NICE Guidance on LARC

I welcome the useful advice in the National Institute for Health and Clinical Excellence (NICE) long-acting reversible contraception (LARC) Guidance,49 though I am pleased to see that it states that all progestogen-only methods may be used by women who have migraine with or without aura.1 However, although this broad recommendation is applied to injectable contraceptives and subdermal implants, it is unclear for the levonorgestrel intrauterine system (LNG-IUS).

The Guidance notes an increase in headache incidence with IUS use and that “In the current WHO-MEC recommendations, the LNG-IUS is assigned to (WHO) category ‘2’ for initiation and category ‘3’ for continuation in women who have migraine with focal symptoms at any age”. Although the subsequent recommendation by NICE is that “progestogen-only methods, including the IUS, may be used by women who have migraine with or without aura”, it is unclear to me if NICE is suggesting that the WHO-MEC guidance does or does not apply.

I understand that increased concern of increased headache reported in LNG-IUS users. However, there are no data to support that its use is associated with increase in aura. Although it is recognised that women who have migraine, particularly with aura, and take combined oral contraceptive pills are at increased risk of ischaemic stroke3,5 hence, progestogen-only contraception can be used by women with any type of migraine, irrespective of whether aura is present before, or develops after, commencing the method.6 Clearly, it may be worth considering stopping the method to assess whether or not symptoms improve, but this should be on clinical grounds, not on safety.

Hence, I recommend that both NICE and WHO should consider re-assigning the LNG-IUS to be WHO Category 2 for both initiation and continuation of all progestogen-only methods.

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References
4 Cardiovascular disease and use of oral and injectable progestogen-only contraceptives and combined injectable contraceptives. Results of an international, multicenter, case-control study. World Health Organization Collaborative Study of Cardiovascular Disease and Steroid Hormone Contraception. Contraception 1998; 57: 315–324.

Emergency contraception and liver enzyme-inducing drugs

The CEU Guidance on drug interactions with hormonal contraception1 includes discussion on progestogen-only emergency contraception for women using liver enzyme-inducing drugs. In Table 2 of page 145 I read: “Take a total dose of 2.25 mg levonorgestrel. If 1.5 mg LNG is not available, take 2.25 mg LNG immediately and 750 µg taken 12 hours later.”

A previous CEU Guidance on emergency contraception in women taking liver enzyme-inducing drugs4 made the same recommendations as BNF Volumes 49 and 50. BNF states in the prefecture on page iii that the current edition must always be used when making clinical decisions.

Please clarify this discrepancy.

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Reply

Thank you for the opportunity to respond to the letter from Dr Nader Al-Hassan pointing out apparent inconsistencies within our CEU Guidance on drug interactions with hormonal contraception.1 I share Dr Al-Hassan’s frustrations about conflicting guidance from different sources. As Dr Al-Hassan says, in our 2003 CEU Guidance on emergency contraception2 we recommended a regimen of levonorgestrel 2.25 mg as a divided dose for women taking concurrent enzyme-inducing drugs; in our 2005 Guidance on drug interactions with hormonal contraception we recommended 2.25 mg as a single dose. There is no research evidence about the most appropriate contraception regimen for women taking concurrent enzyme-inducers and our evidence about the drug interactions that are of concern. CEU Guidance was, in fact, based on the advice in the volume of the BNF that was current at the time of writing. In our Guidance we refer to Volume 45 of the BNF (September 2004). A posteriori, we conclude that of that volume contains the advice on interactions with hormonal emergency contraception: “the dose of levonorgestrel should be increased to 2.25 mg taken as a single dose”. We note that in an earlier volume (Volume 43) and in a later volume (Volume 49) the BNF does recommend a divided dose in this circumstance. We do not know the reason why the BNF has altered its advice from a divided dose to a single dose, and back again, in successive volumes. However, on the basis of available data, we doubt that the difference in regimen makes any difference to efficacy.

The CEU is currently updating our Guidance on emergency contraception for publication in the April 2006 issue of this Journal. We will again be reviewing available evidence in developing an updated recommendation on concurrent emergency contraception and enzyme-inducers.

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