Contraception
GP Update, 2025

Frequently Asked Questions, with Dr Simone Gonzo

Q: Is there a risk of meningioma with Depo-Provera?
A: There is a very small increased risk of meningioma associated with long-term use of certain progestogen formulations. The risk remains extremely low, but clinicians should inform patients as part of shared decision-making.
Q: If a patient has a history of ectopic pregnancies, can they still use a Mirena or IUD?
A: Yes. Previous ectopic pregnancies are not a contraindication. If the IUD is in situ, ectopic pregnancy is rare but possible; remove and refer if suspected.
Q: For patients with heavy bleeding on Mirena or Implanon, should we skip sugar pills during three-month COCP trial?
A: It is recommended not to skip sugar pills initially to monitor normal cycles and stabilise bleeding, then reassess after three months and can skip cycles.
Q: Are progestogen-only options safe in patients at risk of VTE?
A: The progestogen-only pill (POP) has a very low risk of VTE and is considered safe in most patients. Combined hormonal contraception carries a higher (though still small) risk and should be avoided in high-risk patients.
Q: How do we confirm menopause in patients still on contraception?
A: Stop hormonal contraception for six weeks and check FSH levels if safe to do so, or assess clinically based on symptoms. Barrier methods may be used during this period. Some contraceptives (Mirena, COCP) can double as HRT.
Q: Can Depo-Provera be given to patients with a family history of osteoporosis?
A: Yes. Family history alone is not a contraindication. Continue to monitor bone health and review risks every two years.
Q: Which method is most effective overall?
A: LARC (IUDs and implant). Copper IUD also doubles as the most effective emergency contraception.
Q: Can patients quick-start today if we're not 100% sure about pregnancy?
A: Yes — if reasonably certain they're not pregnant. Start method plus backup (typically 7 days), and arrange a pregnancy test 21 days after the last UPSI.
Q: What if a POP is taken late?
A: Traditional POP (>3 h late): take ASAP + 48 h condoms.
Drospirenone POP (>24 h late): take ASAP + 7 days condoms.
Q: How long can a 52 mg LNG-IUD stay in for contraception?
A: Up to 8 years for contraception (5 years if used for HRT endometrial protection).
Q: What's the best emergency contraception and when?
A: Copper IUD up to 5 days after UPSI/ovulation.
UPA up to 120 h; delay hormones 5 days after UPA.
LNG up to 72 h (+ beyond with reduced efficacy); hormones can start immediately.
Q: Do weight or BMI changes affect efficacy?
A: Generally no for CHC/POP/implant. Oral EC may be less effective at higher BMI — prefer Copper IUD or UPA (or double-dose LNG).
Q: What to use for patients on enzyme-inducing medications?
A: Prefer Copper IUD, LNG-IUD, or DMPA. If oral/implant used, add condoms during therapy and for 28 days after stopping the inducer.
Q: Lamotrigine and CHC — safe together?
A: They interact (can alter lamotrigine levels and seizure control). Seek specialist advice; consider LARC.
Q: Post-partum IUD timing?
A: Insert within 48 h or ≥28 days. Avoid 48 h to 4 weeks.
Q: Troublesome bleeding on implant or LNG-IUD — what helps?
A: Trial 3 months CHC (if eligible), courses of NSAIDs or tranexamic acid; reassess.
Q: DMPA and bones, weight, fertility?
A: Small reversible BMD reduction; weight gain risk higher in adolescents and BMI > 30; return to fertility may take up to 12 months after last injection.
Q: Migraine with aura — can they use CHC?
A: No (contraindicated). Offer progestogen-only methods or IUD.
Q: Current breast cancer—what's preferred?
A: Avoid hormonal methods (UKMEC 4). Copper IUD is preferred.
Q: Can LNG-IUD or implant cause weight gain, acne, or depression?
A: Evidence for causal links is weak. Discuss expectations; review and switch if side effects are troublesome.

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