Contraceptive Challenges

A Walk Through the Life Cycle

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Adolescents

Patti's case

Patti, 16, is Para 1, Abortion 1. She requests contraception following a recent therapeutic abortion.

Patti has a history of chlamydia infection (two years ago). She smokes one half-pack of cigarettes daily.

What would be appropriate contraceptive choices for Patti?

Unintended pregnancy and sexually transmitted infections are major reproductive health concerns for adolescents.

Consistent and proper use of effective contraception can prevent these problems. Challenges encountered by primary care physicians in caring for sexually active adolescents are related to difficulties in initiating conversations about sex, confidentiality issues, reluctance to undergo pelvic exams and inconsistency in using contraceptive methods, especially combining use of condoms with other contraceptives.

Compliance also poses difficulties for many adolescents and noncompliance results in reduced efficacy and unintended pregnancy.

Counselling must focus on harm reduction strategies for individuals in whom abstinence from health risk behaviours (such as smoking, substance use and high-risk sexual activities) may not be appropriate.

Contraceptive use should be individualized to meet the needs of each patient (Table 1). Emergency contraception should be discussed long before the actual need for this method presents itself.

Adults

Lauren's case

Lauren, 26, is Para 2, Abortion 1. She is uncertain if she would like to have more children.

She has had migraines with visual symptoms since adolescence. She is a moderate drinker, but a nonsmoker.

She has heard combined oral contraceptives (COCs) are easy to use and effective; she'd like to give them a try.

If COCs are not an appropriate choice, what other method(s) might be? Why?

Before COCs are prescribed, current and past medical conditions should be explored. Distinguish severe headaches from migraines, evaluate any new headaches with aura and note marked changes in headaches.

The World Health Organization states that women with migraines can safely use COCs if they do not have focal neurologic symptoms and are younger than 35.

Nonhormonal contraceptives, such as intrauterine devices or barrier methods, are recommended if neurologic symptoms are present. COCs are not recommended in women who are over 35 and have migraines.

When counselling women with chronic health conditions about their contraceptive options, physicians must strike a careful balance between the risks and benefits, safety, effectiveness and acceptability of various methods, as well as the risk of pregnancy.

For many women with chronic medical conditions, the risk of an unintended pregnancy may exceed that related to contraception. The physician must take into account the separate risks and contraceptive contraindications of each condition.

Older reproductive-aged women

Katie's case

Katie, 38, is Para 2, Abortion 1. She is divorced and starting a new relationship.

Katie would like to discuss options for contraception. Her former husband had a vasectomy, therefore, contraception was not an issue.

Her menses are becoming heavier and irregular. She is a moderate drinker, but a nonsmoker.

What would be appropriate contraceptive choices for Katie?

An unintended pregnancy at an older age presents difficult choices between abortion and continuation of a pregnancy that may be at high-risk for a genetic disorder.

During this transition, the emphasis of clinical care changes. Besides the need for effective contraception, other health concerns—hormonal fluctuations that impact quality of life; osteoporosis; dysfunctional uterine bleeding; ovarian, endometrial, colorectal and breast cancers; and cardiovascular diseases—will become prominent concerns in the lives of women.

Hormonal contraceptives can be viewed as a strategy not only to provide effective contraception and reduce some long-term health risks, but also to enhance the quality of life for perimenopausal women.

Oral contraceptives or patches offer many benefits for healthy, nonsmoking, perimenopausal women and may make menses more regular in women with dysfunctional uterine bleeding, thereby reducing the need for surgical intervention for benign menstrual conditions.

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Table 1

Choice of contraceptive method

Options	Comments
Barrier methods	• Condoms (male and female types) are recommended at all ages • Effectiveness is increased if the barrier method is combined with spermicide
Combined oral contraceptive (COC) and patch	• Highly effective at all ages and have special advantages by offering good cycle control or preventing ovarian cysts • Women may continue with the pill or patch up to age 50, provided they are fit, slim, nonsmokers and have no risk factors for heart disease or stroke • Not an option for women over age 35 who smoke (due to increased risk of thromboembolic disease)
Progestin-only pill (POP)	• Used by women who are unsuitable for the standard COC and by older women • Ideal for women with problems such as high blood pressure, migraines or who are overweight or have had a previous thrombosis • May cause erratic periods or cause periods to stop altogether • 5% of women using POPs will have an unintended pregnancy within the first year of typical use compared to 3% for COC users
Injectable progestin	• Valuable option for adolescents and older women who are unable or unsuitable for COCs • In older women, contraceptive effectiveness approaches that of sterilization • Menstrual irregularity is the most common complaint • Common side-effects include mood changes, headaches, weight gain and changes in complexion • Can still be continued up to older ages and is a good treatment for heavy or painful periods and premenstrual syndrome
Intrauterine device (IUD)	• Very effective and provides long-term contraception (up to 5 years) at any age, although not generally recommended for adolescents who are nulliparous • Excellent choice for contraception in older women in mutually monogamous relationships • Newer levonorgestrel-releasing intrauterine system drastically cuts down the amount of bleeding and pain with menstrual periods and is an ideal method for those who have menstrual problems
Emergency contraception	• Prevents pregnancy after unprotected sexual intercourse or when woman's regular contraceptive method fails • Provided in several ways, *e.g.*, using increased doses of COC, progestins or insertion of a copper IUD within 5 to 7 days • Can reduce the risk of pregnancy up to 120 hours after unprotected vaginal intercourse • Best when taken within 72 hours of contraception (during which risk of pregnancy can be reduced 75-89%) • The number of pills in a dose depends on the brand
Sterilization	• Remains a common method of contraception for individuals who have completed childbearing • Effective, but with certain inherent disadvantages • Significant "regret rate" associated; while reversals can often be done, they involve a fairly major surgical procedure with considerable expense and no guarantee of success

References available—contact *The Canadian Journal of Diagnosis* at **diagnosis@sta.ca**.