Women need access to information about methods of birth control. Nurses can extend choice by improving knowledge of long-acting reversible contraception.

Using LARC to avoid unplanned pregnancy

In this article...

- The advantages of long-acting reversible contraception (LARC)
- An overview of four types of LARC
- How nurses can help to widen contraceptive choice

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Long-acting reversible contraception (LARC) extends choice for women about when and how they use contraception. This article outlines the advantages and disadvantages of different LARC methods.

Long-acting reversible contraception (LARC) is a highly effective method of preventing unwanted pregnancies without women having to think about contraception every day, week, month or before intercourse. It is extremely cost effective as it results in fewer unplanned pregnancies and so reduces the money spent on abortion and maternity services. LARC methods include injections, implants, intrauterine devices and systems.

Injections

There are two types of injection – Depo-Provera (medroxyprogesterone acetate) and Noristerat (norethisterone enantate) – which are effective for 12 weeks and eight weeks respectively (British Medical Association and Royal Pharmaceutical Society, 2011). Both are more than 99% effective; fewer than four women in 1,000 will conceive over two years (FPA, 2011).

Depo-Provera is the most commonly used in the UK; it is given as a deep muscular injection and slowly releases progestogen, which stops ovulation, thickens cervical mucus to prevent sperm penetrating and thins the endometrium, making it an unfavourable environment for implantation (FPA, 2011; Faculty of Sexual and Reproductive Healthcare Clinical Effectiveness Unit, 2009a). Menstrual bleeding may stop completely, be irregular or prolonged; irregular bleeding can continue for some months after stopping use of Depo-Provera (FPA, 2011). Amenorrhoea occurs in up to 70% of women at one year of use (FSRHCEU, 2009a).

There is a link between Depo-Provera and weight gain (FPA, 2011); it can also cause loss of bone mineral density (BMD) in women under 18 who have not reached their peak bone mass and those who have used it for two years or more. This is not usually a problem as the bone replaces itself once the injection is stopped (FPA, 2011). Women at risk of developing osteoporosis are normally advised to use another method of contraception, and adolescents should consider all other suitable methods first (BMA and RPS, 2011).

Contraceptive injections are not affected by other medicines and may reduce dysmenorrhoea and help with premenstrual symptoms (FPA, 2011).

Implants

The implant is a flexible rod that is placed under the skin of the inner upper arm, releasing a daily dose of the progestogen etonogestrel. There is a small risk of infection after insertion and, once the initial bruising has resolved, the implant should be palpeable but not visible (FPA, 2011). It lasts for three years and fewer than one woman in 1,000 will conceive over three years (FPA, 2011).

The implant mainly works by stopping ovulation; it also thickens cervical mucus and thins the endometrium. Some 70% of women experience a change in their periods, of which 20% are amenorrhoeic. There is no evidence of a link between implants and headaches, weight, mood, libido or BMD; acne may improve, develop or worsen (FSRHCEU, 2009b). Liver enzyme-inducing drugs reduce the implant’s efficacy, and alternative methods of contraception should be considered if it is to be taken long term (FSRHCEU, 2009b).

Implants last for three years

Intrauterine devices (IUDs)

The IUD is a plastic and copper device that is inserted into the uterus and can last...
from five to 10 years. If fitted after the age of 40, an IUD can stay in place until the menopause (FPA, 2011). All women, regardless of age or whether they have been pregnant before, can be considered for an IUD. Fewer than two women in 100 will conceive over five years, although devices with less copper are less effective (FPA, 2011).

Copper present in the IUD alters the uterine environment, making it hostile to sperm, impeding motility and reducing their ability to fertilise an ovum. Changes to the endometrium can also prevent a fertilised ovum from implanting. Some women using an IUD may experience heavier, prolonged or irregular bleeding; this is most common in the first six months and usually settles over time (FSRHCEU, 2007). There is a small increased risk of infection in the first 20 days after insertion. Very rarely, the device may be expelled, displaced or perforate the uterus (FPA, 2011).

IUDs are a highly effective choice for women who cannot or do not want to use a hormonal method of contraception. Compared with other non-hormonal methods, they require less time, thought and commitment. Postcoital insertion up to five days after unprotected sex can provide emergency and ongoing contraception.

Intrauterine system (IUS)
The IUS is a plastic T-shaped device, which is inserted into the uterus; it releases a daily dose of the progestogen levonorgestrel. It provides contraception for up to five years and until the menopause if fitted after the age of 45. Fewer than one woman in 100 will conceive over five years (Trussell, 2011).

The system works by thickening cervical mucus and thinning the endometrium to prevent implantation. Most women using an IUS continue to ovulate. Periods usually become lighter, shorter and less painful, making this a useful method for women with idiopathic menorrhagia; it can also provide endometrial protection for those taking oestrogen replacement therapy. Erratic bleeding is common in the first six months after insertion and by one year amenorrhoea or light bleeding is usual (FSRHCEU, 2007). The IUS is not affected by other medicines. Like the IUD, there is a risk of expulsion, displacement, perforation and infection after insertion (FPA, 2011).

All LARC methods
Women who are breastfeeding can use LARC safely (FPA, 2011). LARC is also useful for those who cannot or do not want to use combined hormonal contraceptives such as the pill, patch or vaginal ring.

Fertility returns to normal as soon as an implant, IUD or IUS is removed but may take up to a year to return to normal after stopping Depo-Provera (FSRHCEU, 2009a).

LARC does not provide any protection against sexually transmitted infections; women at increased risk should be informed about safer sex and advised to use condoms as well.

Choosing a LARC
Almost all women are able to use one of the LARC methods. The methods are useful for those with busy lifestyles, long working hours or unusual shift patterns for whom taking a pill at the same time every day can be difficult. They also extend the choice for women with conditions such as epilepsy, diabetes, hypertension and migraine with aura (FSRHCEU, 2009c).

After initial visits to a health professional, women do not have to attend routine check-ups (unless using injections), making LARC a useful option for those who are physically disabled or housebound.

Sexual health nurses who extend their role by training to insert IUDs and implants benefit patients by improving the choice and availability of methods (Royal College of Nursing, 2011).

Choice is vital for consistent and effective contraceptive use. If women choose a method that suits and fits their lifestyle they are more likely to use it correctly and consistently (Grimes, 2009). To enable choice, women need access to information about all methods of contraception; attempts by health professionals to anticipate contraceptive choice are not helpful to women seeking advice. Allowing them time to discuss their concerns openly and explore their lifestyle choices helps support them in choosing a method that suits their stage of life. Box 1 features a case study on contraceptive choice.

References
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BOX 1. CASE STUDY
Amanda Drake, aged 28, visits a clinic for advice on contraception. She already had three young children and had an abortion after conceiving while taking the contraceptive pill. She is now confused about which method of contraception to use and has not used any since her abortion.

Ms Drake suffers from acne, which is exacerbated by the pill, and worries about gaining weight. She used to use the injection, which gave her prolonged bleeding, and the implant, which made her “moody”. She would like a non-hormonal method and considered an IUD but has heard “horror stories” about it.

Ms Drake needs a method she can trust. The high efficacy of the IUD, which can be fitted and forgotten about, may help. It is non-hormonal and should not affect her skin, moods, menstrual cycle or weight, while its long-acting nature gives her time to consider whether or not she has completed her family.

The “horror stories” need to be explored in more detail. It may help Ms Drake to look at and handle an IUD, discuss the fitting process and be told a local anaesthetic is an option. She may also be concerned that the IUD will damage her health or fertility, or be worried her partner will feel affected. Providing written information that reinforces verbal advice and signposting to other organisations or websites can help to inform patients’ decision-making.

“The patient’s name has been changed.”