



Complete Summary

GUIDELINE TITLE

Canadian consensus guideline on continuous and extended hormonal contraception, 2007.

BIBLIOGRAPHIC SOURCE(S)

Guilbert E, Boroditsky R, Black A, Kives S, Leboeuf M, Mirosh M, Senikas V, Wagner MS, Weir E, York-Lowry J, Reid R, Trussell J, Society of Obstetricians and Gynaecologists of Canada. Canadian consensus guideline on continuous and extended hormonal contraception, 2007. J Obstet Gynaecol Can 2007 Jul;29(7 Suppl 2):S1-32. [172 references] [PubMed](#)

GUIDELINE STATUS

This is the current release of the guideline.

COMPLETE SUMMARY CONTENT

SCOPE

METHODOLOGY - including Rating Scheme and Cost Analysis

RECOMMENDATIONS

EVIDENCE SUPPORTING THE RECOMMENDATIONS

BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS

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QUALIFYING STATEMENTS

IMPLEMENTATION OF THE GUIDELINE

INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT

CATEGORIES

IDENTIFYING INFORMATION AND AVAILABILITY

DISCLAIMER

SCOPE

DISEASE/CONDITION(S)

- Unintended pregnancy
- Any disease or condition in which menstrual suppression may be beneficial:
 - Endometriosis
 - Abnormal uterine bleeding
 - Hemorrhagic diatheses
 - Hormone withdrawal symptoms
 - Premenstrual dysphoric disorders
 - Perimenopause

GUIDELINE CATEGORY

Assessment of Therapeutic Effectiveness
Counseling
Evaluation
Management
Prevention
Treatment

CLINICAL SPECIALTY

Family Practice
Obstetrics and Gynecology

INTENDED USERS

Advanced Practice Nurses
Health Care Providers
Nurses
Pharmacists
Physician Assistants
Physicians

GUIDELINE OBJECTIVE(S)

To serve as a guideline for health care providers on the use of continuous and extended combined hormonal contraception regimens, to prevent pregnancy, and to delay menses that affect health-related quality of life

TARGET POPULATION

Women desiring contraception or who find their menses problematic

INTERVENTIONS AND PRACTICES CONSIDERED

Combined hormonal contraceptive (ChC) methods used in a continuous or extended regimen.*

Refer to Chapter 4 in the original guideline document for a list of ChCs currently available in Canada.

*Although no official definition exists, extended use usually refers to use of ChCs with planned hormone-free intervals (up from 2 contiguous cycles), and continuous use of ChCs usually refers to uninterrupted use without hormone-free intervals.

MAJOR OUTCOMES CONSIDERED

- Efficacy of continuous and extended combined hormonal contraception (CHC) regimens
- Side effects of continuous and extended CHC regimens
- Cost-effectiveness of continuous and extended CHC regimens

- Medical usage and non-contraceptive benefits

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

Medline, PubMed, and Cochrane Database were searched for articles published in English between 1977 and May 2007. Relevant publications and position papers from appropriate reproductive health and family planning organizations were also reviewed.

NUMBER OF SOURCE DOCUMENTS

Not stated

METHODS USED TO ASSESS THE QUALITY AND STRENGTH OF THE EVIDENCE

Weighting According to a Rating Scheme (Scheme Given)

RATING SCHEME FOR THE STRENGTH OF THE EVIDENCE

Level of Evidence*

I: Evidence obtained from at least one properly designed randomized controlled trial.

II-1: Evidence from well-designed controlled trials without randomization.

II-2: Evidence from well-designed cohort (prospective or retrospective) or case-control studies, preferably from more than one centre or research group.

II-3: Evidence from comparisons between times or places with or without the intervention. Dramatic results from uncontrolled experiments (such as the results of treatment with penicillin in the 1940s) could also be included in this category.

III: Opinions of respected authorities, based on clinical experience, descriptive studies, or reports of expert committees.

*Adapted from the Evaluation of Evidence criteria described in the Canadian Task Force on the Periodic Health Exam.

METHODS USED TO ANALYZE THE EVIDENCE

DESCRIPTION OF THE METHODS USED TO ANALYZE THE EVIDENCE

Not stated

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

Classification of Recommendations*

- A. There is good evidence to recommend the clinical preventive action.
- B. There is fair evidence to recommendation the clinical preventive action.
- C. The existing evidence is conflicting and does not allow making a recommendation for or against use of the clinical preventive action; however, other factors may influence decision-making.
- D. There is fair evidence to recommend against the clinical preventive action.
- E. There is good evidence to recommend against the clinical preventive action.
- I. There is insufficient evidence (in quantity or quality) to make a recommendation; however, other factors may influence decision-making.

*Adapted from the Classification of Recommendations criteria described in the Canadian Task Force on Preventive Health Care.

COST ANALYSIS

Published cost analyses were reviewed.

Published studies suggest that continuous or extended combined oral contraceptive use is cost-effective for women because of decreased use of menstrual-hygiene products. However, this is true only if the cost of the contraceptive method remains low. From a societal perspective, combined or extended combined hormonal contraceptive use might be cost-effective if it proved to be more efficient than cyclic use in preventing pregnancy, if the cost of the method were kept low, and if it were associated with greater productivity.

Refer to Chapter 9 of the original guideline document for a more detailed discussion of these studies.

METHOD OF GUIDELINE VALIDATION

Internal Peer Review

DESCRIPTION OF METHOD OF GUIDELINE VALIDATION

This consensus guideline has been reviewed and approved by the Executive and Council of the Society of Obstetricians and Gynecologists of Canada.

RECOMMENDATIONS

MAJOR RECOMMENDATIONS

The level of evidence (I-III) and classification of recommendations (A-E, I) are defined at the end of the "Major Recommendations" field.

Background

Statement

Personal, religious, and cultural beliefs may affect women's attitudes towards bleeding and menstruation. **(III)**

Recommendation

1. Health care providers should enquire about individual preferences and respect these preferences when counseling on the use of continuous or extended combined hormonal contraceptive regimen. **(III-A)**

Current Usage

Statements

Continuous or extended combined hormonal contraception is commonly used to various degrees worldwide. **(III)**

Given the choice, many women in all age groups would consider using continuous or extended combined hormonal contraception. **(III)**

Recommendation

2. Health care providers should be aware of the option of using continuous or extended combined hormonal contraception and consider offering it to women for contraception, medical reasons, and personal preferences. **(III-A)**

What Is Used?

Society of Obstetricians and Gynaecologists of Canada (SOGC) Clinical Tip

The length of the continuous and/or extended (C/E) combined hormonal contraceptive (ChC) regimen can be altered, depending on the experience of side effects.

SOGC Clinical Tip

All currently available sub 50 microgram ethinyl estradiol (EE) contraceptives (oral [monophasic or multiphasic], transdermal, vaginal) can be used in a C/E regimen.

SOGC Clinical Tip

The length of the C/E combined hormonal contraceptive (ChC) regimens should be administered according to the preference of the woman or the provider.

Statements

A number of currently available combined hormonal contraceptives, originally designed for cyclic use, have been studied using a range of continuous or extended regimens. **(I)**

A few dedicated continuous or extended combined hormonal contraceptive products have been studied in a variety of regimens. **(I)**

A number of physicians currently counsel women about how to use combined hormonal contraceptives in continuous or extended regimens. **(III)**

A number of women currently use combined hormonal contraceptives in continuous or extended regimens for their own convenience, at their own discretion. **(III)**

Efficacy and Adherence

Statement

Continuous combined hormonal contraceptive regimens are as effective as cyclic regimens in preventing pregnancy. **(I)**

SOGC Clinical Tip

In combined hormonal contraception (CHC) users, frequent lack of adherence may lead to increased failure. Use of C/E combined hormonal contraception may be more "forgiving" about missed combined hormonal contraceptives (ChCs) because of the absence of a cyclic hormone-free interval (HFI).

Side Effects

Statements

A continuous or extended combined hormonal contraceptive regimen compared with a cyclic regimen will result in fewer total bleeding days. **(I)**

The frequency of unscheduled bleeding and/or spotting with a continuous or extended combined hormonal contraceptive regimen is similar to that of a cyclical regimen **(I)** and reduces over time with both regimens. **(II-2)**

Some trials on continuous or extended combined oral contraceptive regimens showed evidence of lower frequency of side effects such as headaches, genital itch, bloating, and menstrual pain than cyclic regimen, but others showed no difference. **(I)**

Recommendation

3. Women using continuous or extended combined hormonal contraceptive regimens should be counseled about expected bleeding patterns. **(I-A)**

SOGC Clinical Tip

The side-effect profile with C/E ChC regimens is not worse than with cyclic regimens and may be better.

SOGC Clinical Tip

If irregular bleeding and/or spotting persist with the use of any C/E ChC regimen, rule out pregnancy, non-compliance, cervical infection, smoking, malabsorption, and use of concomitant medications.

SOGC Clinical Tip

Women will be more likely to accept irregular persistent bleeding and/or spotting if they are informed about it before the initiation of C/E CHC. A three-day HFI should be considered. After a three-day HFI, if the woman uses CoCs, she must take the next pill of her pack, if the woman uses the patch or the ring, she must use a new patch or a new ring.

Medical/Non-Contraceptive Usage

Statements

In women with surgically proven endometriosis, continuous or extended combined hormonal contraceptives administered for six months are shown to be effective in

reducing the frequency and the intensity of dysmenorrhea, deep dyspareunia, and non-menstrual pelvic pain over this period. **(I)**

Many women with abnormal uterine bleeding, including bleeding related to uterine fibroids, may benefit from menstrual suppression with continuous or extended combined hormonal contraceptive regimens. **(III)**

SOGC Clinical Tip

For women in the perimenopausal transition who may be ovulating, C/E CHC is preferred to hormonal replacement therapy for controlling problematic bleeding and vasomotor symptoms.

Women with hemorrhagic diatheses may consider continuous or extended administration of combined hormonal contraceptives in order to decrease monthly withdrawal bleeding. **(III)**

Women experiencing hormonal withdrawal symptoms such as nausea, vomiting, breast tenderness, bloating, swelling, and mood changes during the hormone-free interval while using cyclic combined hormonal contraceptives, may benefit from continuous or extended combined hormonal contraceptive regimens. **(II-2)**

Menstrual migraine and headaches may improve with continuous or extended combined hormonal contraceptive regimens. **(III)**

Women in the perimenopause with problematic bleeding and vasomotor symptoms may benefit from continuous or extended combined hormonal contraceptive regimens rather than cyclic regimens because of the elimination of the hormone-free interval. **(III)**

Patient Safety

SOGC Clinical Tip

The SOGC defines use of low-dose combined hormonal contraceptives as use of combined hormonal contraceptives containing less than 50 micrograms of ethinyl estradiol per day. Total estrogen exposure over one year with any low dose continuous or extended combined hormonal contraceptive regimen falls into this SOGC definition.

Statements

The short-term safety of continuous or extended combined hormonal contraceptive regimens is similar to that of cyclic regimens. **(III)**

Direct evidence on long-term safety of continuous or extended combined hormonal contraceptive regimens is currently unavailable. **(III)**

SOGC Clinical Tip

SOGC Clinical Tip

Health care providers wonder whether or not a greater exposure to ethinyl estradiol over one year relates to a greater number of side effects. Although uncertain, studies do not indicate that side effects are made worse with continuous or extended combined hormonal contraceptive regimens, and, in fact, such regimens may decrease some of these side effects.

The extensive body of data on the long-term safety of combined oral contraceptives over the past 50 years is reassuring. If there is a greater risk associated with long-term use of continuous or extended combined hormonal contraceptive regimens than with long-term use of cyclic regimens, it is likely to be minimal. **(III)**

Cost-Effectiveness

Statements

Continuous or extended use of combined hormonal contraceptive regimens is associated with significantly less menstrual-hygiene product consumption than cyclic regimens. **(I)**

Provided that the total annual cost of hormonal contraception remains lower than the total annual cost of menstrual-related products and medications, continuous or extended use regimens are a cost saving for the individual compared with cyclic regimens. **(III)**

From a societal perspective, there may be cost savings with continuous or extended combined hormonal regimens in terms of reduced absenteeism and doctor visits for menstruation-related complaints. However, the magnitude of these savings is uncertain and likely to be low. **(III)**

Recommendation

4. The annual cost of dedicated products for continuous or extended hormonal regimens should be similar to that for cyclic regimens. **(I)**

Definitions:

Level of Evidence*

I: Evidence obtained from at least one properly designed randomized controlled trial.

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III: Opinions of respected authorities, based on clinical experience, descriptive studies, or reports of expert committees.

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*The quality of evidence reported in these guidelines has been adapted from the Evaluation of Evidence criteria described in the Canadian Task Force on the Periodic Health Exam.

**Recommendations included in these guidelines have been adapted from the Classification of Recommendations criteria described in the Canadian Task Force on the Periodic Health Exam.

CLINICAL ALGORITHM(S)

None provided

EVIDENCE SUPPORTING THE RECOMMENDATIONS

TYPE OF EVIDENCE SUPPORTING THE RECOMMENDATIONS

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

BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS

POTENTIAL BENEFITS

- To help reduce unintended pregnancies and improve health-related quality of life in women who find their menses problematic.
- Increased awareness and empowerment of women, their partners, and health care professionals will improve their ability to make appropriate choices between continuous or extended and cyclic usage of these regimens.

POTENTIAL HARMS

- The side-effect profile of continuous or extended combined hormonal contraception is similar to or better than that of cyclic use.
- Unscheduled bleeding and spotting may occur.
- Delay in recognition of pregnancy is possible, although not teratogenic if inadvertently taken during pregnancy.
- Although short-term safety is documented (up to 2 years), evidence for long-term safety is not available.

Refer to Chapter 8 in the original guideline document for a full discussion of patient safety issues.

CONTRAINDICATIONS

CONTRAINDICATIONS

Women with contraindications to combined hormonal contraception are not appropriate candidates for continuous or extended combined hormonal contraceptive regimens.

QUALIFYING STATEMENTS

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This guideline reflects emerging clinical and scientific advances as of the date issued and are subject to change. The information should not be construed as dictating an exclusive course of treatment or procedure to be followed. Local institutions can dictate amendments to these opinions. They should be well documented if modified at the local level. None of these contents may be reproduced in any form without prior written permission of the Society of Obstetricians and Gynaecologists of Canada (SOGC).

IMPLEMENTATION OF THE GUIDELINE

DESCRIPTION OF IMPLEMENTATION STRATEGY

An implementation strategy was not provided.

IMPLEMENTATION TOOLS

Resources

For information about [availability](#), see the "Availability of Companion Documents" and "Patient Resources" fields below.

INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES

IOM CARE NEED

Getting Better
Staying Healthy

IOM DOMAIN

Effectiveness
Patient-centeredness
Safety

IDENTIFYING INFORMATION AND AVAILABILITY

BIBLIOGRAPHIC SOURCE(S)

Guilbert E, Boroditsky R, Black A, Kives S, Leboeuf M, Mirosch M, Senikas V, Wagner MS, Weir E, York-Lowry J, Reid R, Trussell J, Society of Obstetricians and Gynaecologists of Canada. Canadian consensus guideline on continuous and extended hormonal contraception, 2007. J Obstet Gynaecol Can 2007 Jul;29(7 Suppl 2):S1-32. [172 references] [PubMed](#)

ADAPTATION

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

DATE RELEASED

2007 Jul

GUIDELINE DEVELOPER(S)

Society of Obstetricians and Gynaecologists of Canada - Medical Specialty Society

SOURCE(S) OF FUNDING

Society of Obstetricians and Gynaecologists of Canada

GUIDELINE COMMITTEE

Continuous/Extended Hormonal Contraception Guideline 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 [Society of Obstetricians and Gynaecologists of Canada Web site](#).

Print copies: Available from the Society of Obstetricians and Gynaecologists of Canada, La société des obstétriciens et gynécologues du Canada (SOGC) 780 promenade Echo Drive Ottawa, ON K1S 5R7 (Canada); Phone: 1-800-561-2416

AVAILABILITY OF COMPANION DOCUMENTS

Patient education information is provided in the [original guideline document](#).

PATIENT RESOURCES

None available

NGC STATUS

This NGC summary was completed by ECRI Institute on February 5, 2009. The information was verified by the guideline developer on March 4, 2009.

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