SASKATCHEWAN REGISTERED NURSES' ASSOCIATION

RNs WITH ADDITIONAL AUTHORIZED PRACTICE
CLINICAL DECISION TOOL
DECEMBER 1, 2016

CONTRACEPTION ADULT & PEDIATRIC

DEFINITION
Prevention of pregnancy.

IMMEDIATE CONSULTATION REQUIRED IN THE FOLLOWING SITUATIONS
- Client wanting to use combined hormonal contraceptives or progesterone-only hormonal contraceptives in the presence of relative or absolute contraindications. Refer to Appendix A and B.
- Client whose medical condition has changed so that they might be using combined hormonal contraceptives or progesterone-only contraceptives in the presence of relative or absolute contraindications. Refer to Appendix A and B.
- Client who is currently taking combined hormonal contraceptives and demonstrates any of the following symptoms:
  - ACHES (abdominal pain, chest pain, headache, eye problems and severe leg pain); unexplained vaginal bleeding; jaundice; syncope; blood pressure > 140/> 90; severe migraine headaches (with aura); severe depression; and/or severe allergic skin rash.
- Client who is currently taking progesterone-only contraceptives and demonstrates any of the following symptoms:
  - ACHES; jaundice; syncope; severe depression; unexplained vaginal bleeding; severe or worsening migraine headaches (with or without aura); or severe allergic reaction.

CAUSES
- Not applicable

PREDISPOSING AND RISK FACTORS
- Sexual intercourse

HISTORY
- Review past use of birth control: methods, effectiveness, problems, reason for discontinuation and specific contraindications. Enquire on past use of emergency contraception (e.g., Plan B).
- Discuss contraceptive options based on health history including:
  - Barrier contraception:

- Condoms (male/female), diaphragm, cervical cap, cervical shield, spermicidal foam, sponges, and film
  - Relative contraindications to diaphragm use include recurrent cystitis and previous history of toxic shock syndrome.
- Hormonal contraception including:
  - Combined hormonal contraception (estrogen/progesterone product) including oral contraceptive pill (OCP), vaginal ring, and transdermal patch
    - Before combined estrogen/progesterone product can be started, perform a detailed history to determine absolute contraindications, relative contraindications, and possible relative contraindications to use. Refer to Appendix A.
  - Progesterone-only hormonal contraception including oral pill and depot medroxyPROGESTERone acetate (Depo-Provera) injection
    - Before a progesterone-only product can be started, perform a detailed history to determine absolute contraindications and relative contraindications to use. Refer to Appendix B.
- Intrauterine device (IUD)
- Sterilization

PHYSICAL FINDINGS

- Initial blood pressure measurement for initiation of all hormonal contraception.

DIFFERENTIAL DIAGNOSIS

- Not applicable

COMPLICATIONS

Combined Hormonal Contraceptives and Progesterone-Only Hormonal Contraceptives

- Malabsorption related to chronic gastrointestinal inflammation and active diarrhea might cause ineffectiveness.
- Repeated vomiting (e.g., bulimia) and/or severe, persistent diarrhea can decrease the absorption of the pill and might decrease its effectiveness.
- The following should be investigated immediately, referred to a physician/ RN(NP):

  - ACHES
    - **A**bdominal pain
    - **C**hest pain
    - **H**eadaches
    - **E**ye problems
    - **S**evere leg pain
  - Severe depression
  - Jaundice
  - Unexplained vaginal bleeding
  - Syncope
  - Blood pressure > 140/> 90
  - Severe or worsening migraine headaches with or without aura
  - Severe allergic reaction
- **Specific to Progesterone-Only Hormonal Contraceptives**
  - Vomiting within 2 hours of pill ingestion might require repeated doses.
  - Depot medroxyPROGESTERone acetate (Depo-Provera) injection is associated with decreased bone mineral density that is generally temporary and reversible.

INVESTIGATIONS AND DIAGNOSTIC TESTS

- A pelvic exam and a Pap smear are not mandatory for provision of hormonal contraception and should not be a requirement to receive contraception.
- Urine nucleic acid amplification test (NAAT) or swab for Chlamydia and *Neisseria gonorrhoeae* as needed based on sexual history.
- Urine pregnancy test if deemed necessary based on history.

MAKING THE DIAGNOSIS

- Contraceptive counselling including history, physical exam, results of diagnostics tests, and client preference will inform choice of contraception.

MANAGEMENT AND INTERVENTIONS

Goals of Treatment

- Prevent pregnancy
- Prevent sexually transmitted diseases

- Identify and manage side effects

Appropriate Consultation

- Presentation consistent with those identified in the Immediate Consultation Required in the Following Situations section.

Combined Hormonal Contraception (CHC)
Client: • wanting to use CHCs in the presence of relative or absolute contraindications. Refer to Appendix A. • whose medical condition has changed so that they might be using CHC in the presence of relative or absolute contraindications. • with chronic health conditions that increase serum potassium or women taking medications that increase serum potassium if considering use of a drosperinone containing CHC. o Drospirenone containing oral CHCs can interact with other potassium-sparing drugs (e.g., ACE inhibitors, angiotensin-II antagonists, potassium-sparing diuretics, heparin, aldosterone antagonists and long term NSAID use). o These clients should have their serum potassium checked about 14 days following initiation of a drospirenone-containing CHC. • who is currently taking CHCs and demonstrates any of the following symptoms: o ACHES; unexplained vaginal bleeding; jaundice; syncope; blood pressure > 140/> 90; severe migraine headaches (with aura); severe depression; and/or severe allergic skin rash. • who uses a transvaginal ring and has a history of toxic shock syndrome. • with a strong family history consistent with inherited thrombophilia (e.g., unprovoked venous thromboembolism (VTE) in a first or second degree relative under the age of fifty). • reporting headaches that are new and or worsening with the use of hormonal contraception. • taking medications that might be affected by hormonal contraception including: o Herbal preparations (e.g., red clover and St. John's Wort) o Anticonvulsants including: phenytoin, carBAMazepine, barbiturates, primidone, topiramate, OXcarbazepine and lamoTRIgine alone (lamoTRIgine/valproate combo does not interact with hormones) o Protease inhibitors (e.g., nelfinavir, ritonavir) o Antibiotics including: Rifampicin or Rifabutin therapy • taking theophylline, tricyclic antidepressants, diazepam or lithium may need dosage adjustments. • who becomes pregnant. o There is no known harm to the client, the course of her pregnancy or the fetus if CHCs are inadvertently used during pregnancy. However, if a CHC is inadvertently initiated

with a pregnant client or the client becomes pregnant during CHC use, the CHC should be discontinued immediately.
Progesterone-only Hormonal Contraception (POHC)
Client: • wanting to use a POHC in the presence of relative or absolute contraindications. Refer to Appendix B. • whose medical condition has changed so that they might be using a POHC in the presence of relative or absolute contraindications. • who is currently taking POHCs and demonstrates any of the following symptoms: ACHES; jaundice; syncope; severe depression; unexplained vaginal bleeding; severe or worsening migraine headaches (with or without aura) or severe allergic reaction. • taking medications that might be affected by hormonal contraception.

- **Diaphragm**
  - Refer to a physician/RN(NP) for fitting
- **Intrauterine Device (IUD)**
  - Consultation required
- **Sterilization**
  - Consultation required

Non-Pharmacological Interventions

- Discuss all methods of contraception: barrier methods, spermicidal agents, diaphragm, CHC, POHC and IUD.
- Educate client on methods of barrier contraception including:
  - Condoms (male/female), diaphragm, cervical cap, cervical shield, spermicidal foam, sponges, and film.
  - Encourage client to use condoms in addition to chosen method of contraception to prevent sexually transmitted diseases.

Pharmacological Interventions

- Choice of product will be based on history (including contraindications to use), physical exam, and client preference.

Combined Hormonal Contraceptive			
• All oral, transdermal and vaginally administered CHCs with < 50 mcg of ethinyl estradiol (EE) can be used for continuous or extended use. • Extended or continuous use increases contraceptive efficacy. Client takes consecutive packages of pills for 63-84-91 days followed by 4-7 day hormone free interval for menstruation. • The rate of side effects and adverse events with continuous use regimes is similar to conventional CHC use. • The length of the continuous use or extended use of combined hormonal contraceptive CHC regimens should be administered according to the preference of the client. • Combined hormonal contraception contains EE and a progestin in various doses and combinations. The amount of EE in CHCs ranges from 15 mcg-50 mcg. The amount and type of progestin vary and differ in potency and metabolic effect. A low-dose CHC preparation is preferred to provide effective contraception, acceptable cycle control and the least amount of side effects for that individual. All CHCs providing a daily dose of less than 50 mcg EE are considered low-dose.			
	Oral	**Ring**	**Transdermal Patch**
Initiation	Most effective if started on Day 1 of menstrual period but can be started any day of cycle. Advise the client to take daily at the same time each day. To avoid weekend period, start on first Sunday after period begins. Refer to the current Rx Files for prescribing information on the various formulations which include: • Monophasic (each tablet contains a fixed amount of estrogen and progestin) e.g., Alesse and MIN Ovral (Portia) • Biphasic (each tablet contains a fixed amount of estrogen; the amount of progestin increases in the	Insert on or before Day 5 of cycle (even if period not finished). Insert a vaginal ring every 3 weeks and remove for 1 week prior to inserting new ring.	Apply on Day 1 of menstrual period, or to avoid weekend period apply on first Sunday after period begins. Advise client to change the patch on the same day every week for 3 weeks and off for one week. Can be used continuously for 9-12 weeks followed by

	second half of the cycle) e.g., Synphasic • Triphasic (the amount of estrogen can be fixed or variable; the amount of progestin increases in three equal phases) e.g., tri-cyclen (Triphasic)		hormone free interval of 1 week.
Back up contraception	Recommended for first 7-10 days especially if started after Day 5.	Recommended until after the first 7 days during the first cycle.	Recommended for first week of first cycle.
Additional Information	There are a range of different sequence formulations of oral CHCs available, for example 21-7, 24-4 or extended use packaging. Product selection should be based on signs and symptoms of estrogen deficiency, progestin deficiency, estrogen excess and/or progestin deficiency, excess estrogen, excess progestin, excess androgen, and/or the presence of acne.	The intravaginal contraceptive ring is a cold chain medication. Once the cold chain has been broken, it is stable at room temperature for up to 4 months. The "insert by" expiry date should be indicated on the package as soon as cold-chain storage is broken.	

Progesterone Only	
Oral	**Injection**
The client is to start on Day 1 of menstrual period and daily thereafter. The client is to take the pill (e.g., Micronor) at the same time every day without a hormone free period.	Inject depot medroxyPROGESTERone acetate (Depo-Provera) 150 mg/mL IM using a 1 to 1.5 inch 21-23 gauge needle during first 5 days of menses or anytime if pregnancy is ruled out, and repeat every 12 weeks. Mix the suspension well by shaking the vial before drawing up the medication.
The client is to use a backup method for the first 7 days.	

Client and Caregiver Education

- Encourage client to use condoms in addition to chosen method of contraception to prevent sexually transmitted diseases.
- Demonstrate use of chosen method of barrier contraception.
- Counsel client/caregiver about the appropriate use of medications (dose, frequency, compliance, etc.).

Combined Hormonal Contraception		
Oral	**Ring**	**Transdermal Patch**
Missed pills -If at any time during the cycle, the client delays taking a pill < 24 hours, they are to take the pill ASAP, no backup contraception required. In Week 1 of cycle: -If 1 or more pills are missed, the client is to take 1 pill ASAP and daily until end of pack. The client should use back up method of contraception for 7 days. In Week 2 or 3 of cycle: -If 1 or more pills are missed, the client is to take 1 pill ASAP and daily until end of pack. The client is to discard any placebo pills and start new cycle without a hormone free interval. The client is to use a backup method of contraception for 7 days and consider emergency contraception. Refer to Appendix C for additional information.	Clients who have significant pelvic relaxation, vaginal stenosis or utero-vaginal prolapse, are unable to touch their genitalia or who have vaginal obstruction are not good candidates for the intravaginal ring. The ring may not be suitable for clients who have conditions that make the vagina more susceptible to irritation or ulceration. Clients who have genital outbreaks of herpes simplex virus are able to use the intravaginal contraceptive ring. Should not be used in conjunction with the diaphragm as it could dislodge this barrier. Ring expulsion of > 3 hours is of concern. -If this occurs during Week 1 of cycle, replace with new ring and use backup method of	The effectiveness of the patch might be somewhat decreased among clients weighing > 90 kg or who are obese (BMI > 30). Clients with conditions that affect the skin (e.g., eczema, psoriasis, cuts, rash or sunburn) should not apply the patch to these areas. Refer to Appendix E for additional information.

	contraception for 7 days. -If this occurs during Week 2 or 3 of cycle and more than 1 day is missed, start a new cycle and skip hormone free interval. The client is to use a backup method of contraception for 7 days and consider emergency contraception. Refer to Appendix D for additional information.	

Progesterone Only Hormonal Contraceptive	
Irregular menses is common within the first several months of POHC use. After 6-12 months, amenorrhea is more likely.	
Oral	**Injection**
A missed oral POHC pill by > 3 hours from the regular time requires use of backup contraception for 48 hours. Clients might consider use of emergency contraception if unprotected intercourse occurred within the past 5-7 days.	If it has been 14 weeks or more since the last depot medroxyPROGESTERone acetate (Depo-Provera) injection, a urine pregnancy test should be performed. Use of emergency contraception may be considered if intercourse has occurred within the last 5-7 days. A backup method should be recommended for the next 7 days. Depending on the client's risk of pregnancy, a repeat urine pregnancy test may be indicated at 2 weeks or prior to the next injection. Clients should be informed about the potential effects of depot medroxyPROGESTERone acetate (Depo-Provera) injection on bone mineral density and counselled about bone health, including calcium and vitamin D supplements, smoking cessation, weight-bearing exercise, and decreased alcohol and caffeine consumption. To rule out a rare but possible severe allergic reaction to depot medroxyPROGESTERone acetate (Depo-Provera) injection, clinicians should

	recommend that clients wait 15-20 minutes following injection. Depot medroxyPROGESTERone acetate (Depo-Provera) injection might have a slower return to fertility than other hormonal contraceptives. The average return to fertility is 10 months from the last depot medroxyPROGESTERone acetate (Depo-Provera) injection. Weight gain is possible with depot medroxyPROGESTERone acetate (Depo-Provera) use.

Monitoring and Follow-Up

- First follow-up examination should be done at 3 months.
- Blood pressure measurements should be repeated between 3-6 months following initiation of a CHC and then at least annually thereafter.
- Blood pressure measurements should be evaluated at initiation of a POHC and then at least annually thereafter.

Referral

- Refer to a physician/RN(NP) all clients requesting fitting for diaphragm, IUDs or sterilization.

DOCUMENTATION

- As per employer policy

REFERENCES

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no-143-february-2004-no-174-april-2006-no-195-july-2007-no-219-november-2008-no-280-september-2012/

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Appendix A

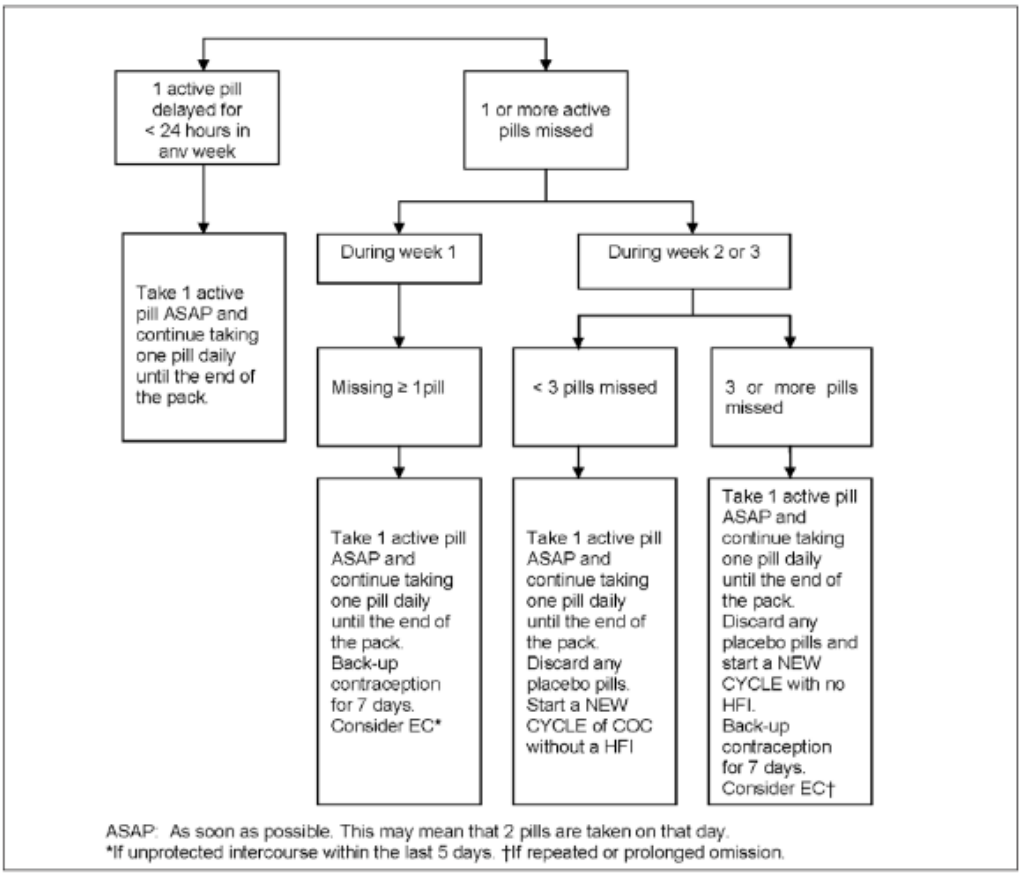
Absolute, Relative and Possible Relative Contraindications to use of Combined Contraceptive Product		
Absolute contraindications	Relative Contraindications	Possible Relative Contraindications
• Smoker > 35 years of age (≥ 15 cigarettes/day) • Hypertension (systolic ≥ 160 mm Hg or diastolic ≥ 100 mm Hg) • Current or past history of thromboembolism (VTE) and thromboembolic disorders • Coagulation factor deficiency • Cerebrovascular disorders • Ischemic heart disease, coronary artery disease • Known or suspected cancer of the breast • Known or suspected pregnancy • < 6 weeks postpartum if breastfeeding • Liver tumour (adenoma or hepatoma) • Undiagnosed abnormal genital bleeding • Migraine with aura or focal neurological symptoms • Diabetes with retinopathy/nephropathy/ neuropathy • Severe cirrhosis	• Post-thrombophlebitis • Severe headaches • Adequately controlled hypertension • Hypertension (systolic 140-159 mm Hg, diastolic 90-99 mm Hg) • Migraine headache > 35 years of age • Symptomatic gallbladder disease • Infectious mononucleosis, with hepatic involvement • Mild cirrhosis • History of combined OCP-related cholestasis • Elective major surgery planned in the next 4 weeks or major surgery requiring immobilization • Long-leg cast or major injury to lower leg • < 35 years of age and currently a heavy smoker (> 15 cigarettes/day) • Use of medications that may interfere with metabolism of oral contraceptives (antiepileptic, antipsychotic)	• Strong family history of diabetes mellitus • Previous cholestasis during pregnancy • Congenital hyperbilirubinemia (Gilbert's disease) • Impaired liver function at the time of presentation or within the past year • Known unreliability and low likelihood of correct administration

Appendix B

Absolute and Relative Contraindications to use of Progesterone-Only Contraceptive Product	
Oral	
Absolute	Relative
• Current breast cancer	• History of bariatric surgery with a malabsorptive procedure (e.g., gastric bypass) • Ischemic heart disease or stroke (current or history of)—for continuing method • Systemic lupus erythematosus (SLE) (positive for antiphospholipid antibodies or status unknown) • Migraine with aura—for continuing method (e.g., if migraines worsen in a client who is already using progestin-only pills) • Breast cancer in the past; no evidence of disease for 5 years • Severe cirrhosis • Malignant liver tumor • Certain antiretroviral and anticonvulsant o RifAMPin or rifabutin therapy
Injectable	
• Current breast cancer	• Multiple risk factors for arterial cardiovascular disease (e.g., older age, smoking, diabetes, and hypertension) • Hypertension (systolic ≥ 160 mm Hg or diastolic ≥ 100 mm Hg) • Vascular disease • Ischemic heart disease or stroke (current or history of) – for initiating or continuing method • SLE (positive for antiphospholipid antibodies or status unknown; or if severe thrombocytopenia) • Rheumatoid arthritis • Migraine with aura – for continuing method (e.g., if migraines worsen in a woman who is already using depot medroxyPROGESTERone acetate (Depo-Provera) • Unexplained vaginal bleeding prior to evaluation • Breast cancer in past; no evidence of disease for 5 years • Diabetes (only if nephropathy, retinopathy, neuropathy, or other vascular disease is present, or the duration of diabetes is > 20 years) • Severe cirrhosis • Malignant liver tumor • Certain antiretroviral and anticonvulsant medications

Appendix C

Figure 1. Missed combined oral contraceptives



Box 1. During the first week of use (week 1), delay in taking one pill ≥ 24 hours (i.e. missing one or more pills) increases the HFI and may allow ovulation during this week. Missing 1 active pill before ovulation is effectively inhibited (achieved after taking 1 active pill daily x 7 consecutive days) may also allow ovulation during this week. If intercourse occurred during the day of pill omission or in the 5 days prior, consider EC.

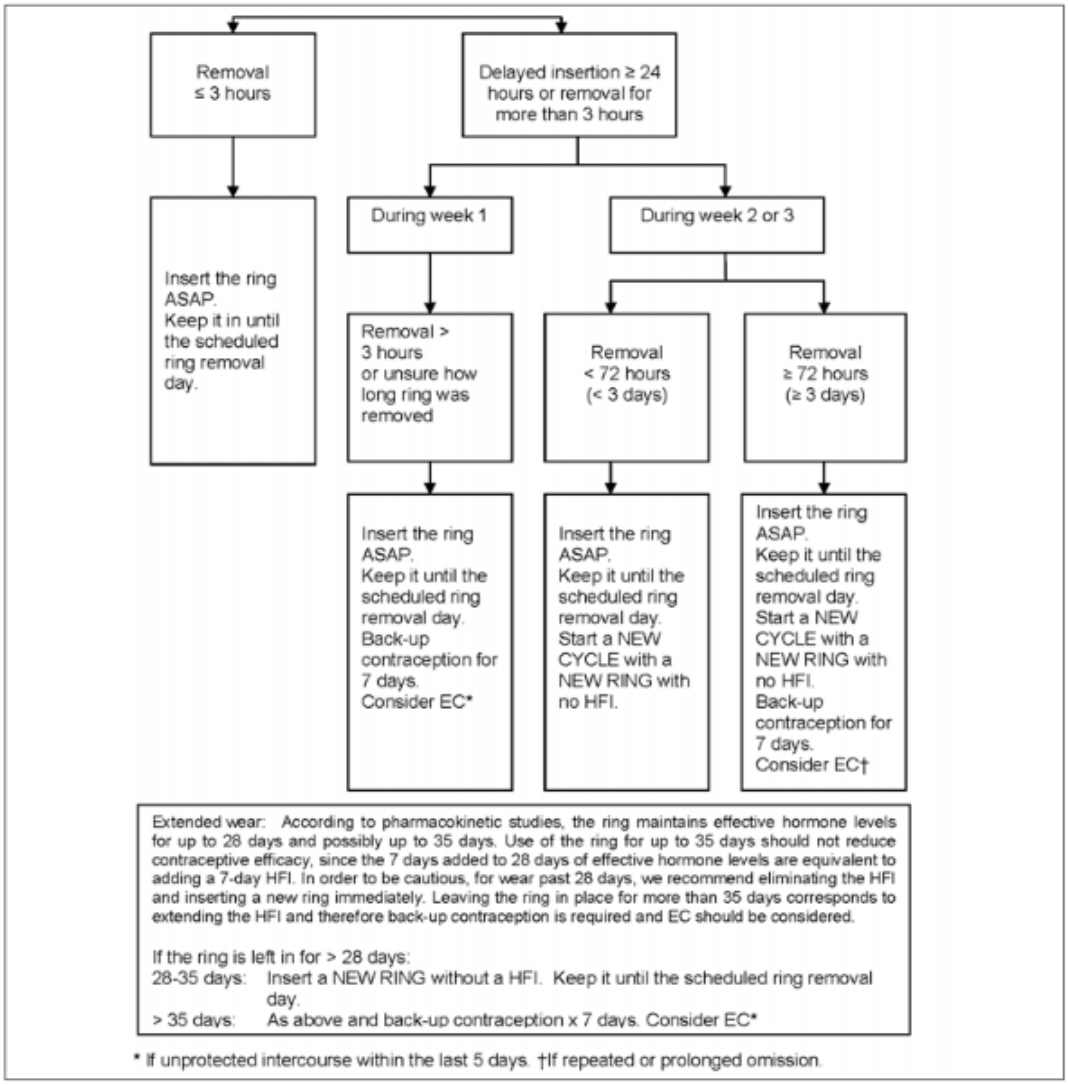
Box 2. Missing fewer than 3 pills in a row during week 2 or 3 is the same as having a short HFI after achieving effective inhibition of ovulation during the preceding week (1 pill daily x 7 consecutive days). Therefore, efficacy is not expected to be reduced, although breakthrough bleeding may occur. Eliminating the HFI may reduce the risk of unintended pregnancy when pills are missed in week 3. Eliminating the HFI when pills are missed in week 2 is proposed to simplify this algorithm.

Box 3. Missing 3 or more pills in a row during week 3 is likely to impair contraceptive effectiveness, because the HFI comes immediately after week 3. Eliminating the HFI and using a back-up method until 7 consecutive days of pills are taken should reduce the risk of unintended pregnancy. EC can be considered if unprotected intercourse has occurred during the interval of missed pills up until 7 consecutive pills have been taken. The same recommendation is proposed for week 2 to simplify the algorithm.

Note. Adapted from *Missed Hormonal Contraceptives: New Recommendations,* p. 1055, by The Society of Obstetricians and Gynecologists of Canada, 2008. Retrieved from http://sogc.org/wp-content/uploads/2013/01/gui219ECO0811.pdf

Appendix D

Figure 3. Missed contraceptive ring

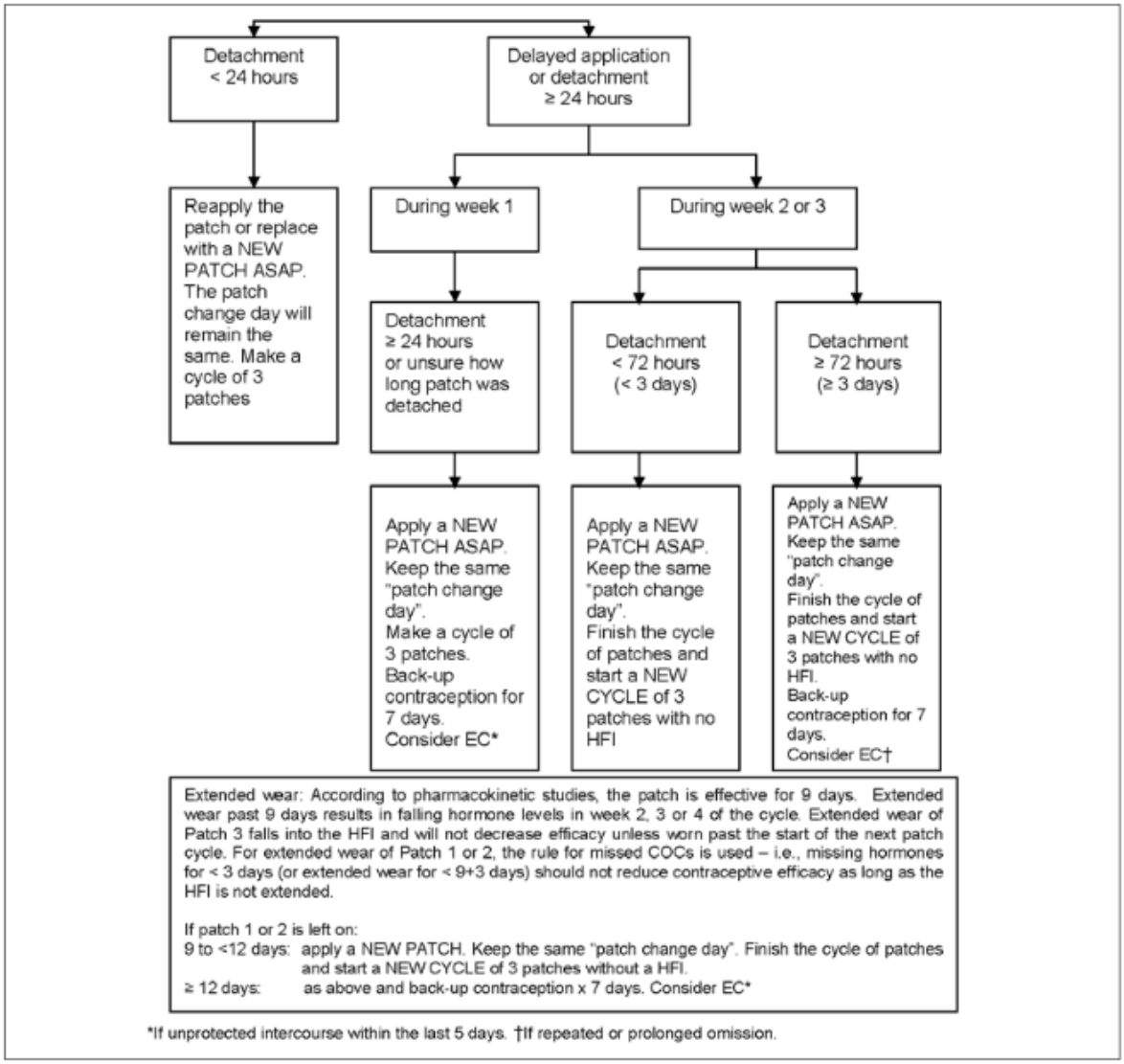


Box 1. Removal of the ring > 3 hours in week 1 is analogous to missing one active pill ≥ 24 hours in week 1. When a woman is unsure how long the ring was removed in week 1, it is safer to consider it as a removal > 3 hours. The scheduled ring removal day is day 21 after taking out the ring from the foil.
Box 2. Removal of the ring < 72 hours in week 2 or 3 is analogous to missing < 3 pills.
Box 3. Removal of the ring ≥ 72 hours in week 2 or 3 is analogous to missing ≥ 3 pills.

Note. Adapted from *Missed Hormonal Contraceptives: New Recommendations,* p. 1057, by The Society of Obstetricians and Gynecologists of Canada, 2008. Retrieved from http://sogc.org/wp-content/uploads/2013/01/gui219ECO0811.pdf

Appendix E

Figure 2. Missed contraceptive patch



Box1. Detachment ≥ 24 hours in week 1 is analogous to missing one COC by 24 hours or more in week 1. When a woman is unsure how long the patch was detached in week 1, it is safer to consider it as a detachment of ≥ 24 hours.
Box 2. Detachment < 72 hours in week 2 or 3 is analogous to missing < 3 COCs. The suggestion to keep the same "patch change day" provides more simple patient advice than having changing the "patch change day" as recommended in the product monograph.
Box 3. Detachment ≥ 72 hours in week 2 or 3 is analogous to missing ≥ 3 COCs.

Note. Adapted from *Missed Hormonal Contraceptives: New Recommendations,* p. 1056, by The Society of Obstetricians and Gynecologists of Canada, 2008. Retrieved from http://sogc.org/wp-content/uploads/2013/01/gui219ECO0811.pdf

SASKATCHEWAN REGISTERED NURSES' ASSOCIATION

RNs WITH ADDITIONAL AUTHORIZED PRACTICE
CLINICAL DECISION TOOL
DECEMBER 1, 2016

CONTRACEPTION ADULT & PEDIATRIC

NOTICE OF INTENDED USE OF THIS CLINICAL DECISION TOOL

This SRNA Clinical Decision Tool (CDT) exists solely for use in Saskatchewan by an RN with additional authorized practice as granted by the SRNA. The CDT is current as of the date of its publication and updated every three years or as needed. A member must notify the SRNA if there has been a change in best practice regarding the CDT. This CDT does not relieve the RN with additional practice qualifications from exercising sound professional RN judgment and responsibility to deliver safe, competent, ethical and culturally appropriate RN services. The RN must consult a physician/RN(NP) when clients' needs necessitate deviation from the CDT. While the SRNA has made every effort to ensure the CDT provides accurate and expert information and guidance, it is impossible to predict the circumstances in which it may be used. Accordingly, to the extent permitted by law, the SRNA shall not be held liable to any person or entity with respect to any loss or damage caused by what is contained or left out of this CDT.