Eligibility criteria for COCs

Absolute contraindications to COCs or other combined methods (e.g. Evra)

As already mentioned, all lists of absolute or relative contraindications in this book are based on UKMEC, with a very few differences based on the author's judgement of the evidence. Compare with the Faculty Guidance document *First Prescription of Combined Oral Contraception*, at www.fsrh.org: several important conditions below (e.g. porphyria, hypertriglyceridaemia, pemphigoid gestationis and idiopathic intracranial hypertension) are not mentioned in relation to the COC there, or in UKMEC 2009.

All conditions in this first list are WHO 4 for the COC. However, as will be shown later, for the same conditions progestogen-only Pills (POPs), including Cerazette, and other progestogen-only methods, are in most cases classified no higher than WHO 2.

1. **Past or present circulatory disease**
   - Any *past proven arterial or venous thrombosis*
   - Established *ischaemic heart disease or angina or coronary arteritis* (current Kawasaki disease—past history is WHO 3 or 2, depending on completeness of recovery). Also significant *peripheral vascular disease*
   - *Multiple risk factors* for venous or arterial disease
   - *Severe* single factors can also be enough for the WHO 4 category (see Tables 5 and 6):
     - *BMI* $\geq$ *40*,
     - *BP* $\geq$ *160/>95* and
     - *diabetes with tissue damage*
   - *Atherogenic lipid disorders* (some not all, a complex issue, take advice from an expert)
   - Known prothrombotic states:
     - i.e. any of above *congenital or acquired thrombophilias*, including *SLE if antiphospholipid antibodies positive* (or unknown). Secondary Raynaud's phenomenon indicates testing for these
     - from at least 2 (preferably 4) weeks before until 2 weeks after mobilization following *elective major surgery* (do not demand that the COC be stopped for minor surgery such as brief laparoscopy with minimal post-operative immobilization) and *almost all leg surgery* (e.g. operative arthroscopy of knee, or for varicose veins)
     - during *leg immobilization (e.g. after fracture)*
   - *Migraine* ***with aura*** (described on pp. 41–43)
   - Definite *aura without a headache following*
   - Past *ischaemic stroke, transient ischaemic attacks*
   - Past *cerebral haemorrhage*
   - *Pulmonary hypertension, any cause*
   - *Structural heart disease* such as valvular heart disease or shunts/septal defects is only WHO 4 if there is an *added arterial or venous thromboembolic risk* (persisting, if there has been surgery). Always discuss this with the cardiologist—could be WHO 3, especially if the patient is always anticoagulated. Important WHO 4 examples:
     - *Atrial fibrillation or flutter* whether sustained or paroxysmal—or not current but high risk (e.g. mitral stenosis)
     - *Dilated left atrium* (>4 cm)
     - *Cyanotic heart disease*
     - Any *dilated cardiomyopathy*; but this is classified as only WHO 2 when in full remission after a past history of any type (including pregnancy cardiomyopathy)
   - In other structural heart conditions, if there is little or no direct or indirect risk of thromboembolism (this being the crucial point to check with the cardiologist), the COC is usable (WHO 3 or 2)
2. **Liver**
   - *Liver adenoma, carcinoma*
   - *Active liver cell disease, whenever liver function tests are currently significantly abnormal*, including infiltrations, severe chronic hepatitis B and C, and cirrhosis (though UKMEC allows WHO 1 for the latter if it is compensated, no complications)
   - Past *Pill-related cholestatic jaundice*; if this was only in pregnancy and never with the COC, this can be classified WHO 2. (Contrast UKMEC, who permit WHO 3, not WHO 4 as I advise here, if the attack was Pill-related)
   - During *any acute viral hepatitis*: but COCs may be resumed once liver function tests have become normal (and a clinical test of two units of alcohol consumption is tolerated)
   - Dubin–Johnson and Rotor syndromes are rare benign genetic disorders of hepatic secretion. COCs like pregnancy can cause overt jaundice (Gilbert's disease is WHO 2)

3. **History of serious condition affected by sex steroids or related to previous COC use**
   - *SLE*—suggestion COCs may worsen the condition, but there is thrombotic risk anyway.
   - *COC-induced hypertension*
   - *Pancreatitis due to hypertriglyceridaemia*
   - *Pemphigoid gestationis*
   - *Chorea*
   - *Stevens–Johnson syndrome* (erythema multiforme), if COC-associated
   - *Haemolytic uraemic syndrome* (HUS) and *thrombotic thrombocytopenic purpura* (TTP); HUS in past is WHO 2
4. **Pregnancy**
5. **Estrogen-dependent neoplasms**
   - *Breast cancer*
   - Past breast biopsy showing *pre-malignant epithelial atypia*
6. **Miscellaneous**
   - *Allergy* to any COC constituent
   - Past *idiopathic intracranial hypertension*
   - Specific to Yasmin (or Yaz): avoid, because of the unique spironolactone-like effects of drospirenone, in anyone at risk of high potassium levels (including severe renal insufficiency, hepatic dysfunction and treatment with potassium-sparing diuretics)
   - *Sturge–Weber syndrome* (thrombotic stroke risk)
   - Post-partum for 6 weeks if breastfeeding (according to UKMEC, but is anyway redundant for contraception)
7. **Woman's anxiety about COC safety unrelieved by counselling**

Note that several of the above (e.g. 4, 5 and 8) are not necessarily permanent contraindications. Moreover, many women over the years have been unnecessarily deprived of COCs for reasons now believed to have no link, such as thrush or otosclerosis; or that would have positively benefited from the method, such as secondary amenorrhoea with hypo-estrogenism.