this & that

09

OBGYN QUICK GUIDES · IF THIS, THEN THAT

NO.



Contraception

& postpartum and troubleshooting

Dr. Abdulrahman Bogis

Obstetrics & Gynaecology

Counselling & management

Verified against CDC · ACOG · CoSRH/NICE · SOGC · WHO — October 2026

Contraception & troubleshooting

At a glance: the numbers to remember

0.1 vs 7	Day 21	7 days	5 days	13 + 1–2 wk
pregnancies per 100/year: implant vs pill (typical use)	postpartum: contraception needed (CoSRH)	back-up after a late start (POP: 2 days)	EC window; wait 5 days after UPA to start hormones	DMPA grace: UK 14 wk, US 15 wk

Scope: reversible contraception, postpartum and breastfeeding, emergency contraception and problems with each method. Eligibility categories are from UKMEC 2025 and US MEC 2024 (key in Section 2). Where the UK and US differ, both are shown. Abbreviations are listed in Section 12. Local brands: Microgynon/Yasmin/Yaz (COC), Cerazette (desogestrel POP), Slynd (drospirenone POP), Depo-Provera/Sayana Press (DMPA), Implanon NXT/Nexplanon, Mirena (LNG-IUD), copper T380A.

01 Counselling and choosing a method

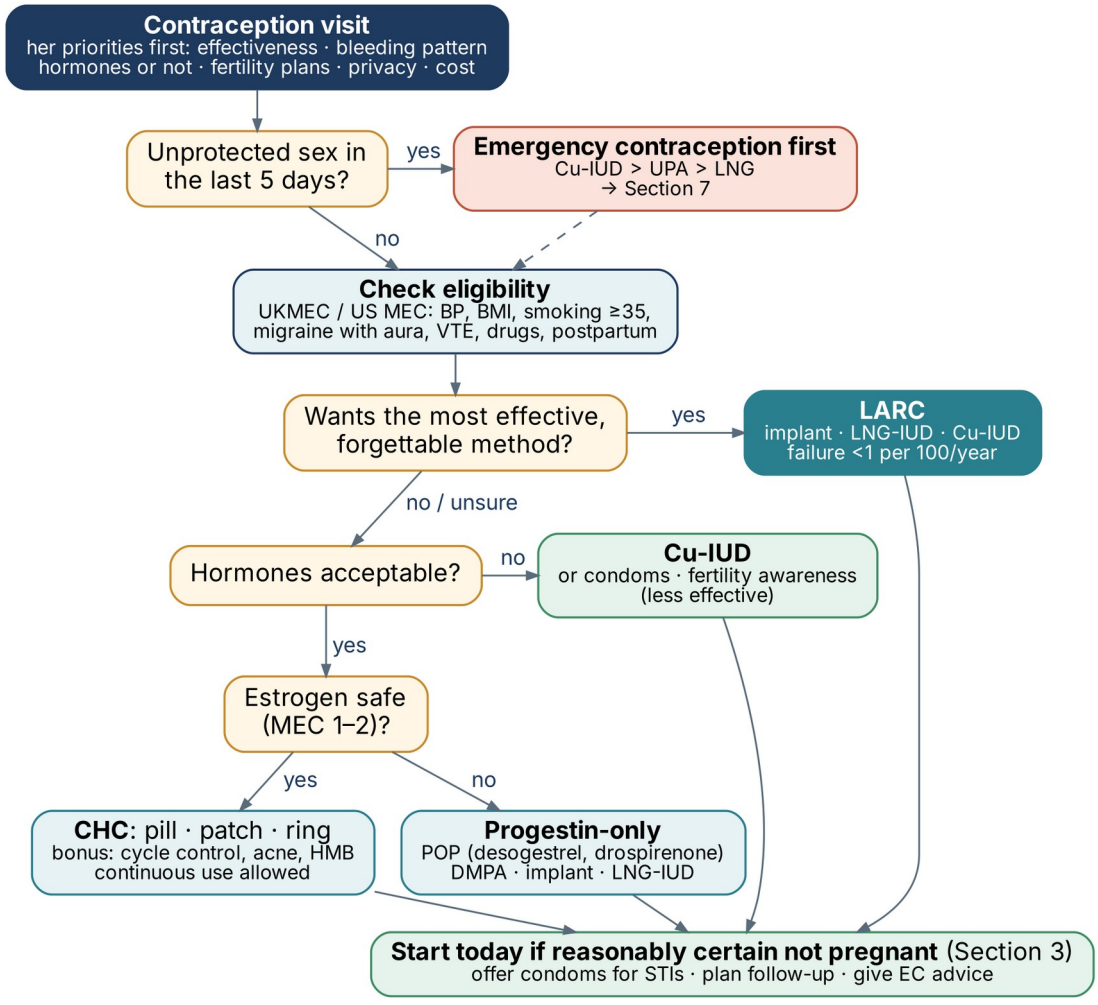


Figure 1. *Choosing a method: emergency contraception first if needed, then eligibility, then her priorities.*

Method	Failure, 1st year (typical / perfect %)	Lasts	Bleeding pattern	Fertility after stopping
Implant (etonogestrel 68 mg)	0.1 / 0.1	UK 3 y (licence); US 5 y (FDA 2026)	Unpredictable: about 1 in 5 no bleeding, about 1 in 4 frequent or prolonged	Immediate

Method	Failure, 1st year (typical / perfect %)	Lasts	Bleeding pattern	Fertility after stopping
LNG-IUD 52 mg (Mirena)	0.4 / 0.3 (all LNG-IUDs)	8 y (contraception); to 55 if inserted ≥45 (UK)	Spotting 3–6 months, then light or absent	Immediate
Cu-IUD (T380A)	0.8 / 0.6	5–10 y; to menopause if inserted ≥40 (UK)	Heavier, more painful periods	Immediate
DMPA (IM 150 mg / SC 104 mg)	4 / 0.2	13 weeks	Irregular at first; ≈50–80% amenorrhoea with time	Delayed up to 1 year
CHC: pill, patch, ring	7 / 0.3	Daily / weekly / 3-weekly	Predictable; can be bleed-free with tailored use	Immediate
POP: desogestrel, drospirenone, traditional	7 / 0.3	Daily	Irregular (drospirenone 24/4 more regular)	Immediate
Condom (external)	13 / 2	Each act	Unchanged	Immediate
Withdrawal	20 / 4	Each act	Unchanged	Immediate

Failure rates: Contraceptive Technology, 22nd ed. (2023).

IF	THEN
Every visit	• Start with her goals: pregnancy plans, what matters (effectiveness, bleeding, hormones, privacy, partner, cost), past experience • Present all suitable methods, most to least effective; do not push LARC (ACOG Committee Statement 1, 2022; SOGC 419 on coercion-free care) • Take a focused history for eligibility: BP, BMI, smoking, migraine (with or without aura), VTE history and family history, drugs, breastfeeding • No pelvic exam, smear or blood tests are needed before starting pills, patch, ring, POP, DMPA or implant
She chooses an IUD	STI testing by risk; do not delay insertion waiting for results if asymptomatic (UKMEC 2025). Offer analgesia (local anaesthetic, e.g. paracervical block or lidocaine spray).
She chooses DMPA	Discuss bone density (reversible), weight gain (mainly adolescents with BMI ≥30) and delayed return of fertility (up to 1 year).
Teratogenic drug (valproate, topiramate, isotretinoin)	Highly effective method: LARC or sterilisation (failure <1%), or two methods including a barrier (MHRA pregnancy prevention programmes). Check for interactions (Section 9).
STI risk	Condoms in addition to any method.

02 Eligibility: the conditions that change the choice

Condition	Cu-IUD	LNG-IUD	Implant	DMPA	POP	CHC
VTE history (not on anticoagulation)	1	2	2	2–3	2	4
Known thrombophilia	1	2	2	3	2	4
Migraine with aura	1	1–2	1–2	1–2	1–2	4
Migraine without aura	1	1–2	1–2	1–2	1–2	UK 2 start / 3 continue; US 2
Age ≥35 and smoking ≥15/day	1	1	1	1	1	4 (<15/day: 3)
BP ≥160/100 or vascular disease	1	2	2	3	2	4

Condition	Cu-IUD	LNG-IUD	Implant	DMPA	POP	CHC
BP controlled or 140–159/90–99	1	1	1	2	1	3
BMI ≥35 (UK) / ≥30 (US)	1	1	1	UK 2 / US 1	1	UK 3 / US 2
Diabetes with vascular disease	1	2	2	3	2	3–4
SLE with antiphospholipid antibodies	1	2	2	3	2	4
Breast cancer, current (incl. on tamoxifen/AI, UK)	1	4	4	4	4	4
Breast cancer, treatment completed	1	3	3	3	3	3
Enzyme-inducing drugs (rifampicin, carbamazepine, phenytoin…)	1	1	2*	1	3*	3*
Lamotrigine monotherapy	1	1	1	1	1	3
Malabsorptive bariatric surgery	1	1	1	1	3	COC 3; patch/ring 1
Age ≥40	1	1	1	1–2	1	2 (stop at 50)

1	2	3	4
no restriction: use the method	benefits generally outweigh risks	risks usually outweigh benefits: specialist judgement	unacceptable health risk: do not use

UKMEC 2025 and US MEC 2024 agree unless stated; ranges show where they or sub-rows differ (e.g. initiation vs continuation, or lower vs higher VTE recurrence risk). * UKMEC gives no category for drug interactions: CoSRH advises against CHC, POP and implant during an enzyme inducer and for 28 days after. Meningioma (current or past): avoid DMPA and desogestrel/etonogestrel methods (MHRA 2024; EMA 2026; CoSRH June 2026).

03 Starting, quick starting and switching

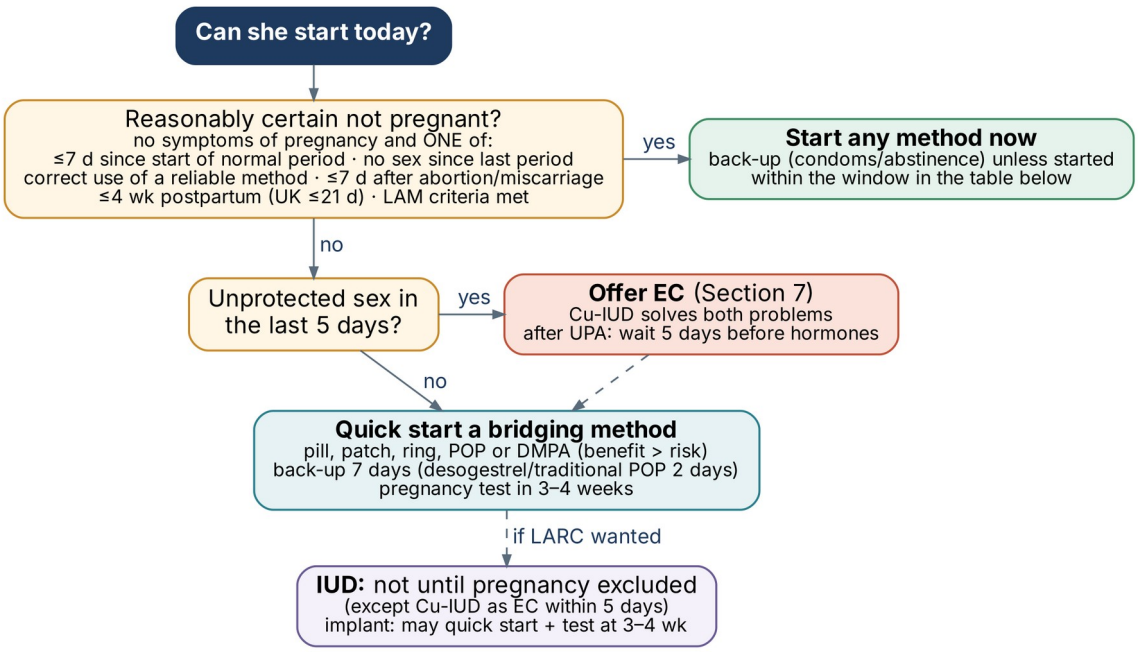


Figure 2. *Can she start today? Quick starting when pregnancy cannot yet be excluded.*

Method	No back-up if started	Otherwise back-up for	Notes
Cu-IUD	Any day if not pregnant	None	Effective immediately; also EC within 5 days

Method	No back-up if started	Otherwise back-up for	Notes
LNG-IUD	Day 1–7	7 days	
Implant	Day 1–5	7 days	Postpartum: any time; ≤21 days no back-up (UK)
DMPA	Day 1–7 (UK day 1–5)	7 days	
CHC	Day 1–5	7 days	Quick start any day
Desogestrel / traditional POP	Day 1–5	2 days	
Drospirenone POP (Slynd)	Day 1 (US) / day 1–5 (UK)	7 days	Longer back-up than other POPs

Day 1 = first day of a normal period. Sources: US SPR 2024; CoSRH method guidelines.

IF	THEN
Not reasonably certain she is not pregnant, but wants hormones	• Quick start CHC, POP or DMPA (benefits outweigh any risk to an early pregnancy; no teratogenicity) • Back-up 7 days (desogestrel/traditional POP 2 days); pregnancy test 3–4 weeks after the last unprotected sex
Wants an IUD but pregnancy not excluded	Bridge with a quick-start method and fit once pregnancy is excluded (Cu-IUD as EC is the exception).
Switching between hormonal methods	• Switch directly with no gap if the current method has been used correctly; otherwise follow the new method's back-up rule • DMPA → other method: start any time up to 14 wk (UK) / 15 wk (US) after the last injection, no back-up
Switching from an IUD	Unprotected sex in the last 7 days: start the new method 7 days before removal (2 days for POP), or keep the IUD until the next period.

04 Method by method

Combined hormonal contraception (pill, patch, ring)

IF	THEN
Which pill first	Monophasic, ≤30 µg EE with levonorgestrel or norethisterone (lowest VTE risk; CoSRH). Acne/PCOS: a pill with an antiandrogenic progestin is acceptable after discussing the higher VTE risk.
Regimen	• Tailored regimens are as safe as 21/7 and may be more effective (CoSRH): • shortened break (4 days), tricycling (9 weeks then 4–7 days), flexible extended (until 3–4 days of breakthrough bleeding, then 4 days off), continuous (no break)
Patch	Weekly × 3, then 1 week off. US labels (Xulane, Twirla): contraindicated at BMI ≥30 (boxed). Patch worn up to 9 days is still effective (UK).
Ring	3 weeks in, 1 week out (NuvaRing; can stay in up to 4 weeks, UK). Out <3 h: no action (US label: >3 h → 7 days back-up). Annovera: one ring for 13 cycles; out >2 h → 7 days back-up.
VTE risk per 10,000 women-years	• Non-users 2 · LNG, NET, norgestimate 5–7 · patch/ring 6–12 · desogestrel, gestodene, drospirenone 9–12 (MHRA 2014) • Pregnancy ≈29 · immediate postpartum 300–400 (CoSRH, via secondary source)

IF	THEN
Stop	At 50 (switch to a non-estrogen method). Before major surgery or prolonged immobility: stop 4 weeks before.

Progestogen-only pills

POP	Late if more than	Action when late	Notes
Traditional (norethisterone 350 µg, levonorgestrel 30 µg; norgestrel 75 µg OTC in US)	3 h	Take now; condoms 48 h	Same time daily
Desogestrel 75 µg (Cerazette; UK pharmacy sale)	12 h	Take now; condoms 48 h	Inhibits ovulation; to age 55
Drospirenone 4 mg (Slynd) 24 active + 4 inactive	24 h	Take now; condoms **7 days** (UK); US: back-up only if ≥2 missed; if late in the last 7 active pills, skip the inactive ones	Avoid with hyperkalaemia, potassium-sparing drugs; contraindicated in severe renal failure

EC is needed if a POP was late and there was unprotected sex before 2 days of correct pill-taking were restored (7 days for drospirenone).

Injectable (DMPA)

IF	THEN
Repeat interval	• Every 13 weeks • Up to 14 weeks (UK) or 15 weeks (US) late: give without back-up • Later: give if reasonably certain not pregnant, back-up 7 days, consider EC (not UPA), pregnancy test in 3 weeks
Sayana Press (SC 104 mg)	Self-injection every 13 weeks; offer it.
Bone	• Bone loss is largely reversible; no DXA needed • Under 18s: use only after other methods considered (MHRA). Review every 2 years; switch at 50
Meningioma	Contraindicated with current or past meningioma (MHRA letter 2024; FDA label warning 2025).
Planning pregnancy within a year	Choose another method: return of fertility may take up to 1 year.

Implant

IF	THEN
Duration	UK: licensed 3 years; CoSRH does not recommend routine use beyond 3 years. US: FDA approved 5 years (2026). Remove or replace by then.
Insertion	Subdermal, inner non-dominant upper arm, 8–10 cm above the medial epicondyle, over the triceps; palpate after insertion and get her to feel it.
Impalpable implant	Back-up until located. Ultrasound (high-frequency) first, then X-ray (radio-opaque) or MRI; refer for deep removal. Etonogestrel level if still not found.
Enzyme inducers	Efficacy reduced during use and for 28 days after: switch to IUD or DMPA.

Intrauterine devices

IF	THEN
Durations	• LNG 52 mg (Mirena and equivalents): 8 years (UK all 52 mg devices; US Mirena and Liletta). Inserted at ≥45 (UK): to age 55 • Kyleena 5 years · Jaydess/Skyla 3 years • Cu-IUD: 5–10 years by device; ≥300 mm² copper inserted at ≥40: until menopause (UK) • Endometrial protection with HRT: any 52 mg LNG-IUD for 5 years (UK)
When effective	Cu-IUD immediately; LNG-IUD after 7 days unless fitted on day 1–7.
Insertion	Offer analgesia. Perforation 1–2 per 1000 (higher postpartum and when breastfeeding); expulsion ≈5% in year 1 (higher postpartum, age <20, BMI >25).
Previous ectopic	IUDs are acceptable; they lower the absolute ectopic risk. But if a pregnancy occurs with an IUD, a high proportion are ectopic (Speroff).

05 Postpartum and breastfeeding

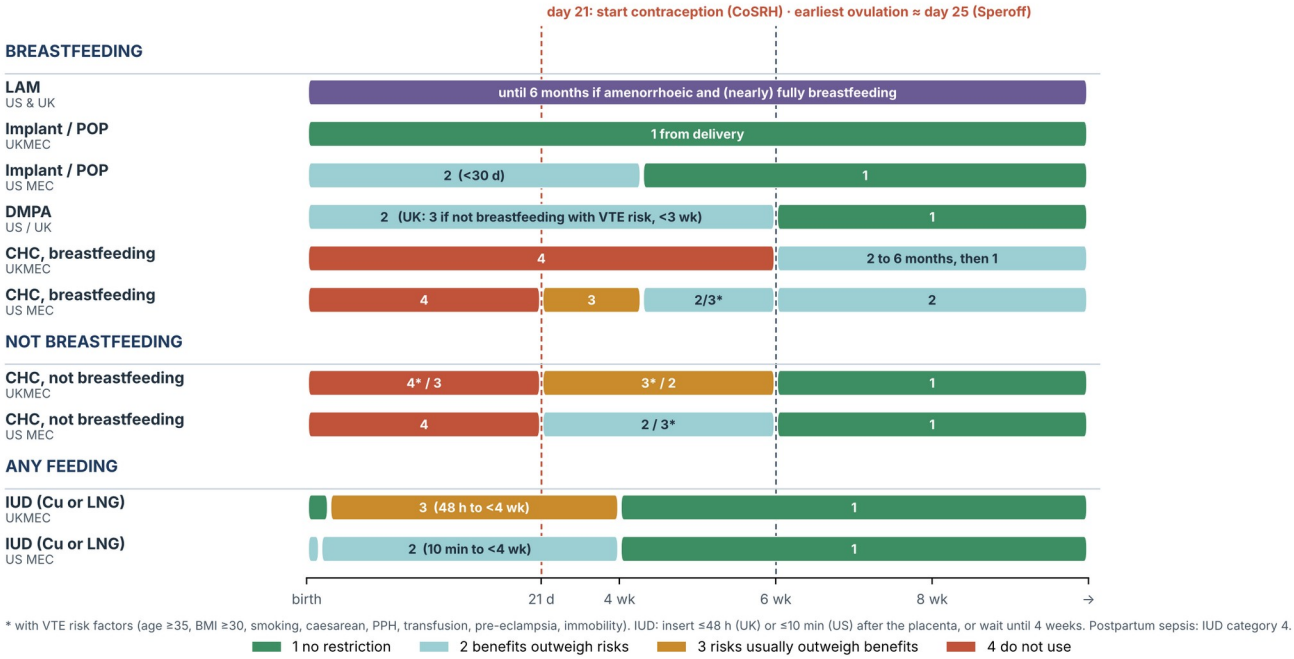


Figure 3. *Postpartum eligibility by method, feeding and time since birth (UKMEC 2025 and US MEC 2024).*

IF	THEN
All women	• Discuss contraception antenatally and before discharge; fit the chosen method before she leaves when possible • Contraception needed from **day 21** (CoSRH); non-breastfeeding women can ovulate from about day 25, often before the first period (Speroff) • Interpregnancy interval: at least 18 months (ACOG Obstetric Care Consensus 8)
Breastfeeding, wants LAM	• Protects only if **all three**: <6 months postpartum, amenorrhoeic, fully or nearly fully breastfeeding (gaps no more than 4 h by day, 6 h by night: US MEC 2024) • Any one criterion lost → start another method at once

IF	THEN
Breastfeeding, wants hormones	• Progestogen-only methods any time: implant and POP UKMEC 1 from delivery; US MEC 2 for the first 30 days (theoretical effect on milk; no evidence of harm) • DMPA: 2 until 6 weeks • **CHC not before 6 weeks** (UKMEC 4 before 6 weeks; US MEC 4 before 21 days, 3 at 21–30 days)
Not breastfeeding, wants CHC	From 3 weeks if no VTE risk factors; from 6 weeks if risk factors (age ≥35, BMI ≥30, smoking, caesarean, PPH, transfusion, pre-eclampsia, immobility).
Wants an IUD	• **Within 48 h** of birth (UK) or within 10 min of the placenta (postplacental, US), at vaginal or caesarean birth; otherwise **from 4 weeks** • Postplacental expulsion ≈10% (vaginal birth ≈15%, caesarean ≈4%; LNG more than Cu): counsel and check at 6 weeks • Not if chorioamnionitis, endometritis or postpartum sepsis (category 4)
Wants an implant	Any time, including before discharge; no back-up if inserted ≤21 days postpartum (UK).
Emergency contraception postpartum	Not needed before day 21. Breastfeeding after UPA: no interruption needed (CoSRH 2025; the old 1-week advice is outdated).

06 After miscarriage or abortion

IF	THEN
First-trimester miscarriage or abortion (surgical, medical or spontaneous)	• Every method can start straight away (IUD category 1) • Start within 5 days (UK) / 7 days (US) → no back-up
Medical abortion	• Implant or DMPA can be given with mifepristone (US: DMPA at mifepristone is category 2, small rise in ongoing pregnancy) • IUD once the abortion is complete (ultrasound or hCG)
Second-trimester	IUD category 2 (higher expulsion); all other methods immediately.
Septic abortion	No IUD (category 4) until treated.

07 Emergency contraception

Method	Time limit	Choose it when	Then
Cu-IUD	5 days after the first unprotected sex, or up to 5 days after the earliest likely ovulation	First choice for everyone eligible: most effective (<0.1% failure), unaffected by BMI or drugs, gives ongoing contraception	Keep as long-term method or remove after the next period
Ulipristal 30 mg (ellaOne/ella)	120 h	Sex 72–120 h ago, or near ovulation; BMI >26 or weight >70 kg (UK) / BMI ≥30 (US)	Wait **5 days** before starting hormones; back-up 7 days (POP 2 days, drospirenone 7) after that
Levonorgestrel 1.5 mg	72 h licensed; ineffective beyond 96 h (UK)	Within 72 h when UPA is unsuitable (e.g. on regular progestogen she can't pause, severe asthma on oral steroids)	Start hormones immediately; back-up 7 days
Levonorgestrel 3 mg	As above	BMI >26 or weight >70 kg (UK, or use UPA); enzyme inducers (or Cu-IUD)	As above

IF	THEN
Unprotected sex more than once this cycle	Hormonal EC can still be given; Cu-IUD if within 5 days of the earliest likely ovulation.
Vomits within 3 h of oral EC	Repeat the dose.
LNG-IUD as EC	Not recommended by CoSRH (April 2026) and not in US SPR 2024: evidence is limited. Offer the Cu-IUD; if she declines it but wants an LNG-IUD, give oral EC and discuss quick-start fitting with a pregnancy test at 3–4 weeks.
After any oral EC	Pregnancy test 3 weeks after the sex if no normal period (or if lighter/later than usual).

08 Troubleshooting

Missed pills, late injections, displaced devices

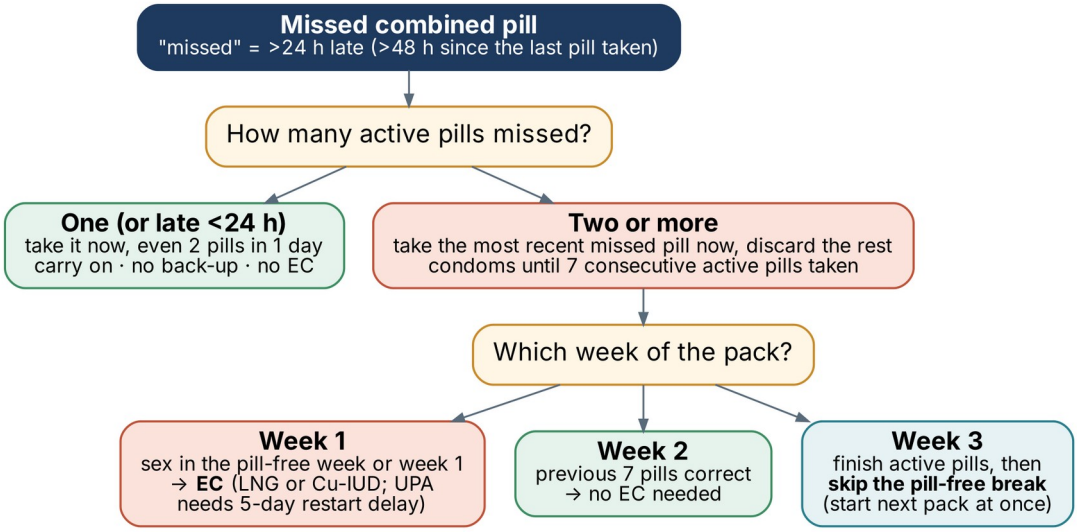


Figure 4. *Missed combined pill: the UK (CoSRH) and US (SPR 2024) rules give the same actions.*

IF	THEN
Vomiting or diarrhoea on a pill	• UK (CoSRH): vomiting within 2 h of a CHC pill → take another; persistent vomiting or severe diarrhoea → treat as missed pills • US SPR: no extra pill; back-up only if it lasts ≥48 h • Drospirenone POP: replacement tablet if vomiting within 3–4 h (label)
Patch or ring off, or late restart	<48 h: replace, no back-up. ≥48 h (or unknown): replace, back-up 7 days; EC if in week 1 with sex in the free interval; skip the break if in week 3.
Missing IUD threads	• Exclude pregnancy, consider EC, give back-up until found • Look in the canal with a cytobrush; ultrasound; if not in the uterus → abdominal X-ray (perforation vs expulsion) • Intra-abdominal device → laparoscopic removal
IUD partly expelled or low on scan	Remove; refit at the same visit if not pregnant (give EC first if sex in the last 5 days).
Pregnant with an IUD	• Exclude ectopic • Strings visible → remove now (reduces miscarriage from ≈50% to ≈30%) • Strings not visible → ultrasound; hysteroscopic retrieval possible; if left, counsel on miscarriage, preterm birth and infection

IF	THEN
PID with an IUD in place	Treat with antibiotics and leave the IUD; review at 48–72 h. Remove if no improvement, or if she wants it out (after antibiotics have started; consider EC).
Actinomyces on cytology, no symptoms	No treatment, no removal. Symptoms (pain, pelvic mass) → antibiotics, then remove.

Bleeding problems

First rule out pregnancy, chlamydia/gonorrhoea, cervical pathology, missed pills, interacting drugs and smoking. New bleeding after months of good control, or persistent bleeding, needs examination ± ultrasound.

Method	Expected	Treatment options
CHC	Spotting in the first 3 months in 10–30%, settling	Reassure; check adherence. Persistent: higher EE (30–35 µg) or another progestin. Extended/continuous use: 3–4-day break (not in the first 21 days, not more than once a month). Doubling the pill does not work (Speroff)
Implant	About 1 in 4 frequent or prolonged bleeding	UK: COC for 3 months (off-licence, if eligible) or mefenamic acid 500 mg tds × 5 days. US SPR 2024: NSAID 5–7 days, tranexamic acid 5 days, tamoxifen 10 mg bd 7–10 days, or COC/estrogen (works only while taken)
DMPA	Irregular in the first year; amenorrhoea with time	NSAID 5–7 days, or COC or estrogen 10–20 days (US SPR); estradiol 2 mg or CEE 1.25 mg × 7 days (Speroff). Giving the injection early does not help
LNG-IUD	Spotting 3–6 months	Counsel; check position. TXA, mefenamic acid and UPA showed no benefit (US SPR 2024)
Cu-IUD	Heavier, longer periods	NSAID 5–7 days from the start of bleeding (mefenamic acid 500 mg tds); TXA. Persistent heavy bleeding → LNG-IUD
POP	Irregular bleeding common	Desogestrel or drospirenone (24/4) instead of traditional POP; COC for 3 months if eligible

Side effects and worries

IF	THEN
No withdrawal bleed on CHC	Pregnancy test if pills missed; otherwise reassure (thin endometrium; <2% in year 1). Not harmful and not a reason to stop.
Weight gain	Good evidence only for DMPA (mainly adolescents with BMI ≥30; >5% gain in 6 months predicts more). Others: no consistent effect.
Mood change	Warnings on all hormonal methods (EMA 2018). Review timing and history; trial a different method or a non-hormonal one if symptoms track the method.
Headache or new migraine on CHC	**New aura** (visual or sensory, lasting 5–60 min) → stop CHC now (UKMEC 4); progestogen-only or IUD are fine.
Acne	Worse on implant or LNG-IUD: COC with antiandrogenic progestin if eligible; topical treatment.
Symptoms of VTE on CHC	Stop, investigate; after VTE, CHC is category 4 for life (CHC 3 while on anticoagulation, US).

09 Special situations

IF	THEN
Enzyme-inducing drugs (rifampicin, rifabutin, carbamazepine, phenytoin, topiramate, efavirenz, St John's wort)	• Best: Cu-IUD, LNG-IUD or DMPA (unaffected) • Avoid CHC, POP and implant during and for 28 days after • If CHC must be used (not with rifampicin/rifabutin): 50 µg EE daily, continuous or tricycled with a 4-day break (CoSRH) • EC: Cu-IUD, or LNG 3 mg
Lamotrigine	CHC lowers lamotrigine levels (seizure risk) and the break causes toxicity: avoid CHC, or use continuously with dose review. IUDs and DMPA are unaffected.
Over 40	• All methods possible; CHC to 50 (lowest dose), DMPA switch at 50, POP/implant/LNG-IUD to 55 • Stop non-hormonal methods after 2 years without periods (<50) or 1 year (≥50); FSH ≥30 IU/L twice 6 weeks apart (≥50, on progestogen-only methods) allows stopping a year later
Adolescents	All methods including IUDs are suitable (IUD category 2 under 20, expulsion). DMPA: only after considering alternatives (bone). Assess capacity and safeguarding; confidentiality.
Obesity / after bariatric surgery	All methods effective except patch at BMI ≥30 (US contraindication). Malabsorptive surgery: avoid oral methods; prefer LARC. Oral EC: UPA or LNG 3 mg.
VTE history or thrombophilia	Cu-IUD, LNG-IUD, implant, POP (DMPA 3 in UKMEC for thrombogenic mutations). Never CHC.
Heavy menstrual bleeding or dysmenorrhoea	LNG-IUD (treats HMB), CHC (continuous), DMPA; avoid Cu-IUD. See No. 08.
Wants to stop for pregnancy	Stop any time; no wait is needed for CHC, POP, implant or IUDs. Folic acid 400 µg from 3 months before. DMPA: fertility may take up to a year.

10 Do not

- Withhold a method for lack of a pelvic exam, smear or blood test (except BP for CHC, and BMI).
- Start CHC within 6 weeks of birth in a breastfeeding woman, or within 3 weeks in any woman.
- Give CHC with migraine with aura, VTE history, thrombophilia, age ≥35 smoking ≥15/day, or BP ≥160/100.
- Start hormonal contraception within 5 days after ulipristal.
- Rely on a POP, implant or CHC with an enzyme inducer, or on LAM once periods return or feeds are supplemented.
- Remove an IUD for asymptomatic Actinomyces, or routinely for PID.
- Use DMPA in a woman with a meningioma, or desogestrel/etonogestrel methods (EMA 2026).
- Use the contraceptive patch at BMI ≥30 (US label).
- Push LARC on a woman who does not want it, or delay removal she asks for.

11 Where the guidelines differ

Topic	CDC / ACOG (USA)	CoSRH / UKMEC (UK)	SOGC / WHO
POP and implant, breastfeeding <30 d	Category 2	Category 1	WHO 2 (<6 wk)

Topic	CDC / ACOG (USA)	CoSRH / UKMEC (UK)	SOGC / WHO
DMPA, breastfeeding <6 wk	2 (<30 d)	2	WHO 2025: 2 (was 3)
CHC, breastfeeding	4 <21 d · 3 21–30 d · 2–3 to 6 wk · 2 after	4 <6 wk · 2 to 6 months · 1 after	WHO 4 <6 wk · 3 to 6 mo · 2 after
Postpartum IUD window	≤10 min of placenta (2), then ≥4 wk	≤48 h (1), then ≥4 wk; 48 h–4 wk is 3	WHO ≤48 h
DMPA late injection	Up to 15 wk	Up to 14 wk	—
Implant duration	5 years (FDA 2026)	3 years (licence)	—
Drospirenone POP back-up	Late = <24 h; back-up only if ≥2 missed	7 days if >24 h late	—
Migraine without aura, CHC	2	2 start, 3 continue	WHO splits by age
Oral EC and weight	LNG may be less effective at BMI ≥30; UPA preferred	LNG 3 mg or UPA if BMI >26 or >70 kg	—
LNG-IUD as EC	Not in SPR 2024	Not recommended (2026)	—

12 Abbreviations

Abbr.	Meaning	Abbr.	Meaning	Abbr.	Meaning
ACOG	American College of Obstetricians and Gynecologists	**FSH**	follicle-stimulating hormone	**PCOS**	polycystic ovary syndrome
AI	aromatase inhibitor	**HMB**	heavy menstrual bleeding	**PID**	pelvic inflammatory disease
BMI	body mass index	**HRT**	hormone replacement therapy	**POP**	progestogen-only pill
BP	blood pressure	**IM / SC**	intramuscular / subcutaneous	**PPH**	postpartum haemorrhage
CDC	US Centers for Disease Control	**IUD**	intrauterine device	**SLE**	systemic lupus erythematosus
CEE	conjugated equine estrogen	**LAM**	lactational amenorrhoea method	**SOGC**	Soc. of Obstetricians and Gynaecologists of Canada
CHC	combined hormonal contraception	**LARC**	long-acting reversible contraception	**SPR**	US Selected Practice Recommendations
COC	combined oral contraceptive	**LNG**	levonorgestrel	**STI**	sexually transmitted infection
CoSRH	College of Sexual and Reproductive Healthcare (formerly FSRH)	**LNG-IUD**	levonorgestrel intrauterine device	**TXA**	tranexamic acid
Cu-IUD	copper intrauterine device	**MEC**	Medical Eligibility Criteria	**UKMEC**	UK Medical Eligibility Criteria
DMPA	depot medroxyprogesterone acetate	**MHRA**	UK medicines regulator	**UPA**	ulipristal acetate
DXA	dual-energy X-ray absorptiometry	**MPA**	medroxyprogesterone acetate	**VTE**	venous thromboembolism
EC	emergency contraception	**NET**	norethisterone	**WHO**	World Health Organization
EE	ethinylestradiol	**NICE**	National Institute for Health and Care Excellence		
EMA	European Medicines Agency	**NSAID**	non-steroidal anti-inflammatory drug		
FDA	US Food and Drug Administration	**OTC**	over the counter		

13 Sources

Textbooks

- Taylor HS, Pal L, Seli E. Speroff's Clinical Gynecologic Endocrinology and Infertility, 9th ed. Ch. 22 Hormonal Contraception; Ch. 23 Long-Acting Methods; postpartum contraception and lactation.
- Hoffman BL et al. Williams Gynecology, 4th ed. Ch. 5 Contraception and Sterilization (2020).
- Cunningham FG et al. Williams Obstetrics, 26th ed. Ch. 38 Contraception (2022).
- Berek JS (ed). Berek & Novak's Gynecology, 16th ed. Family Planning chapter (emergency contraception).

Guidelines and labels checked (October 2026)

- CDC. US Medical Eligibility Criteria for Contraceptive Use, 2024 (MMWR Recomm Rep 73(4)); US Selected Practice Recommendations, 2024 (MMWR Recomm Rep 73(3)).
- ACOG Committee Statement 1, Patient-Centered Contraceptive Counseling (2022); Committee Statement 5, Increasing Access to IUDs and Implants (2023); Committee Statement 21, Access to Contraception (2025); Practice Bulletin 186, LARC (2017, reaffirmed 2024); Practice Bulletin 152, Emergency Contraception (2015, reaffirmed 2025); Obstetric Care Consensus 8, Interpregnancy Care (2019); Clinical Consensus 9, Pain Management for In-Office Procedures (2025).
- CoSRH (formerly FSRH): UKMEC 2025; Combined Hormonal Contraception (2019, amended 2023); Recommended actions after incorrect use of CHC (2021); Progestogen-only Pills (2022, amended 2026); Progestogen-only Implants (2021, amended 2023); Progestogen-only Injectables (2014, amended 2023); Intrauterine Contraception (2023, amended 2025); Emergency Contraception (2017, amended 2026); Contraception After Pregnancy (2017, amended 2020); Drug Interactions (2022); Women Aged Over 40 (2017, amended 2025); statements on UPA and breastfeeding (2025) and meningioma (2026).
- MHRA Drug Safety Update, CHC and VTE (2014); MPA and meningioma (2024); valproate (2018–2025) and topiramate (2024) pregnancy prevention programmes. EMA PRAC, desogestrel/etonogestrel and meningioma (2026).
- NICE CG30, Long-acting Reversible Contraception (2005, updated 2019 and 2020; general recommendations only).
- SOGC Canadian Contraception Consensus No. 329 (2015–2017) and EC addendum (2016); Committee Opinion 419, Coercion-free Contraceptive Care (2021). WHO Medical Eligibility Criteria, 6th ed. (2025) and Selected Practice Recommendations, 4th ed. (2025; secondary sources).
- Labels: Nexplanon (FDA, 5 years, 2026); Mirena, Liletta, Kyleena, Skyla, Paragard; Depo-Provera CI and depo-subQ provera 104 (2025); Slynd (FDA; EMC 2023); Xulane, Twirla, NuvaRing, Annovera, Opill.
- Contraceptive Technology, 22nd ed. (2023). EURAS-IUD (Heinemann 2015; Barnett 2017); APEX-IUD (Reed, Lancet 2022); Averbach, AJOG 2020 (postplacental expulsion).

Decision aid only: it does not replace clinical judgement or local protocols. Verify drug doses against your formulary.