Combined Hormonal Contraception (CHC)

The section on combined hormonal contraception (CHC) includes the following types:

- Combined oral contraception (COC)
- Combined contraception transdermal patches
- Combined contraception vaginal rings.

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

Combined oral contraception (COC)
The recommendations in the UKMEC refer to low-dose combined oral contraception (COC) containing ≤35 µg ethinylestradiol (EE) combined with a progestogen. Data relating to newer COC containing estradiol are very limited. Currently, UKMEC recommendations for these preparations are as for EE-containing COC. Recommendations in the UKMEC are the same for all COC formulations, irrespective of their progestogen content.

Venous thromboembolism (VTE) is rare among women of reproductive age. All COC are associated with an increased risk for VTE compared to non-use. Studies have found differences in risk for VTE associated with COC containing different progestogens. Current evidence suggests that COC containing LNG, NET and norgestimate are associated with the lowest risk. The absolute differences, however, are very small.[2]

Combined contraceptive transdermal patch and vaginal rings
The combined contraceptive patch and ring are relatively new contraception methods. Limited information is available on the short- and long-term safety of these methods among women with specific medical conditions. Most of the available studies received support from the manufacturers of these methods.

After reviewing the available limited evidence, the UKMEC GDG considers the evidence available for COC to be applicable to the combined contraceptive patch and ring, and therefore should have the same categories as COC. This is presented in the UKMEC tables as the method ‘CHC’.

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CONDITION *See additional comments at end of section	**CATEGORY** I = Initiation C = Continuation	**CLARIFICATION/EVIDENCE** Most evidence available relates to COC use. However, his evidence is also applied to use of the contraceptive patch and ring.

PERSONAL CHARACTERISTICS AND REPRODUCTIVE HISTORY		
Pregnancy	NA	**Clarification:** There is no known harm to the woman, the course of pregnancy or the fetus if CHC is accidentally used during pregnancy.
Age		
a) Menarche to <40 years	1	
b) ≥40 years	2	**Clarification:** Guidance from the FSRH supports use of CHC up to age 50 years if there are no medical contraindications to use.[2]
Parity		
a) Nulliparous	1	
b) Parous	1	
Postpartum (in breastfeeding women)		**Evidence**: One systematic review reports that the impact of COC on breastfeeding duration and success is inconsistent. Results are conflicting on whether early initiation of COC affects infant outcomes, but generally find no negative impact on infant outcomes with later initiation of COC.[3]
a) 0 to <6 weeks	4	
b) ≥6 weeks to <6 months (primarily breastfeeding)	2	
c) ≥6 months	1	

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Combined Hormonal Contraception (CHC) which includes **Combined oral contraception (COC)** **Combined contraceptive transdermal patch and vaginal ring**	**CHC 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.**	
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Postpartum (in non-breastfeeding women)		**Clarification:** This includes any births, including stillbirths from 24 weeks gestation. **Clarification**: In the presence of 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, use of CHC may pose an additional increased risk for VTE. **Evidence**: VTE risk is elevated during pregnancy and the postpartum period; this risk is most pronounced in the first 3 weeks after delivery, declining to near baseline levels by 42 days postpartum.[4–8] Use of CHC, which increase the risk of VTE in women of reproductive age, may pose an additional risk if used during this time.[9] Risk of pregnancy during the first 21 days postpartum is very low, but increases after that time in non-breastfeeding women; ovulation before first menses is common.[10-14]
a) 0 to <3 weeks		
(i) With other risk factors for VTE	4	
(ii) Without other risk factors	3	
b) 3 to <6 weeks		
(i) With other risk factors for VTE	3	
(ii) Without other risk factors	2	
c) ≥6 weeks	1	

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Post-abortion		**Clarification:** Includes induced abortions and spontaneous miscarriage <24 weeks gestation. **Clarification**: CHC may be started immediately post-abortion. **Evidence**: Women who start taking COC immediately after first-trimester medical or surgical abortion do not experience more side effects, adverse vaginal bleeding outcomes or clinically significant changes in coagulation parameters compared with women who use a placebo, an IUD, a non-hormonal contraception method or delayed COC initiation.[14-21] Limited evidence on women using the contraceptive ring immediately after first-trimester medical or surgical abortion suggests no serious adverse events and no infection related to use of the contraceptive ring during three cycles of follow-up post-abortion.[22]
a) First trimester	1	
b) Second trimester	1	
c) Post-abortion sepsis	1	
Past ectopic pregnancy	1	
History of pelvic surgery	1	

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Smoking		
a) Age <35 years	2	**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 becomes apparent from this age.[35] 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.[35–37]
b) Age ≥35 years		
(i) <15 cigarettes/day	3	
(ii) ≥15 cigarettes/day	4	
(iii) Stopped smoking <1 year	3	
(iv) Stopped smoking ≥1 year	2	
Obesity		**Clarification:** The absolute risk of VTE in women of reproductive age is low. The relative risk of VTE increases with CHC use. Nevertheless, the absolute risk of VTE in CHC users is still low. **Evidence:** The risk of VTE rises as BMI increases over 30 and rises further with BMI over 35. Use of CHC raises this inherent increased risk further.[28,34,38–41] Limited evidence suggests that obese women who use COC do not have a higher risk of acute MI or stroke than obese non-users.[34,42–44]
a) BMI ≥30–34 kg/m^2	2	
b) BMI ≥35 kg/m^2	3	

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History of bariatric surgery		**Comment:** UKMEC categories relate to safety of use. 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 undergo laparoscopic placement of an adjustable gastric band or biliopancreatic diversion.[45,46] However, evidence from pharmacokinetic studies report conflicting results of oral contraception effectiveness among women who undergo a jejunoileal bypass.[47,48]
a) With BMI <30 kg/m^2	1	
b) With BMI ≥30–34 kg/m^2	2	
c) With BMI ≥35 kg/m^2	3	
Organ transplant		
a) Complicated: graft failure (acute or chronic), rejection, cardiac allograft vasculopathy	3	**Clarification**: Women with Budd-Chiari syndrome should not use CHC because of the increased risk of thrombosis and graft rejection. **Evidence:** One study reports discontinuation of COC use in 2/26 (8%) women as a result of serious medical complications, and one case report recounts a woman developing cholestasis associated with high-dose COC use.[49–52]
b) Uncomplicated	2	

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CARDIOVASCULAR DISEASE (CVD)		
Multiple risk factors for CVD (such as smoking, diabetes, hypertension, obesity and dyslipidaemias)	3	**Clarification**: When a woman has multiple major risk factors, any of which alone would substantially increase the risk of CVD, use of CHC may increase her risk to an unacceptable level. However, a simple addition of categories for multiple risk factors is not intended; for example, a combination of two risk factors assigned a Category 2 may not necessarily warrant a higher category.
Hypertension*		**Clarification:** For all categories of hypertension, classifications are based on the assumption that no other risk factors for CVD exist. When multiple risk factors do exist, the risk of CVD may increase substantially. **Clarification:** Women adequately treated for hypertension are at reduced risk of acute MI and stroke compared to untreated women. Although there are no data, CHC users with adequately controlled and monitored hypertension should be at reduced risk of acute MI and stroke compared with untreated hypertensive CHC users. Antihypertensive therapy may be initiated when the BP is consistently 160/100 mmHg or higher.[53] **Evidence**: Among women with hypertension, COC users are at an increased risk of stroke, acute MI and peripheral arterial disease compared with non-users.[23,25,28,32-34,54–69] Discontinuation of COC in women with hypertension may improve BP control.[70]
a) Adequately controlled hypertension	3	
b) Consistently elevated BP levels (properly taken measurements)		
(i) Systolic >140–159 mmHg or diastolic >90–99 mmHg	3	
(ii) Systolic ≥160 mmHg or diastolic ≥100 mmHg	4	

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c) Vascular disease	4	**Clarification:** This includes coronary heart disease presenting with angina, peripheral vascular disease presenting with intermittent claudication, hypertensive retinopathy and TIA.
History of high BP during pregnancy	2	**Clarification:** Where current BP is measurable and normal. **Evidence:** COC users with a history of high BP in pregnancy have an increased risk of MI and VTE, compared with COC users who do not have a history of high BP during pregnancy. The absolute risks of acute MI and VTE in this population remained small.[34,56–58,60,71–76]
Current and history of ischaemic heart disease*	4	
Stroke* (history of cerebrovascular accident, including TIA)	4	
Known dyslipidaemias	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 a much higher lifetime risk for CVD and may warrant further clinical consideration.

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Venous thromboembolism (VTE)		
a) History of VTE	4	**Clarification:** VTE includes DVT and PE.
b) Current VTE (on anticoagulants)	4	***On anticoagulants:*** Women on anticoagulant therapy are at risk for gynaecological complications of therapy, such as haemorrhagic ovarian cysts and HMB. Hormonal contraception methods can be of benefit in preventing or treating these complications. When a contraception method is used as a therapy, rather than solely to prevent pregnancy, the risk/benefit ratio may differ and should be considered on a case-by-case basis.
c) Family history of VTE		***Family history of VTE:*** May alert clinicians to women who may have an increased risk but alone cannot identify with certainty an underlying thrombophilia.
(i) First-degree relative age <45 years	3	
(ii) First-degree relative age ≥45 years	2	
d) Major surgery		***Major and minor surgery***: CHC should preferably be discontinued (and adequate alternative contraception arrangements made) 4 weeks before major elective surgery (>30 minutes' duration) and all surgery on the legs or surgery which involves prolonged immobilisation of a lower limb; CHC should normally be recommenced at least 2 weeks after full mobilisation. POC may be offered as an alternative and the CHC restarted after mobilisation, as above. When discontinuation of CHC is not possible (e.g. after trauma or if a patient admitted for an elective procedure is still using CHC), thromboprophylaxis (with low molecular weight heparin and graduated compression hosiery) is advised. These recommendations do not apply to minor surgery with short duration of anaesthesia (e.g. laparoscopic sterilisation or tooth extraction), or to women using estrogen-free hormonal contraception.[77]
(i) With prolonged Immobilisation	4	
(ii) Without prolonged Immobilisation	2	
e) Minor surgery without immobilisation	1	
f) Immobility (unrelated to surgery) (e.g. wheelchair use, debilitating illness)	3	

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Superficial venous thrombosis*		
a) Varicose veins	1	**Evidence**: One study suggests that among women with varicose veins, the rate of VTE and superficial venous thrombosis is higher in COC users compared with non-users, however statistical significance is not reported and the number of events in this study is small.[78]
b) Superficial venous thrombosis	2	**Clarification**: Superficial venous thrombosis may be associated with an increased risk of VTE. **Evidence**: Among women with superficial venous thrombosis, the risk of VTE is higher in COC users compared with non-users.[79]
Known thrombogenic mutations (e.g. factor V Leiden, prothrombin mutation, protein S, protein C and antithrombin deficiencies)	4	**Clarification**: Routine screening for these genetic mutations is not cost effective.[80–82] **Evidence**: Among women with thrombogenic mutations, COC users have a two- to twenty-fold higher risk of thrombosis than non-users.[41,83–105]
Valvular and congenital heart disease*		
a) Uncomplicated	2	**Clarification:** Uncomplicated cases could be considered to be 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).[106] *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.[106]
b) Complicated (e.g. pulmonary hypertension, history of subacute bacterial endocarditis)	4	

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Cardiomyopathy*		**Clarification:** A woman who is not on cardiac medication can be considered as having normal cardiac function. COC may increase fluid retention that may worsen heart failure in women with cardiomyopathy. Women with cardiomyopathy have a high incidence of cardiac arrhythmias which may be increased with CHC use.
a) Normal cardiac function	2	
b) Impaired cardiac function	4	
Cardiac arrhythmias*		
a) Atrial fibrillation	4	
b) Known long QT syndrome	2	
NEUROLOGICAL CONDITIONS		
Headaches		**Clarification:** Headache is a common condition affecting women of reproductive age. **Evidence:** Among women with migraine, women who also have aura are at a higher risk of stroke than those without aura.[107,108] Women with a history of migraine who use COC are about two to four times as likely to have an ischaemic stroke as non-users with a history of migraine.[23,42,59,65,66,109,110] Classification depends on making an accurate diagnosis of those severe headaches that are migrainous and, in addition, those complicated by aura.[111–113] See additional resource on diagnosis of migraines with or without aura.
a) Non-migrainous (mild or severe)	I: 1 / C: 2	
b) Migraine without aura, at any age	I: 2 / C: 3	
c) Migraine with aura, at any age	4	
d) History (≥5 years ago) of migraine with aura, any age	3	
Idiopathic intracranial hypertension (IIH)	2	

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Epilepsy	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. [114]	
DEPRESSIVE DISORDERS		
Depressive disorders	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**: COC use does not increase depressive symptoms in women with depression compared to baseline or to non-users with depression.[115–124]
BREAST AND REPRODUCTIVE TRACT CONDITIONS		
Vaginal bleeding patterns*		
a) Irregular pattern without heavy bleeding	1	**Clarification:** Abnormal menstrual bleeding should raise suspicion of a serious underlying condition and should be investigated appropriately .[125–128] **Evidence**: COC are shown to be an effective treatment in heavy menstrual bleeding (HMB).[129–131]
b) Heavy or prolonged bleeding (includes regular and irregular patterns)	1	
Unexplained vaginal bleeding* (suspicious for serious condition) before evaluation	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.

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Endometriosis*	1	
Benign ovarian tumours (including cysts)	1	
Severe dysmenorrhoea	1	**Evidence**: There is no increased risk of side effects with COC use among women with dysmenorrhoea compared with women not using COC. Some COC users experience a reduction in pain and bleeding.[127,128]
Gestational trophoblastic disease (GTD)		**Clarification:** Includes hydatidiform mole (complete and partial) and gestational trophoblastic neoplasia. **Evidence**: Following molar pregnancy evacuation, the balance of evidence finds COC use does not increase the risk of gestational trophoblastic neoplasia, and some COC users experience a more rapid regression in hCG levels compared with non-users.[132–140] Limited evidence suggests that use of COC during chemotherapeutic treatment does not significantly affect the regression or treatment of gestational trophoblastic neoplasia compared with women who use a non-hormonal contraception method or DMPA during chemotherapeutic treatment.[141]
a) Undetectable hCG levels	1	
b) Decreasing hCG levels	1	
c) Persistently elevated hCG levels or malignant disease	1	
Cervical ectropion*	1	
Cervical intraepithelial neoplasia (CIN)	2	**Evidence**: Among women with persistent HPV infection, long-term COC use (≥5 years) may increase the risk of carcinoma *in situ* and invasive carcinoma.[142–144]

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Cervical cancer*			
a) Awaiting treatment	2		
b) Radical trachelectomy	2		
Breast conditions*			**Clarification:** Breast cancer is a hormone-sensitive tumour and therefore the prognosis of women with current or past breast cancer may be affected by hormonal methods of contraception.
a) Undiagnosed mass/breast symptoms	**I**	**C**	
	3	2	
b) Benign breast conditions	1		
c) Family history of breast cancer	1		
d) Carriers of known gene mutations associated with breast cancer (e.g. BRCA1/BRCA2)	3		**Evidence**: Women with inherited breast cancer gene mutations (such as *BRCA1* and *BRCA2*) have a much higher baseline risk of breast cancer than women without these genes. The very limited evidence in this area suggests that the risk of breast cancer among women with either a family history of breast cancer or with known inherited breast cancer gene mutations is probably not modified by the use of COC.[145–163]
e) Breast cancer			**Clarification:** For a woman with a history of breast cancer, a decision to initiate hormonal contraception may be best made in consultation with the local oncology team.
(i) Current breast cancer	4		
(ii) Past breast cancer	3		
Endometrial cancer*	1		
Ovarian cancer*	1		

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Uterine fibroids*		
a) Without distortion of the uterine cavity	1	
b) With distortion of the uterine cavity	1	
Pelvic inflammatory disease (PID)		
a) Past PID (assuming no current risk factors for STIs)	1	
b) Current PID	1	
Sexually transmitted infections (STIs)		
a) Chlamydial infection (current)		
(i) Symptomatic	1	
(ii) Asymptomatic	1	
b) Purulent cervicitis or gonorrhoea (current)	1	
c) Other current STIs (excluding HIV and hepatitis)	1	
d) Vaginitis (including *Trichomonas vaginalis* and bacterial vaginosis) (current)	1	
e) Increased risk for STIs	1	**Evidence**: Evidence suggests that there may be an increased risk of chlamydial cervicitis among COC users at high risk of STIs. For other STIs, there is either evidence of no association between COC use and STI acquisition or too limited evidence to draw any conclusions.[164–244]

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HIV INFECTION		
HIV infection*		Evidence: Low-to-moderate-quality evidence from 11 observational studies suggested no association between COC use (it was assumed that studies that did not specify oral contraceptive type examined mostly, if not exclusively, COC use) and HIV acquisition. No studies of the patch or ring were identified.[355]
a) High risk of HIV infection	1	
b) HIV infected		
(i) CD4 count ≥200 cells/mm^3	1	**Evidence:** Seven studies suggest no association between use of COC and progression of HIV, as measured by CD4 count <200 cells/mm^3, initiation of ART or mortality.[255–261] One randomised controlled trial finds an increased risk of a composite outcome of declining CD4 count or death among COC users when compared with Cu-IUDs.[262,263] The majority of indirect studies measuring whether various hormonal contraception methods affect plasma HIV viral load find no effect.[264–280]
(ii) CD4 count <200 cells/mm^3	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.[281]	

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OTHER INFECTIONS		
Tuberculosis		
a) Non-pelvic	1	
b) Pelvic	1	
ENDOCRINE CONDITIONS		
Diabetes*		
a) History of gestational disease	1	**Evidence**: The development of non-insulin dependent diabetes in women with a history of gestational diabetes is not increased by the use of COC.[282–289] Likewise, lipid levels appear to be unaffected by COC use.[290–292]
b) Non-vascular disease		**Evidence**: Among women with insulin or non-insulin-dependent diabetes, COC use has limited effect on daily insulin requirements and no effect on long-term diabetes control (e.g. HbA1c levels) or progression to retinopathy. Changes in lipid profile and haemostatic markers are limited and most changes remain within normal values.[293–302]
(i) Non-insulin dependent	2	
(ii) Insulin-dependent	2	
c) Nephropathy/retinopathy/ neuropathy	3	**Clarification**: The category should be assessed according to the severity of the condition.
d) Other vascular disease	3	
Thyroid disorders		
a) Simple goitre	1	
b) Hyperthyroid	1	
c) Hypothyroid	1	

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GASTROINTESTINAL CONDITIONS		
Gallbladder disease*		
a) Symptomatic		
(i) Treated by cholecystectomy	2	
(ii) Medically treated	3	
(iii) Current	3	
b) Asymptomatic	2	
History of cholestasis*		
a) Pregnancy related	2	
b) Past COC related	3	
Viral hepatitis*		
a) Acute or flare	I: 3 / C: 2	**Clarification:** *Acute or flare:* this category should be assessed on the severity of the condition. **Evidence**: Data suggest that in women with chronic hepatitis, COC use does not increase the rate or severity of cirrhotic fibrosis, nor does it increase the risk of hepatocellular carcinoma.[303,304] For women who are carriers, COC use does not appear to trigger liver failure or severe dysfunction.[305–307] Evidence is limited for COC use during active hepatitis.[308,309]
b) Carrier	1	
c) Chronic	1	
Cirrhosis*		**Clarification:** *Severe (decompensated) cirrhosis:* development of major complications (such as ascites, jaundice, encephalopathy or gastrointestinal haemorrhage).[310]
a) Mild (compensated without complications)	1	
b) Severe (decompensated)	4	

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Liver tumours*		**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.[311–313] There is no evidence relating to use of hormonal contraception by women with other liver tumours. **Clarification:** Continuation may need to be reviewed if the woman has an acute exacerbation, acute surgery or prolonged immobilisation (see section on VTE). **Evidence:** Risk for disease relapse is not significantly higher among women with IBD using oral contraception (most studies do not specify whether it is POP or COC) than among non-users.[314–318] Absorption of COC among women with mild ulcerative colitis and no or small ileal resections is similar to the absorption among healthy women.[319,320] Findings may not apply to women with Crohn's disease or more extensive bowel resections. No data exist that evaluate the increased risk for VTE among women with IBD using CHC. However, women with IBD are at higher risk than unaffected women for VTE.[320]
a) Benign		
(i) Focal nodular hyperplasia	2	
(ii) Hepatocellular adenoma	4	
b) Malignant (hepatocellular carcinoma)	4	
Inflammatory bowel disease (IBD)* (including Crohn's disease and ulcerative colitis)	2	

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ANAEMIAS		
Thalassaemia*	1	
Sickle cell disease	2	
Iron deficiency anaemia*	1	
RHEUMATIC DISEASES		
Rheumatoid arthritis	2	**Clarification:** Risk of CVD is increased among women with rheumatoid arthritis.[321] **Evidence:** Limited evidence shows no consistent pattern of improvement or worsening of rheumatoid arthritis with use of oral contraception.[321–329]
Systemic lupus erythematosus (SLE)		**Clarification:** People with SLE are at an increased risk of ischaemic heart disease, stroke and VTE and this is reflected in the categories given. There is no evidence that use of CHC causes disease flare. Available evidence indicates that many women with SLE can be considered good candidates for most methods of contraception, including hormonal contraception.[330–351]
a) No antiphospholipid antibodies	2	
b) Positive antiphospholipid antibodies	4	

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Positive antiphospholipid antibodies	4	**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.[352–354]
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
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 reassessed and monitored according to current guidelines.

SUPERFICIAL VENOUS THROMBOSIS
Varicose vein: Varicose veins are not a risk factor for VTE.

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 increases the risk of thrombus formation. Cyanotic defects are associated with hyperviscosity because of increased erythrocytosis.

Congenital heart disease: Surgical correction, co-existing complications and degree of cardiac disability will vary between individuals and should be taken into account when considering contraception use.

UNEXPLAINED VAGINAL BLEEDING
There are no conditions that cause vaginal bleeding that will be worsened in the short term by use of CHC.

ENDOMETRIOSIS
CHC do not worsen, and may alleviate, the symptoms of endometriosis.

CERVICAL ECTROPION
Cervical ectropion is not a risk factor for cervical cancer and there is no need for restriction of CHC.

CERVICAL CANCER
Awaiting treatment: There is some theoretical concern that CHC use may affect prognosis of the existing disease. While awaiting treatment, women may use CHC since the period of waiting is likely to be brief and pregnancy would be contraindicated.

ENDOMETRIAL AND OVARIAN CANCER
COC use reduces the risk of developing endometrial cancer. While awaiting treatment, women may use COC.

UTERINE FIBROIDS
There is no evidence that CHC affect growth of fibroids.

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

DIABETES
Although carbohydrate tolerance may change with CHC use, the major concerns are vascular disease due to diabetes and additional risk of arterial thrombosis due to use of CHC.

GALLBLADDER DISEASE
COC may cause a small increased risk of gallbladder disease. There is also concern that COC may worsen existing gallbladder disease.

HISTORY OF CHOLESTASIS
Pregnancy-related: History of pregnancy-related cholestasis may predict an increased risk of developing COC-associated cholestasis.

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Past COC-related: History of COC-related cholestasis predicts an increased risk with subsequent COC use.

VIRAL HEPATITIS, CIRRHOSIS AND LIVER TUMOURS
COC are metabolised by the liver, and their use may adversely affect women whose liver function is compromised.

INFLAMMATORY BOWEL DISEASE (IBD)
Risk of VTE may increase if unwell, bed-bound or undergoing acute surgery or with major surgery and prolonged immobilisation. Under these circumstances the use of combined methods should be avoided and alternative methods used.

THALASSAEMIA
There is anecdotal evidence from countries where thalassaemia is prevalent that COC use does not worsen the condition.

IRON-DEFICIENCY ANAEMIA
CHC use may decrease menstrual blood loss.

DRUG INTERACTIONS
Generally, the safety of using combined hormonal methods is unaffected. Nevertheless, use of liver enzyme inducing medication may reduce contraception efficacy, increasing risk of unintended pregnancy. Contraception choice may depend on the likely duration of use of concurrent medications and need for additional or alternative methods.

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