SOUTH AFRICAN SOCIETY OF OBSTETRICS AND GYNAECOLOGY
2016 CONGRESS – SPOTLIGHT ON CONTRACEPTION ISSUES

Introduction
This report from the recent 2016 congress of the South African Society of Obstetrics and Gynaecology (SASOG) held in Sun City from 1 to 4 May 2016 focuses on presentations in the field of reproductive health, in particular contraception choices, sterilisation, menstrual disturbances in the adolescent and emergency contraception. These topics were presented by South African and international experts and have been collated by deNovo Medica into a clinically orientated report directed at local issues in everyday clinical practice.

Long-acting reversible contraceptives (LARCs): the new way forward?

KEY MESSAGES

- LARCs are both highly effective and reversible
- LARC can be introduced/administered as an outpatient procedure
- LARC are cost-effective
- LARC, like any other contraception, should be offered to patients in the context of a human rights framework

“Unmet needs in family planning remain high in many settings. Many women are not satisfied with their method of contraception, raising the risk of discontinuation and consequent unintended pregnancies,” said Professor Petrus Steyn, speaking at the 2016 SASOG congress. The challenges are considerable. Citing 2014 statistics, he observed that the women with unmet needs total 225 million; there are 80 million unintended pregnancies and 20 million unsafe abortions annually.

An international commitment to revitalise family planning has produced a human rights framework to facilitate the provision of high-quality contraceptive information and services. It is based on nine key standards: non-discrimination, availability; accessibility; acceptability; quality of services and information; privacy; informed decision-making; participation; accountability. “Studies have shown that satisfaction rates are much higher when there is choice,” he said.

Interestingly, a novel study has been done looking specifically at South Africa’s national contraceptive policy for adolescents and evaluating this policy in terms of this WHO Human Rights Guidance and Recommendations for the Provision of Contraceptive Information and Services. It concluded that South Africa’s policy and clinical guidelines for adolescents are well grounded in a human rights framework, but still need improvement.1

The most important recommendations include improving availability and extent of the range of methods, including
emergency contraception, within the essential medicine supply chain. Also, that provision of LARC methods should include both insertion and removal services, and counselling on side effects in the same locality. In essence, every adolescent must be able to make an informed choice on their own use of modern contraception, which should include a range of emergency, short-acting, long-acting and permanent methods supplied without discrimination.

A LARC is a method of contraception that requires administration less than once per cycle or month. Different types of LARC include injections, intrauterine devices (IUDs) and subdermal contraceptive implants. Some examples of LARCs are the etonogestrel (progestin-only) implant (Implanon NXT), the hormonal IUD (Mirena), the non-hormonal copper IUD and the older depot medroxyprogesterone acetate injection (Depo Provera), now being replaced in many health systems by the etonogestrel implant.

A key advantage is that they combine high effectiveness with reversibility. They are associated with higher continuation rates than oral contraceptives and even when one looks at ‘typical’ rather than ‘perfect’ use, they show good continuation rates at one year.

“They are more effective in preventing unwanted pregnancy than other methods of contraception,” he continued. “They can safely be used in adolescent patients, despite some myths to the contrary.”

LARCs do have some side effects and these need to be explained to the patient and treated if they occur. “The choice to use a LARC must always be informed by the human rights principles I outlined earlier,” he concluded.

Sterilisation: Still a relevant procedure in South Africa?

KEY MESSAGES

• Despite the increasing popularity of the LARCs, it would be short-sighted to say that there is no place for sterilisation in South Africa
• Patient selection is key
• Sterilisation at a younger age has a higher cost/benefit ratio, but carries a higher risk of regret.

With the world’s population now greater than seven billion, there is still a place for sterilisation and, specifically, female sterilisation. “Sterilisation can take place at different times (either post partum, post abortion or so-called ‘interval sterilisation’) and there are different routes, each with its own advantages and disadvantages,” said Dr Tome Honing in her presentation at the 2016 congress of SASOG.

The increased availability of the LARCs, the trend towards delayed childbearing, and less stable relationships and marriages have been associated with a decrease in the rate of sterilisation, but it nonetheless remains the second most common method of contraception in South Africa. “It is generally viewed as safe and effective, with a complication rate of <1%. With laparoscopic procedures the risk is even lower. And there is no difference between laparotomy and laparoscopy in respect of morbidity.”

There are currently no long-term data comparing failure rates between hysteroscopic and laparoscopic sterilisation. The hysteroscopic route has the advantage of avoiding peritoneal cavity entry, and can be undertaken as an office procedure without the need for general anaesthesia. Complications are rare, the most notable one being vasovagal symptoms in the office setting. However, the procedure is not immediately effective.

Patient selection is important as some women, especially younger ones, experience regret post-sterilisation, as it is generally irreversible. That said, only 2% of couples request reversal. It’s also important to debunk the myths. “So-called post-sterilisation syndrome probably doesn’t exist. Neither does sterilisation increase the risk for future hysterectomy,” said Dr Honing.
Alternatives to sterilisation include the subdermal contraceptive implant, Implanon NXT, which is highly effective, though it comes with a bleeding risk. A big advantage is that return to fertility is fast. Copper IUDs can also be used, but are sometimes associated with menstrual irregularities and pelvic infection after insertion. “Again, certain myths need to be addressed. There is no long-term risk of pelvic inflammatory disease, insertion is not painful and the device does not need to be removed to treat a sexually transmitted infection. The risk of pelvic actinomycosis is also rare. The hormonal IUD, Mirena, is another excellent choice, and not only for its contraceptive effects, as it decreases dysmenorrhea.”

Summarising, Dr Honing noted that the key differences between the LARCs and sterilisation is that the former are reversible and make low demands in respect of compliance. The latter, while permanent, requires no compliance at all. As a parting aside, she noted that while female sterilisation has a good cost/benefit ratio, male vasectomy is even cheaper, more straightforward than female sterilisation and has a low rate of both failure and complications.

Modern oral contraception

**KEY MESSAGES**

- Combined oral contraceptives (COCs) have an important role to play in modern contraception
- It’s important to address any negative perceptions expressed by patients by emphasising the non-contraceptive benefits of these agents
- Non-contraceptive benefits include positive effects on cycle-related symptoms, cancer risk and bone mineral density
- More data are required to change guidelines in order to obtain licensing for COC use in many other conditions, including premenstrual dysphoric disorder (PMDD), acne, polycystic ovarian syndrome and endometriosis

So is there still a place for COCs in the era of the LARCs and when sterilisation remains an alternative choice? In her presentation at the 2016 SASOG congress, Dr Annie Evans expressed the view that there is indeed, but that they need to be viewed not only in terms of their contraceptive efficacy – there is an overall failure rate of 5/100 users per annum – but also in terms of their extensive and varied non-contraceptive benefits.

“Many women do not have a positive view of hormonal contraception, perceiving it as unsafe and believing wrongly that it can cause cancer, blood clots, weight gain, mood changes and hair loss.” It’s therefore important to allay these concerns and focus on add-on benefits beyond pregnancy avoidance. “Underscore the COCs’ ease of use and reversibility and their ability to improve quality of life.”

Inconsistent use also contributes to patient dissatisfaction with COCs.5 “So we need protocols for missed pills and ways to take the pill daily.”

Among the non-contraceptive benefits of COCs are that women who take them experience less painful bleeding – extended regimens are more effective than cyclical ones at controlling symptoms. “COCs have the positive effect of lessening dysmenorrhea, and heavy menstrual bleeding can be controlled with second-line use of COCs, even when used 21/7. Continuous use can lead to almost absent bleeds.”

COCs can safely be used up to the age of 53 in non-smokers without arterial disease or the risk thereof. “They can help women sail through the perimenopause,” said Dr Evans, “helping to control estrogen deficiency symptoms and protecting bone. However, one needs to be aware of venous thromboembolism and cardiovascular risk and not prescribe them to ‘risky women’.”

COCs can enhance quality of life, especially in women with endometriosis. “While they won’t eradicate the condition, they will delay its onset or recurrence so long as COC use is maintained. Yet again, extended regimens have proven the most effective. One study showed that 80% of patients were either satisfied or very satisfied at one year.”

5 The incidence of premenstrual syndrome

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(now more commonly called PMDD) is also lower in women on COCs, especially the newer agents.

COCs can reduce the risk of acne, and have shown benefits in the prevention of endometrial hyperplasia. They are superior to insulin-sensitising drugs in the treatment of polycystic ovarian syndrome and are efficient in reducing fibroids and adenomyosis. “A 40% reduction in ovarian cancer risk has been observed, although this related to duration of treatment. COCs may also reduce ovarian cancer, with benefits persisting beyond the end of use. Women of normal weight might benefit in respect of bone mineral density loss. And the progestogenic side effects are all better with the newer agents,” she concluded.

Menstrual disturbances in the adolescent

**KEY MESSAGES**

- Adolescence is a window of opportunity for interventions that can affect an individual’s future health status
- It is a period characterised by the onset of activity in the hypothalamic-gonadal-pituitary (HPG) and hypothalamic-pituitary-adrenal (HPA) axes
- Dysfunctional uterine bleeding and dysmenorrhoea are the most common adolescent menstrual disturbances that negatively affect quality of life
- Most disturbances are functional, but occult pathology may be involved
- If conventional therapy is not successful, consider a differential diagnosis

“Adolescence is a period of physiological maturation, and menstrual disturbances in adolescent females are common,” Dr Mushi Matjila told delegates at the 2016 SASOG congress. “These disturbances impact education (through increased absenteeism), the quality of relationships and mental health and can have long-term consequences for a woman’s future health, especially if underlying pathology, e.g. polycystic ovarian syndrome, is missed.”

About 35% of the global burden of disease has its roots in adolescence, while 11% of all births worldwide are to girls aged 15-19 years.

“The role of the HPG and HPA axes is key to the understanding of menstrual disturbances. Gonadal steroids stimulate endometrial growth and sexual functioning, while also affecting bone and promoting lipogenesis and body fat distribution,” he said. “It’s therefore important, firstly, to know what is normal.”

There is no single trigger for puberty, which is characterised by a gradual increase in gonadotropin-releasing hormone (GnRH) pulsatility. Variation in pubertal onset can be due to a variety of factors, including both genetic and environmental ones, as well as nutritional status.

Dr Matjila listed the main disturbances as follows: precocious puberty, delayed puberty, amenorrhoea, dysfunctional uterine bleeding and dysmenorrhoea. “In other words, it’s a case of ‘too early’, ‘too late’, ‘too little’, ‘too much’ or ‘too painful’.”

In the case of delayed puberty, once it begins it generally follows a normal course and catch-up growth occurs. However, it is important to exclude gonadal failure, which often leads to amenorrhoea, and which usually requires investigation at the age of 16 years. It’s also important to exclude pregnancy as a cause of amenorrhoea.”

Dysfunctional uterine bleeding is the most common disturbance in adolescents and is a diagnosis of exclusion. “Fluctuations in estrogen levels can create havoc in the body,” observed Dr Matjila. “Once again, be alert to pregnancy-related issues, and also do not miss endocrine disorders or possible genital trauma/signs of sexual assault.”

Dysmenorrhoea is pain unresponsive to non-steroidal anti-inflammatory drugs (NSAIDs) or COCs. “A significant proportion of those affected will have endometriosis, so decisions about when to investigate are important.”
Emergency contraception

KEY MESSAGES

• Emergency contraception is safe and effective
• It reduces the incidence of unintended pregnancies and abortions
• Effective use of emergency contraception depends on increasing both public and professional awareness and improving access to this therapeutic intervention

“Human error and scant access to preventive options will inevitably result in unintended pregnancies,” said Prof Lineo Matsela in her presentation at the 2016 SASOG congress. “Emergency contraception used within a few days of unprotected sex therefore has a valuable role to play in this context.” She underscored, however, that it is only an occasional back-up option and should never be used routinely.

Unintended pregnancies are very common and are associated with a huge human and economic burden worldwide. “These negative outcomes include high infant mortality, less breastfeeding, overcrowded adoption centres, fewer educational and other opportunities for the mothers and many unloved, unwanted children. In addition, there are 20-22 million unsafe abortions performed worldwide every year, which carry the risk of permanent infertility.”

When should emergency contraception be used? Some of the circumstances include both voluntary sex with no contraception, as well as involuntary sex/rape; failure of contraception, e.g. condom breakage; failed coitus interruptus; and failure to take oral contraceptives for three consecutive days.

Oral agents for emergency contraception include the progestogen-only pill, a progestogen-estrogen combination and ‘the new kid on the block’, ulipristal acetate. “The copper IUD is another option and one that is more effective than pills in respect of preventing fertilisation and implantation. However, it does require an office visit and there are possible complications, including pelvic pain, abnormal bleeding, pelvic infection and possible expulsion of the device,” she said.

Returning to oral agents, Prof Matsela noted that the earlier levonorgestrel is used, the more effective it is. It reduces the risk of pregnancy by anything from 58% to 89%. Ulipristal acetate’s effectiveness is even higher at 90%.

Overall, the average effectiveness of emergency contraception is at least 50%, with the copper IUD being the most effective option. The chance of pregnancy when using the copper IUD is less than one in 500. Oral contraceptives are safe and contain the same hormones as regular contraceptives.

Prof Matsela expressed her concern that despite emergency contraception being safe and effective, “We are doing very badly in getting the word out about it. In the interests of reducing unwanted pregnancies and unsafe abortions, it is our duty to increase the promotion of it, improve knowledge about it and counter prevailing negative attitudes toward it,” she concluded.

References