

Care and Treatment Plan: Progestin-Only Hormonal Contraceptives

Definition

Progestin-only hormonal contraception (POHC) is a hormonal contraceptive method that contains only progestin. There are four types of POHCs available in Canada:

- Progestin-only oral contraceptive pills
- Progestin-only injectable (Depot-Medroxyprogesterone Acetate) (Injectable)
- Progestin-only implant device
- Levonorgestrel-releasing intrauterine system (see DST 803: Insertion and Removal of Intrauterine Contraceptives)

Registered Nurses who hold **Reproductive Health – Contraceptive Management** Certified Practice (RN(C)) designation are authorized to independently prescribe,¹ dispense, administer, insert, or remove oral, injectable, and implant types of POHC in accordance with the parameters identified in this DST.²

This DST provides guidance for RN(C)s to prescribe, dispense, administer, insert, or remove oral, injectable, and implant types of POHC. Therefore, POHC in this DST refers only to the first three progestin-only methods of contraception: oral, injectable, and implant. For guidance on intrauterine systems, see DST 803: Insertion and Removal of Intrauterine Contraceptives. This DST is meant to be used in concert with DST 800: Assessment and Diagnostic Guideline: Contraceptive Management.

Note: A *consultation* refers to the RN(C) collaborating with members of the care team, such as a physician, nurse practitioner, or pharmacist, to support decision-making processes related to the diagnosis, treatment, and management of the diseases, disorders, and conditions that the RN(C) are authorized to diagnose, treat, and manage. A *referral* is when an RN(C) refers a patient to a medical care provider for further treatment, care, or management. This occurs when patients are presenting with symptoms outside of what is provided in this document, including symptoms that require urgent referral.

Indications

For the purposes of RN(C)s certified in Contraceptive Management, POHCs are indicated for any client who is seeking a reliable, reversible method of contraception. POHCs are a reliable and effective contraceptive option for clients unable to use estrogen-containing contraception.³ In addition to pregnancy prevention, hormonal contraception may be indicated for the management of menstrual and bleeding-related conditions and offers several non-contraceptive health benefits.^{4,3} However, clients seeking or using hormonal contraception solely for purposes other than contraception must be referred for a client-specific order or transfer of care. Please see DST 800: Assessment and Diagnostic Guideline: Contraceptive Management for examples.

Pharmacokinetics

Oral

Oral POHCs are supplied in packages of 28 tablets.

Most formulations have 28 active pills each containing 35mcg of norethindrone.³ A new formulation with a 24-2 regimen, containing drospirenone has been released and has a longer half-life than norethindrone.⁴

Injectable

Injectable POHCs are supplied in vials of 150mg to be injected intramuscularly every 12-13 weeks, with a range of 10 to less than 15 weeks being acceptable.³

Implant

Implant POHC is supplied as a 68mg etonogestrel, radiopaque implant device to be inserted subdermally in the upper arm once every three years.³

Action

The primary method of action of POHCs is the inhibition of the secretion of pituitary gonadotropins, which then suppresses ovulation (except for IUCs).³ POHCs also make cervical mucus more viscous, which impedes sperm transport and induces endometrial atrophy, making the endometrium unreceptive to implantation.³

Onset

The contraceptive benefits of POHCs are realized within seven days of consistent and correct POHC use.

If the POHC is initiated less than five days since the menstrual/monthly bleeding pattern started, no backup is needed. Otherwise, contraceptive benefits are realized within seven days.^{3,5}

Consultation and/or Referral

RN(C)s are restricted to prescribing, dispensing, administering or inserting POHCs to clients who classify as category 1 or 2 as defined by the *U.S. Medical Eligibility Criteria for Contraceptive Use*.⁶

RN(C)s cannot independently prescribe, dispense, administer or insert POHCs without an order to clients who classify as category 3 or 4.⁶

RN(C)s consult with, refer to, or transfer care to other health professionals about the treatment plan or as needed to meet the client's needs as per BCCNM's practice standards: Acting Within Autonomous Scope of Practice (Certified Practice).²

Relative Contraindications

As per *U.S. Medical Eligibility Criteria for Contraceptive Use*, Category 3.⁶

Absolute Contraindications

As per *U.S. Medical Eligibility Criteria for Contraceptive Use*, Category 4.⁶

RN(C)s must refer or consult with a physician or nurse practitioner for the following clients:

- Clients wanting to use a POHC in the presence of relative or absolute contraindications (*U.S. Medical Eligibility Criteria for Contraceptive Use* categories 3 and 4).⁶
- On follow-up, clients whose medical condition has changed so that they might be using CHCs in the presence of relative or absolute contraindications as defined by the *U.S. Medical Eligibility Criteria for Contraceptive Use*, Categories 3 and 4.⁶ For Example:
 - ACHES (abdominal pain, chest pain, headache, eye problems and severe leg pain)
 - Clients taking POHCs containing drospirenone:
 - Drospirenone may increase potassium. Clients should be advised to inform their healthcare provider if they have kidney, liver, or adrenal disease, as the use of drospirenone-containing POHCs in the presence of these conditions could cause serious heart and/or health problems.
 - Clients should also inform their healthcare provider if they are currently on daily, long-term medications for chronic conditions such as NSAIDs, potassium-sparing diuretics, potassium supplementation, ACE inhibitors, or angiotensin-II receptor antagonists, heparin, aldosterone antagonists, or strong CYP3A4 inhibitors.^{7,8}

Drug Interactions

The following drugs and drug classes are considered *U.S. Medical Eligibility Criteria* category 3 or 4 and could have some effect on POHC absorption and metabolism.⁹ Clinicians should always refer to the most current *U.S. Medical Eligibility Criteria* for up-to-date drug interactions. RN(C)s must refer or consult with a physician or nurse practitioner for clients taking any of the following medications:

Oral

- Certain anticonvulsants: phenytoin, carbamazepine, barbiturates, primidone, topiramate, oxcarbazepine.⁶
- Certain antimicrobials: Rifampicin or Rifabutin therapy.⁶
- Tirzepatide (Mounjaro): Decreases bioavailability of OCPs. Recommend client to use barrier contraception for 4 weeks after initiation or a dosage increase, or to switch to a non-oral contraceptive.^{10,11}

Note: With the exception of Rifampicin or Rifabutin therapy, antibiotic use does not affect POHC efficacy. Barrier methods should be used while on Rifampicin or Rifabutin therapy. Hormonal contraceptives should not be stopped. Antibiotics need to be taken for their full course.¹²

Injectable

- Aminoglutethimide used to treat Cushing's disease, may interact with DMPA.¹³

Note: This interaction is not found in the U.S. Medical Eligibility Criteria, but aminoglutethimide may decrease the effectiveness of injectable POHC.¹⁴

Implant

- There are no drug interactions noted in the *U.S. Medical Eligibility Criteria*.⁶

Pregnancy and Breastfeeding/Chestfeeding

Pregnancy

There is no known harm to the person, the course of the pregnancy, or the fetus if POHCs are inadvertently used during pregnancy.¹⁵

The relationship between injectable POHC use during pregnancy and its effects on the fetus remains unclear.¹⁵

If a POHC is inadvertently initiated with a pregnant client or the client becomes pregnant during POHC use, the POHC should be discontinued immediately.¹⁵

Postpartum

- Initiation of POHCs can occur directly post-partum regardless of breastfeeding/chestfeeding status.^{6,15}

Breastfeeding/Chestfeeding

Progestin is excreted in human milk in small quantities but is unlikely to have an effect on the infant.¹⁵

- Breastfeeding/chestfeeding is not a contraindication for POHC use.^{6,15}

Precautions and Considerations

Precautions and Considerations Specific to ORAL Progestin-Only Hormonal Contraceptives

- Clients who have undergone malabsorptive procedures, such as gastric bypass or biliopancreatic diversion, are categorized as *U.S. Medical Eligibility Criteria* category 3.⁶
- Malabsorption related to chronic gastrointestinal inflammation and active diarrhea might cause ineffectiveness of any oral contraception.⁶
- Repeated vomiting (e.g., bulimia, severe GI illness) and/or severe, persistent diarrhea can decrease the absorption of the pill and might decrease its effectiveness. Vomiting within 3 hours of pill ingestion might require repeated doses.¹⁶

Precautions and Considerations Specific to INJECTABLE Progestin-Only Hormonal Contraceptives

- Injectable POHCs have been associated with decreased bone mineral density that is generally temporary and reversible.¹³ The advantages of injectable use generally outweigh theoretical concerns regarding fracture risk. The available evidence does not justify limiting the duration of injectable use due to bone density concerns. Use of injectable POHCs in the absence of symptoms or other risk factors (e.g., strong family history of osteoporosis) is not an indication for bone mineral density testing.¹³
- Clients should be informed about the potential effects of injectable POHCs on bone mineral density and counselled about bone health, including calcium and vitamin D supplements, smoking cessation, weight-bearing exercise, and decreased alcohol and caffeine consumption.¹³
- To rule out a rare but possible severe allergic reaction to injectable POHCs, clinicians should recommend that clients wait in the care setting for 15 minutes following injection.
- Injectable POHCs may lead to a slower return to fertility than other hormonal contraceptives. The average return to fertility is 10-17 months from the last injection.³

Precautions and Considerations Specific to IMPLANTED Progestin-Only Hormonal Contraceptives

- The implant can be felt under the skin and is approximately the size of a matchstick.⁵
- Clients with known clotting disorders or those on anticoagulant therapy may not be suitable candidates and should be assessed by a nurse practitioner or physician prior to receiving the implant.⁵
- Clients may return to the provider at 4-6 weeks for follow-up for any side effects, concerning menstrual changes/monthly bleeding pattern changes, difficulty palpating the implant, or if a local reaction occurs.⁵

Adverse Effects

Side effects from POHCs are often mild and transient and respond to a change in formulation.¹⁵ Acknowledgment and management of side effects are crucial to the successful continuation of POHCs.

Common Possible Side Effects

Common side effects of POHCs include, but are not limited to:

- Appetite changes (can result in weight gain)
- Breast/chest tenderness
- Menstrual/monthly bleeding pattern disturbance, including breakthrough bleeding, irregular bleeding, and amenorrhea
- Headaches (mild, without aura)
- Decreased libido
- Mood changes
- Delayed return to fertility (injectable POHC only)
- Weight gain (injectable and implanted POHC only)
- Pain/bruising at the site of insertion (implanted POHC only)

Warning and Precautions

Serious complications from POHCs are rare.¹⁵

The following symptoms should be investigated immediately, and the client should be referred to a physician or nurse practitioner. These symptoms might also warrant the discontinuation of POHCs:^{6,15}

- ACHES (abdominal pain, chest pain, headache, eye problems and severe leg pain)
- Moderate to severe depression
- Blood pressure >160/100
- Under the *U.S. Medical Eligibility Criteria for Contraceptive Use*, RN(C)s may prescribe, dispense, administer, and insert oral and implant POHC as Category 2; however, RN(C)s should refer the client for a hypertension assessment
- Under the *U.S. Medical Eligibility Criteria for Contraceptive Use*, injectable POHC is Category 3; RN(C)s must refer the client for contraception and a hypertension assessment
- Jaundice
- Severe or worsening migraine headaches with or without aura
- Severe allergic reaction
- Unexplained vaginal/genital bleeding
- In rare circumstances, the implant may migrate. If the client cannot feel the implant, they should visit their healthcare provider.

Client Education Specific to POHC Use

Irregular menses are common within the first several months of POHC use, and after 6-12 months, amenorrhea is more likely.³

Oral

For Norethindrone containing POHC, a missed pill by more than three hours from the regular time requires the use of backup

contraception (e.g., a condom) for 48 hours after the missed dose.³

For Drospirenone containing POHC, missing more than 1 pill, take as soon as possible to maintain contraceptive protection, if 2 or more pills are missed use of back up contraception for 7 days.

Note: If available, advise the client to follow the product monograph, or advise the client to contact a health care provider or clinic. Some clinics choose to develop client handouts or resources specific to missed or late POHC doses. The Society of Obstetricians and Gynecologists of Canada (SOGC) or the US Medical Eligibility Criteria Selected Practice Recommendations for Hormonal Contraceptive Use (2024) have guidelines for missed hormonal contraceptives that can be used as a resource for health care providers.

Injectable

- Weight gain is possible with the injectable contraceptive.⁶
- Regarding bone health, clients using injectable POHCs should be counselled regarding calcium intake and or supplementation, supported with smoking cessation and perform weight-bearing exercises at least three times a week.¹⁵
- If it has been 15 weeks or more since the last injection, a urine pregnancy test should be performed. Use of emergency contraception can be considered if intercourse has occurred within the last 5-7 days. A backup contraceptive method should be recommended for the subsequent seven days. Depending on the client's risk of pregnancy, a repeat urine pregnancy test may be indicated at two – four weeks or before the next injection.³
- Counsel the client that once the injectable POHC is administered, there is no way to reverse it.³
- Clients should be counselled about the longer return to fertility with injectable POHCs (see Precautions Specific to INJECTABLE Progestin-Only Hormonal Contraceptives above).

Implant

- Weight gain is possible with the injectable contraceptive.⁵
- Counsel clients to contact their healthcare provider if they are unable to palpate the implant at any time (Merck, 2020).
- Counsel the client that once the implant is administered, it must be removed by a health care provider to have it reversed.
- Provide resources for providers who can remove implant, if your clinic does not.

Prescribing, Dispensing, Administering, and Inserting POHC

For prescribing and dispensing POHCs, refer to DST 800: Assessment and Diagnostic Guideline: Contraceptive Management.

If EC is required, dispense, prescribe or refer for EC as follows:

- Oral EC, 750mg Levonorgestrel
- EC IUC Insertion (RN(C)s who meet requirements to insert IUCs or referral)
- Oral EC, Ulipristal Acetate (requires referral)

Administering Injectable POHC

- Mix the suspension well by shaking the vial before drawing up the medication.
- Using a 21-23-gauge needle appropriate for muscle mass, administer 1cc of 150mg/mL injectable POHC via intramuscular injection into the deltoid or ventrogluteal muscle, depending on the client's preference.³ The ventrogluteal muscle might be less painful for the client.
- Do not massage the injection site.

Administering and Removing Implanted POHC

RN(C)s Certified Practice in Reproductive Health: Contraceptive Management MUST complete implant-specific, hands-on recommended training or equivalent (e.g., UBC CPD) program prior to autonomous insertion or removal of a contraceptive implant.

Procedural pain relief for insertion:

- 1-2% Lidocaine - injected at site of insertion.^{16,17}

Post Procedure pain relief:

- **Oral Ibuprofen:** 200 mg every 4 to 6 hours as needed; if no relief, may increase to 400 mg every 4 to 6 hours as needed; maximum dose: 1.2 g/day. Use for >10 days is not recommended unless directed by health care provider.¹⁸
- **Oral Naproxen:** 200 to 400 mg once, followed by 200 mg every 8 to 12 hours as needed; maximum dose: 400 mg in any 8- to 12-hour period or 600 mg in a 24-hour period.¹⁹

Documentation

Refer to DST 800: Assessment and Diagnostic Guideline: Contraceptive Management for documentation requirements.

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