

3.0 COMBINED HORMONAL CONTRACEPTIVES

TITLE	DESCRIPTION
DEFINITION:	Combined contraceptives contain both an estrogen and a progestin and through the combined actions, reduce the risk of pregnancy primarily by suppressing ovulation and thickening cervical mucus. Combined oral contraceptives, vaginal ring delivery system, and transdermal patch are all combined contraceptives.
SUBJECTIVE:	<p>Must Include:</p> <ol style="list-style-type: none"> 1. LMP. <p>Should Include:</p> <ol style="list-style-type: none"> 1. Comprehensive medical, sexual, and contraceptive use history (initial or update) as appropriate.
OBJECTIVE:	<p>Must Include:</p> <ol style="list-style-type: none"> 1. BP. <p>Should Include:</p> <ol style="list-style-type: none"> 2. Height, weight, BMI. 3. Age-appropriate physical exam as indicated.
LABORATORY:	<p>May Include:</p> <ol style="list-style-type: none"> 1. Pap smear, as indicated. 2. STD screening, as indicated. 3. Sensitive urine pregnancy test, as indicated. 4. Other lab work, as indicated.
ASSESSMENT:	<p>Client is candidate for CHCs as evidence by: No condition that represents an unacceptable risk for the use of CHCs (US Medical Eligibility Criteria for Contraceptive Use Category 4).</p> <p>If client has condition that represents a theoretical or proven risk that usually outweighs the advantages of using CHCs (US Medical Eligibility Criteria for Contraceptive Use Category 3), may be a candidate if clinic protocols support use and/or with consultation with medical provider.</p> <p>RN dispensing: RNs dispensing hormonal contraceptives may dispense Category 1 [no restrictions] methods. RNs may dispense Category 2 [advantages generally outweigh theoretical or proven risks] methods with the following exceptions: undiagnosed breast mass; history of a DVT/PE in a first degree relative; inflammatory bowel disease; and unexplained vaginal bleeding.</p> <p>**RNs may not dispense Category 3 or 4 contraceptive methods**</p>
PLAN:	<ol style="list-style-type: none"> 1. Counsel about the full range of methods they are medically eligible to use to identify the optimal method. 2. Discuss potential barriers of using the method(s) under consideration. 3. Prescribe the CHC, including dosage, # of cycles and directions for use. 4. Develop a plan with the client for using the method correctly and consistently.

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	<ol style="list-style-type: none"> 5. Client can start the CHC anytime if the provider is reasonably sure she is not pregnant. 6. Discuss the benefits of shortening the hormone-free interval from 7 days to 3-4 days. 7. Instruct the client her cycle will be 25 days instead of 28 days. 8. Advise back-up method per information in the current Selected Practices Recommendations for Contraceptive Use. 9. Postpartum client wanting to start CHCs: <ol style="list-style-type: none"> a. Category 4: <21 days status post vaginal delivery. b. Category 3: 21 to 42 days status post vaginal delivery with other risk factors for VTE (such as ≥ 35 years or age, previous VTE, thrombophilia, immobility, transfusion at delivery, BMI ≥ 30, postpartum hemorrhage, post-cesarean delivery, preeclampsia, or smoking). c. Category 2: 21 to 42 days status post vaginal delivery without risk factors for VTE. d. Category 1: >42 days status post vaginal delivery. 10. Discuss method benefits (contraceptive and non-contraceptive), mechanism of action, effectiveness, correct use of method, possible side effects, STI protection and danger signs and document in the chart. 11. Discuss emergency contraception (EC) and how to obtain it either through Title X services or OTC. Consider sending a cycle of (EC) home with client especially if just starting BC, is an adolescent, has transportation issues or lives in a rural area. 12. Ensure client understanding. 												
EDUCATION:	<ol style="list-style-type: none"> 1. Instruct client to report any pill warning signs: <table border="1" data-bbox="548 1119 1393 1696" style="margin-left: 20px;"> <thead> <tr> <th colspan="2" style="text-align: center;">PILL WARNING SIGNALS -ACHES</th> </tr> </thead> <tbody> <tr> <td style="width: 50%;">Abdominal pain</td> <td>Blood clot in liver or pelvis Gall bladder disease</td> </tr> <tr> <td>Chest pain</td> <td>Blood clot in the lungs Heart attack Angina (heart pain)</td> </tr> <tr> <td>Headaches</td> <td>Stroke Migraine headache with neurological problems (blurred vision, spots, zigzag lines, weakness, difficulty speaking) New onset or worsening headache High blood pressure</td> </tr> <tr> <td>Eye problems</td> <td>Stroke Blurred vision, double vision, or loss of vision Migraine headache with neurological problems (blurred vision, spots, zigzag lines) Blood clots in the eyes Change in shape of cornea (e.g. contacts don't fit)</td> </tr> <tr> <td>Severe leg pain</td> <td>Inflammation and blood clots of a vein in the leg</td> </tr> </tbody> </table> 2. Instruct client regarding management of missed pills: See recommendations for missed pills in the Selected Practices Recommendations for Contraceptive Use, 2016, page 28. 3. Data show conflicting reports related to the risk of venous thromboembolism (VTE) with transdermal patch use (See Reference 1). Regardless, the risk of 	PILL WARNING SIGNALS -ACHES		Abdominal pain	Blood clot in liver or pelvis Gall bladder disease	Chest pain	Blood clot in the lungs Heart attack Angina (heart pain)	Headaches	Stroke Migraine headache with neurological problems (blurred vision, spots, zigzag lines, weakness, difficulty speaking) New onset or worsening headache High blood pressure	Eye problems	Stroke Blurred vision, double vision, or loss of vision Migraine headache with neurological problems (blurred vision, spots, zigzag lines) Blood clots in the eyes Change in shape of cornea (e.g. contacts don't fit)	Severe leg pain	Inflammation and blood clots of a vein in the leg
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	<p>VTE with patch use is still far below the risk of VTE during pregnancy.</p> <ol style="list-style-type: none"> 4. The risk of blood clots may be higher in pills containing greater than 35mcg of estrogen (See Reference 2). 5. Educate client of clinical trials suggesting that transdermal patches may be less effective in women with body weight > 198 lbs. than in women with lower body weights. 6. Review safer sex education, if appropriate. 7. Counsel women 35 years of age and older that tobacco use is considered an absolute contraindication per the MT Family Planning Medical Standards Committee. Women 35 years and older that use tobacco are not eligible for CHC use. 8. Recommend to client to RTC annually, PRN for problems or as indicated per individual plan.
REFERRAL TO MEDICAL PROVIDER:	Any client with prescribing precautions in categories 3 or 4 for combined contraceptives (see current U.S. Medical Eligibility Criteria for Contraceptive Use).
REFERENCES:	<ol style="list-style-type: none"> 1. Hatcher RA, Trussell J, Nelson A, Cates W, Kowal D, Policar M. <i>Contraceptive Technology</i>. 20 edition. Atlanta GA: Ardent Media, Inc., 2015. Pp. 249-369. 2. Centers for Disease Control and Prevention. US Medical Eligibility Criteria for Contraceptive Use. <i>MMWR</i> 2016;65(3):55-80. (www.cdc.gov/reproductivehealth/unintendedpregnancy/USMEC.htm). (Retrieved 1/30/2017). 3. Centers for Disease Control and Prevention. <i>U.S. Selected Practice Recommendations for Contraceptive Use, 2016</i>, <i>MMWR Vol. 65. No. 4</i>. 4. Greziottin A, <i>The shorter, the better: A review of the evidence for a shorter contraceptive hormone-free interval</i>. <i>Eur J Contracept Report Health Care</i>. 2016;21(2):93-105. 5. Sulak PJ, <i>Continuous oral contraception: changing times</i>. <i>Best Practice & Research Clinical Obstetrics & Gynaecology</i> 2008 Apr; 22(2):355-74. 6. Willis SA, Kuehl TJ, Spiekerman AM, Sulak PJ. <i>Greater inhibition of the pituitary-ovarian axis in oral contraceptive regimens with a shortened hormone-free interval</i>. <i>Contraception</i>, 2006 Aug;74(2):100-3.