Five Myths about Contraception

Pervasive myths about contraception pose challenges for primary care and family planning specialists alike. In this article, we will debunk five common myths and provide strategies to support women seeking contraceptive care.

**Myth #1: Oral Contraceptive Pills (OCPs) Cause Weight Gain**

In both short-term and long-term studies, no association exists between use of OCPs and weight gain. In a Cochrane review of short-term trials, differences in weight gain were not observed in any placebo-controlled comparison. Similar results were found in a systematic review of eight studies involving adolescent patients. One long-term study of 614 women in 10- and 20-year cohorts failed to show any difference in weight gain between users and non-users.

In most studies, both OCP users and non-users gain weight similarly over time. Interestingly, even in studies where no weight gain was noted, some women discontinued their medication due to perceived weight gain. It is therefore useful to weigh patients at the initial and follow-up contraceptive visits. Lifestyle management should be considered as a first-line treatment for weight gain in combined hormonal contraception (CHC) users.1,2

**Myth #2: The Intrauterine Contraceptive Device (IUD) Increases the Risk of Pelvic Inflammatory Disease (PID)**

Infection from IUD use is uncommon (about 0.5%) and is usually related to ascension of vaginal flora or pre-existing infection at the time of insertion. The risk of infection is slightly higher, but still less than 5%, for women with an asymptomatic STI at the time of IUD insertion. This period of elevated PID risk only persists for 20 days post-insertion and then decreases to 0.16% for the remainder of the lifecycle of the IUD.

Molly’s Case

A 19-year-old woman presents to a walk-in clinic for a referral for therapeutic abortion following the diagnosis of an unintended pregnancy. In a review of her medication history, she informs you that she had a contraceptive failure while using the oral contraceptive pill, which she attributes to frequently missed pills. When asked about other contraceptive methods, she tells you that her primary care provider advised against an intrauterine device, as it would place her at high risk for pelvic inflammatory disease.
which is no higher than the rate in women without IUDs.

The initiation of any effective birth control method may transiently increase the risk of PID due to the discontinuation of condoms. It is, therefore, important to reinforce dual protection and minimizing sexual risk-taking at the contraception consult and in follow-up.³

**Myth #3: It Is Safer to Have Monthly Periods than to Use Combined Hormonal Contraception on an Extended Basis**

The inventors of the first oral contraceptive pill chose a 28-day pill cycle for the sole reason of seeking approval from the Catholic Church as a form of natural family planning. Up to 60% of women have used CHCs to self-regulate the timing of menses, and these women may come to you with questions about the safety of this practice.

Because combined hormonal contraceptives are “progestin-dominant,” amenorrhea arises from suppression of the endometrium and is safe. Extended CHC use may have additional benefits, including improvement in PMS, greater protection from endometriosis, and theoretically improved contraceptive effectiveness. All currently available forms of CHC in Canada can be used on a continuous or extended basis.⁴

**Myth #4: Prophylactic use of Misoprostol Improves IUD Insertion**

The use of misoprostol prior to insertion of intrauterine contraceptive devices should be discouraged in both nulliparous and parous women. Five randomized, placebo-controlled trials (496 patients) have shown that misoprostol does not improve ease of insertion. It does, however, increase patient pain scores during insertion, and it increases prostaglandin-related side effects (nausea, vomiting, diarrhea and abdominal pain).⁵

![Myth #5: Drospirenone-containing OCPs Are Associated with a Significantly Increased Risk of Venous Thromboembolism (VTE) Compared to Other Oral Preparations](image)

Early reports of VTE, media coverage in the US, and methodological challenges in obtaining...
accurate risk estimates have created concern for women using drospirenone-containing OCPs.

Two retrospective studies using data from administrative databases, including a Danish study of 3.3 million women, suggest that the risk of VTE with drospirenone-containing oral contraception is higher than with OCPs containing the first-generation progestin, levonorgestrel (7.83 vs. 5.47 per 10,000 women-years). This was statistically comparable to the risk with “third generation” progestins, such as desogestrel (6.82 per 10,000 women-years). The conclusion is that the risk of VTE in drospirenone users may be slightly higher than in levonorgestrel users but not higher than in users of other brands already on the market. If a true difference exists, the attributable risk of harm is only 0.024%.6

More recently, four prospective trials, including a multinational post-marketing surveillance trial of 58,674 women, showed no statistically significant difference in VTE risk between combined OCPs containing the four major progestin types. The hazard ratio for drospirenone was 1.0 [0.6–1.6] when compared to levonorgestrel.7

All CHC users should be informed of the increased risk of VTE compared to non-users; however, the risk of VTE from CHC use is five-times less than the risk of VTE in pregnancy and 25-times less than the risk of VTE in the early postpartum period (see Figure 1).

**Take-home Message**

Contraceptive myths are common, but understanding the wealth of evidence devoted to debunking these myths can reassure physicians and patients alike.

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**References**


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