Long-Acting Reversible Contraception (LARC)

Introduction

Long Acting Reversible Contraception (LARC) is recommended for all contraceptive users and are recommended by NICE. Advantages include:

- They are the most effective forms of contraceptive available
- LARC methods contain progesterone only, and therefore have a good safety profile.
- See the UK medical eligibility criteria (UKMEC) for more details on safety
- They contain lower daily doses of hormones compared to pills
- They are the most cost-effective contraceptives
- Fertility returns to baseline quickly when stopped.
- The exception is MDPA which may result in 6-12 months delayed return of ovulation
- Patients can compare different methods 'side by side' on the Which method of contraception is right for me? | Sexwise

Types of LARC and duration
Intrauterine contraception (IUC)
Hormone-containing coils (3-5 years)
Non-hormone coils (5-10 years)
Subdermal implant (SDI, Nexplanon®) (3 years)
Medroxyprogesterone acetate (MDPA) Injectables (12 weeks)
Intramuscular injection (depo provera®)
Subcutaneous injection for patient self-administration (sayana press®)

How to refer

- If you need to refer a complex or vulnerable patient, please complete the LARC referral form with details.
- Send the referral form to the appropriate email address:
- Email subject heading **Complex LARC referral**

Cheshire West & Chester	vcl.cheshirewestandchestershreferrals@nhs.net

Who to refer:

Please use the flow diagram to guide referral decisions. More details about steps to take for referral are below.

There is a separate pathway for emergency contraception intrauterine devices (EC IUD)

1) Does your patient need referral to secondary care?

- IUCs should be inserted in primary care (including sexual health) unless:
- There are specific medical issues preventing primary care fit
- It is fitted as part of an operative procedure or TOP
- Please note HCRG Sexual health cannot fit coils for purely non-contraceptive purposes (e.g., for hormone replacement therapy (HRT) or menorrhagia management alone)

- If a coil cannot be fitted in Primary Care for non-contraceptive reasons, please refer to the relevant Gynae clinic for the condition to be treated e.g menorrhagia.
- Please note extended use of IUC in women over 40 (up to age 55 for IUDs inserted over 40, and up to age 55 for Mirena IUS inserted over 45 for contraception reasons) for women requesting coil exchange

2) Does your patient need referral to sexual health?

- Patients aged <20 can self-refer
- Vulnerable patients aged>20 can be discussed on a case-by-case basis
- **Where patients are eligible to self-refer, but have presented to their GP first, a referral letter is still helpful for our triage process**
- There is a separate pathway for emergency intrauterine contraceptive devices (EC IUD) MDPA Injectables do not require referral

3) What to do before referral for IUC or SDI

1) Referral for fitting

a. Prevent pregnancy whilst the patient awaits LARC

i. Consider bridging with another form of contraception e.g. POP

b. IUC fit considerations

i. An IUC can only be fitted if there is no risk of pregnancy. This is assessed using the criteria in Box 1, page 5 of the Intrauterine contraception guideline

c. SDI fit considerations

i. The SDI can be quick started even if there is a pregnancy risk

ii. Further information for patients about SDI

2) Referral for removal/ refit

a. Provide information and advice on stopping contraception
b. IUC removal considerations
i. There is a risk of pregnancy if an IUC is removed within 7 days of having (unprotected sexual intercourse) UPSI. Therefore, unless planning to conceive, an IUC cannot be **removed, or removed and replaced with another IUC** if unprotected sex has taken place in the last 7 days
c. If the referral is for a complex removal, ensure the **steps below** have been taken

Complex referrals / problems with IUC / SDI

If the referral is for a complex removal or refit or there are problems with an IUC/SDI

IUC

1) Post-fit symptoms and information

a. Mild pain and bleeding are common after an IUC fit. Patients should be provided with both verbal and written information following post-fit including duration of use, side effects and those symptoms that require urgent assessment.
b. The FSRH have a Problematic bleeding guide for clinicians

2) Lost threads

a. Women should be taught to self-examine for coil threads and if they are non-palpable, be advised to book an appointment for a thread check 4-6 weeks after fit. If coil threads are present, there is no need for a routine appointment.
b. Lost threads may indicate that the threads have moved inside the cervix, but coil is in the correct place (most common), that the coil has been expelled (1 in 20), or that the coil has perforated (~1 in 1000)
c. The following steps are initial advice for managing lost threads in primary care
1. Take menstrual and sexual history
a. Is there a pregnancy risk?
b. Provide alternative contraception and/or post coital contraception if indicated by history.
c. Concerns about perforation? (Recent fit, difficult procedure, pain)
2. Examination
a. Speculum – are threads visible?
3. Assessment
a. Perform pregnancy test
b. If no threads seen:
i. Emergency contraception
ii. Quick-start alternative contraception
iii. Refer for a transvaginal ultrasound scan (TVUSS) to locate IUC
c. If threads seen at speculum:
i. reassure patient
ii. teach patient how to check threads

iii. If the patient is pregnant and the threads are visible or can easily be retrieved the intrauterine contraceptive device should be removed up to 12 weeks gestation. The women should be informed of the increased risk of second trimester miscarriage, preterm delivery and infection is the intrauterine device if left in situ. Removal would reduce adverse outcomes but is associated with small risk of miscarriage.

3) Referral to HCRG for lost threads

1. If a TVUSS shows the IUC in the uterus, the patient can be referred to HCRG Care Group integrated sexual health service for a complex ('lost threads') removal using the LARC referral form.

a. The patient needs to have had a TVUSS within the last 6 months for removal to take place.

2. If TVUSS shows no IUC in the uterus:

a. The patient will need abdominal imaging (AXR) to exclude a perforation

<u>Post SDI Implant fit</u>

Routine follow-up after implant fitting is not required. Review if:

a. They cannot feel their implant
b. It appears to have changed shape or been damaged
i. If a device is damaged it is recommended that the problem is reported to the manufacturer and the MHRA yellow card scheme.
c. They notice any skin changes, sensation changes, or pain around the site of the implant
d. They have a positive pregnancy test
e. They develop any condition which may contraindicate continuation of the method
f. They start or are due to start an enzyme-inducing drug.

2) Implant problems

a. If the patient has any neurological symptoms the GP should directly refer the patient to Plastics without further delay.
b. For non-urgent problems, use the LARC referral form and please state the nature of the problem, and always state whether the implant is palpable.
i. If you have attempted removal, we will need 3 weeks for the wound to heal before we can see them
c. If the implant is impalpable, do not assume that this is due to a 'deep insertion'. Occasionally it may be due to a removal that has not been documented, or a non-insertion.
i. Check pregnancy test
ii. Offer emergency and alternative contraception
iii. Refer to HCRG Care Group integrated sexual health service for a complex (impalpable implant) removal

3) **Other Implant troubleshooting:** refer to SDI guideline

Additional resources

- Contraceptive safety (UKMEC)
- FSRH method guides https://www.fsrh.org/standards-and-guidance/fsrh-guidelines-and-statements/method-specific/
- LARC decision making aid for patients Family Planning Association/Sexwise website