 2 |

| | |
|---|---|
| c) Nephropathy/retinopathy/neuropathy | 3 |
| d) Other vascular disease or diabetes of >20 years' duration | 3 |
| **THYROID DISORDERS** | |
| a) Simple goitre | 1 |
| b) Hyperthyroid | 1 |
| c) Hypothyroid | 1 |
| | |
| **GALL BLADDER DISEASE** | |
| a) Symptomatic | 2 |
| i. treated by cholecystectomy | 2 |
| ii. medically treated | 2 |
| iii. current | 2 |
| b) Asymptomatic | 2 |
| **HISTORY OF CHOLESTASIS** | |
| a) Pregnancy related | 1 |
| b) Past COC related | 2 |
| **VIRAL HEPATITIS** | |
| a) Acute or flare | 1 |
| b) Carrier | 1 |
| c) Chronic | 1 |
| **CIRRHOSIS** | |
| a) Mild (compensated without complications) | 1 |
| b) Severe (decompensated) | 3 |
| **LIVER TUMOURS** | |
| a) Benign (adenoma)<br>i) focal nodular hyperplasia<br>ii) Hepatocellular (adenoma) | <br>2<br>3 |
| b) Malignant (hepatoma) | 3 |
| **INFLAMMATORY BOWEL DISEASE (includes Crohn's disease, Ulcerative colitis)** | 1 |
| | |
| **THALASSAEMIA** | 1 |
| **SICKLE CELL DISEASE** | 1 |
| **IRON DEFICIENCY ANAEMIA** | 1 |
| **RAYNAUD'S DISEASE** | |
| a) Primary | 1 |
| b) Secondary | |
| i. *without* lupus anticoagulant | 1 |
| ii. *with* lupus anticoagulant | 2 |
| | |
| **DRUGS WHICH AFFECT LIVER ENZYMES (e.g.: Rifampicin, Rifabutin, St John's Wort, Griseofulvin, certain anticonvulsants (phenytoin, carmazepine, barbiturates, primidone, topiramate, oxcarbazepine)** | 1 |
| **NON LIVER ENZYME INDUCING ANTIBIOTICS** | 1 |
| **HIGHLY ACTIVE ANTIRETROVIRAL THERAPY (HAART)** | 2 |
| | |
| **RHEUMATIC DISEASES** | |
| **SYSTEMIC LUPUS ERYTHEMATOSUS (SLE)**<br>**People with SLE are at an increased risk of ischaemic heart disease, stroke and venous thromboembolism and this is reflected in the categories given.** | |
| a) Positive (or unknown) antiphospholipid antibodies | 3 |
| b) Severe thrombocytopenia | I C |

| | | |
|---|---|---|
| | 3 | 2 |
| c) Immunosuppressive | 2 | |
| d) None of the above | 2 | |
| | | |

## *References*

MRHA Updated Prescribing Advice On The Effect Of Depo Provera Contraception – November 2004.

FFPRHC. UK Medical eligibility criteria for contraceptive use. Nov 2009.

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FSRH Drug Interactions with Hormonal Contraception January 2011

With sincere thanks to the West of Scotland Sexual Health Managed Clinical Network for sharing their guidelines and protocols
http://www.centralsexualhealth.org/west-of-scotland-managed-clinical-network