INTRAUTERINE CONTRACEPTION (IUC)

Intrauterine contraception (IUC) is highly effective and long-acting. The licensed duration of use of IUC ranges from 3 to 10 years. IUC is significantly more cost effective than shorter-acting methods due to very low failure rates and requirement for very minimal action by the user apart from undergoing the initial insertion procedure.

IUC comprises two types:

- Copper-bearing intrauterine device (Cu-IUD)
- Levonorgestrel-releasing intrauterine system (LNG-IUS).

FSRH guidance on IUC[1] is available on the FSRH website.

Copper-bearing intrauterine device (Cu-IUD)
Cu-IUDs have copper on their central stems and may also be banded with copper sleeves on the arms. The surface area from which copper is released varies between devices. In general, banded Cu-IUDs which have the higher surface areas of copper are the most effective and long-lasting so are recommended as the first-choice copper devices.

Levonorgestrel-releasing intrauterine system (LNG-IUS)
Several LNG-IUS devices are now available with two dosages of LNG. The 13.5 mg LNG-IUS (releasing 6 µg LNG/day) is licensed for 3 years and the 52 mg LNG-IUS (releasing 20 µg LNG/day) for 5 years. Although there are significantly more data for the 52 mg LNG-IUS, the categories within the UKMEC can be extrapolated to the 13.5 mg LNG-IUS.

Intrauterine Contraception (IUC) Copper-bearing IUD (Cu-IUD) Levonorgestrel-releasing IUS (LNG-IUS)	**IUC does not protect against STI/HIV. If there is a risk of STI/HIV (including during pregnancy or postpartum), the correct and consistent use of condoms is recommended, either alone or with another method of contraception. Male condoms reduce the risk of STI/HIV.**		
CONDITION *See additional comments at end of section	**CATEGORY** **I = Initiation,** **C = Continuation**		**CLARIFICATION/EVIDENCE**
	Cu-IUD	**LNG-IUS**	
PERSONAL CHARACTERISTICS AND REPRODUCTIVE HISTORY			
Pregnancy	NA	NA	**Clarification:** Most pregnancies which occur in women using IUC will be intrauterine, but ectopic pregnancy must be excluded. Women who become pregnant whilst using IUC should be informed of the increased risks of second-trimester septic miscarriage, preterm delivery and infection if the IUC is left *in situ*. Women who are pregnant with IUC *in situ* and wish to continue with the pregnancy should be informed that, when possible, IUC removal reduces the risk of an adverse outcome. However, removal itself carries a small risk of miscarriage. Whether or not IUC is removed, pregnant women should be advised to seek medical care if they develop heavy bleeding, cramping pain, abnormal vaginal discharge or fever.[1]
Age			
a) Menarche to <20 years	2	2	**Evidence:** Risks of pregnancy, infection and perforation are low among IUC users of all ages. Removals for bleeding issues do not appear to be related to age. Younger women using IUC may have an increased risk of expulsion compared with older women.[2–18]
b) ≥20 years	1	1	
Parity			
a) Nulliparous	1	1	**Evidence:** Risks for expulsion, perforation, pregnancy and infection are low among all IUC users and differences by parity may not be clinically meaningful. Data do not suggest an increased delay in return to fertility for nulliparous IUC users.[2,4,8–11]
b) Parous	1	1	

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	Cu-IUD	**LNG-IUS**	
Postpartum (in breastfeeding or non-breastfeeding women, including post-caesarean section)			
a) 0 to <48 hours	1	1	**Evidence:** A systematic review concludes that insertion of an IUC within the first 48 hours of vaginal or caesarean delivery is safe. Post-placental insertion and insertion between 10 minutes and 48 hours after delivery result in higher expulsion rates than insertion 4–6 weeks postpartum or non-postpartum insertion. Insertion at the time of a caesarean section is associated with lower expulsion rate than post-placental insertion at the time of vaginal delivery.[19] There are limited data on insertion between 48 hours and 4 weeks. Three cohort studies[20–22] of poor to fair quality compare outcomes of post-placental Cu-IUD insertion with insertion between 10 minutes and 72 hours after delivery. The studies show a wide range of expulsion rates; one study reports an expulsion rate of >70%.[22] The rate of uterine perforation associated with IUC use is very low. The most important risk factors for uterine perforation are insertion during lactation and insertion in the 36 weeks after giving birth.[23] The majority of studies show no significant differences in breastfeeding outcomes in women using LNG-IUS with insertion either immediately postpartum or after 4 weeks.[24–30]
b) 48 hours to <4 weeks	3	3	
c) ≥4 weeks	1	1	
d) Postpartum sepsis	4	4	**Clarification:** Immediate insertion of an IUC may substantially worsen the condition.

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	Cu-IUD	**LNG-IUS**	
Post-abortion			
a) First trimester	1	1	**Evidence**: IUC can be inserted immediately after first- or second-trimester, surgical or medical abortion.[31] **Evidence**: There is no difference in risk of complications for immediate versus delayed insertion of an IUC after abortion. Expulsion may be greater when an IUC is inserted following a second-trimester abortion versus following a first-trimester abortion.[31–50]
b) Second trimester	2	2	
c) Post-abortion sepsis	4	4	**Clarification:** Immediate insertion of an IUC may substantially worsen the condition.
Past ectopic pregnancy	1	1	
History of pelvic surgery	1	1	
Smoking			**Clarification:** UKMEC currently does not include use of e-cigarettes, as risks associated with their use are not yet established. **Evidence:** COC users who smoke are at an increased risk of CVD, especially MI, compared with those who do not smoke. Studies also show an increased risk of MI with an increasing number of cigarettes smoked per day.23–34 The 35 year age cut off is identified because any excess mortality associated with smoking is only apparent from this age.[51] The mortality rate from all causes (including cancers) decreases to that of a non-smoker within 20 years of smoking cessation. The cardiovascular disease (CVD) risk associated with smoking decreases within 1 to 5 years of smoking cessation.[51–53]
a) Age <35 years	1	1	
b) Age ≥35 years			
(i) <15 cigarettes/day	1	1	
(ii) ≥15 cigarettes/day	1	1	
(iii) Stopped smoking <1 year	1	1	
(iv) Stopped smoking ≥1 year	1	1	

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	Cu-IUD	**LNG-IUS**	
Obesity			
a) BMI ≥30–34 kg/m^2	1	1	
b) BMI ≥35 kg/m^2	1	1	
History of bariatric surgery			
a) With BMI <30 kg/m^2	1	1	
b) With BMI ≥30–34 kg/m^2	1	1	
c) With BMI ≥35 kg/m^2	1	1	
Organ transplant			
a) Complicated: graft failure (acute or chronic), rejection, cardiac allograft vasculopathy	**I** 3 / **C** 2	**I** 3 / **C** 2	**Evidence:** No comparative studies have examined IUC use among transplant patients. Four case reports of transplant patients using IUC provide inconsistent results, including beneficial effects and contraceptive failures.[54–57]
b) Uncomplicated	2	2	
CARDIOVASCULAR DISEASE (CVD)			
Multiple risk factors for CVD (such as smoking, diabetes, hypertension, obesity and dyslipidaemias)	1	2	

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	Cu-IUD	**LNG-IUS**	
Hypertension*			**Clarification:** For all categories of hypertension, classifications are based on the assumption **that no other risk factor for CVD exists.** When multiple risk factors do exist, risk of CVD may increase substantially. *Vascular disease* includes coronary heart disease presenting with angina, peripheral vascular disease presenting with intermittent claudication, hypertensive retinopathy and TIA.
a) Adequately controlled hypertension	1	1	
b) Consistently elevated blood pressure (BP) levels (properly taken measurements)			
(i) Systolic >140–159 mmHg or diastolic >90–99 mmHg	1	1	
(ii) Systolic ≥160 mmHg or diastolic ≥100 mmHg	1	1	
c) Vascular disease	1	2	
History of high BP during pregnancy	1	1	**Clarification:** When current BP is measurable and normal.
Current and history of ischaemic heart disease*	1	**I** 2 / **C** 3	**Clarification:** LNG-IUS may be continued if women develop ischaemic heart disease while using the method. Clinical judgement and assessment of pregnancy risk and other factors are required.
Stroke* [history of cerebrovascular accident, including transient ischaemic attack (TIA)]	1	**I** 2 / **C** 3	
Known dyslipidaemias	1	2	**Clarification:** Routine screening for these genetic mutations is not cost effective. Increased levels of total cholesterol, low-density lipoproteins (LDL) and triglycerides, as well as decreased levels of high-density lipoproteins (HDL), are known risk factors for CVD. Women with known, severe, genetic lipid disorders are at a much higher lifetime risk for CVD and may warrant further clinical consideration.

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	Cu-IUD	**LNG-IUS**	
Venous thromboembolism (VTE)*			**Clarification**: VTE includes deep vein thrombosis (DVT) and pulmonary embolism (PE) of any aetiology. **Evidence:** Limited evidence indicates that insertion of the LNG-IUS does not pose major bleeding risks in women on long-term anticoagulant therapy.[58–60] **Clarifications:** **Major surgery:** Includes major elective surgery (>30 minutes' duration) and all surgery on the legs, or surgery which involves prolonged immobilisation of a lower limb.[61] **Minor surgery:** Includes operations lasting <30 minutes with a short duration of anaesthesia (e.g. laparoscopic sterilisation or tooth extraction).[61]
a) History of VTE	1	2	
b) Current VTE (on anticoagulants)	1	2	
c) Family history of VTE			
(i) First-degree relative age <45 years	1	1	
(ii) First-degree relative age ≥45 years	1	1	
d) Major surgery			
(i) With prolonged immobilisation	1	2	
(ii) Without prolonged immobilisation	1	1	
e) Minor surgery without immobilisation	1	1	
f) Immobility (unrelated to surgery) (e.g. wheelchair use, debilitating illness)	1	1	
Superficial venous thrombosis			
a) Varicose veins	1	1	
b) Superficial venous thrombosis	1	1	
Known thrombogenic mutations (e.g. factor V Leiden, prothrombin mutation, protein S, protein C and antithrombin deficiencies)	1	2	**Clarification:** Routine screening for these genetic mutations is not cost effective. [62–89]

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	Cu-IUD	**LNG-IUS**	
Valvular and congenital heart disease			
a) Uncomplicated	1	1	**Clarification:** Uncomplicated cases can be considered where: there is (i) no requirement for cardiac medication, (ii) the woman is asymptomatic and (iii) a cardiology review is required annually or less. If in doubt, discussion with a specialist cardiologist is advised. *Valvular heart* disease: Occurs when any of the heart valves are stenotic and/or incompetent (e.g. aortic stenosis, mitral regurgitation, tricuspid valve abnormalities, pulmonary stenosis).[90] *Congenital heart disease*: Aortic stenosis, atrial septal defects, atrioventricular septal defect, cardiomyopathy (hypertrophic or dilated), coarctation of the aorta, complex transposition of the great arteries, Ebstein's anomaly; Eisenmenger syndrome, patent ductus arteriosus, pulmonary atresia, pulmonary stenosis, tetralogy of Fallot, total anomalous pulmonary venous connection, tricuspid atresia, truncus arteriosus, ventricular septal defect.[90] Prophylaxis against bacterial endocarditis is no longer indicated for women with artificial heart valves or previous endocarditis when inserting or removing IUC.[91,92] However, this does not necessarily mean that there is no risk.[1]
b) Complicated (e.g. pulmonary hypertension, history of subacute bacterial endocarditis)	2	2	

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Cardiomyopathy					
a) Normal cardiac function	1		1		**Clarification**: A woman who is not on cardiac medication can be considered as having normal cardiac function.
b) Impaired cardiac function	2		2		**Evidence:** No direct evidence exists on the safety of IUC among women with cardiomyopathy. Limited indirect evidence from non-comparative studies does not demonstrate any cases of arrhythmia or infective endocarditis in women with cardiac disease who used IUC.[93,94] **Clarification:** IUC insertion may induce cardiac arrhythmias in women with cardiomyopathy. The IUC should be fitted in a hospital setting as a vasovagal reaction presents a particularly high risk of cardiac events.[91]
Cardiac arrhythmias					
a) Atrial fibrillation	1		2		
b) Known long QT syndrome	**I**	**C**	**I**	**C**	**Clarification:** Cervical stimulation during the insertion of intrauterine methods can cause a vasovagal reaction including bradycardia, which increases the risk of a cardiac event in women with long QT syndrome. The IUC should be fitted in a hospital setting if vasovagal reaction presents a particularly high risk of cardiac events.[91]
	3	1	3	1	

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NEUROLOGICAL CONDITIONS			
Headaches			
a) Non-migrainous (mild or severe)	1	1	**Clarification:** Headache is a common condition affecting women of reproductive age. There is no identified evidence which specifically considers migraine in women using an LNG-IUS. Classification depends on making an accurate diagnosis of those severe headaches that are migrainous and, in addition, those complicated by aura.[95–97] See additional resource on diagnosis of migraines with or without aura.
b) Migraine without aura, at any age	1	2	
c) Migraine with aura, at any age	1	2	
d) History (≥5 years ago) of migraine with aura, any age	1	2	
Idiopathic intracranial hypertension (IIH)	1	1	
Epilepsy	1	1	
Taking anti-epileptic drugs	Certain anti-epileptic drugs have the potential to affect the bioavailability of steroid hormones in hormonal contraception. Additionally, hormonal contraception may affect the levels of certain anti-epileptic drugs with potential adverse effects. For up-to-date information on the potential drug interactions between hormonal contraception and anti-epileptic drugs, please refer to the online drug interaction checker available on Stockley's Interaction Checker website.[98]		
DEPRESSIVE DISORDERS			
Depressive disorders	1	1	**Clarification**: The classification is based on data for women with selected depressive disorders. No data are available on bipolar disorder or postpartum depression.

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BREAST AND REPRODUCTIVE TRACT CONDITIONS					
Vaginal bleeding patterns*					
a) Irregular pattern without heavy bleeding	1		1		**Clarification:** Abnormal menstrual bleeding should raise suspicion of a serious underlying condition and be investigated appropriately.[99–102] **Evidence:** Evidence from studies examining the treatment effects of the 52 mg LNG-IUS among women with heavy or prolonged bleeding report no increase in adverse effects and finds the 52 mg LNG-IUS beneficial in treating heavy menstrual bleeding (HMB).[103–110]
b) Heavy or prolonged bleeding (includes regular and irregular patterns)	2		**I** 1	**C** 2	
Unexplained vaginal bleeding (suspicious for serious condition) before evaluation	**I** 4	**C** 2	**I** 4	**C** 2	**Clarification:** If pregnancy or an underlying pathological condition (such as pelvic malignancy) is suspected, it must be evaluated and the category adjusted accordingly. The IUC does not need to be removed before evaluation.
Endometriosis*	2		1		**Evidence:** 52 mg LNG-IUS use among women with endometriosis decreases dysmenorrhoea, pelvic pain and dyspareunia.[111–115]
Benign ovarian tumours (including cysts)	1		1		
Severe dysmenorrhoea*	2		1		

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Gestational trophoblastic disease (GTD)*			**Clarification:** Includes hydatidiform mole (complete and partial) and gestational trophoblastic neoplasia. **Evidence:** Limited evidence suggests that women using an IUC after uterine evacuation for a molar pregnancy are at no greater risk for gestational trophoblastic neoplasia than are women using other methods of contraception.[116–119]
a) Undetectable hCG levels	1	1	
b) Decreasing hCG levels	3	3	
c) Persistently elevated hCG levels or malignant disease	4	4	
Cervical ectropion	1	1	
Cervical intraepithelial neoplasia (CIN)*	1	2	
Cervical cancer*			
a) Awaiting treatment	**I** 4 / **C** 2	**I** 4 / **C** 2	**Clarification:** Concern exists about the increased risk of infection and bleeding at insertion. The IUC will normally be removed at the time of surgery, but until then the woman is at risk of pregnancy.
b) Radical trachelectomy	3	3	**Clarification:** Insertion of IUC should be conducted with caution in a specialist setting due to abnormal anatomy.

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Breast conditions					
a) Undiagnosed mass/breast symptoms	1		2		**Clarification:** Breast cancer is a hormonally sensitive tumour. Concerns about progression of the disease may be less with LNG-IUS than with COC or higher-dose POC. Use of the LNG-IUS in women with breast cancer for gynaecological reasons can be considered on an individual basis in consultation with the woman's oncology team.[1]
b) Benign breast conditions	1		1		
c) Family history of breast cancer	1		1		
d) Carriers of known gene mutations associated with breast cancer (e.g. BRCA1/BRCA2)	1		2		
e) Breast cancer					
(i) Current breast cancer	1		4		
(ii) Past breast cancer	1		3		
Endometrial cancer*	**I**	**C**	**I**	**C**	
	4	2	4	2	
Ovarian cancer*	1		1		
Uterine fibroids					
a) Without distortion of the uterine cavity	1		1		**Evidence:** Among women with uterine fibroids, evidence shows no adverse health events with 52 mg LNG-IUS use and a decrease in symptoms and size of fibroid. Most women experience improvements in serum levels of haemoglobin, haematocrit, ferritin and menstrual blood loss.[120–131]

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CONDITION *See additional comments at end of section	**CATEGORY** **I = Initiation,** **C = Continuation**		**CLARIFICATION/EVIDENCE**
	Cu-IUD	**LNG-IUS**	
b) With distortion of the uterine cavity	3	3	**Clarification**: In women with a distorted uterine cavity it may be appropriate to attempt insertion of IUC after discussion. **Evidence:** Available studies show that rates of 52 mg LNG-IUS expulsion are higher in women with uterine fibroids than in women without fibroids; however, these findings are either not statistically significant or significance testing was not conducted.[129, 132] Rates of expulsion from non-comparative studies ranged from 0% to 20%.[126–131]
Anatomical abnormalities			
a) Distorted uterine cavity	3	3	**Clarification:** Includes any congenital or acquired uterine abnormality distorting the uterine cavity in a manner that is incompatible with IUC insertion. In some women with a distorted uterine cavity it may be appropriate to attempt insertion of IUC after discussion.
b) Other abnormalities	2	2	**Clarification:** Includes cervical stenosis or cervical lacerations not distorting the uterine cavity or interfering with IUC insertion.

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Intrauterine Contraception (IUC) Copper-bearing IUD (Cu-IUD) Levonorgestrel-releasing IUS (LNG-IUS)	IUC does not protect against STI/HIV. If there is a risk of STI/HIV (including during pregnancy or postpartum), the correct and consistent use of condoms is recommended, either alone or with another method of contraception. Male condoms reduce the risk of STI/HIV.		
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Pelvic inflammatory disease (PID)					
a) PID (assuming no current risk factors for STIs)	1		1		**Clarification:** ***Initiation:*** For routine IUC insertion, women with symptomatic pelvic infection should be tested for and treated. Insertion should be delayed until symptoms have resolved. Appropriate provision of alternative contraception should be provided until the IUC can be inserted.[1] ***Continuation:*** For women with symptomatic pelvic infection, treat using appropriate antibiotics and perform testing for STIs. There is usually no need to remove the IUC if the woman wishes to continue its use.[1] Continued use of an IUC depends on the woman's informed choice and her current risk factors for STIs and PID. Among IUC users treated for PID, there is no difference in clinical course if the IUC is removed or left in place.[133–135]
b) Current PID	**I**	**C**	**I**	**C**	
	4	2	4	2	

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	Cu-IUD	**LNG-IUS**	

Sexually transmitted infections (STIs)					
a) Chlamydial infection (current)	I	C	I	C	**Clarification for chlamydia:** In a woman with asymptomatic infection in an emergency situation (i.e. EC), the IUC can be inserted without delay on the same day as treatment is instituted.[1] **Clarification for Initiation:** Screening for STIs in advance of insertion (when indicated or requested) will allow infection to be treated before insertion. If results are unavailable before insertion then prophylactic antibiotics should be considered for women at higher risk of STIs at time of insertion. The antibiotic regimen chosen should cover *Chlamydia trachomatis*. **Clarification for continuation:** Treat the STI using appropriate antibiotics. The IUC usually does not need to be removed if the woman wishes to continue using it. Continued use of an IUC depends on the woman's informed choice and her current risk factors for STIs and PID.[1] **Evidence:** There is no evidence whether IUC insertion among women who contract STIs increases the risk for PID over that of women with no IUC insertion. Among women who have IUC inserted, the absolute risk for subsequent PID is low among women with an STI at the time of insertion but greater than among women with no STI at the time of IUC insertion.[136–145]
(i) Symptomatic	4	2	4	2	
(ii) Asymptomatic	3	2	3	2	
b) Purulent cervicitis or gonorrhoea (current)	4	2	4	2	
c) Other current STIs (excluding HIV and hepatitis)	2		2		
d) Vaginitis (including *Trichomonas vaginalis* and bacterial vaginosis) (current)	2		2		

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e) Increased risk for STIs	2	2	**Clarification:** IUC insertion may further increase the risk of PID among women at increased risk of STIs, although limited evidence suggests that this risk is low. Risk of STIs varies by individual behaviour and local STI prevalence. Therefore, while many women at increased risk of STIs can have IUC inserted, some women at very high risk of STIs may be advised to wait appropriate testing and treatment occur. **Evidence:** One small study shows a low incidence of PID after IUC insertion (2.2%) in a cohort of women considered to be high risk.[137] Another study reports that 11% of women classed as at high STI risk experienced IUC-related complications compared with 5% of those not classified as high risk.[141]
HIV INFECTION			
HIV infection*			
a) High risk of HIV infection	1	1	Evidence: High-quality evidence from one randomised controlled trial observed no statistically significant differences in HIV acquisition between: DMPA-IM versus Cu-IUD, DMPA-IM versus LNG implant, and Cu-IUD versus LNG implant. Of the low-to-moderate-quality evidence from 14 observational studies, some studies suggested a possible increased risk of HIV with progestogen-only injectable use, which was most likely due to unmeasured confounding. Low-quality evidence from 3 observational studies did not suggest an increased HIV risk for implant users. No studies of sufficient quality were identified for POP or etonogestrel implant.

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b) HIV infected					
(i) CD4 count ≥200 cells/mm^3	2		2		**Clarification:** The initiation of an IUC method may be appropriate in some women with low CD4 counts who have an undetectable viral load. **Evidence**: Among IUC users, limited evidence shows no increased risk of infection or overall complications when comparing HIV-infected with non-infected women. IUC use is not found to adversely affect progression of HIV when compared to hormonal contraception use among HIV-infected women. IUC use among HIV-infected women is not associated with increased risk of transmission to sexual partners.[157–165] No difference is found in antiretroviral therapy initiation or CD4 count between users and non-users of the LNG-IUS.[166]
(ii) CD4 count <200 cells/mm^3	**I**	**C**	**I**	**C**	
	3	2	3	2	
c) Taking antiretroviral (ARV) drugs	Certain ARV drugs have the potential to affect the bioavailability of steroid hormones in hormonal contraception. For up-to-date information on the potential drug interactions between hormonal contraception and ARV drugs, please refer to the online HIV drugs interaction checker.[167]				
OTHER INFECTIONS					
Tuberculosis*					
a) Non-pelvic	1		1		
b) Pelvic	**I**	**C**	**I**	**C**	
	4	3	4	3	

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ENDOCRINE CONDITIONS			
Diabetes			
a) History of gestational disease	1	1	
b) Non-vascular disease			**Evidence:** Limited evidence on the use of the LNG-IUS among women with insulin-dependent or non-insulin-dependent diabetes suggests that these methods have little effect on short- or long-term diabetes control (e.g. glycosylated haemoglobin levels), haemostatic markers or lipid profile.[168,169]
(i) Non-insulin dependent	1	2	
(ii) Insulin-dependent	1	2	
c) Nephropathy/retinopathy/ neuropathy	1	2	
d) Other vascular disease	1	2	
Thyroid disorders			
a) Simple goitre	1	1	
b) Hyperthyroid	1	1	
c) Hypothyroid	1	1	
GASTROINTESTINAL CONDITIONS			
Gallbladder disease			
a) Symptomatic			
(i) Treated by cholecystectomy	1	2	
(ii) Medically treated	1	2	
(iii) Current	1	2	
b) Asymptomatic	1	2	

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History of cholestasis			
a) Pregnancy related	1	1	
b) Past-COC related	1	2	
Viral hepatitis*			
a) Acute or flare	1	1	
b) Carrier	1	1	
c) Chronic	1	1	
Cirrhosis*			
a) Mild (compensated without complications)	1	1	**Clarification:** *Severe (decompensated) cirrhosis:* development of major complications (ascites, jaundice, encephalopathy or gastrointestinal haemorrhage).[170]
b) Severe (decompensated)	1	3	
Liver tumours*			
a) Benign			
(i) Focal nodular hyperplasia	1	2	
(ii) Hepatocellular adenoma	1	3	
b) Malignant (hepatocellular carcinoma)	1	3	
Inflammatory bowel disease (IBD)* (including Crohn's Disease and ulcerative colitis)	1	1	
ANAEMIAS			
Thalassaemia*	2	1	
Sickle cell disease*	2	1	

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Iron deficiency anaemia*	2	1	
RHEUMATIC DISEASES			
Rheumatoid arthritis	1	2	
Systemic lupus erythematosus (SLE)			**Clarification:** People with SLE are at increased risk of ischaemic heart disease, stroke and VTE and this is reflected in the categories given. Available evidence indicates that many women with SLE can be considered good candidates for most methods of contraception, including hormonal contraception.[171–189]
a) No antiphospholipid antibodies	1	2	
b) Positive antiphospholipid antibodies	1	2	
Positive antiphospholipid antibodies	1	2	**Clarification:** Positive antiphospholipid antibodies (aPL) is not itself a disease state and in the absence of manifestations of the antiphospholipid syndrome a stratification of risk with specialist advice if necessary is recommended. In particular, persistence of aPL positivity, high titre of aPL, lupus anticoagulant (LA) positivity, triple positivity for anticardiolipin antibodies (aCL), anti-β2-glycoprotein I (βgPI) and LA and immunoglobulin G (IgG) aPL have greater risk for future events.[190–192]
DRUG INTERACTIONS			
Taking medication	See section on drug interactions with hormonal contraception.		

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Additional Comments

HYPERTENSION, CURRENT AND HISTORY OF ISCHAEMIC HEART DISEASE, STROKE
There is theoretical concern about the effect of LNG on lipids. There is no restriction for Cu-IUD.

VENOUS THROMBOEMBOLISM (VTE)
The LNG-IUS may be a useful treatment for HMB in women on long-term anticoagulation therapy.

VAGINAL BLEEDING PATTERNS
LNG-IUS use frequently causes changes in menstrual bleeding patterns. Over time, LNG-IUS users are more likely than non-users to become amenorrhoeic particularly if they have a 52 mg LNG-IUS fitted. 52mg LNG-IUS are used as a treatment for HMB.

ENDOMETRIOSIS
Cu-IUD use may worsen dysmenorrhoea associated with the condition.

SEVERE DYSMENORRHOEA
Dysmenorrhoea may intensify with Cu-IUD use. LNG-IUS use has been associated with reduction of dysmenorrhoea.

GESTATIONAL TROPHOBLASTIC DISEASE (GTD)
There is theoretical concern about increased risk of perforation in the presence of persistent molar tissue.

CERVICAL INTRAEPITHELIAL NEOPLASIA (CIN)
There is some theoretical concern that progestogens may enhance progression of CIN.

CERVICAL CANCER
Awaiting treatment: There is concern about the increased risk of infection and bleeding at insertion. The IUC may need to be removed at the time of treatment but, until then, the woman is at risk of pregnancy.

ENDOMETRIAL CANCER
There is concern about the increased risk of infection, perforation and bleeding at insertion.

The IUC may need to be removed at the time of treatment but, until then, the woman is at risk of pregnancy.

OVARIAN CANCER

The IUD may need to be removed at the time of treatment but, until then, the woman is at risk of pregnancy.

HIV INFECTION

Women with HIV infection often have co-morbidities that may influence their choice of contraception.

TUBERCULOSIS

Pelvic: Insertion of an IUC may substantially worsen the condition.

VIRAL HEPATITIS AND CIRRHOSIS

POC are metabolised by the liver and their use may adversely affect women whose liver function is compromised.

LIVER TUMOURS

POC are metabolised by the liver and their use may adversely affect women whose liver function is compromised. No evidence is available regarding hormonal contraceptive use in women with hepatocellular adenoma. COC use is associated with growth of hepatocellular adenoma, but it is still unknown whether other hormonal contraceptives have similar effects.

INFLAMMATORY BOWEL DISEASE (IBD)

Risk of VTE may increase in women who are unwell, bed-bound or undergoing emergency or major surgery and prolonged immobilisation. Under these circumstances the use of the Cu-IUD or LNG-IUS is safe.

THALASSAEMIA, SICKLE CELL DISEASE, IRON-DEFICIENCY ANAEMIA

There is concern about an increased risk of blood loss with Cu-IUD. However, LNG-IUS is generally associated with reduced blood loss.