Combined Oral Contraceptive Pill (Follow-up and Common Problems)

Good practice for the first prescription of the combined oral contraceptive pill (COCP) is described in the separate article Combined Oral Contraceptive Pill (First Prescription). This article covers good practice for follow-up, safe ongoing prescribing and issues which may be encountered in doing so.

When to follow up[1,2]
After the first prescription, review at 3 months. If all is well, follow up at 6- to 12-month intervals. Supplies of up to a year may be issued.

Stress to the woman that she should return earlier if she develops any problems or side-effects, or if she has any concerns.

What to do in the follow-up consultation
- Ask:
  - Has she found it easy to use/remember?
  - Has she noticed any adverse effects?
  - Does she understand how to take it?
  - Does she know how to manage missed pills?
  - Has the pattern of withdrawal bleeds been regular?
  - Has there been any breakthrough bleeding (BTB)?
  - Have there been developments in her medical history (eg, new medication) or social history (eg, age and smoking) which need to be considered.

- Examination:
  - Check blood pressure.
  - Measure body mass index (BMI)

- Consider whether contraception is still required and if the combined pill is still the most appropriate and the safest method.
- Check whether cervical screening is due.
- Give the patient the opportunity to ask questions

Common problems

Breakthrough bleeding (BTB)[3]
See separate article Breakthrough Bleeding with Combined Hormonal Contraception. Women should be advised that this can occur with the COCP, most commonly in the first few months. If there has been no vomiting or diarrhoea and there have been no missed pills, it has not been shown to indicate reduced efficacy. Consider sexually transmitted infections, pregnancy, missed pills, and malabsorption as possible causes, but BTB is a common side-effect.

Weight gain
Cochrane reviews have consistently failed to show any evidence that significant weight gain is a side-effect of the pill[4].

Interactions[1, 5, 6]
There are many commonly used medications which can affect the efficacy of the pill:

- Antibacterials - enzyme inducers only (eg, rifampicin, rifabutin).
- Antidepressants - St John's wort (which can be bought over-the-counter).
- Anticonvulsants - carbamazepine, oxcarbazepine, eslicarbazepine, phenobarbital, phenytoin, primidone and topiramate, due to their enzyme-inducing activity. Also lamotrigine which has a specific safety warning - there is an increased risk of seizure whilst taking the COCP with lamotrigine, and a risk of toxicity during the pill-free week, when levels rise. Therefore, risk may outweigh benefit (UKMEC category 3).
- Antiretrovirals - in particular, ritonavir-boosted protease inhibitors.
- Ulipristal acetate (the 'morning after pill' ellaOne®).
<table>
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<tr>
<th>Type of medication</th>
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| Non-enzyme-
inducing
antibacterial. | Women should be advised that no additional contraception is required. |
| Short course (two months or less) of enzyme-inducing antibacterials rifampicin or rifabutin. | Women are advised to continue taking the COC and use additional precautions. Monophasic 21-day pills should be taken either as an extended regimen (continue packets without a break until 3-4 days of BTB occurs, then have 4-day pill-free interval) or a tricycling regimen (three packets without a break then a 4-day pill-free interval). Additional contraception should be continued for 28 days after stopping the rifampicin/rifabutin. |
| Long-term course of enzyme-inducing antibacterials rifampicin or rifabutin. | Should be advised to use an alternative, non-hormonal method where possible (very potent enzyme inducers). |
| Other enzyme-inducing drugs, including anticonvulsants, St John's wort, etc. | Short course: advice is as per that above for rifampicin/rifabutin. Long course: women should be encouraged to use alternative methods of contraception. If, having considered alternatives, they still choose the COC, the patient should be advised of the increased risk of pregnancy. Should use a preparation containing at least 50 micrograms of oestrogen. Trialling or extended regimens as above should be used. If BTB occurs on 50 micrograms, the dose should be increased to a maximum of 70 micrograms. |
| Lamotrigine. | Women should be advised not to take lamotrigine with the COC and should seek another form of contraception (unless also taking a non-enzyme-inducing anticonvulsant such as sodium valproate). |
| Antiretroviral therapies. | Those women on ritonavir-boosted protease inhibitors should be advised to use alternative methods of contraception. |
| Ulipristal acetate. | Women should use additional contraceptive precautions for 14 days after taking ulipristal acetate as ellaOne® for emergency contraception (16 days for Qlaira®). Those taking ulipristal in a higher dose as Esmya® for fibroids should not be advised to use alternative contraception. |

Women on medication which may interact with the contraceptive pill should be advised to carry out a pregnancy test and seek medical advice if there is a very light or no withdrawal bleed. They should also seek advice if they have BTB, which may indicate reduced efficacy in this situation.

Other medications may cause lack of efficacy of the contraceptive pill by causing side-effects such as diarrhoea or vomiting. Women on the anti-obesity pill orlistat who experience severe diarrhoea, for example, are advised to use additional contraceptive precautions as there is a theoretical risk of lack of absorption.

Concomitant administration of the COCP with some medications may increase levels. This may be the case with theophylline, and levels should be monitored. Tacrolimus levels may also be increased, and effect should be monitored.

**Diarrhoea and vomiting**
- Vomiting within 2 hours of taking the pill, or very severe diarrhoea, can affect the absorption of the pill.
- The advice for women who experience vomiting or diarrhoea for more than 24 hours is to follow the same advice as if they had missed pills.

**Surgery**[2, 6]

For any woman on the COCP about to undergo a major elective operation, the risk of thromboembolism needs to be balanced with the risk of unwanted pregnancy. Usually the COCP would be discontinued 4 weeks before elective major surgery and restarted on day one of the next period, occurring at least 2 weeks after mobilisation. Progestogen-only contraception can be offered as an alternative during this time.

Women requiring emergency surgery should receive subcutaneous heparin and compression stockings.

This does not apply to women having minor surgery where there are short periods of anaesthesia, such as tooth extractions or laparoscopic sterilisation.

**Amenorrhoea**
- There can be amenorrhoea following cessation of using the COCP. This is usually due to the pill's withdrawal bleeds masking an underlying problem.
- Any amenorrhoea lasting more than 6 months after stopping the pill should be investigated as for secondary amenorrhoea.
**Mature women**
This is detailed in the separate Contraception from 40 to the Menopause article.

**Other uses for the combined hormonal contraceptive pill**

**Menorrhagia and dysmenorrhoea**
- In women with heavy and/or painful menses the COCP has been shown to be beneficial. There is evidence for its efficacy in reducing menorrhagia, similar to mefenamic acid\[^{11}\]. There is weak evidence for its efficacy for primary treatment of dysmenorrhoea\[^{8}\]. There is no evidence for benefit of one type of COCP being better than any other.
- It can also make the cycle more manageable by running packs together, and in avoiding the pill-free week, women can avoid the withdrawal bleed. This is particularly useful for travel, but also for athletes. It is good practice to advise women that they can manipulate their cycle in this way.

**Polycystic ovary syndrome (PCOS)**\[^{9}\]
- Women who have PCOS are often oligo-menorrhoeic.
- Endometrial cystic hyperplasia is associated with prolonged periods of anovulation, as found in PCOS.
- There is an association between PCOS and endometrial hyperplasia and carcinoma. They should be offered protective therapy from prolonged exposure to relatively unopposed oestrogen. The COCP does this effectively, as well as providing contraception. However, cardiovascular risks should be taken into account, as women with PCOS are also at risk of the metabolic syndrome, and may be more likely to be overweight.

**Acne**\[^{10}\]
- Randomised controlled trials have shown significant improvements in acne vulgaris whilst using the COCP.
- The evidence is specific for preparations containing the progestogens levonorgestrel and norethisterone. There is no consistent evidence to support the use of any particular pill as being more effective than another for this purpose.
- Diane\(^{\text{reg}}\) is also indicated for use in acne or moderately severe hirsutism. It should be withdrawn if there is no improvement after 3 months of use. Diane\(^{\text{reg}}\) carries a 50-80% greater risk of venous thromboembolism (VTE) than COCPs containing levonorgestrel, but no higher than those containing gestodene, desogestrel, or drospirenone with 30-35 micrograms of ethinylestradiol\[^{11}\].

**Reducing the risk of cancer**\[^{12, 13}\]
- The pill has been shown to reduce the risk of ovarian, endometrial and colorectal cancer.
- The risk reduction is most significant for ovarian cancer. For every 5 years of use, there is a 20% reduction in the risk of ovarian cancer, and after 15 years of use a woman's risk is half that of a woman who has never taken the pill\[^{14}\].
- There is currently insufficient evidence to support or advise against the use of the COCP for the primary prevention of ovarian cancer\[^{15}\].
- The pill does, however, slightly increase the risk of breast cancer.

**Further reading & references**

1. Drug Interactions with Hormonal Contraception; Faculty of Sexual and Reproductive Healthcare (January 2011 - updated January 2012)
2. Contraception - combined hormonal methods; NICE CKS, June 2012 (UK access only)
3. Combined Hormonal Contraception; Faculty of Sexual and Reproductive Healthcare (2011 updated August 2012)
5. UK Medical Eligibility Criteria for Contraceptive Use; Faculty of Sexual and Reproductive Healthcare (2009 - Revised May 2010)
6. British National Formulary (BNF); NICE Evidence Services (UK access only)
9. Long-term Consequences of Polycystic Ovary Syndrome; Royal College of Obstetricians and Gynaecologists (November 2014)

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