A contraception adapted to each age-group

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Contraception for young people

Adapting contraception to sexual, social, and emotional life of young people

- Age of first sexual relation is quite young in Europe

  17,2/17,4 for both sexes in France

- Age for first birth quite late
  30 years old in France

- An average of 10 years of sexual activity at a time of highest fertility

- Period of sexual activity followed by long period of sexual inactivity

A first contraception consult is above all, a time for a dialogue and to listen

From the teen ager point of view :

They are afraid of….

- Pelvic exam
- to talk about her sexuality
- important to recall the concept of professional secrecy
- If possible consult without parents

From the provider point of view

Has to be a non parental adult referent theoretically neutral

Has to take into account the anxiety around normality, STD, weight, acne, fertility.

But also to check for risks factors

Family History

- deep vein thrombosis, pulmonary embolism
- Stroke/ischemic heart disease at young age (less than 50 years old)
- Diabetes melitus

Personal History

- Known high pressure or dyslipidemia
- Smoking (not a CI when less than 35 years old)
- Migraines with auras
- eating disorders (bulimia and vomiting)
- Interaction with other drugs

Limited clinical exam

- Measure of blood pressure
- Weight

Women can begin using hormonal contraception

- without a pelvic examination
- Without any blood test or other routine lab test
- Without cervical screening
- Without a breast examination

Guidelines Committee of the American College of Physicians. Screening Pelvic Examination in Adult Women: A Clinical Practice. (2014)

- Clinicians do not need to perform pelvic examination before prescribing oral contraceptives.
- Screening for sexually transmitted disease can be performed with urine testing or vaginal swabs and does not require a pelvic examination.
- Evaluation is often indicated in women with such symptoms as vaginal discharge, abnormal bleeding, pain, urinary problems and sexual dysfunction.
- When screening for cervical cancer, examination should be limited to visual inspection of the cervix and cervical swabs

To counsel or/and prescribe a contraception…

Take into account

- Medical contraindications
- What she wants
- What she needs and her fears

Give all information about possible side effects (changes in bleeding patterns, spotting, amenorrhea)

Which hormonal contraception?

COC if no contraindications

- The lowest dose of estrogen (less than 35µg)
- Second generation progestin but switch to 3rd or 4th if need
- Monophasic(easy for missing pills)
- Continuous with or without placebo (to propose)
- Ring and patch if compliance is not good
- The cheapest one if possible

Why COC on first line

- Very effective contraception
- Benefits on dysmenorrhea
- Less irregular bleedings
- Can improve slightly mild/moderate acne?

Which hormonal contraception?

- **Progestogen-only pill**

if contraindication to estrogen

- Less effective for some of them

- More side effects (frequent erratic bleedings and amenorrhea)

- **Implant and injectable** for a longer acting contraception`

- Very effective

- More side effects (Erratic bleedings and amenorrhea, Gain weight, acne)

Copper or LNG-IUD is a good option

- No increase of infection
- Insertion more painful but tolerance is very good (more dysmenorrhea with copper-IUD).
- No prophylactic antibiotics
- IST screening is an option

Not to forgot the other contraception methods

- Less effective but useful

- Spermicides
- Diaphragm
- Condoms
- *Fertility awareness method*

AND information on emergency contraception has to be given at every contraception consult

Contraception after 35 years old

Fertility after 35 years

- Decrease of the fertility

- Probability to become pregnant after 12 months (INED 2008) :

  75 % at 25 years

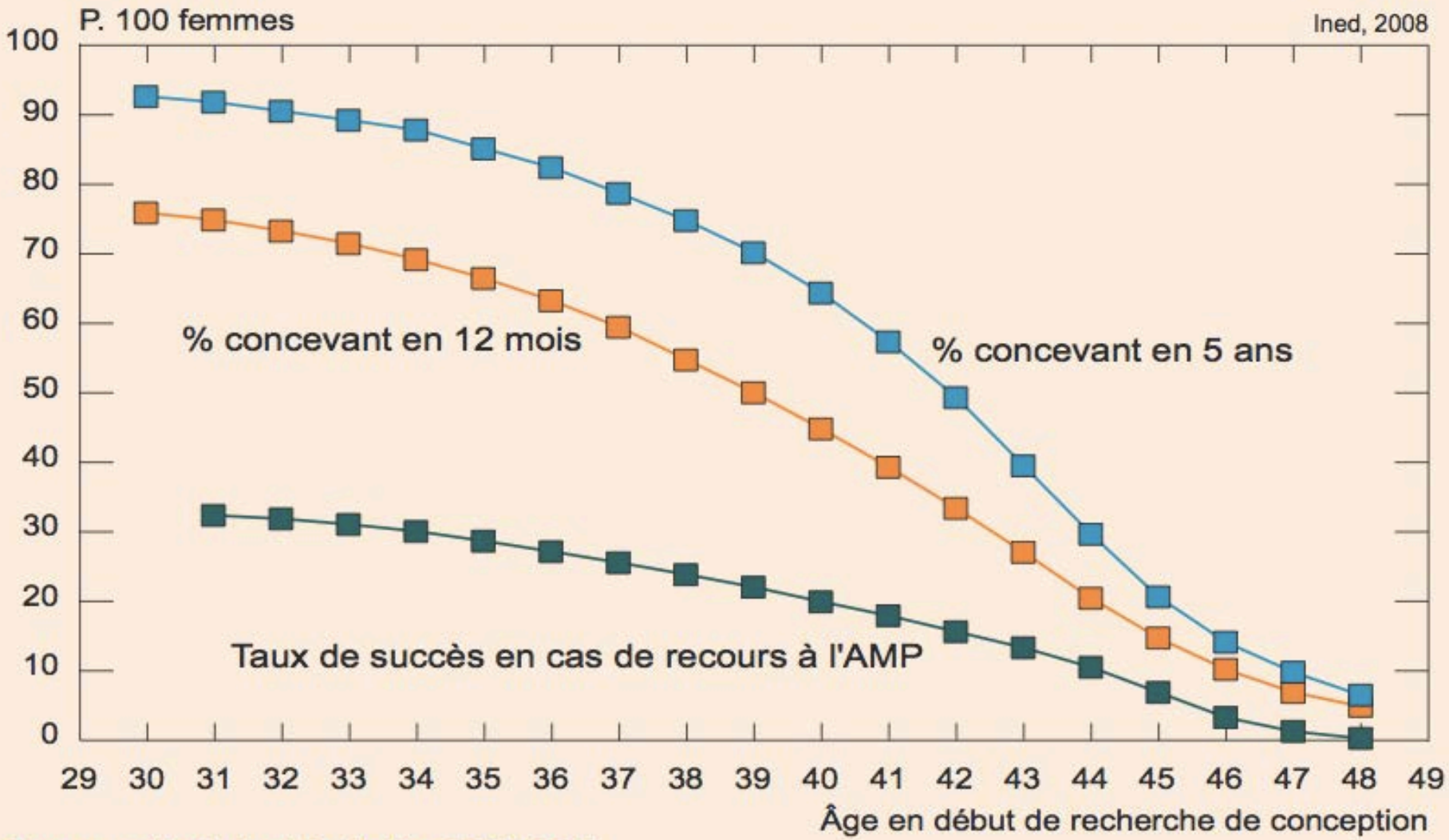
  66 % at 35 years

  44% at 40 years

- Less than 60 pregnancies come to term between 50/54 years old (on 811 000 births)

- High risk of miscarriage (30% at 43 years)

Figure 1. Probabilité d'obtenir une grossesse (conduisant à une naissance vivante) selon l'âge en début de tentative : spontanément en 12 mois ou en 5 ans, au moyen d'un traitement d'aide médicale (deux tentatives de FIV)



Source : modèle de simulation (Leridon, 2004 et 2005).

Women after 35 years old need a contraceptive method

Fertility is variable from one woman to another one and impossible to know

therefore

Contraception is essential and choice of the method has to take into account age and risk factors (CVD, smoking, cancers)

Which contraceptive method?

- **Hormonal contraception**

COC can be continued if no CI
be aware of CVD risks and smoking after 35 yo

- **Progestin-only pill/Implant**

Option when estrogen has to be stopped

--- *When can she stops?*

COC are hiding menopause symptoms

POCs give amenorrhea and reduce hot flushes

Around 50, propose a few months break with a back up methods (condom, spermicides)

Which contraceptive method?

- **IUD**

No need to change it after 35/40 yo (WHO, Wu) even if inserted more than 5 years ago.

LNG-IUD : good alternative if heavy bleeding

--- *When to remove the IUD*

Copper-IUD: after one year of amenorrhea

LNG-IUD function of the symptoms (hot flushes)

And also..

- **Barriers methods** (condoms, spermicides)
- **Male and female sterilization**

Regardless the age…

- To prescribe or to counsel a contraceptive method need to Take into account medical contraindications

But also what the woman or the couple want, the needs and the fears

- Give a complete information of the possible side effects (modification of the bleeding pattern)
- Need not to be dogmatic “pill for the youngs and IUD for the olders