Progestogen-only Contraception (POC)

The section on progestogen-only contraception (POC) includes the following methods:

- Progestogen-only implant (IMP)
- Progestogen-only injectable: depot medroxyprogesterone acetate (DMPA)
- Progestogen-only pill (POP).

FSRH guidance on the IMP,[1] progestogen-only injectable[2] and POP[3] is available on the FSRH website.

Progestogen-only implant (IMP)
The recommendations in the UKMEC refer to the single-rod implant containing 68 mg etonogestrel licensed for 3 years of use in the UK. For women using LNG implants the UKMEC categories are considered the same as for etonogestrel implants.

Progestogen-only injectables: depot medroxyprogesterone acetate (DMPA)
The recommendations in the UKMEC refer to DMPA given intramuscularly (IM) or subcutaneously (SC) at 13-weekly intervals.[2]

The available evidence reviewed by the UKMEC GDG suggests that DMPA-SC and DMPA-IM appear to be therapeutically equivalent with similar safety profiles when used by healthy women. The GDG considers the evidence available for DMPA-IM to be applicable to DMPA-SC and, therefore, DMPA-SC should have the same categories as DMPA-IM. This is presented in the UKMEC tables as the method 'DMPA'. For women using intramuscular norethisterone enantate (NET-EN), which is not licensed in the UK for long-term contraception, the UKMEC categories are considered the same as for DMPA.

There are theoretical concerns that higher doses of progestogen in injectables and longer duration of action may be associated with increased risk compared to IMP and POP in some conditions. The higher UKMEC classifications reflect this.

Progestogen-only pill (POP)

The recommendations in the UKMEC refer to the POP currently available in the UK which contain either norethisterone (NET) 350 µg, LNG 30 µg or desogestrel (DSG) 75 µg.

Theoretically, the DSG pill may be expected to be more effective than traditional POP, especially with typical use, because ovulation is suppressed more consistently and it has a longer missed pill window.[4]

Progestogen-only Contraception (POC) Progestogen-only pill (POP) Progestogen-only injectable: depot medroxyprogesterone acetate (DMPA) Progestogen-only implant (IMP)	POC do 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 contraception method. Male condoms reduce the risk of STI/HIV.			
CONDITION *See additional comments at end of section	**CATEGORY** I = Initiation, C = Continuation			**CLARIFICATION/EVIDENCE**
	IMP	DMPA	POP	
PERSONAL CHARACTERISTICS AND REPRODUCTIVE HISTORY				
Pregnancy	NA	NA	NA	**Clarification**: There is no known harm to the woman, the course of pregnancy or the fetus if POC is accidentally used during pregnancy.
Age				
a) Menarche to <18 years	1	2	1	**Clarification:** A guideline from the National Institute for Health and Care Excellence (NICE) recommends that women should be informed that use of DMPA is associated with a small reduction in bone mineral density (BMD) but this usually recovers after discontinuation. Evidence for any long-term effects of DMPA on BMD in women aged <18 years is lacking.[5] Evidence on long-term fracture risk is sparse but women choosing to continue DMPA should be reviewed every 2 years to assess individual situations and to discuss the risks and benefits. Women should be supported in their choice of whether or not to continue.[2] In women aged <18 years, DMPA can be used as a first-line option after consideration of other methods.[6]
b) 18–45 years	1	1	1	
c) >45 years	1	2	1	
Parity				
a) Nulliparous	1	1	1	
b) Parous	1	1	1	

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CONDITION *See additional comments at end of section	**CATEGORY** I = Initiation, C = Continuation			**CLARIFICATION/EVIDENCE**
	IMP	DMPA	POP	
Postpartum (in breastfeeding women)				
a) 0 to <6 weeks	1	2	1	**Evidence:** Direct evidence demonstrates no harmful effect of POC on breastfeeding performance[7–54] and generally demonstrates no harmful effects on infant growth, health or development.[15,30,39,45]
b) ≥6 weeks to <6 months (primarily breastfeeding)	1	1	1	
c) ≥6 months	1	1	1	
Postpartum (in non-breastfeeding women)				
a) 0 to <3 weeks				**Clarification:** This includes any births, including stillbirths from 24 weeks' gestation. **Clarification:** POC may be safely used by non-breastfeeding women immediately postpartum, although they are not required for contraception until Day 21.[55,56] **Clarification**: Other risk factors for VTE, such as immobility, transfusion at delivery, BMI >30 kg/m^2, postpartum haemorrhage, immediately post-caesarean delivery, pre-eclampsia or smoking may pose an additional increased risk for VTE.
(i) With other risk factors for VTE	1	2	1	
(ii) Without other risk factors	1	2	1	
b) 3 to <6 weeks				
(i) With other risk factors for VTE	1	2	1	
(ii) Without other risk factors	1	1	1	
c) ≥6 weeks	1	1	1	
Post-abortion				
a) First trimester	1	1	1	**Clarification:** Includes induced abortions and spontaneous miscarriages <24 weeks' gestation. POC can be started immediately following surgical abortion or medical abortion.[57]
b) Second trimester	1	1	1	
c) Post-abortion sepsis	1	1	1	

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	IMP	DMPA	POP	
Past ectopic pregnancy	1	1	1	**Clarification:** All POC reduce the risk of pregnancy (intrauterine and extrauterine).
History of pelvic surgery	1	1	1	
Smoking				**Clarification:** UKMEC currently does not include use of e-cigarettes, as risks associated with their use are not yet established. POC do not appear to increase the risk of CVD even in smokers.[58–61] The mortality rate from all causes (including cancers) decreases to that of a non-smoker within 20 years of smoking cessation. The CVD risk associated with smoking decreases within 1 to 5 years of smoking cessation.[61-64] The 35 year age cut-off is identified because any excess mortality associated with smoking is only apparent from this age.[64]
a) Age <35 years	1	1	1	
b) Age ≥35 years				
(i) <15 cigarettes/day	1	1	1	
(ii) ≥15 cigarettes/day	1	1	1	
(iii) Stopped smoking <1 year	1	1	1	
(iv) Stopped smoking ≥1 year	1	1	1	
Obesity				
a) BMI ≥30–34 kg/m^2	1	1	1	**Evidence:** Weight gain is common. Among adult women, there is generally no association between baseline weight and weight gain among DMPA users compared with non-users. Evidence is mixed for adolescent DMPA users, with some studies observing greater weight gain among obese women compared with normal weight users, yet other studies showing no association. Data on other POC methods and weight issues are limited.[65–82]
b) BMI ≥35 kg/m^2	1	1	1	

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	IMP	DMPA	POP	
History of bariatric surgery				
a) With BMI <30 kg/m^2	1	1	1	**Clarification:** Bariatric surgical procedures involving a malabsorptive component have the potential to decrease oral contraception effectiveness, perhaps further decreased by postoperative complications such as long-term diarrhoea and/or vomiting. **Evidence:** Limited evidence demonstrates no substantial decrease in effectiveness of oral contraception among women who underwent laparoscopic placement of an adjustable gastric band.[83] Limited evidence demonstrates no substantial decrease in effectiveness of oral contraception among women who undergo a biliopancreatic diversion;[84] however, evidence from pharmacokinetic studies suggests conflicting results of oral contraception effectiveness among women who undergo a jejuno-ileal bypass.[85,86]
b) With BMI ≥30–34 kg/m^2	1	1	1	
c) With BMI ≥35 kg/m^2	1	1	1	
Organ transplant				
a) Complicated: graft failure (acute or chronic), rejection, cardiac allograft vasculopathy	2	2	2	
b) Uncomplicated	2	2	2	
CARDIOVASCULAR DISEASE (CVD)				
Multiple risk factors for CVD (such as smoking, diabetes, hypertension, obesity and dyslipidaemias)	2	3	2	**Clarification**: When multiple major risk factors exist, the risk of CVD may increase substantially.

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	IMP	DMPA	POP	
Hypertension*				For all categories of hypertension, classifications are based on the assumption **that no other risk factor for CVD exist.** When multiple risk factors do exist, risk of CVD may increase substantially. **Clarification:** Women adequately treated for hypertension are at a reduced risk of acute myocardial infarction (MI) and stroke compared with untreated hypertensive women. Although there are no data, POC users with adequately controlled and monitored hypertension should be at reduced risk of acute MI and stroke compared with untreated hypertensive POC users. Antihypertensive therapy may be initiated when the BP is consistently 160/100 mmHg or greater.[87] **Evidence:** Limited evidence suggests that among women with hypertension, those who used POP or DMPA have a small increased risk of cardiovascular events compared with women who do not use these methods.[58]
a) Adequately controlled hypertension	1	2	1	
b) Consistently elevated BP levels (properly taken measurements)				
(i) Systolic >140–159 mmHg or diastolic >90–99 mmHg	1	1	1	
(ii) Systolic ≥160 mmHg or diastolic ≥100 mmHg	1	2	1	
c) Vascular disease	2	3	2	**Clarification:** *Vascular disease* includes: coronary heart disease presenting with angina, peripheral vascular disease presenting with intermittent claudication, hypertensive retinopathy and TIA.

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	IMP	DMPA	POP	
History of high BP during pregnancy	1	1	1	**Clarification:** Where current BP is measurable and normal.
Current and history of ischaemic heart disease*	**I** 2 / **C** 3	3	**I** 2 / **C** 3	**Clarification:** The duration of use of POC in relation to the onset of disease should be carefully considered when deciding whether or not continuation of the method is appropriate. **Evidence:** Cohort studies do not show an increased risk of MI and stroke in users of POC.[58,88]
Stroke* (history of cerebrovascular accident, including TIA)	**I** 2 / **C** 3	3	**I** 2 / **C** 3	
Known dyslipidaemias	2	2	2	**Clarification:** Routine screening for these genetic mutations is not cost effective. Increased levels of total cholesterol, LDL and triglycerides, as well as decreased levels of HDL, are known risk factors for CVD. Women with known, severe, genetic lipid disorders are at much higher lifetime risk for CVD and may warrant further clinical consideration.
Venous thromboembolism (VTE)				
a) History of VTE	2	2	2	**Clarification:** Includes DVT and PE.
b) Current VTE (on anticoagulants)	2	2	2	**Evidence**: There is no direct evidence on the use of POC among women with DVT/PE on anticoagulant therapy. Although evidence on the risk of VTE with the use of POC is inconsistent in otherwise healthy women, any small increased risk is substantially less than that with COC.[58,88,89] Limited evidence indicates that DMPA-IM in women on chronic anticoagulation therapy does not pose a significant risk of haematoma at the injection site or increase the risk of heavy or irregular vaginal bleeding.[90,91]

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	IMP	DMPA	POP	
c) Family history of VTE				
(i) First-degree relative age <45 years	1	1	1	
(ii) First-degree relative age ≥45 years	1	1	1	
d) Major surgery				**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.[92] **Minor surgery:** Includes operations lasting <30 minutes with short duration of anaesthesia (e.g. laparoscopic sterilisation or tooth extraction).[92]
(i) With prolonged immobilisation	2	2	2	
(ii) Without prolonged immobilisation	1	1	1	
e) Minor surgery without immobilisation	1	1	1	
f) Immobility (unrelated to surgery) (e.g. wheelchair use, debilitating illness)	1	1	1	
Superficial venous thrombosis				
a) Varicose veins	1	1	1	
b) Superficial venous thrombosis	1	1	1	
Known thrombogenic mutations (e.g. factor V Leiden, prothrombin mutation, protein S, protein C and antithrombin deficiencies)	2	2	2	**Clarification**: Routine screening for these genetic mutations is not cost effective.[93–95]

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	IMP	DMPA	POP	
Valvular and congenital heart disease*				
a) Uncomplicated	1	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).[96] *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.[96]
b) Complicated (e.g. pulmonary hypertension, history of subacute bacterial endocarditis)	1	1	1	

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	IMP	DMPA	POP	
Cardiomyopathy				
a) Normal cardiac function	1	1	1	**Clarification:** A woman who is not on cardiac medication can be considered as having normal cardiac function. **Evidence:** No direct evidence exists on the safety of POC among women with cardiomyopathy. Limited indirect evidence from non-comparative studies of women with cardiac disease demonstrates few cases of hypertension, thromboembolism and heart failure in women with cardiac disease using POP and DMPA.[97,98]
b) Impaired cardiac function	2	2	2	
Cardiac arrhythmias				
a) Atrial fibrillation	2	2	2	
b) Known long QT syndrome	1	2	1	**Evidence:** Case reports suggest exacerbation of LQTS2 with use of DMPA as postpartum contraception.[99,100]

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	IMP	DMPA	POP	
NEUROLOGICAL CONDITIONS				
Headaches				
a) Non-migrainous (mild or severe)	1	1	1	**Clarification:** Headache is a common condition affecting women of reproductive age. **Evidence:** Few studies have specifically assessed migraine in POC users. Since there are no studies comparing active POC with placebo, the true effect of POC on migraine is not clear. However, there is no evidence that the use of progestogen-only POC is associated with an increased risk of ischaemic stroke.[101] Classification depends on making an accurate diagnosis of those severe headaches that are migrainous and, in addition, those complicated by aura.[101–103] See additional resource on diagnosis of migraines with or without aura.
b) Migraine without aura, at any age	2	2	I: 1, C: 2	
c) Migraine with aura, at any age	2	2	2	
d) History (≥5 years ago) of migraine with aura, any age	2	2	2	
Idiopathic intracranial hypertension (IIH)	1	1	1	
Epilepsy	1	1	1	
Taking anti-epileptic drugs	Certain anti-epileptic drugs have the potential to affect the bioavailability of steroid hormones in hormonal contraception. In addition, 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.[104]			

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	IMP	DMPA	POP	
Depressive disorders	1	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. **Evidence**: POC use is not shown to increase depressive symptoms in women with depression compared with baseline.[105–108]
BREAST AND REPRODUCTIVE TRACT CONDITIONS				
Vaginal bleeding patterns				
a) Irregular pattern without heavy bleeding	2	2	2	**Clarification:** Abnormal menstrual bleeding should raise suspicion of a serious underlying condition and be investigated appropriately.[109,110] Bleeding patterns in women using POC are often altered particularly in the initial months of use and may not settle with time.[110]
b) Heavy or prolonged bleeding (includes regular and irregular patterns)	2	2	2	
Unexplained vaginal bleeding* (suspicious for serious condition) before evaluation	3	3	2	**Clarification:** If pregnancy or an underlying pathological condition (such as pelvic malignancy) is suspected, it must be evaluated and the category adjusted after evaluation.[110]
Endometriosis	1	1	1	
Benign ovarian tumours (including cysts)	1	1	1	
Severe dysmenorrhoea	1	1	1	

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	IMP	DMPA	POP	
Gestational trophoblastic disease (GTD)				
a) Undetectable hCG levels	1	1	1	**Clarification:** Includes hydatidiform mole (complete and partial) and gestational trophoblastic neoplasia. A small study which included women using POP and DMPA concluded that current use of hormonal contraception is not associated with development of gestational trophoblastic neoplasia or delayed time to hCG remission.[111]
b) Decreasing hCG levels	1	1	1	
c) Persistently elevated hCG levels or malignant disease	1	1	1	
Cervical ectropion	1	1	1	
Cervical intraepithelial neoplasia (CIN)	1	2	1	**Evidence:** Among women with persistent human papilloma virus (HPV) infection, long-term DMPA use (≥5 years) may increase the risk of carcinoma *in situ* and invasive carcinoma.[112]
Cervical cancer*				
a) Awaiting treatment	2	2	1	**Clarification:** There is some theoretical concern that POC use could affect prognosis of the existing disease. While awaiting treatment, women may use POC.
b) Radical trachelectomy	2	2	1	

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	IMP	DMPA	POP	
Breast conditions				
a) Undiagnosed mass/breast symptoms	2	2	2	**Clarification:** Breast cancer is a hormonally sensitive tumour and therefore the prognosis of women with current or past breast cancer may be affected by hormonal methods of contraception.
b) Benign breast conditions	1	1	1	
c) Family history of breast cancer	1	1	1	
d) Carriers of known gene mutations associated with breast cancer (e.g. BRCA1/BRCA2)	2	2	2	
e) Breast cancer				**Clarification:** For women with a history of breast cancer, the decision to initiate hormonal contraception may be best made in consultation with the local oncology team.
(i) Current breast cancer	4	4	4	
(ii) Past breast cancer	3	3	3	
Endometrial cancer*	1	1	1	
Ovarian cancer*	1	1	1	
Uterine fibroids				
a) Without distortion of the uterine cavity	1	1	1	
b) With distortion of the uterine cavity	1	1	1	
Pelvic inflammatory disease (PID)				
a) Past PID (assuming no current risk factors for STIs)	1	1	1	
b) Current PID	1	1	1	

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CONDITION *See additional comments at end of section	**CATEGORY** I = Initiation, C = Continuation			**CLARIFICATION/EVIDENCE**
	IMP	DMPA	POP	
Sexually transmitted infections (STIs)				
a) Chlamydial infection (current)				**Evidence:** Limited evidence suggests that there may be an increased risk of chlamydial cervicitis among DMPA users at high risk of STIs. For other STIs, there is either evidence of no association between DMPA use and STI acquisition or evidence that is too limited to draw any conclusions. There is no evidence for other POC.[113–119]
(i) Symptomatic	1	1	1	
(ii) Asymptomatic	1	1	1	
b) Purulent cervicitis or gonorrhoea (current)	1	1	1	
c) Other current STIs (excluding HIV and hepatitis)	1	1	1	
d) Vaginitis (including *Trichomonas vaginalis* and bacterial vaginosis) (current)	1	1	1	
e) Increased risk for STIs	1	1	1	

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CONDITION *See additional comments at end of section	**CATEGORY** I = Initiation, C = Continuation			**CLARIFICATION/EVIDENCE**
	IMP	DMPA	POP	
HIV INFECTION				
HIV infection*				
a) High risk of HIV infection	1	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.[208]

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	IMP	DMPA	POP	
b) HIV infected				**Evidence:** Five studies suggest no association between use of progestogen-only injectables and progression of HIV, as measured by CD4 count <200 cells/mm^3, initiation of ART or mortality.[121–127] One randomised trial shows an increased risk of a composite outcome of declining CD4 count or death among oral contraceptive users (COC and POP) when compared with users of Cu-IUDs, but has significant confounders limiting its interpretation.[128,129] Most indirect studies measuring whether various hormonal contraception methods affect plasma HIV viral load find no effect.[130–146]
(i) CD4 count ≥200 cells/mm^3	1	1	1	
(ii) CD4 count <200 cells/mm^3	1	1	1	
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.[147]			
OTHER INFECTIONS				
Tuberculosis				
a) Non-pelvic	1	1	1	
b) Pelvic	1	1	1	

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	IMP	DMPA	POP	
ENDOCRINE CONDITIONS				
Diabetes*				
a) History of gestational disease	1	1	1	**Evidence**: POC has no adverse effects on serum lipid levels in women with a history of gestational diabetes according to two small studies.[148,149] Limited evidence is inconsistent regarding the development of non-insulin dependent diabetes among users of POC with a history of gestational diabetes.[150–154]
b) Non-vascular disease				
(i) Non-insulin dependent	2	2	2	**Evidence**: Among women with insulin or non-insulin dependent diabetes, limited evidence on the use of POC suggests that these methods have little effect on short-term or long-term diabetes control (e.g. HbA1c levels), haemostatic markers or lipid profile.[154–157]
(ii) Insulin-dependent	2	2	2	
c) Nephropathy/retinopathy/ neuropathy	2	2	2	
d) Other vascular disease	2	2	2	
Thyroid disorders				
a) Simple goitre	1	1	1	
b) Hyperthyroid	1	1	1	
c) Hypothyroid	1	1	1	

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	IMP	DMPA	POP	
GASTROINTESTINAL CONDITIONS				
Gallbladder disease				
a) Symptomatic				
(i) Treated by cholecystectomy	2	2	2	
(ii) Medically treated	2	2	2	
(iii) Current	2	2	2	
b) Asymptomatic	2	2	2	
History of cholestasis*				
a) Pregnancy related	1	1	1	
b) Past-COC related	2	2	2	
Viral hepatitis*				
a) Acute or flare	1	1	1	
b) Carrier	1	1	1	
c) Chronic	1	1	1	
Cirrhosis*				
a) Mild (compensated without complications)	1	1	1	**Clarification**: *Severe (decompensated) cirrhosis*: development of major complications (ascites, jaundice, encephalopathy or gastrointestinal haemorrhage).[158]
b) Severe (decompensated)	3	3	3	

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Liver tumours*				
a) Benign				**Evidence**: There is limited direct evidence that hormonal contraception use does not influence either progression or regression of liver lesions among women with focal nodular hyperplasia.[159–161] There is no evidence relating to use of hormonal contraception by women with other liver tumours.
(i) Focal nodular hyperplasia	2	2	2	
(ii) Hepatocellular adenoma	3	3	3	
b) Malignant (hepatocellular carcinoma)	3	3	3	
Inflammatory bowel disease (IBD)* (including Crohn's disease and ulcerative colitis)	1	1	2	**Evidence:** Risk for disease relapse among women with IBD using oral contraception (most studies do not specify whether it is POP or COC) does not increase significantly from that for non-users.[162–166]
ANAEMIAS				
Thalassaemia	1	1	1	
Sickle cell disease	1	1	1	**Evidence:** One systematic review concludes that among women with sickle cell disease, POC use does not have adverse effects on haematological parameters and, in some studies, proves beneficial with respect to clinical symptoms.[167–175]
Iron deficiency anaemia	1	1	1	

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RHEUMATIC DISEASES				
Rheumatoid arthritis	2	2	2	**Clarification:** Risk of CVD is increased among women with rheumatoid arthritis.[176] There is no evidence that POC are associated with reduced BMD or fragility fractures in women with rheumatoid arthritis. **Evidence:** Limited evidence shows no consistent pattern of improvement or worsening of rheumatoid arthritis with use of oral contraception.[177–184] (most studies do not specify whether it is POP or COC).
Systemic lupus erythematosus (SLE)				**Clarification:** Women with SLE are at an 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.[185-204]
a) No antiphospholipid antibodies	2	2	2	
b) Positive antiphospholipid antibodies	2	2	2	
Positive antiphospholipid antibodies	2	2	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.[205–207]
DRUG INTERACTIONS*				
Taking medication	See section on drug interactions with hormonal contraception.			

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Additional Comments

HYPERTENSION

A single reading of BP level is not sufficient to classify a woman as hypertensive. If elevated, the BP should be reassessed at the end of the consultation. If BP is increased, it should be re-assessed and monitored according to current guidelines.

CARDIOVASCULAR DISEASE, ISCHAEMIC HEART DISEASE AND STROKE

There is concern regarding hypoestrogenic effects and reduced HDL levels among users of DMPA. However, there is little concern about these effects with regard to POP or IMP. The effects of DMPA may persist for some time after discontinuation.

VALVULAR AND CONGENITAL HEART DISEASE, CARDIOMYOPATHY AND CARDIAC ARRHYTHMIAS

Stasis, endothelial injury and hyperviscosity (Virchow's triad) increase the risk of clot formation. Impaired cardiac function and/or dilated heart chambers or arrhythmia increase the risk of stasis. Closure of a cardiac defect within the last 6 months or presence of a mechanical heart valve increase the risk of thrombus formation. Cyanotic defects are associated with hyperviscosity because of erythrocytosis.

UNEXPLAINED VAGINAL BLEEDING

POC may cause irregular bleeding patterns which may mask symptoms of underlying pathology. The effects of DMPA may persist for some time after discontinuation.

CERVICAL, ENDOMETRIAL AND OVARIAN CANCER

While awaiting treatment, women with gynaecological cancers may use POC since the period of waiting is likely to be brief and pregnancy would be contraindicated.

CERVICAL CANCER

There is some theoretical concern that POC use could affect prognosis of cervical cancer.

HIV INFECTION

Women at high risk of HIV infection should be informed that progestogen-only injectables may or may not increase their risk of HIV acquisition. Women and couples at high risk of HIV acquisition considering DMPA should also be informed about and have access to HIV preventive measures, including male and female condoms.

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

DIABETES

There is concern regarding hypoestrogenic effects and reduced HDL levels among users of DMPA. The effects of DMPA may persist for some time after discontinuation.

HISTORY OF CHOLESTASIS

Theoretically, a history of COC-related cholestasis may predict subsequent cholestasis with POC use.

VIRAL HEPATITIS AND CIRRHOSIS

POC are metabolised by the liver and their use may adversely affect women whose liver function is compromised. This concern is similar to, but less than, that with COC.

LIVER TUMOURS

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

INFLAMMATORY BOWEL DISEASE (IBD)

Risk of VTE may increase if a woman is unwell, bed-bound or undergoing acute surgery, or with major surgery and prolonged immobilisation. Under these circumstances, POC can be continued.

Oral methods may be less reliable if there is significant malabsorption or small bowel resection (particularly with Crohn's disease). Oral methods are unaffected by colectomy and ileostomy.

DRUG INTERACTIONS

Generally, the safety of using POC is unaffected. Nevertheless, use of liver enzyme inducers may reduce contraception efficacy of POP and IMP, increasing the risk of an unintended pregnancy. DMPA is unaffected by liver enzyme inducing drugs and injection intervals need not be reduced. Contraception choice may depend on the likely duration of use of concurrent medications and need for additional or alternative methods.