Long-Acting Reversible Contraception Protocol

Primary Care Service

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Standard Operating Procedure for Long Acting Reversible Contraception Services in Primary Care

Version 1.0

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This policy will be subject to review every two years, or, in light of any changes to national standards or Trust policy.

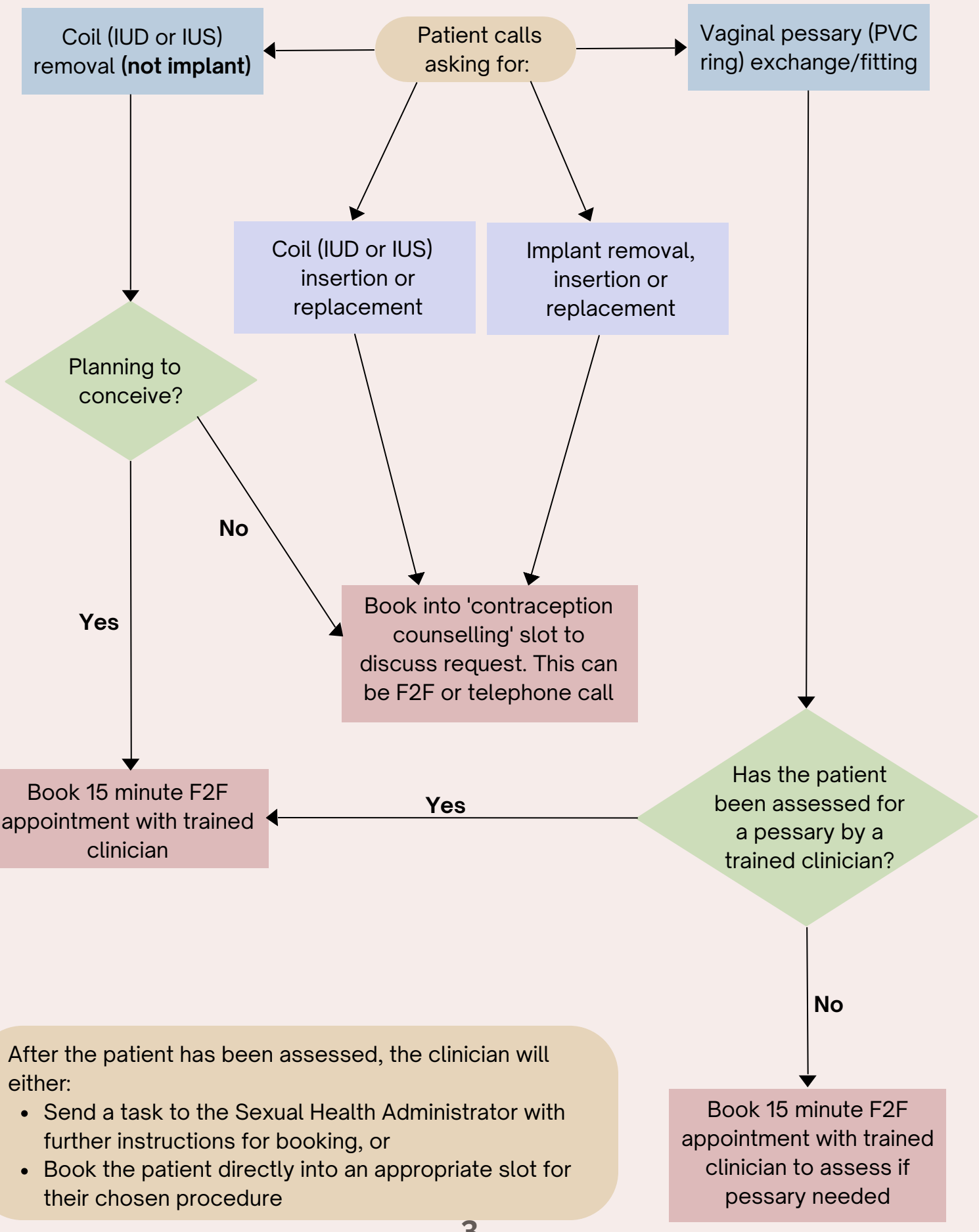
East London NHS
NHS Foundation Trust

Long-Acting Reversible Contraception Protocol

Primary Care Service

This document is not exhaustive of all knowledge required for appropriate LARC provision and management. For further information please check the individual FSRH clinical guidelines.

01 Contraception Pathway



After the patient has been assessed, the clinician will either:

- Send a task to the Sexual Health Administrator with further instructions for booking, or
- Book the patient directly into an appropriate slot for their chosen procedure

02 Intra-Uterine Device Protocol

IUCD procedures must only be performed when appropriate resuscitation equipment and medication available.

IUCD insertion/replacement must only be performed by appropriately trained healthcare professional holding the FSRH Loc-IUT. Trained clinicians and assisting staff must be trained in dealing with emergencies and administering basic life support.

Reception

Prior to IUD (coil) fitting or replacement, the patient will require an initial appointment with a clinician trained in contraception options to check suitability. Patients can be booked into a 'contraception counselling' slot.

Contraception Counselling
15 minutes

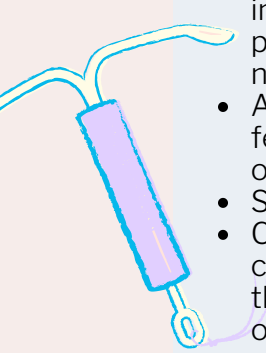
Fitting Appointment
30 minutes

Contraception Counselling

To assess suitability, a history must be taken using the relevant Ardens templates covering the following areas:

- Risk of pregnancy
- Last menstrual period (LMP)
- No menstrual disturbance or pelvic pain requiring investigation prior to fitting
- Parity - IUC is suitable for both parous and nulliparous individuals
- No medical problems that may affect the fitting. However, refer to the UKMEC
- Medication history - including anticoagulants and antiplatelet medications
- Some circumstances may make the fitting difficult such as, previous failed fitting, cervical surgery, including treatment for cervical intra-epithelial neoplasia (CIN), congenital uterine abnormality
- Sexual health assessment

Useful Facts



- IUC can be used by young people, individuals who have never been pregnant and individuals who have never been sexually active
- All IUD's do not affect return to fertility and do not interact with other medications
- Safe to be used if breastfeeding
- Cu-IUD can be used for emergency contraception within 120 hours of the first episode of UPSI in a cycle, or up to 5 days after the earliest estimated day of ovulation
- There is little or no increased risk of venous thromboembolism or myocardial infarction for IUS
- Mirena IUS can also be used for endometrial protection in HRT
- IUCD insertion in those who have previously undergone endometrial ablation should be undertaken in a specialist setting, with ultrasound or hysteroscopic assessment of the cavity to determine suitability

STI Screening

- Screening for chlamydia trachomatis and neisseria gonorrhoea should be offered to all individuals, especially those who are at higher risk of STI:
  - <25 years of age
  - A new partner in last 3 months
  - More than one partner in the last 12 months
- Infection is most likely to become apparent in the first 20 days following insertion of IUC
- IUC fitting should not be delayed in an asymptomatic user awaiting results of STI screen
- Prophylactic antibiotics are of no proven value
- Ensure accurate contact details are documented and stress the need for prompt treatment in the event of a positive result
- Current chlamydia or gonorrhoea infection or PID are contraindications to insertion of an IUC
- IUC may be fitted in individuals with a history of treated STI, including past PID

IUCD Options

There are currently five LNG (levonorgestrel) IUSs available in the UK. Only Mirena and Kyleena are stocked at CMC but others can be ordered/prescribed for individual patients.

Mirena, Levosert, Benilexa (52mg LNG-IUS)

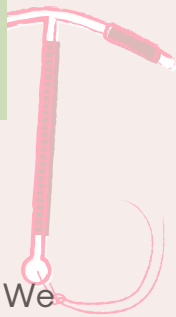
- Can be used for contraception for up to 6 years
- If inserted at age ≥45 years can be used for contraception until age 55 years
- Licensed to treat heavy menstrual bleeding
- Can be used for 5 years as endometrial protection as part of hormone replacement therapy (HRT). Although Levosert and Benilexa are unlicensed for endometrial protection, the FSRH supports this use for any 52mg LNG-IUS
- Mirena has a slightly smaller insertion tube diameter of 4.4mm (compared to 4.8mm for Levosert and Benilexa)
- Mirena has brown threads, Levosert and Benilexa have blue threads

Kyleena (19.5mg LNG-IUS)

- Licensed for contraception use for 5 years
- Smaller insertion tube diameter of 3.8mm (same as Jaydess)
- Blue threads and silver ring for visibility on USS

Jaydess (135mg LNG-IUS)

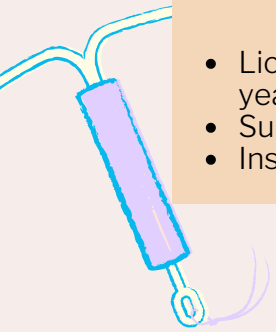
- Licensed for contraception use for 3 years
- Smaller insertion tube diameter of 3.8mm (same as Jaydess)
- Brown threads and silver ring for visibility on USS



There are currently four 10 year Cu-IUDs and fifteen 5 year Cu-IUDs available in the UK. We currently stock two at CMC, one 5 year and one 10 year IUD. These are T-Safe 380A QL and Neo-Safe T380 but others can be ordered/prescribed for individual patients.

T-Safe 380A QL

- Licensed for contraception use for 10 years
- Suitable for uterine length 6.5-9cm
- Insertion tube diameter of 4.75mm



Neo-Safe T380

- Licensed for contraception use for 5 years
- Suitable for uterine length 6.5-9cm
- Insertion tube diameter of 3.7

If offering an IUCD not currently in stock at CMC, please ensure an FP10 is generated and given to the patient **prior to the fitting appointment.** The patient will need to collect the device from the pharmacy and bring it with her, ready for insertion.

Fitting Appointment

Counselling

Patient will have already had counselling about disadvantages, benefits, risks and possible complications as well as the procedure.

Consent

Consent for the procedure can be written or verbal. At CMC we prefer written consent - using the Arden's form.

BP

Measurement of blood pressure/pulse both pre and post insertion is good practice. Any change from baseline will be monitored closely to assess condition of the patient

Equipment

Have all equipment ready for the procedure (see list below). Use the relevant Ardens template to ensure correct coding.

Assistant

A chaperone/trained assistant should be present during the procedure. The person may be required to call for additional assistance, monitor the condition of the woman, or perform basic life support

Fitting

Perform a bimanual examination of the pelvis
Insert the speculum
Perform a speculum examination
Stabilise and measure uterine cavity length
Insert the IUCD
Only clinicians who hold the FSRH LoC-IUT can fit IUCDs

Aftercare

Ensure patient's remains well throughout procedure and manage complications appropriately as they arise. Accurately document the procedure. Provide aftercare advice.

Emergency Equipment

- Anaphylaxis kit including Adrenaline
- Atropine 500mg or 600mcg IV/IM (two doses)
- Oxygen
- Essential resuscitation equipment should be available, accessible, maintained and its location known to all staff. Locally agreed risk management policies for the treatment of emergencies should be in place and take into account national recommendations

Standard Equipment List

- Pack of sterile gauze
- Plastic sound
- Metal sound
- Sponge holding forceps (long)
- Tenaculum
- Allis forceps
- Cusco speculum (variety of sizes)
- Instillagel and Instillaquil
- Cervical dilators (variety of sizes)
- Scissors
- Unisept sachet (chlorhexidine)
- Gloves
- Lubricant
- Blood pressure machine
- Sanitary pad

Complications & Risks

Perforation

Perforations are generally rare but they are an important risk that must be discussed with the patient. Perforations are related to the skill of the fitter.

The risk is 1-2 per 1000 insertions but there is approximately a six fold higher risk in breast feeding individuals.

There is also an increased risk if insertion within 36 weeks after giving birth. IUD insertion should be delayed for at least 4 weeks post partum.

Ectopic Pregnancy

Should a pregnancy occur there is an increased likelihood of it being ectopic.

Compared with no contraception, the overall risk of ectopic pregnancy is reduced. Should pregnancy occur, there is an 18% to 50% risk that it will be ectopic.

A previous ectopic pregnancy is not a contraindication to using IUC.

Bacterial Vaginosis

Bacterial vaginosis (BV) is associated with use of Cu-IUD and individuals who experience recurrent BV may wish to consider switching to an alternative method of contraception.

Association between BV and use of the LNG-IUS is unclear.

Vulvovaginal Candida

Cu-IUD has been identified as a risk factor for recurrent vulvovaginal candida.

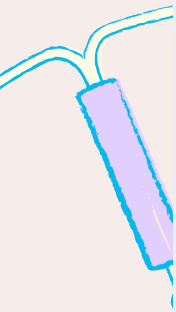
Individuals who experience recurrent vulvovaginal candida with Cu-IUD or LNG-IUS may wish to consider an alternative method of contraception.

Expulsion

The risk of expulsion is around: 1 in 20. It is most common in the first year of use, particularly within 3 months of insertion.

There is a small increased risk of expulsion following insertion of an IUC post- abortion. However, there is no need to delay insertion providing the individual is aware of this risk.

Increased expulsion rates have been seen following insertion immediately after vaginal delivery and menstrual cup users may have a slightly increased risk of expulsion compared to tampon and pad users.



Allergies

Although allergic reactions to Cu-IUDs are uncommon, ensure there is no allergy to copper for those requesting Cu-IUD.

Ensure no allergy to silver for those requesting Kyleena or Jaydess due to the presence of the small silver ring which helps distinguish it from Mirena or Levosert on ultrasound or x-ray.

During fitting, check for any relevant allergies depending on equipment or analgesia used, for example latex.

Myth Busting

"An IUCD can only be fitted whilst the woman is menstruating"

An IUC can be fitted when you are reasonably sure that the woman has no signs or symptoms of pregnancy and one or more of the following criteria are met:

- She has not had intercourse since the last normal expected menses
- She has been correctly and consistently using a reliable method of contraception
- She is within the first 7 days of the onset of a normal menstrual period
- She is fully or nearly fully breastfeeding, amenorrhoeic and less than 6 months postpartum
- She is within the first 7 days post-abortion or miscarriage

"All women need a IUCD check after fitting"

Most women will not require an IUCD check 6 weeks after fitting. It is more important to advise individuals as to signs and symptoms of infection, perforation and expulsion, returning if they have any problems relating to their IUC method. Individuals should be taught to self-check for threads and only attend for a thread check if they are unable to feel their own threads or have concerns/pain.

When IUC has been inserted within 48 hours of a vaginal or caesarean birth (PPIUC), an IUC check-up with a clinician 4–6 weeks after insertion is recommended.

"Sterile gloves must be used during fitting"

It is not essential to use sterile gloves or clean the vaginal secretions with sterile solution, but it is important to use an aseptic 'no-touch' technique for the insertion procedure.

An aseptic 'no-touch technique' means that any instrument passing through the internal cervical os into the uterine cavity, is completely sterile and has not been touched.

"All IUCDs are fitted in the same way"

Each IUCD has its own unique loading technique prior to insertion, and the technique to fit them varies accordingly.

With coils that have their arms facing upwards, on release they require room for the arms to open before the coil is placed fundally, whereas when the arms are facing downwards the coil can be released at the fundus of the uterus.

"Women should expect IUCD insertion to be painful"

Everyone has a different level of pain tolerance, but most people experience a heavy period cramp sensation. Fitter experience and assistant distraction (vocal local) often ensure that women are find fitting more comfortable. Other analgesics such as pre fitting oral analgesics, cervical block, lidocaine or instillagel can also be considered.

Period-like cramping following IUC fitting is due to attempts by the uterus to expel the device. Although the pain settles with time, analgesia or anti-inflammatory medication may be recommeded.

03 Procedure Complications

IUCD Expulsion

If the device tip is visible, this suggests partial expulsion. The decision to remove the device immediately may be influenced by timing of last sex and the presence of symptoms. A pregnancy test should be performed, and if the individual is suitable, they could have IUC refitted.

If the individual is at risk of pregnancy; a pregnancy test, emergency contraception and a bridging method of contraception should be offered as appropriate until they are eligible for re-insertion of the IUC.

Non-visible IUCD threads

Cause of non-visible IUCD threads include:

- Expulsion
- Perforation
- Enlarged uterus: pregnancy or fibroids
- Retraction of the threads into the cervical canal or uterus
- For individuals with postpartum intrauterine contraception (PPIUC) fitted at the time of caesarean section the IUC threads may have not descended through the cervix after fitting
- If no threads are visible on speculum examination; pregnancy should be excluded, additional precautions advised, and request USS to locate the device.

Difficult IUCD Insertions

There are various reasons that IUCD fitting may be challenging which can include:

- pinpoint cervical os, narrow cervical canal or spasm of internal os
- bend in the cervical canal
- flexed uterus
- fibroids
- pain during insertion
- patient anxiety
- vasovagal reaction

Dilation of the cervix may be required, especially if there is stenosis, scarring or narrowing of the cervical canal. A pinpoint os will require a small dilator to begin with, gradually increasing the size of the dilator until the os is sufficiently dilated for coil insertion.

Difficulties due to an acutely flexed uterus can be overcome by the use of vulsellum and traction to straighten the cervical canal.

Failed insertions and any complex issues with insertions should be referred to a specialist service. It is important to recognise your own competence in difficult insertions and refer any procedures that you feel require further specialist input.

Anaphylaxis

Presenting with anaphylaxis is an extremely rare adverse effect of IUD procedures. It can be a reaction to the:

- Analgesia used
- Solution used to clean the cervical discharge
- Hormone in the IUS

The patient can present with an allergic reaction. Symptoms can include: itchiness, redness, wheals, urticaria, or even angioedema

Perforation

Perforation can occur both during the insertion procedure or post insertion with a delay. If a perforation is suspected at the time of insertion:

- The procedure should be stopped and the IUC removed
- Vital signs and level of discomfort monitored until the patient is stable
- Assess ABCDE for all patients

For a stable patient, a pelvic ultrasound is required to identify the location of the IUC device in the uterine cavity. If a perforation of the bowel or vessel perforation is suspected, the patient will require an emergency referral to hospital.

Seizures

Seizures may also occur during insertion and removal procedures in some individuals. If seizure control is poor, they may be at higher risk of having a seizure during such a procedure. It is helpful to be aware of this risk and to keep up to date with local resus training.

Vasovagal Syncope

During any insertion and removal procedure, there is a risk of vasovagal syncope. Symptoms may include:

- Feeling lightheaded/dizzy/faint
- Ringing in ears
- Tingling in peripheries
- Nausea/vomiting
- Low pulse rate
- Low blood pressure
- Pallor and sweating
- Loss of consciousness
- Very rarely, cardiac arrest, if vasovagal syncope is not dealt with effectively

This is a particularly serious risk for women with cardiac conditions and they may not respond to standard treatment in the same way. Prior to insertion of an IUC in this situation, it is best to involve a cardiologist in the decision to use an IUC. Those women who are at an increased risk of a vasovagal reaction should have IUC fitted in a hospital setting.

Actions

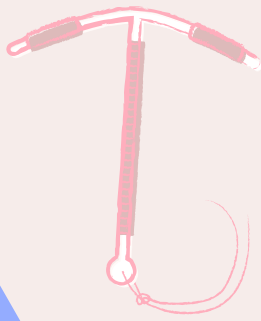
- Stop the procedure
- Ask for assistance from your chaperone
- Do not leave the patient alone
- Call for help
- Assess the patient
- Follow the ABCDE approach as per Faculty guidance (see below)
- Ensure emergency equipment is within reach

If the patient is conscious and responsive:

- Lower the head of the bed and elevate legs
- Monitor pulse and blood pressure

If the patient is unconscious:

- Provide BLS and await emergency services

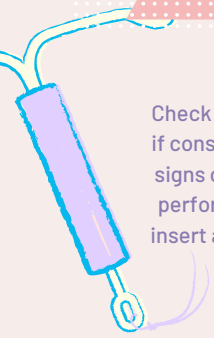


Breathing

Check for breathing and give oxygen. Attach pulse oximeter and loosen tight clothing. Provide ventilation if not breathing and call 999.

Disability

Assess the level of consciousness.



Airway

Check airway is patent, reassure if conscious. If deteriorating and signs of any airway obstruction; perform airway manoeuvre and insert an oropharyngeal airway if trained to do so.

Circulation

Look for signs of shock (pallor, sweating, feeling faint, nausea) and check pulse and BP. Lay the patient flat as soon as possible and raise the legs. The vast majority of vasovagal syncopal attacks will resolve with the above measures. Observe the patient – keep them laying down until they feel better.

Exposure

Expose the skin and assess the body appearance - body temperature, bruising, any bleeding etc.

Insertion or removal of an IUC should only be done in settings with appropriate resuscitation equipment and medication available.

Anaphylaxis

Anaphylaxis?

A = Airway **B** = Breathing **C** = Circulation **D** = Disability **E** = Exposure

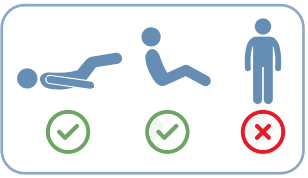
Diagnosis – look for:

- Sudden onset of Airway and/or Breathing and/or Circulation problems1
- And usually skin changes (e.g. itchy rash)

Call for HELP

Call resuscitation team or ambulance

- Remove trigger if possible (e.g. stop any infusion)
- Lie patient flat (with or without legs elevated)
  - A sitting position may make breathing easier
- If pregnant, lie on left side



Give intramuscular (IM) adrenaline2

Inject at **anterolateral aspect** – middle third of the thigh

- Establish airway
- Give high flow oxygen
- Apply monitoring: pulse oximetry, ECG, blood pressure

If no response:

- Repeat IM adrenaline after 5 minutes
- IV fluid bolus3

If no improvement in Breathing or Circulation problems1 despite TWO doses of IM adrenaline:

- Confirm resuscitation team or ambulance has been called
- Follow REFRACTORY ANAPHYLAXIS ALGORITHM

1. **Life-threatening problems**

Airway
Hoarse voice, stridor

Breathing
↑work of breathing, wheeze, fatigue, cyanosis, SpO2 <94%

Circulation
Low blood pressure, signs of shock, confusion, reduced consciousness

2. **Intramuscular (IM) adrenaline**
Use adrenaline at 1 mg/mL (1:1000) concentration

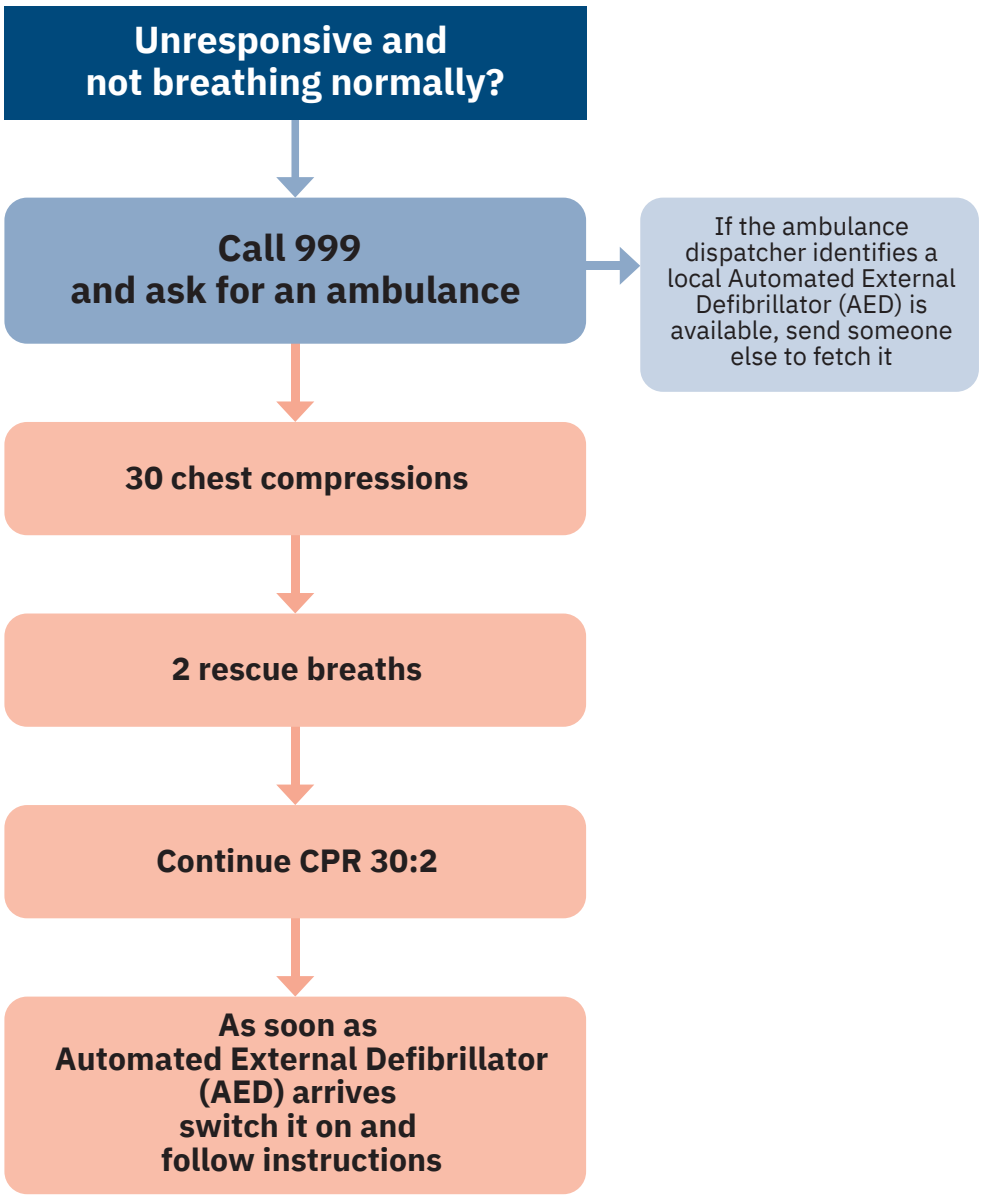
Adult and child >12 years: 500 micrograms IM (0.5 mL)
Child 6–12 years: 300 micrograms IM (0.3 mL)
Child 6 months to 6 years: 150 micrograms IM (0.15 mL)
Child <6 months: 100–150 micrograms IM (0.1–0.15 mL)

The above doses are for IM injection **only**.
Intravenous adrenaline for anaphylaxis to be given **only by experienced specialists** in an appropriate setting.

3. **IV fluid challenge**
Use crystalloid

Adults: 500–1000 mL
Children: 10 mL/kg

Adult basic life support in community settings



04 Implant (Nexplanon) Protocol

Sub-dermal implant procedures should only be performed by appropriately trained healthcare professional holding the FSRH Loc-SDI. Trained clinicians and assisting staff must be familiar with dealing with emergencies and administering basic life support.

Reception

Prior to implant removal, insertion or replacement, the patient will require an initial appointment with a clinician trained in contraception options to check suitability. Patients can be booked into a 'contraception counselling' slot.

Contraception Counselling
15 minutes

Insertion/Removal
30 minutes

Contraception Counselling

To assess suitability, a history must be taken using the relevant Ardens templates covering the following areas:

- Risk of pregnancy
- Last menstrual period (LMP)
- Assesses relevant medical history, in particular medical contraindications, interacting drugs/herbal preparations and allergies
- Checks a suitable time to insert and any requirement for additional contraception/follow-up pregnancy testing
- Discusses contraceptive effectiveness, bleeding patterns and other potential side-effects
- Discusses the insertion procedure and associated risks including local reaction/haematoma, deep insertion, intravascular insertion, migration of device and neurovascular damage as well as options for analgesia
- Discusses removal procedure
- Sexual health assessment

Enzyme Inducing Drugs and Drug Interactions

- Anti-epileptics: Carbamazepine phenytoin and topiramate are the most common antiepileptics to affect the cytochrome P450 enzymes.
- Lamotrigine is NOT an enzyme inducer and can be used with an SDI
- Desogestrel might increase levels of lamotrigine and increase adverse effects of lamotrigine.
- Rifampicin is the most common antibiotic to affect the cytochrome P450 enzymes
- St John's Wort.
- Some HIV drugs.
- Modafinil - this can be used as a recreational drug and is marketed as a 'study drug' to improve cognitive ability
- Griseofulvin (antifungal) - not thought to be enzyme inducing, however contraceptive efficacy may be reduced and concurrent use of the implant is not recommended.
- If taking an enzyme inducing drugs in short term (<2 months), individuals should be encouraged to use an additional method of contraception (such as careful and consistent condom use) to provide protection while taking the enzyme inducing drug and for 28 days after stopping it.

Nexplanon Stock

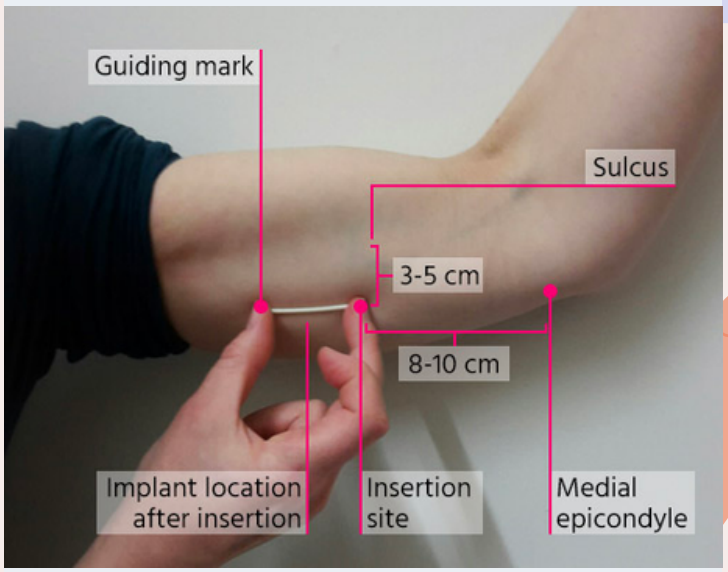
We do not stock Nexplanon devices at CMC. If a device is required, this must be prescribed prior to the procedure appointment (ideally when counselling) and the patient instructed to collect the device from the pharmacy and bring to their fitting appointment.

Considerations

Useful Facts

- If an SDI is replaced immediately and after no longer than 3 years since insertion, there is no need for additional contraceptive precautions at replacement.
- Emergency contraception is not required for any intercourse prior to removal.
- Contraceptive protection is regarded as lost immediately on removal. Prior to removal there is no need for abstinence or additional contraception.
- SDIs have very low failure rates (<1 in 1000 women over 3 years).

Location



Lidocaine

- It is recommended to use a maximum of 2-3 ml for insertion and a maximum of 0.5-1 ml for removal.
- Always use the lowest concentration and the smallest possible dose.
- Systemic reactions are very rare and these are mainly central nervous system and cardiovascular reactions.
- Effects initially include a feeling of nervousness, inebriation and light-headedness. There may be dizziness, blurred vision, tinnitus and tremors followed by sedation, circumoral paraesthesia and twitching, restlessness, irritability, hallucinations and depression.
- Hypersensitivity reactions to lidocaine are rare but may include cutaneous lesions, urticaria, odema and anaphylactoid reactions.
- Lidocaine is safe to use while breastfeeding although it is secreted in breast milk. There is a very small chance of allergic reaction in the infant, but this is very rare.

Lidocaine Contraindications

- Complete heart block
- Hypovolaemia
- Known sensitivity to local anaesthetic
- Allergy to hydroxybenzoate (paraben an antioxidant and antimicrobial agent used in cosmetics and food preservation)

Lidocaine Cautions

- Cardiac rhythm disturbance
- Hepatic impairment
- Renal impairment (CrCl <10 ml/min)
- Acute porphyrias
- Myasthenia gravis
- Never inject into inflamed or infected areas

Lidocaine Interactions

- Beta blockers, cimetidine, antiviral agents and noradrenaline increase the action of lidocaine
- QT prolonging drugs such as antipsychotics increase the risk of ventricular tachycardia (VT)
- Hypokalaemia (care with those on diuretics) decreases the action of lidocaine
- Lidocaine crosses the placenta and should not be used in early pregnancy unless the benefits outweigh the risks

Insertion Appointment

Counselling

Patient will have already had counselling about disadvantages, benefits, risks and possible complications as well as the procedure.

Consent

Consent for the procedure can be written or verbal. At CMC we prefer written consent - using the Arden's form.

Equipment

Have all equipment ready for the procedure (see list below). As assistant may also be used if required. To ensure correct coding, use the relevant Ardens template.

Positioning

Identify correct insertion site and position patient supine with the arm well supported (abducted to 90°, elbow flexed and the hand behind the head)

Anaesthetic

Administer the local anaesthetic safely in accordance with FSRH implant guidance If using 1% lidocaine, then no more than 3 ml should be used. Lidocaine with adrenaline may be used to reduce bleeding.

Insertion

Insert the implant superficially 8-10 cm proximally along the sulcal line from the medial epicondyle and 3-5 cm posteriorly, perpendicular to the sulcal line (over the triceps muscle)

Aftercare

Ensure procedure is accurately documented.
Provide aftercare and wound care advice. Advise the implant should always be palpable and advise to seek review if any concerns.

Standard Equipment List

- For the local anaesthesia:
  - Antiseptic solution
  - 2 ml syringe
  - Green needle (21 G) or orange needle (25 G)
  - Local anaesthetic (1% lidocaine)
- For the procedure:
  - Sterile gloves (or non-sterile gloves if using the no-touch technique)
  - Dressing pack with gauze swabs
  - Implant device
  - Hypoallergenic plaster
  - Bandage
  - Sharps safe bin

Emergency Equipment

- Anaphylaxis kit including Adrenaline
- Oxygen
- Essential resuscitation equipment should be available, accessible, maintained and its location known to all staff. Locally agreed risk management policies for the treatment of emergencies should be in place and take into account national recommendations

Removal Appointment

Counselling

Should be aware of procedure, including potential side-effects of the procedure, asses allergy history and discuss future contraception

Consent

Consent for the procedure can be written or verbal. At CMC we prefer written consent - using the Arden's form.

Equipment

Have all equipment ready for the procedure (see list below). As assistant may also be used if required.

Positioning

Position with patient supine and arm well supported, identify the implant by palpation and ensure that the distal end pops up to the skin surface when gentle pressure is applied at the proximal end

Anaesthetic

Administer the local anaesthetic safely in accordance with FSRH implant guidance If using 1% lidocaine, then no more than 1ml (3 ml if replacement) should be used. Lidocaine with adrenaline may be used to reduce bleeding.

Removal

Make a longitudinal incision at the distal end of the implant of an appropriate length for removal and remove carefully. Ensure that the complete implant has been removed (4 cm) and apply pressure until haemostasis is achieved. If a further SDI is requested, this can be inserted at the same time as removal.

Aftercare

Ensure procedure is accurately documented. Provide aftercare and wound care advice. Routine follow-up is not required.

Standard Equipment List

- For the local anaesthesia:
  - Antiseptic solution
  - 2 ml syringe
  - Green needle (21 G) or orange needle (25 G)
  - Local anaesthetic (1% lidocaine)
- For the procedure:
  - Sterile gloves (or non-sterile gloves if using the no-touch technique)
  - Dressing pack with gauze swabs
  - Implant device (if replacing)
  - Hypoallergenic plaster
  - Bandage
  - Sharps safe bin
  - Scalpel
  - Steri-strips
  - Mosquito forceps

Emergency Equipment

- Anaphylaxis kit including Adrenaline
- Oxygen
- Essential resuscitation equipment should be available, accessible, maintained and its location known to all staff. Locally agreed risk management policies for the treatment of emergencies should be in place and take into account national recommendations

Complications & Risks

Reaction to Lidocaine

If reaction to local anaesthetic occurs, stop the administration and most of these symptoms will settle quite quickly.
If symptoms do not settle and are severe, stop administration, manage Airway Breathing and Circulation and call 999.

Insertion Risks

Risks of insertion include:

- Incorrect insertion e.g. non-insertion, deep, intravascular
- Injury e.g. nerve, vascular
- Implant issues e.g. breakages, migration
- Wound issues e.g. local fibrosis, scarring, discomfort, bruising, haematoma, skin atrophy

Local Migrations

Local migration occurs when the implant moves from the insertion site but remains in the arm.

Intravascular migration can also occur, albeit rarely. Incidence of intravascular migration has been estimated at one case for every 1.3 million implants sold).

Broken Implant

In the event of a broken implant, the decision to remove lies with the patient and healthcare professional. There is no agreed method to do this. A midpoint incision may allow both ends to be removed in one incision. Always check and measure that the whole 4 cm length of SDI has been removed and always report a broken SDI to the MRHA yellow card scheme.

In vitro studies suggest that the hormone release rate of broken implants increased only slightly compared to undamaged implants and thus the manufacturer recommends that efficacy will be unaffected.

Impalpable Implant

Individuals should be encouraged to feel the implant gently with their fingertips after insertion both at the time of the procedure and again on removal of the dressing. They should be advised to seek medical advice urgently if they cannot feel their implant at any time after insertion. If an implant is impalpable:

- Check both arms to make sure the implant cannot be felt and look for a site of insertion
- Undertake a pregnancy test (pregnancy is most likely a risk if the impalpable implant is as a result of an insertion failure)
- Give additional contraception or emergency contraception, if required, until the implant is located
- Refer the individual to a specialist sexual and reproductive health care service
- Do not attempt removal of an impalpable implant that has not been localised.

Locally, we can refer difficult to remove or impalpable implants to iCaSH. It is not necessary to perform ultrasound prior to referral as iCaSH can scan directly. A referral letter should be emailed to the iCaSH team locally.

Bleeding with Implant

Patients require careful management as problematic bleeding is a leading cause of method discontinuation. This can be prevented by managing the patient's expectations with thorough pre-initiation counselling.

Remember that problematic bleeding may be a symptom of significant genital tract pathology (e.g. sexually transmitted infections (STIs) or gynaecological malignancy) and vigilance in the management of these situations is necessary. Management of problematic bleeding should differ for individuals presenting within 3 months of starting a new contraceptive method and those experiencing longer-term bleeding difficulties or a change in bleeding pattern on an established method. Persistent problematic bleeding for more than 3 months or an altered bleeding pattern on an established method, warrant further assessment which should include a clinical history, clinical examination (where indicated) and investigations. The FSRH has produced a management plan for the assessment and investigation of unscheduled bleeding in women using contraceptives.

05 DMPA (Injection) Protocol

Reception

Prior to starting the depo injection for the first time, the patient will require an initial appointment with a clinician trained in contraception options to check suitability. Patients can be booked into a 'contraception counselling' slot.

Contraception Counselling
15 minutes

Injection Appointment
20 minutes (with nurse)

Contraception Counselling

To assess suitability, a history must be taken using the relevant Ardens templates covering the following areas:

- Risk of pregnancy
- Last menstrual period (LMP)
- Assesses relevant medical history, in particular medical contraindications, interacting drugs/herbal preparations and allergies
- Checks a suitable time to initiate and any requirement for additional contraception/follow-up pregnancy testing
- Discusses contraceptive effectiveness, bleeding patterns and other potential side-effects
- Sexual health assessment

Advantages

- May be used when COCs are contraindicated – similar to POPs
- Long-acting – given at 13-week intervals
- Reversible – but may be a delay of up to 1 year in return of fertility following discontinuation
- Still effective with vomiting and diarrhoea
- Efficacy not affected by enzyme inducers
- Amenorrhoea or reduced bleeding is common and may benefit those with heavy periods and anaemia
- May reduce pain in endometriosis
- No increase in ovarian or endometrial cancer, and possible protective effect
- May reduce pain during sickle crises, although insufficient evidence to recommend DMPA over other contraceptives

Disadvantages

- Any effects, including unwanted effects, will continue for 12-14 weeks, and possibly longer
- May require attendance at a clinic/surgery unless self-administering Sayana Press®
- Interaction with ulipristal emergency contraception
- Ovulation may be delayed up to a year after discontinuation of DMPA, but fertility may return sooner
- Possible weak association between current DMPA use and breast cancer. Any increased risk is likely to be small and reduce with time after stopping
- Use for 5 years or more is weakly associated with cervical cancer. Any increased risk reduces with time after stopping and may be due to confounding factors

Side Effects

- Reduced bone mineral density, usually recovers after discontinuation. Careful consideration of risks is necessary in those at increased risk of osteopenia/osteoporosis such as those on long-term carbamazepine or sodium valproate, living with HIV, immobilised for long periods or those who have inadequate sun exposure or dietary calcium
- Altered bleeding patterns are common (including amenorrhoea, infrequent bleeding, spotting and prolonged bleeding).
- Weight gain: Especially in individuals under 18 years of age with a baseline BMI of >30 kg/m2. Those gaining >5% of their baseline weight in the first 6 months are likely to continue to gain.
- Injection site reactions: Including induration, atrophy and scarring.
- Other side-effects: Such as alopecia, acne, headaches, mood swings, vasomotor symptoms, reduced libido and vaginitis have been reported with DMPA, although there is little evidence demonstrating causation.

Injection Appointment

Counselling

The patient should be aware of procedure, including potential side-effects of the injection and regime to ensure efficacy.

Eligibility

Unless the person administering the injection is an independent prescriber, the clinician will need to ensure an appropriate PSD is in place and in date. Check that injection is on time.

Injection

Have all equipment ready for the procedure (see list below). Depo-Provera is kept in stock at CMC. Confirm identity and check the dose and expiry date of the injection. Shake pre-loaded depo syringe vigorously to ensure all the contents are dispersed, connect needle and expel the air.

Template

Use the Ardens 'Drug Injection' template - ensure all fields completed and generate FP10. FP10 to be passed to admin team to claim cost of injection stock back.

Administer

Expose only the area of the body needed to give the injection safely.
Insert full length of needle (that came with injection) and withdraw plunger to check not in a vein and inject. Dispose of sharp in appropriate sharps bin.

Recall

Confirm date next injection due, book if able to. Reiterate importance of ensuring injections are administered on time. If any concerns or patient wishes to change method, book with suitable clinician.

Document

Ensure procedure is accurately documented.

Emergency Equipment

- Anaphylaxis kit including Adrenaline
- Oxygen
- Essential resuscitation equipment should be available, accessible, maintained and its location known to all staff. Locally agreed risk management policies for the treatment of emergencies should be in place and take into account national recommendations

Standard Equipment List

- Depo-Provera Injection
- Gloves
- Spot plaster or cotton ball
- Sharps Bin

Injection Sites

DMPA is available in the UK as:
Depo Provera® - 150 mg MPA in 1 ml for intramuscular (IM) injection
Sayana® Press - 104 mg MPA in 0.65 ml for subcutaneous (SC) injection

IM DMPA (Depo Provera)

The needle that comes with DMPA is longer than a standard green needle and should be used.

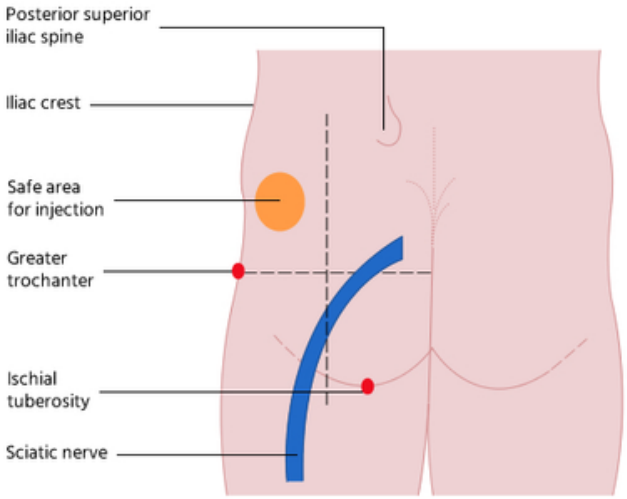
However, the depth of adipose tissue at the gluteal site may be more than the length of the standard needle in the DMPA pack. In individuals who are overweight or obese, it may not be possible to ensure IM delivery at either of the gluteal sites. IM injections into the deltoid muscle in the upper arm or use of SC DMPA are alternatives

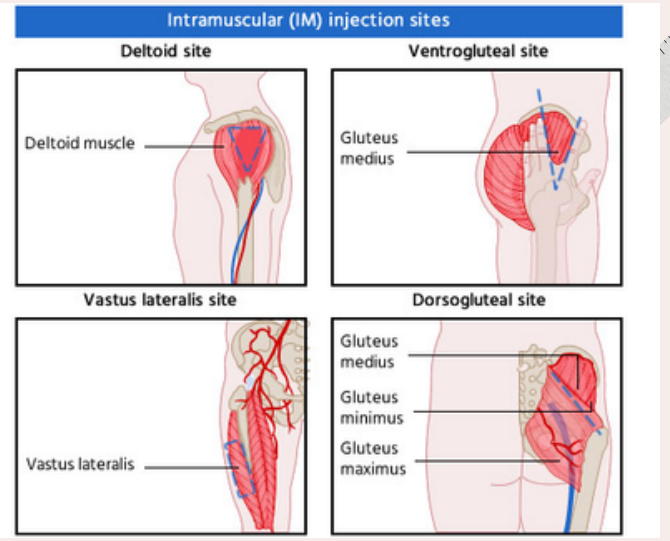
In this instance, it is especially useful to be aware of alternative sites in which the IM injection may be administered. For example, the deltoid may be used as an alternative site in individuals with a higher BMI or according to individual preference.

It is important to shake the injection vigorously until fully mixed and appears a uniform milky-white colour.

Sites for administering IM DMPA:

- Dorsogluteal (upper outer quadrant of buttock) – traditional but higher chance of shallow injection in those with higher BMIs, especially 40+
- Ventrogluteal site - advantages of the fat layer being thinner and a reduced risk of sciatic nerve injury



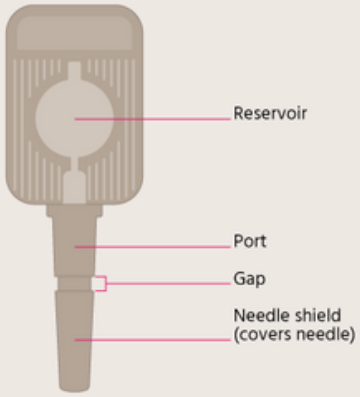


SC DMPA (Sayana Press)

SC DMPA comes as a prefilled injector and should be given at room temperature. It is important to shake the injector vigorously until fully mixed and appears a uniform milky-white colour.

Sites for administering SC DMPA:

- Abdomen, avoid the umbilicus and any scars
- Upper thighs, avoiding bony areas and any scars



Dosing Interval

The FSRH recommends a dosing interval of 13 weeks for both IM DMPA (outside the product license) and SC DMPA. However, it also advises that DMPA can be given, if necessary, from 10 weeks and up to 14 weeks after the last injection (outside of product license).

Long-term Use

Review Appointment

The FSRH recommends annual prescriptions (PSD authorisation) and 2-yearly review in long-term users of DMPA.

Each injection administration appointment is an opportunity to review:

- Interval since last injection – is it 14 weeks or less?
- Weight – has there been weight gain and how much?
- Bleeding pattern – has this changed and is investigation needed?
- Any other side-effects
- Changes in sexual health and medical history
- Changes in individual's UKMEC category – should DMPA be discontinued?
- Long-term users' osteoporosis risk should be reviewed every 2 years and considered alongside the benefits and their preferences.

Blood pressure monitoring is not required.

Late Injection

There is risk of pregnancy with late injections (>14 weeks for DMPA). This should be carefully assessed and discussed.

If EC is indicated, it is important to remember that the efficacy of ulipristal acetate (UPA) may be reduced by progestogens taken in the 7 days before or the 5 days after UPA. Therefore, use of UPA would necessitate delay of the next injection by 5 days and may not be the best choice.

DMPA Duration

There is no maximum duration of use for DMPA At age 50 years, discuss alternative contraceptive methods with users as there are safer equally efficacious methods. Use over the age of 45 years is UKMEC 2 and individuals may choose to remain on DMPA or start it at or over 50 years, following assessment and discussion of risks and benefits.

Generally all forms of contraception may cease at age 55 years as spontaneous conception after this age is extremely rare. Those over 50 years old, who are amenorrhoeic on DMPA and wish to cease contraception before age 55, may have their serum FSH levels measured. As DMPA itself may suppress FSH levels, it is possible to be menopausal with no apparent rise in FSH levels, and the optimal time for measurement is just before the next injection. If the FSH level is >30 IU/L, contraception may be discontinued after one further year

06 LARC Administrator Role

The Sexual Health Administrator should be a Health Care Assistant (HCA) with additional specific training to support the safety and success of the sexual health clinics.

Responsibilities

The SHA will be responsible for organising LARC services at Cauldwell Medical Centre. Duties will include:

- Ordering all necessary equipment and devices to use during LARC procedure clinics
- Maintain adequate stock levels
- Organise fitting clinics
- Ensure emergency drugs and equipment are available
- Collate all PPA's for claiming and pass to allocated admin staff
- Collate all consent forms for scanning to patient records
- Assist where necessary for LARC procedures
- Setting up equipment and ensuring everything is ready on time in consulting room where the procedure is going to be performed
- Tidying up and cleaning down equipment in between patients
- Ensuring equipment trolley is set up as normal after the procedure
- Organise appointments and ensure all booked correctly
- Confirm attendance with patients prior to appointment and remind them to bring Nexplanon device where necessary

Minimum Stock Levels

IUS

- 5 Mirena
- 2 Kyleena
- Benilexa, Levosert and Jaydess can be prescribed if needed.

IUD

- 5 T-Safe 380A QL (10 year)
- 5 Neo-Safe T380 (5 year)
- Other IUD's can be prescribed if needed.

Implant

- Must be prescribed and brought to the appointment.

Injection

- 10 Depo-Provera

References

1. https://portal.e-lfh.org.uk/myElearning/Index?HierarchyId=0_44791&programmeId=44791
2. https://www.fsrh.org/documents/ceuguidanceintrauterinecontraception/
3. https://www.fsrh.org/standards-and-guidance/fsrh-guidelines-and-statements/method-specific/progestogen-only-injectables/
4. https://www.fsrh.org/standards-and-guidance/fsrh-guidelines-and-statements/method-specific/progestogen-only-implants/
5. https://www.resus.org.uk/sites/default/files/2021-04/Anaphylaxis%20algorithm%202021.pdf
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