Complete Summary

GUIDELINE TITLE

Contraceptive choices for women with inflammatory bowel disease.

BIBLIOGRAPHIC SOURCE(S)

Contraceptive choices for women with inflammatory bowel disease. J Fam Plann Reprod Health Care 2003 Jul;29(3):127-34. [76 references] PubMed

GUIDELINE STATUS

This is the current release of the guideline.

COMPLETE SUMMARY CONTENT

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SCOPE

DISEASE/CONDITION(S)

- Unintended pregnancy
- Inflammatory bowel disease (Crohn's disease, ulcerative colitis)

GUIDELINE CATEGORY

Counseling
Management
Prevention

CLINICAL SPECIALTY

Family Practice
Gastroenterology

Internal Medicine
Obstetrics and Gynecology

INTENDED USERS

Advanced Practice Nurses
Nurses
Patients
Physician Assistants
Physicians

GUIDELINE OBJECTIVE(S)

- To provide information on the effects of inflammatory bowel disease (IBD) in women of reproductive age with particular reference to contraceptive choices, fertility, and pregnancy
- To provide recommendations on contraceptive choices for women with IBD

TARGET POPULATION

Women of reproductive age with inflammatory bowel disease

INTERVENTIONS AND PRACTICES CONSIDERED

1. Discussing the potential effects of inflammatory bowel disease (IBD) on reproductive health, pregnancy and contraceptive requirements
2. Contraceptive use:
    - Combined oral contraception (COC)
    - Progestogen-only pill (POP)
    - Depot medroxyprogesterone acetate (DMPA) (not recommended in women with low bone density or who have had repeated courses of corticosteroids)
    - Progestogen-only implants
    - Levonorgestrel-releasing intrauterine system (IUS)
    - Copper-bearing intrauterine device (IUD)
    - Laparoscopic sterilization (most appropriate at the time of elective surgery; not recommended in women who have had previous pelvic or abdominal surgery)
    - Barrier methods (inappropriate alone in women using potentially teratogenic drugs)
    - Progestogen-only emergency contraception
3. Referral for pre-pregnancy counseling
4. A multidisciplinary approach to improve IBD management

MAJOR OUTCOMES CONSIDERED

- Effect of medications used for treatment of inflammatory bowel disease (IBD) on fertility, pregnancy, and contraception
- Effect of surgery for IBD on fertility, pregnancy, and contraceptive use
- Risks and benefits of contraceptive use in women with inflammatory bowel disease

METHODOLOGY

METHODS USED TO COLLECT/SELECT EVIDENCE

Hand-searches of Published Literature (Primary Sources)
Hand-searches of Published Literature (Secondary Sources)
Searches of Electronic Databases

DESCRIPTION OF METHODS USED TO COLLECT/SELECT THE EVIDENCE

Electronic searches were performed for: MEDLINE (CD Ovid version) (1996-2003); EMBASE (1996-2003); PubMed (1996-2003); the Cochrane Library (to 2003), and the US National Guideline Clearing House. The searches were performed using relevant medical subject headings (MeSH), terms, and text words. The Cochrane Library was searched for systematic reviews, meta-analyses and controlled trials relevant to emergency contraception. Previously existing guidelines from the Faculty of Family Planning and Reproductive Health Care (FFPRHC), the Royal College of Obstetricians and Gynaecologists (RCOG), the World Health Organization (WHO), and reference lists of identified publications were also searched. Similar search strategies have been used in the development of other national guidelines.

NUMBER OF SOURCE DOCUMENTS

Not stated

METHODS USED TO ASSESS THE QUALITY AND STRENGTH OF THE EVIDENCE

Weighting According to a Rating Scheme (Scheme Not Given)

RATING SCHEME FOR THE STRENGTH OF THE EVIDENCE

Not applicable

METHODS USED TO ANALYZE THE EVIDENCE

Systematic Review with Evidence Tables

DESCRIPTION OF THE METHODS USED TO ANALYZE THE EVIDENCE

Selected key publications were appraised according to standard methodological checklists before conclusions were considered as evidence. Evidence was graded using a scheme similar to that adopted by the Royal College of Obstetricians and Gynaecologists (RCOG) and other guideline development organizations.

Evidence tables (available on the Faculty Web site [www.ffprhc.org.uk]) summarise relevant published evidence on inflammatory bowel disease, which was identified and appraised in the development of this Guidance.

METHODS USED TO FORMULATE THE RECOMMENDATIONS

Expert Consensus

DESCRIPTION OF METHODS USED TO FORMULATE THE RECOMMENDATIONS

Not stated

RATING SCHEME FOR THE STRENGTH OF THE RECOMMENDATIONS

Grades of Recommendation based on levels of evidence as follows:

A: Evidence based on randomised controlled trials (RCTs)

B: Evidence based on other robust experimental or observational studies

C: Evidence is limited but the advice relies on expert opinion and has the endorsement of respected authorities

Good Practice Point where no evidence exists but where best practice is based on the clinical experience of the Expert Group

COST ANALYSIS

A formal cost analysis was not performed and published cost analyses were not reviewed.

METHOD OF GUIDELINE VALIDATION

Peer Review

DESCRIPTION OF METHOD OF GUIDELINE VALIDATION

Not stated

RECOMMENDATIONS

MAJOR RECOMMENDATIONS

Definitions of the grades of recommendation, based on levels of evidence (A-C, Good Practice Point), are provided at the end of the "Major Recommendations" field.

What effect does inflammatory bowel disease (IBD) have on reproductive health?

1. Health professionals managing women with IBD should discuss its potential effect on reproductive health, pregnancy, and contraceptive requirements (**Grade C**).

Does IBD have an effect on menstrual cycle, fertility, and pregnancy?

2. Pregnancy in women with IBD should be a planned event when disease is well controlled (**Grade B**).

Do medications used in the treatment of IBD affect fertility, pregnancy, or contraception?

3. Effective contraception must be used while taking methotrexate, and for at least 3 months after its discontinuation (**Grade C**).
4. Women using combined oral contraception (COC) should use additional contraception while taking non-enzyme-inducing antibiotic courses of less than 3 weeks and for 7 days after they are discontinued (**Grade C**).
5. COC users who are established on non-enzyme-inducing antibiotics for more than 3 weeks do not require additional contraception unless they change to a different antibiotic (**Grade C**).
6. Women using progestogen-only methods of contraception do not need additional contraceptive protection when taking non-enzyme-inducing antibiotics for any duration (**Grade C**).

How does surgery for IBD affect fertility and pregnancy?

- The risk of subfertility following surgical intervention should be discussed with women with IBD as this may influence decisions regarding the timing of childbearing (**Good Practice Point**).
- Clinicians should consider ectopic pregnancy in their differential diagnosis of abdominal pain in sexually active women with IBD (**Good Practice Point**).

How does pregnancy affect IBD?

- Appropriate referral for pre-pregnancy counselling should be available to all women with IBD to optimise management before conception (**Good Practice Point**).

How might IBD affect contraceptive use?

- Women should be advised that the efficacy of oral contraception is unlikely to be reduced by large bowel disease but may potentially be reduced in women with Crohn's disease (CD) who have small bowel disease and malabsorption (**Good Practice Point**).

How might extra-intestinal manifestations of IBD affect contraceptive use?

7. Co-existing disorders in women with IBD should be considered when assessing eligibility for contraceptive use (**Grade C**).

Women with IBD who have additional risk factors for osteoporosis should have bone mineral density (BMD) measured (**Good Practice Point**).

How might surgery for IBD affect contraceptive use?

- Women with IBD should stop COC at least 4 weeks before major elective surgery, and alternative contraception should be provided (**Good Practice Point**).
- Women with IBD using progestogen-only contraception need not discontinue it prior to major elective surgery (**Good Practice Point**).

What are the contraceptive options for women with IBD?

8. Women with IBD should be offered the same contraceptive choices as women without IBD. Certain contraceptive methods may have specific cautions for disorders associated with IBD (**Grade C**).
9. Women with ulcerative colitis (UC) can use oral contraception (**Grade C**).
10. Women with Crohn's Disease who have small bowel involvement or malabsorption may have a reduced efficacy of oral contraception (**Grade C**).
11. Women with IBD with low bone density or who have had repeat courses of corticosteroids or malabsorption should be advised against the use of depot medroxyprogesterone acetate (DMPA) (**Grade C**).
12. Laparoscopic sterilisation is an inappropriate method of contraception for women with IBD who have had previous pelvic or abdominal surgery (**Grade B**).

Barrier methods may be inappropriate for women with IBD who are using potentially teratogenic drugs or in whom disease is active and severe (**Good Practice Point**).

Does contraceptive use influence IBD?

13. Women can be reassured that a pathogenic role for COC in IBD is unsubstantiated (**Grade B**).

How does IBD affect self-esteem, self-image, and psychosexual health?

- Health professionals should provide an opportunity for women to discuss issues relating to sexuality and body image and know where to refer locally when appropriate (**Good Practice Point**).

How might a multidisciplinary approach improve IBD management?

- Managed clinical care pathways should be developed locally to promote integrated working between different service providers to ensure that all reproductive health care needs of women with IBD are met (**Good Practice Point**).

<u>Definitions</u>

Grades of Recommendation based on levels of evidence as follows:

A: Evidence based on randomised controlled trials (RCTs)

B: Evidence based on other robust experimental or observational studies

C: Evidence is limited but the advice relies on expert opinion and has the endorsement of respected authorities

Good Practice Point where no evidence exists but where best practice is based on the clinical experience of the Expert Group

CLINICAL ALGORITHM(S)

None provided

EVIDENCE SUPPORTING THE RECOMMENDATIONS

TYPE OF EVIDENCE SUPPORTING THE RECOMMENDATIONS

The type of supporting evidence is identified for each recommendation (see "Major Recommendations" field).

BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS

POTENTIAL BENEFITS

- Improved knowledge of the effects of inflammatory bowel disease (IBD) on contraceptive choices, fertility, and pregnancy in women of reproductive age
- Appropriate medical advice regarding contraceptive options for women with IBD

POTENTIAL HARMS

- The efficacy of combined oral contraception (COC) may be reduced by non-enzyme-inducing antibiotics and St. John's Wort.
- COC may increase serum levels of cyclosporin.
- The risk of venous thromboembolism for women using COC containing norethisterone or levonorgestrel is increased three-fold to 15 per 100,000. Use of a third-generation COC (containing desogestrel or gestodene) increases the risk to 25 per 100,000.
- COC and progestogen-only pill (POP) absorption may be reduced in women with small bowel involvement and malabsorption.
- Laparoscopic sterilization is associated with increased complications in women who had previous abdominal or pelvic surgery.
- Barrier methods of contraception have high failure rates and are inappropriate in women using potentially teratogenic drugs.

CONTRAINDICATIONS

CONTRAINDICATIONS

- Combined oral contraception, progestogen-only pills and implants, depot medroxyprogesterone acetate, and levonorgestrel-releasing intrauterine system are contraindicated in primary sclerosing cholangitis.
- Combined oral contraception should not be used by women with personal history of venous thromboembolism or undergoing major surgery with immobilization.

IMPLEMENTATION OF THE GUIDELINE

DESCRIPTION OF IMPLEMENTATION STRATEGY

An implementation strategy was not provided.

INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES

IOM CARE NEED

Living with Illness
Staying Healthy

IOM DOMAIN

Effectiveness
Patient-centeredness

IDENTIFYING INFORMATION AND AVAILABILITY

BIBLIOGRAPHIC SOURCE(S)

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ADAPTATION

Not applicable: The guideline was not adapted from another source.

DATE RELEASED

2003 Jul

GUIDELINE DEVELOPER(S)

Faculty of Sexual and Reproductive Healthcare - Professional Association

SOURCE(S) OF FUNDING

Faculty of Family Planning and Reproductive Health Care

GUIDELINE COMMITTEE

Clinical Effectiveness Committee

COMPOSITION OF GROUP THAT AUTHORED THE GUIDELINE

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FINANCIAL DISCLOSURES/CONFLICTS OF INTEREST

Not stated

GUIDELINE STATUS

This is the current release of the guideline.

GUIDELINE AVAILABILITY

Electronic copies: Available in Portable Document Format (PDF) from the Faculty of Family Planning and Reproductive Health Care Web site.

Print copies: Available from the Faculty of Family Planning and Reproductive Health Care, 27 Sussex Place, Regent's Park, London NW1 4RG

AVAILABILITY OF COMPANION DOCUMENTS

None available

PATIENT RESOURCES

None available

NGC STATUS

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