FSRH guideline: CHC

Appendix 2: Sections of UKMEC that contain conditions that are UKMEC 3 or 4 for use of combined hormonal contraception

**Personal characteristics**

<table>
<thead>
<tr>
<th>Personal characteristic</th>
<th>UKMEC</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Breastfeeding</strong></td>
<td></td>
</tr>
<tr>
<td>a) 0 to &lt;6 weeks postpartum</td>
<td>4</td>
</tr>
<tr>
<td>b) ≥6 weeks to &lt;6 months (primarily breastfeeding)</td>
<td>2</td>
</tr>
<tr>
<td>c) ≥6 months postpartum</td>
<td>1</td>
</tr>
<tr>
<td><strong>Postpartum (in non-breastfeeding women)</strong></td>
<td></td>
</tr>
<tr>
<td>a) 0 to &lt;3 weeks</td>
<td></td>
</tr>
<tr>
<td>(i) With other risk factors for VTE*</td>
<td>4</td>
</tr>
<tr>
<td>(ii) Without other risk factors</td>
<td>3</td>
</tr>
<tr>
<td>b) 3 to &lt;6 weeks</td>
<td></td>
</tr>
<tr>
<td>(i) With other risk factors for VTE*</td>
<td>3</td>
</tr>
<tr>
<td>(ii) Without other risk factors</td>
<td>2</td>
</tr>
<tr>
<td>c) ≥6 weeks</td>
<td>1</td>
</tr>
<tr>
<td><strong>Smoking</strong></td>
<td></td>
</tr>
<tr>
<td>a) Age &lt;35 years</td>
<td>2</td>
</tr>
<tr>
<td>b) Age &gt;35 years</td>
<td></td>
</tr>
<tr>
<td>(i) &lt;15 cigarettes/day</td>
<td>3</td>
</tr>
<tr>
<td>(ii) ≥15 cigarettes/day</td>
<td>4</td>
</tr>
<tr>
<td>(iii) Stopped smoking &lt;1 year</td>
<td>3</td>
</tr>
<tr>
<td>(iv) Stopped smoking ≥1 year</td>
<td>2</td>
</tr>
</tbody>
</table>

**Obesity**

<table>
<thead>
<tr>
<th>Personal characteristic</th>
<th>UKMEC</th>
</tr>
</thead>
<tbody>
<tr>
<td>a) BMI ≥30–34 kg/m²</td>
<td>2</td>
</tr>
<tr>
<td>b) BMI ≥35 kg/m²</td>
<td>3</td>
</tr>
</tbody>
</table>

**History of bariatric surgery**

<table>
<thead>
<tr>
<th>Personal characteristic</th>
<th>UKMEC</th>
</tr>
</thead>
<tbody>
<tr>
<td>a) With BMI &lt;30 kg/m²</td>
<td>1</td>
</tr>
<tr>
<td>b) With BMI ≥30-34 kg/m²</td>
<td>2</td>
</tr>
<tr>
<td>c) With BMI ≥35 kg/m²</td>
<td>3</td>
</tr>
</tbody>
</table>

**Organ transplant**

<table>
<thead>
<tr>
<th>Personal characteristic</th>
<th>UKMEC</th>
</tr>
</thead>
<tbody>
<tr>
<td>a) Complicated: graft failure (acute or chronic), rejection, cardiac allograft vasculopathy</td>
<td>3</td>
</tr>
<tr>
<td>b) Uncomplicated</td>
<td>2</td>
</tr>
</tbody>
</table>

*BMI, body mass index.

*VTE, venous thromboembolism. In the presence of other risk factors for VTE, such as immobility, transfusion at delivery, BMI ≥30 kg/m², postpartum haemorrhage, immediately post-caesarean delivery, pre-eclampsia or smoking, use of combined hormonal contraception may pose an additional increased risk for VTE.*
## Cardiovascular

### Hypertension
- a) Adequately controlled hypertension
  - UKMEC: 3
- b) Consistently elevated blood pressure levels (properly taken measurements)
  - (i) Systolic >140–159 mmHg or diastolic >90–99 mmHg
    - UKMEC: 3
  - (ii) Systolic ≥160 mmHg or diastolic ≥100 mmHg
    - UKMEC: 4
- c) Vascular disease
  - UKMEC: 4
- History of high blood pressure during pregnancy (where current blood pressure is measurable and normal)
  - UKMEC: 2

### Venous thromboembolism (VTE)
- a) History of VTE
  - UKMEC: 4
- b) Current VTE (on anticoagulants)
  - UKMEC: 4
- c) Family history of VTE
  - (i) First-degree relative age <45 years
    - UKMEC: 3
  - (ii) First-degree relative age ≥45 years
    - UKMEC: 2
- d) Major surgery
  - (i) With prolonged immobilisation
    - UKMEC: 4
  - (ii) Without prolonged immobilisation
    - UKMEC: 2
- e) Minor surgery without immobilisation
  - UKMEC: 1
- f) Immobility (unrelated to surgery) e.g. wheelchair use, debilitating illness
  - UKMEC: 3

### Known thrombogenic mutations (e.g. factor V Leiden, prothrombin mutation, Protein S, Protein C and antithrombin deficiencies)
- UKMEC: 4

### Cardiovascular disease
- Multiple risk factors for cardiovascular disease (such as smoking, diabetes, hypertension, obesity and dyslipidaemias)
  - UKMEC: 3
- Current and history of ischaemic heart disease
  - UKMEC: 4
- Stroke (history of cerebrovascular accident, including transient ischaemic attack (TIA))
  - UKMEC: 4
- Valvular and congenital heart disease
  - a) Uncomplicated
    - UKMEC: 2
  - b) Complicated (e.g. pulmonary hypertension, history of subacute bacterial endocarditis)
    - UKMEC: 4
- Cardiac arrhythmias
  - a) Atrial fibrillation
    - UKMEC: 4
  - b) Known long QT syndrome
    - UKMEC: 2
- Cardiomyopathy
  - a) Normal cardiac function
    - UKMEC: 2
  - b) Impaired cardiac function
    - UKMEC: 4

### Headaches
- a) Non-migrainous (mild or severe)
  - UKMEC: 1, 2, C
- b) Migraine without aura, at any age
  - UKMEC: 1, C
  - 2, 3
- c) Migraine with aura, at any age
  - UKMEC: 4
- d) History (≥5 years ago) of migraine with aura, any age
  - UKMEC: 3

C, continuation; I, initiation.
### Breast conditions

**Condition** | **UKMEC**<br>**I**<br>**C**<br>**3**<br>**2**
---|---
**Breast conditions**<br>a) Undiagnosed breast symptoms | 3 2
b) Benign breast conditions | 1
c) Family history of breast cancer | 1
d) Carriers of known gene mutations associated with breast cancer (e.g. BRCA1) | 3
e) Breast cancer<br>(i) Current | 4<br>(ii) Past and no evidence of current cancer for 5 years | 3

### Endocrine conditions

**Condition** | **UKMEC**
---|---
**Diabetes**<br>a) History of gestational disease | 1<br>b) Non-vascular disease<br>(i) Non-insulin dependent | 2<br>(ii) Insulin-dependent | 2
(c) Nephropathy/retinopathy/neuropathy | 3
(d) Other vascular disease | 3

### Rheumatoid diseases

**Condition** | **UKMEC**
---|---
**Systemic lupus erythematosus (SLE)**<br>a) No antiphospholipid antibodies | 2<br>b) Positive antiphospholipid antibodies | 4

### Gastrointestinal conditions

**Condition** | **UKMEC**
---|---
**Gall bladder disease**<br>a) Symptomatic<br>(i) Treated by cholecystectomy | 2<br>(ii) Medically treated | 3<br>(iii) Current | 3
b) Asymptomatic | 2

### History of cholestasis

**Condition** | **UKMEC**
---|---
a) Pregnancy related | 2<br>b) Past COC related | 3

### Viral hepatitis

**Condition** | **UKMEC**
---|---
a) Acute or flare<br>(I) | <br>(C) 3 2<br>b) Carrier | 1<br>c) Chronic | 1

### Cirrhosis*

**Condition** | **UKMEC**
---|---
a) Mild (compensated without complications) | 1<br>b) Severe (decompensated) | 4

### Liver tumours

**Condition** | **UKMEC**
---|---
a) Benign<br>(i) Focal nodular hyperplasia | 2<br>(ii) Hepatocellular adenoma | 4
b) Malignant (hepatoma) | 4

C, continuation; I, initiation.
Questions for continuing professional development

The following multiple choice questions (MCQ) have only one correct answer and have been developed for continuing professional development (CPD). The answers to the questions and information on claiming CPD points can be found in the ‘members-only section’ of the FSRH website (www.fsrh.org).

1. A woman taking lamotrigine is using the combined hormonal transdermal patch (CTP). Which one of the following statements is correct?
   a) Lamotrigine is a liver enzyme inducer and will reduce hormone levels
   b) Serum lamotrigine levels can be reduced by CTP
   c) Lamotrigine levels are unchanged in the hormone-free interval (HFI)
   d) The benefits of using CTP with lamotrigine usually outweigh the risks

2. A woman attends clinic and is 3 days late restarting her combined oral contraception (COC) and had unprotected sexual intercourse (UPSI) only on day 6 of her 7-day HFI having previously taken her pills consistently and correctly. Which one of the following statements is incorrect?
   a) She is at risk of pregnancy
   b) Copper intrauterine device (Cu-IUD) would not be first choice for emergency contraception in this situation.
   c) Ulipristal acetate (UPA) is a suitable choice of emergency contraception in this case
   d) If UPA is chosen, she needs to wait 120 hours before restarting her COC

3. Which one of the following statements about venous thromboembolic (VTE) risk with CHC is correct?
   a) VTE risk when using CHC is lower than VTE risk during pregnancy/after delivery
   b) Taking breaks from the pill is recommended as this reduces VTE risk
   c) VTE risk is higher with LNG- and norethisterone-containing COC compared to those containing desogestrel
   d) A thrombophilia screen is recommended before starting combined hormonal contraception (CHC)

4. A woman suffers from headache and nausea in the HFI. Which one of the following is an inappropriate option to reduce symptoms?
   a) Tricycle pill packets
   b) Take pills continuously
   c) Flexible extended pill taking
   d) Increase estrogen dose to 35µg

5. Which one of the following conditions is not UKMEC 3 for CHC use?
   a) Body mass index (BMI) ≥35 kg/m²
   b) Breast feeding and ≥6 weeks to < 6 months post-partum
   c) Age >35yrs and smoking < 15 cigarettes a day
   d) Hypertension with systolic >140–159 mmHg or diastolic >90–99 mmHg

6. Regarding switching to CHC, which one of the following statements is incorrect?
   a) 7 days of extra precautions are needed if CHC is started after taking desogestrel progestogen-only pills (POP) consistently and correctly
   b) No extra precautions are needed if CHC is started on same day as in-date subdermal implant is removed
   c) 7 days of extra precautions are needed if CHC is started on the same day that an in-date levonorgestrel-releasing intrauterine system (LNG-IUS) is removed
   d) Up to 9 days of extra precautions are required if an estradiol-containing COC is started and an in-date Cu-IUD is removed on day 3 of a menstrual cycle
7. Which one of the following statements is incorrect regarding a woman who wants to switch from CHC and is on day 6 of the HFI?
   a) If she has a Cu-IUD inserted today, no additional precautions are needed.
   b) If she is starts a POP today and has not had UPSI in the HFI, 2 days of additional precautions are needed.
   c) If she has a subdermal implant inserted today and has had UPSI in the HFI she should restart her CHC for 7 days.
   d) If she has a LNG-IUS inserted today, and has not had UPSI in the HFI, no additional precautions are required.

8. Which one of the following statements is incorrect regarding cancer and CHC use?
   a) Use of CHC is contraindicated for a woman whose mother had breast cancer.
   b) Increased risk of breast cancer associated with CHC use declines to become non-significant after 10 years of non-use.
   c) Use of CHC for more than 5 years is associated with a small increase in the risk of cervical cancer.
   d) Use of CHC is associated with reduced risk of endometrial cancer and ovarian cancer.

9. Which one of the following drugs does not alter the effectiveness of CHC?
   a) St. John’s Wort
   b) Modafinil
   c) Sodium valproate
   d) Topiramate

10. Which one of the following statements regarding CHC and migraine is correct?
    a) CHC users with migraine with aura are at greater risk of haemorrhagic stroke than CHC users without migraine.
    b) Starting CHC for a woman who has pre-existing migraine without aura, is UKMEC 2.
    c) If >5 years have elapsed since a woman’s last migraine with aura, benefits of CHC use outweigh risks.
    d) If a woman suffers from migraine without aura in the HFI, using an extended cycle regimen will not be beneficial.

Auditable outcomes

The following auditable outcomes have been suggested by the FSRH Clinical Standards Committee.

<table>
<thead>
<tr>
<th>Auditable outcome</th>
<th>Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>What proportion of patients are informed about and given the choice of standard and tailored regimens on commencing CHC</td>
<td>97%</td>
</tr>
<tr>
<td>What proportion of women have review of medical eligibility and have BP and BMI recorded prior to prescription of CHC</td>
<td>100%</td>
</tr>
</tbody>
</table>
Comments and feedback on published guideline

All comments on published this guideline can be sent directly to the Clinical Effectiveness Unit (CEU) of the Faculty of Sexual & Reproductive Healthcare (FSRH) via the FSRH website (www.fsrh.org).

The CEU may not respond individually to all feedback. However, the CEU will review all comments and provide an anonymised summary of comments and responses, which are reviewed by the Clinical Effectiveness Committee (CEC) and any necessary amendments made subsequently.

The Faculty of Sexual & Reproductive Healthcare (FSRH) is the largest UK professional membership organisation working in the field of sexual and reproductive health (SRH). We support healthcare professionals to deliver high-quality healthcare including access to contraception. We provide our 15 000 doctor and nurse members with NICE-accredited evidence-based clinical guidance, including the UKMEC, the gold standard in safe contraceptive prescription, as well as clinical and service standards.

The FSRH provides a range of qualifications and training courses in SRH, and we oversee the Community Sexual and Reproductive Healthcare (CSRH) Specialty Training Programme to train consultant leaders in this field. We deliver SRH-focused conferences and events, provide members with clinical advice and publish *BMJ Sexual & Reproductive Health* – a leading international journal. As a Faculty of the Royal College of Obstetricians and Gynaecologists (RCOG) in the UK, we work in close partnership with the College but are independently governed.

The FSRH provides an important voice for UK SRH professionals. We believe it is a human right for women and men to have access to the full range of contraceptive methods and SRH services throughout their lives. To help to achieve this we also work to influence policy and public opinion working with national and local governments, politicians, commissioners, policymakers, the media and patient groups. Our goal is to promote and maintain high standards of professional practice in SRH to realising our vision of holistic SRH care for all.

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