# 경구피임제 : WHO

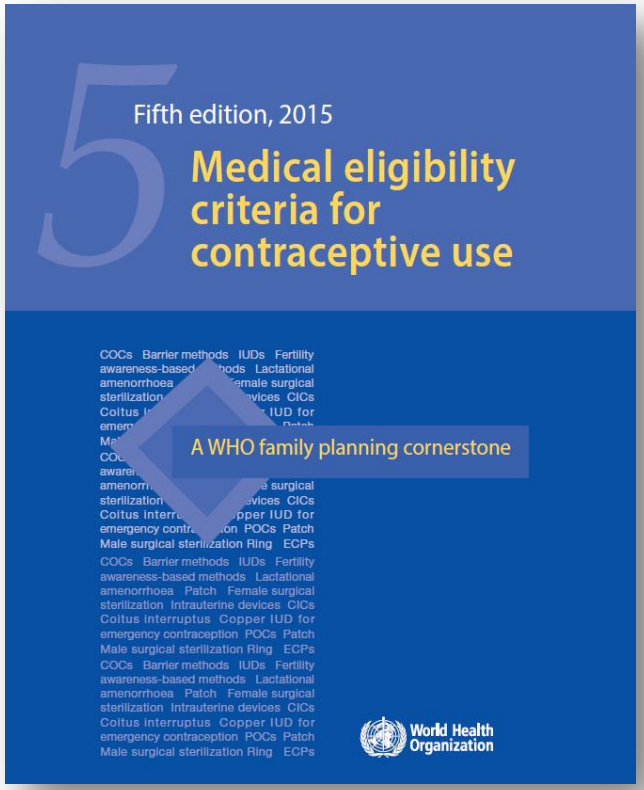
# Medical Eligibility Criteria

이 사 라

*Department of Obstetrics and Gynecology,*
*Ewha Womans University, School of Medicine*

# MEC(Medical Eligibility Criteria) for Contraceptive Use

**2015(5th edition), WHO**




**2016, U.S. (CDC)**

# 2015(5th edition), WHO MEC(Medical Eligibility Criteria) for Contraceptive Use

World Health Organization

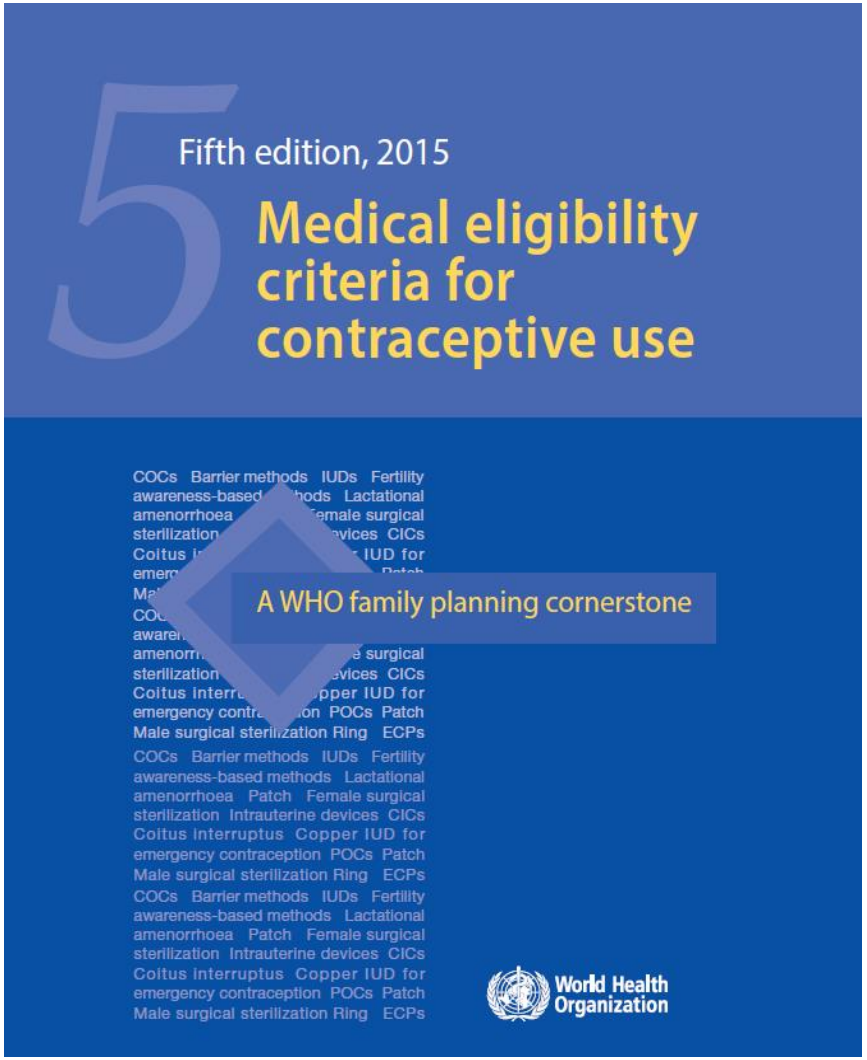
1996

2000

2004

2009

**2015**




**20 contraceptive methods**
**14 topics**
**575 recommendations**

# What's new in 5th edition?

- *4 new contraceptive methods* :
  DMPA-SC; ulipristal acetate for EC; Sino-implant (II); progesterone-releasing vaginal ring

- In response to advances in *HIV care,* four main classes of antiretroviral medications (ARVs)

- For emergency contraception, two new conditions were added: *obesity and CYP3A4 inducers.*

# What's new in 5th edition?

- Terminology updated:

HIV/AIDS
(a) asymptomatic or mild HIV clinical disease
(WHO stage 1 or 2)
(b) severe or advanced HIV clinical disease
(WHO stage 3 or 4)

known hyperlipidemia
➔ ***known dyslipidemias without other C-V risk factors***

superficial thrombophlebitis
➔ ***superficial venous thrombosis***

# MEC Categories

| CATEGORY | WITH CLINICAL JUDGEMENT | WITH LIMITED CLINICAL JUDGEMENT |
|---|---|---|
| 1 | Use method in any circumstances | **Yes** (Use the method) |
| 2 | Generally use the method | |
| 3 | Use of method not usually recommended unless other more appropriate methods are not available or not acceptable | **No** (Do not use the method) |
| 4 | Method not to be used | |

Where warranted, recommendations will differ if a woman is
starting a method (I = initiation) or
continuing a method (C = continuation)

# Methods of contraception

- Combined oral contraceptives
- Combined hormonal contraceptives (1 month injectables, patch, vaginal ring)
- Progestogen-only contraceptives (pills, implants, 2-3 month injectables)
  - DMPA subcutaneous (NEW method)
  - Sino-implant (II) (NEW method)
- Emergency contraceptive pills
  - Ulipristal acetate (NEW method)
- IUDs (copper bearing and levonorgestrel)
- Emergency IUD
- Barrier methods (condoms, spermicides & diaphragm)
- Fertility awareness-based methods
- Lactational amenorrhoea (LAM)
- Progesterone-releasing vaginal ring (NEW method)
- Coitus Interruptus
- Sterilization (male and female)

# Recommendations on specific topics

## Combined Hormonal Contraceptives (CHCs)

- ✓ COMBINED ORAL CONTRACEPTIVES (COCs)
- ✓ COMBINED INJECTABLE CONTRACEPTIVES (CICs)
- ✓ COMBINED CONTRACEPTIVE PATCH (P)
- ✓ COMBINED CONTRACEPTIVE VAGINAL RING (CVR)

# Combined Hormonal Contraceptive use (CHC)

| CONDITION | CATEGORY I = initiation, C = continuation | | | | CLARIFICATIONS/EVIDENCE |
|---|---|---|---|---|---|
| | COC | P | CVR | CIC | |
| † recommendations reviewed for the MEC 5th edition, further details after this table<br>* additional comments after this table | COC = combined oral contraceptive<br>P = combined contraceptive patch<br>CVR = combined contraceptive vaginal ring<br>CIC = combined injectable contraceptive | | | | |
| AGE†* | | | | | **Evidence**: Evidence about whether CHC use affects fracture risk is inconsistent *(78–89)*, although 3 recent studies show no effect *(90–92)*. CHC use may decrease bone mineral density (BMD) in adolescents, especially in those choosing very low dose formulations (< 30 µg ethinyl estradiol-containing COCs) *(91, 93–105)*. CHC use has little to no effect on BMD in premenopausal women *(90, 93–102, 106–109)*, and may preserve bone mass in those who are perimenopausal *(103, 104, 110–117)*. BMD is a surrogate marker for fracture risk that may not be valid for premenopausal women, and which, therefore, may not accurately predict current or future (postmenopausal) fracture risk *(118–120)*. |
| a) Menarche to < 40 years | 1 | 1 | 1 | 1 | |
| b) ≥ 40 years | 2 | 2 | 2 | 2 | |
| PARITY | | | | | |
| a) Nulliparous | 1 | 1 | 1 | 1 | |
| b) Parous | 1 | 1 | 1 | 1 | |

# Combined Hormonal Contraceptive use (CHC)

| CONDITION | CATEGORY I = initiation, C = continuation | | | | CLARIFICATIONS/EVIDENCE |
|---|---|---|---|---|---|
| | COC | P | CVR | CIC | |
| BREASTFEEDING† | | | | | **Evidence:** Clinical studies demonstrate conflicting results regarding effects on breastfeeding continuation or exclusivity in women exposed to COCs during lactation. No consistent effects on infant growth or illness have been reported *(121–126)*. Adverse health outcomes or manifestations of exogenous estrogen in infants exposed to combined contraceptives through breast-milk have not been demonstrated; however, studies have been inadequately designed to determine whether a risk of either serious or subtle long-term effects exists. |
| a) < 6 weeks postpartum | 4 | 4 | 4 | 4 | |
| b) ≥ 6 weeks to < 6 months postpartum (primarily breastfeeding) | 3 | 3 | 3 | 3 | |
| c) ≥ 6 months postpartum | 2 | 2 | 2 | 2 | |

# Combined Hormonal Contraceptive use (CHC)

| CONDITION | CATEGORY I = initiation, C = continuation | | | | CLARIFICATIONS/EVIDENCE |
|---|---|---|---|---|---|
| | COC | P | CVR | CIC | |
| POSTPARTUM (IN NON-BREASTFEEDING WOMEN)† | | | | | |
| Although the risk of venous thromboembolism (VTE) is the same in breastfeeding and non-breastfeeding women, use of CHCs is generally not recommended prior to 6 months postpartum in women who are breastfeeding. | | | | | |
| a) < 21 days | | | | | **Clarification:** For women up to 6 weeks postpartum with other risk factors for VTE, such as immobility, transfusion at delivery, BMI > 30 kg/m$^2$, postpartum haemorrhage, immediately post-caesarean delivery, pre-eclampsia or smoking, use of CHCs may pose an additional increased risk for VTE.<br><br>**Evidence:** One study examined use of CHCs during the postpartum period and found that VTE rates were higher for CHC users compared with non-users at all time points postpartum. Rates were significantly different only after 13 weeks postpartum, but the numbers needed to harm were lowest in the first 6 weeks postpartum (132). VTE risk is elevated during pregnancy and the postpartum period; this risk is most pronounced in the first 3 weeks after delivery, declining to near baseline levels by 42 days postpartum (127-131). |
| i) without other risk factors for VTE | 3 | 3 | 3 | 3 | |
| ii) with other risk factors for VTE | 4 | 4 | 4 | 4 | |
| b) ≥ 21 days to 42 days | | | | | |
| i) without other risk factors for VTE | 2 | 2 | 2 | 2 | |
| ii) with other risk factors for VTE | 3 | 3 | 3 | 3 | |
| c) > 42 days | 1 | 1 | 1 | 1 | |

INNOVATION EWHA

# Combined Hormonal Contraceptive use (CHC)

| CONDITION | CATEGORY I = initiation, C = continuation | | | | CLARIFICATIONS/EVIDENCE |
|---|---|---|---|---|---|
| | COC | P | CVR | CIC | |
| POST-ABORTION | | | | | **Clarification**: COCs, P, CVR or CICs may be started immediately post-abortion.<br><br>**Evidence**: Women who started taking COCs immediately after first-trimester medical or surgical abortion did not experience more side-effects or adverse vaginal bleeding outcomes or clinically significant changes in coagulation parameters compared with women who used a placebo, an IUD, a non-hormonal contraceptive method, or delayed COC initiation *(134–141)*. Limited evidence on women using the CVR immediately after first-trimester medical or surgical abortion indicated no serious adverse events and no infection related to CVR use during 3 cycles of follow-up post-abortion *(77)*. |
| a) First trimester | 1 | 1 | 1 | 1 | |
| b) Second trimester | 1 | 1 | 1 | 1 | |
| c) Immediate post-septic abortion | 1 | 1 | 1 | 1 | |
| PAST ECTOPIC PREGNANCY* | 1 | 1 | 1 | 1 | |

# Combined Hormonal Contraceptive use (CHC)

| CONDITION | CATEGORY I = initiation, C = continuation | | | | CLARIFICATIONS/EVIDENCE |
|---|---|---|---|---|---|
| | COC | P | CVR | CIC | |
| HISTORY OF PELVIC SURGERY | 1 | 1 | 1 | 1 | |
| SMOKING | | | | | **Evidence**: COC users who smoked were at increased risk of cardiovascular diseases, especially myocardial infarction (MI), compared with those who did not smoke. Studies also showed an increased risk of MI with increasing number of cigarettes smoked per day *(30, 31, 142–151)*. |
| a) Age < 35 years | 2 | 2 | 2 | 2 | |
| b) Age ≥ 35 years | | | | | |
| i) < 15 cigarettes/day | 3 | 3 | 3 | 2 | |
| ii) ≥ 15 cigarettes/day | 4 | 4 | 4 | 3 | |

# Combined Hormonal Contraceptive use (CHC)

| CONDITION | CATEGORY I = initiation, C = continuation | | | | CLARIFICATIONS/EVIDENCE |
|---|---|---|---|---|---|
| | COC | P | CVR | CIC | |
| OBESITY | | | | | **Evidence:** Obese women who use COCs are more likely to experience VTE than obese women who do not use COCs. The absolute risk of VTE in healthy women of reproductive age is small. Limited evidence suggests that obese women who use COCs do not have a higher risk of acute MI or stroke than obese non-users *(146, 147, 151–156)*. Limited evidence suggests obese women are no more likely to gain weight after 3 cycles of using CVR or COCs than overweight or normal-weight women. A similar weight gain during 3 months was noted in both the COC group and the CVR group across all BMI categories *(76)*. Overall, evidence suggests that contraceptive effectiveness is maintained among obese CHC users *(157–172)*; however, among women with very high BMI using COC, evidence is inconsistent *(161, 167, 171)*. No association was found between pregnancy risk and BMI among P users *(161, 167, 171)*. The effectiveness of the patch decreased among women who weighed > 90 kg in 1 study *(172)*. |
| a) $\geq$ 30 kg/m$^2$ BMI | 2 | 2 | 2 | 2 | |
| b) Menarche to < 18 years and $\geq$ 30 kg/m$^2$ BMI | 2 | 2 | 2 | 2 | |

# Combined Hormonal Contraceptive use (CHC)

| CONDITION | CATEGORY<br>I = initiation, C = continuation | | | | CLARIFICATIONS/EVIDENCE |
|---|---|---|---|---|---|
| | COC | P | CVR | CIC | |
| BLOOD PRESSURE MEASUREMENT UNAVAILABLE | NA | NA | NA | NA | NA = not applicable<br><br>**Clarification**: It is desirable to have blood pressure measurements taken before initiation of COC, P, CVR or CIC use. However, in some settings, blood pressure measurements are unavailable. In many of these settings, pregnancy-related morbidity and mortality risks are high, and COCs, P, CVR or CICs may be among the few methods widely available. In such settings, women should not be denied use of COCs, P, CVR or CICs simply because their blood pressure cannot be measured. |

# Combined Hormonal Contraceptive use (CHC)

| CONDITION | CATEGORY I = initiation, C = continuation | | | | CLARIFICATIONS/EVIDENCE |
|---|---|---|---|---|---|
| | COC | P | CVR | CIC | |
| **CARDIOVASCULAR DISEASE** | | | | | |
| MULTIPLE RISK FACTORS FOR ARTERIAL CARDIOVASCULAR DISEASE (e.g. older age, smoking, diabetes, hypertension and known dyslipidaemias) | 3/4 | 3/4 | 3/4 | 3/4 | **Clarification:** When a woman has multiple major risk factors, any of which alone would substantially increase the risk of cardiovascular disease, use of COCs, P, CVR or CICs may increase her risk to an unacceptable level. However, a simple addition of categories for multiple risk factors is not intended; for example, a combination of 2 risk factors assigned a Category 2 may not necessarily warrant a higher category. |

# Combined Hormonal Contraceptive use (CHC)

| CONDITION | CATEGORY<br>I = initiation, C = continuation | | | | CLARIFICATIONS/EVIDENCE |
|---|---|---|---|---|---|
| | COC | P | CVR | CIC | |
| **HYPERTENSION**<br>For all categories of hypertension, classifications are based on the assumption that no other risk factors for cardiovascular disease exist. When multiple risk factors do exist, the risk of cardiovascular disease may increase substantially. A single reading of blood pressure level is not sufficient to classify a woman as hypertensive. | | | | | |
| a) History of hypertension, where blood pressure CANNOT be evaluated (including hypertension in pregnancy) | 3 | 3 | 3 | 3 | **Clarification**: Evaluation of cause and level of hypertension is recommended, as soon as feasible.<br><br>**Evidence**: Women who did not have a blood pressure check before initiation of COC use had an increased risk of acute MI and stroke *(26, 32, 33, 173, 174)*. |
| b) Adequately controlled hypertension, where blood pressure CAN be evaluated | 3 | 3 | 3 | 3 | **Clarification**: Women adequately treated for hypertension are at reduced risk of acute MI and stroke as compared with untreated women. Although there are no data, COC, P, CVR or CIC users with adequately controlled and monitored hypertension should be at reduced risk of acute MI and stroke compared with untreated hypertensive COC, P, CVR or CIC users. |
| c) Elevated blood pressure levels (properly taken measurements) | | | | | **Evidence**: Among women with hypertension, COC users were at increased risk of stroke, acute MI, and peripheral arterial disease compared with non-users *(14, 26, 31, 33, 142, 144, 150, 151, 173–185)*. Discontinuation of COCs in women with hypertension may improve blood pressure control *(186)*. |
| i) systolic 140–159 or diastolic 90–99 mm Hg | 3 | 3 | 3 | 3 | |
| ii) systolic ≥ 160 or diastolic ≥ 100 mm Hg | 4 | 4 | 4 | 4 | |
| d) Vascular disease | 4 | 4 | 4 | 4 | |

# Combined Hormonal Contraceptive use (CHC)

| CONDITION | CATEGORY I = initiation, C = continuation | | | | CLARIFICATIONS/EVIDENCE |
|---|---|---|---|---|---|
| | COC | P | CVR | CIC | |
| HISTORY OF HIGH BLOOD PRESSURE DURING PREGNANCY (where current blood pressure is measurable and normal) | 2 | 2 | 2 | 2 | **Evidence**: Women using COCs who had a history of high blood pressure in pregnancy had an increased risk of MI and VTE, compared with COC users who did not have a history of high blood pressure during pregnancy. The absolute risks of acute MI and VTE in this population remained small *(32, 33, 151, 174, 176, 187–192)*. |
| DEEP VEIN THROMBOSIS (DVT)/ PULMONARY EMBOLISM (PE)* | | | | | |
| a) History of DVT/PE | 4 | 4 | 4 | 4 | |
| b) Acute DVT/PE | 4 | 4 | 4 | 4 | |
| c) DVT/PE and established on anticoagulant therapy | 4 | 4 | 4 | 4 | |
| d) Family history (first-degree relatives) | 2 | 2 | 2 | 2 | |
| e) Major surgery | | | | | |
| i) with prolonged immobilization | 4 | 4 | 4 | 4 | |
| ii) without prolonged immobilization | 2 | 2 | 2 | 2 | |
| f) Minor surgery without immobilization | 1 | 1 | 1 | 1 | |

INNOVATION EWHA

# Combined Hormonal Contraceptive use (CHC)

| CONDITION | CATEGORY I = initiation, C = continuation | | | | CLARIFICATIONS/EVIDENCE |
|---|---|---|---|---|---|
| | COC | P | CVR | CIC | |
| SUPERFICIAL VENOUS DISORDERS† | | | | | |
| a) Varicose veins | 1 | 1 | 1 | 1 | **Evidence**: One study suggested that among women with varicose veins, the rate of VTE and superficial venous thrombosis (SVT) was higher in oral contraceptive users compared with non-users; however, statistical significance was not reported and the number of events was small *(215)*. |
| b) Superficial venous thrombosis (SVT) | 2 | 2 | 2 | 2 | **Clarification**: SVT may be associated with an increased risk of VTE.<br><br>**Evidence**: One study demonstrated that among women with SVT, the risk of VTE was higher in oral contraceptive users compared with non-users *(216)*. |
| CURRENT AND HISTORY OF ISCHAEMIC HEART DISEASE | 4 | 4 | 4 | 4 | |
| STROKE (history of cerebrovascular accident) | 4 | 4 | 4 | 4 | |

# Combined Hormonal Contraceptive use (CHC)

| CONDITION | CATEGORY I = initiation, C = continuation | | | | CLARIFICATIONS/EVIDENCE |
|---|---|---|---|---|---|
| | COC | P | CVR | CIC | |
| KNOWN DYSLIPIDAEMIAS WITHOUT OTHER KNOWN CARDIOVASCULAR RISK FACTORS† | 2 | 2 | 2 | 2 | **Clarification**: Routine screening is not appropriate because of the rarity of the condition and the high cost of screening. Increased levels of total cholesterol, low-density lipoprotein (LDL) and triglycerides, as well as a decreased level of high-density lipoprotein (HDL), are known risk factors for cardiovascular disease. Women with known severe genetic lipid disorders are at much higher lifetime risk for cardiovascular disease and may warrant further clinical consideration.<br><br>**Evidence**: Limited evidence on use of CHCs among women with dyslipidaemia and risk of cardiovascular outcomes provided inconsistent results. One study suggested an increased risk for MI among COC users with hypercholesterolaemia compared to non-users without hypercholesterolaemia *(217)*; 1 study suggested an increased risk for VTE and for stroke among COC users with dyslipidaemia compared to COC users without dyslipidaemia *(22)*; and 1 study suggested no worsening of lipid abnormalities among CHC users with dyslipidaemia compared to non-users with dyslipidaemia *(218)*. No evidence of risk for pancreatitis was identified. |

# Combined Hormonal Contraceptive use (CHC)

| CONDITION | CATEGORY I = initiation, C = continuation | | | | CLARIFICATIONS/EVIDENCE |
|---|---|---|---|---|---|
| | COC | P | CVR | CIC | |
| **RHEUMATIC DISEASES** | | | | | |
| SYSTEMIC LUPUS ERYTHEMATOSUS (SLE)<br><br>People with SLE are at increased risk of ischaemic heart disease, stroke and venous thromboembolism (VTE). Categories assigned to such conditions in the *Medical eligibility criteria for contraceptive use* should be the same for women with SLE who present with these conditions. For all categories of SLE, classifications are based on the assumption that no other risk factors for cardiovascular disease are present; these classifications must be modified in the presence of such risk factors. Available evidence indicates that many women with SLE can be considered good candidates for most contraceptive methods, including hormonal contraceptives *(219–236)*. | | | | | |
| a) Positive (or unknown) antiphospholipid antibodies | 4 | 4 | 4 | 4 | **Evidence**: Antiphospholipid antibodies are associated with a higher risk for both arterial and venous thrombosis *(237–239)*. |
| b) Severe thrombocytopenia | 2 | 2 | 2 | 2 | |
| c) Immunosuppressive treatment | 2 | 2 | 2 | 2 | |
| d) None of the above | 2 | 2 | 2 | 2 | |

# Combined Hormonal Contraceptive use (CHC)

| CONDITION | CATEGORY I = initiation, C = continuation | | | | | | | | CLARIFICATIONS/EVIDENCE |
|---|---|---|---|---|---|---|---|---|---|
| | COC | | P | | CVR | | CIC | | |
| **NEUROLOGIC CONDITIONS** | | | | | | | | | |
| HEADACHES* | I | C | I | C | I | C | I | C | **Clarification**: Classification depends on accurate diagnosis of those severe headaches that are migrainous and those that are not. Any new headaches or marked changes in headaches should be evaluated. Classification is for women without any other risk factors for stroke. Risk of stroke increases with age, hypertension and smoking.<br><br>**Evidence**: Among women with migraine, women who also had aura had a higher risk of stroke than those without aura *(240–242)*. Women with a history of migraine who use COCs are about 2–4 times as likely to have an ischaemic stroke as non-users with a history of migraine *(142, 154, 181, 182, 240–246)*. |
| a) Non-migrainous (mild or severe) | 1 | 2 | 1 | 2 | 1 | 2 | 1 | 2 | |
| b) Migraine | | | | | | | | | |
| i) without aura | | | | | | | | | |
| age < 35 years | 2 | 3 | 2 | 3 | 2 | 3 | 2 | 3 | |
| age ≥ 35 years | 3 | 4 | 3 | 4 | 3 | 4 | 3 | 4 | |
| ii) with aura, at any age | 4 | 4 | 4 | 4 | 4 | 4 | 4 | 4 | |
| EPILEPSY | 1 | | 1 | | 1 | | 1 | | **Clarification**: If a woman is taking anticonvulsants, refer to the last section of this table, on drug interactions. Certain anticonvulsants lower COC effectiveness. The extent to which P, CVR or CIC use is similar to COC use in this regard remains unclear. |

# Combined Hormonal Contraceptive use (CHC)

| CONDITION | CATEGORY I = initiation, C = continuation | | | | CLARIFICATIONS/EVIDENCE |
|---|---|---|---|---|---|
| | COC | P | CVR | CIC | |
| **DEPRESSIVE DISORDERS** | | | | | |
| DEPRESSIVE DISORDERS | 1 | 1 | 1 | 1 | **Clarification**: The classification is based on data for women with selected depressive disorders. No data on bipolar disorder or postpartum depression were available. There is a potential for drug interactions between certain antidepressant medications and hormonal contraceptives.<br><br>**Evidence**: COC use did not increase depressive symptoms in women with depression compared to baseline or to non-users with depression *(247–256)*. |

# Combined Hormonal Contraceptive use (CHC)

| CONDITION | CATEGORY I = initiation, C = continuation | | | | CLARIFICATIONS/EVIDENCE |
|---|---|---|---|---|---|
| | COC | P | CVR | CIC | |
| **REPRODUCTIVE TRACT INFECTIONS AND DISORDERS** | | | | | |
| VAGINAL BLEEDING PATTERNS* | | | | | |
| a) Irregular pattern without heavy bleeding | 1 | 1 | 1 | 1 | |
| b) Heavy or prolonged bleeding (includes regular and irregular patterns) | 1 | 1 | 1 | 1 | **Clarification**: Unusually heavy bleeding should raise the suspicion of a serious underlying condition.<br><br>**Evidence**: A Cochrane Collaboration review identified 1 randomized controlled trial evaluating the effectiveness of COC use compared with naproxen and danazol in treating menorrhagic women. Women with menorrhagia did not report worsening of the condition or any adverse events related to COC use *(257)*. |
| UNEXPLAINED VAGINAL BLEEDING* (suspicious for serious condition) | | | | | |
| a) Before evaluation | 2 | 2 | 2 | 2 | **Clarification**: If pregnancy or an underlying pathological condition (such as pelvic malignancy) is suspected, it must be evaluated and the category adjusted after evaluation. |

# Combined Hormonal Contraceptive use (CHC)

| CONDITION | CATEGORY I = initiation, C = continuation | | | | CLARIFICATIONS/EVIDENCE |
|---|---|---|---|---|---|
| | COC | P | CVR | CIC | |
| ENDOMETRIOSIS | 1 | 1 | 1 | 1 | **Evidence**: A Cochrane review identified 1 randomized controlled trial evaluating the effectiveness of COC use compared with a gonadotropin-releasing hormone (GnRH) analogue in treating the symptoms of endometriosis. Women with endometriosis did not report worsening of the condition or any adverse events related to COC use *(258)*. |
| BENIGN OVARIAN TUMOURS (INCLUDING CYSTS) | 1 | 1 | 1 | 1 | |
| SEVERE DYSMENORRHOEA | 1 | 1 | 1 | 1 | **Evidence**: There was no increased risk of side-effects with COC use among women with dysmenorrhoea compared with women not using COCs. Some COC users had a reduction in pain and bleeding *(259, 260)*. |

# Combined Hormonal Contraceptive use (CHC)

| CONDITION | CATEGORY I = initiation, C = continuation | | | | CLARIFICATIONS/EVIDENCE |
|---|---|---|---|---|---|
| | COC | P | CVR | CIC | |
| GESTATIONAL TROPHOBLASTIC DISEASE | | | | | **Evidence**: Following molar pregnancy evacuation, the balance of evidence found COC use did not increase the risk of post-molar trophoblastic disease, and some COC users experienced a more rapid regression in human chorionic gonadotropin (hCG) levels, compared with non-users *(261–268)*. Limited evidence suggests that use of COCs during chemotherapeutic treatment does not significantly affect the regression or treatment of post-molar trophoblastic disease compared with women who used a non-hormonal contraceptive method or depot medroxyprogesterone acetate (DMPA) during chemotherapeutic treatment *(269)*. |
| a) Decreasing or undetectable β-hCG levels | 1 | 1 | 1 | 1 | |
| b) Persistently elevated β-hCG levels or malignant disease | 1 | 1 | 1 | 1 | |
| CERVICAL ECTROPION* | 1 | 1 | 1 | 1 | |
| CERVICAL INTRAEPITHELIAL NEOPLASIA (CIN) | 2 | 2 | 2 | 2 | **Evidence**: Among women with persistent human papillomavirus (HPV) infection, long-term COC use (≥ 5 years) may increase the risk of carcinoma in situ and invasive carcinoma *(64, 270)*. Limited evidence on women with low-grade squamous intraepithelial lesions found use of the vaginal ring did not worsen the condition *(64)*. |

# Combined Hormonal Contraceptive use (CHC)

| CONDITION | CATEGORY I = initiation, C = continuation | | | | CLARIFICATIONS/EVIDENCE |
|---|---|---|---|---|---|
| | COC | P | CVR | CIC | |
| BREAST DISEASE* | | | | | |
| a) Undiagnosed mass | 2 | 2 | 2 | 2 | **Clarification**: Evaluation should be pursued as early as possible. |
| b) Benign breast disease | 1 | 1 | 1 | 1 | |
| c) Family history of cancer | 1 | 1 | 1 | 1 | **Evidence**: Women with breast cancer susceptibility genes (such as *BRCA1* and *BRCA2*) have a higher baseline risk of breast cancer than women without these genes. The baseline risk of breast cancer is also higher among women with a family history of breast cancer than among those who do not have such a history. Current evidence, however, does not suggest that the increased risk of breast cancer among women with either a family history of breast cancer or breast cancer susceptibility genes is modified by the use of combined oral contraceptives *(175, 271–293)*. |
| d) Breast cancer | | | | | |
| i) current | 4 | 4 | 4 | 4 | |
| ii) past and no evidence of current disease for 5 years | 3 | 3 | 3 | 3 | |

# Combined Hormonal Contraceptive use (CHC)

| CONDITION | CATEGORY I = initiation, C = continuation | | | | CLARIFICATIONS/EVIDENCE |
|---|---|---|---|---|---|
| | COC | P | CVR | CIC | |
| CERVICAL CANCER* (AWAITING TREATMENT) | 2 | 2 | 2 | 2 | |
| ENDOMETRIAL CANCER* | 1 | 1 | 1 | 1 | |
| OVARIAN CANCER* | 1 | 1 | 1 | 1 | |
| UTERINE FIBROIDS* | | | | | |
| a) Without distortion of the uterine cavity | 1 | 1 | 1 | 1 | |
| b) With distortion of the uterine cavity | 1 | 1 | 1 | 1 | |

# Combined Hormonal Contraceptive use (CHC)

| CONDITION | CATEGORY I = initiation, C = continuation | | | | CLARIFICATIONS/EVIDENCE |
|---|---|---|---|---|---|
| | COC | P | CVR | CIC | |
| PELVIC INFLAMMATORY DISEASE (PID)* | | | | | |
| a) Past PID (assuming no current risk factors for STIs) | | | | | |
| i) with subsequent pregnancy | 1 | 1 | 1 | 1 | |
| ii) without subsequent pregnancy | 1 | 1 | 1 | 1 | |
| b) PID – current | 1 | 1 | 1 | 1 | |
| STIs | | | | | |
| a) Current purulent cervicitis or chlamydial infection or gonorrhoea | 1 | 1 | 1 | 1 | |
| b) Other STIs (excluding HIV and hepatitis) | 1 | 1 | 1 | 1 | |
| c) Vaginitis (including *Trichomonas vaginalis* and bacterial vaginosis) | 1 | 1 | 1 | 1 | |
| d) Increased risk of STIs | 1 | 1 | 1 | 1 | **Evidence**: Evidence suggests that there may be an increased risk of chlamydial cervicitis among COC users at high risk of STIs. For other STIs, there is either evidence of no association between COC use and STI acquisition or too limited evidence to draw any conclusions *(289–369)*. |

# Combined Hormonal Contraceptive use (CHC)

| CONDITION | CATEGORY I = initiation, C = continuation | | | | CLARIFICATIONS/EVIDENCE |
|---|---|---|---|---|---|
| | COC | P | CVR | CIC | |
| DIABETES | | | | | |
| a) History of gestational disease | 1 | 1 | 1 | 1 | **Evidence**: The development of non-insulin-dependent diabetes in women with a history of gestational diabetes is not increased by the use of COCs *(412–419)*. Likewise, lipid levels appear to be unaffected by COC use *(420–422)*. |
| b) Non-vascular disease | | | | | **Evidence**: Among women with insulin- or non-insulin-dependent diabetes, COC use had limited effect on daily insulin requirements and no effect on long-term diabetes control (e.g. haemoglobin A1c levels) or progression to retinopathy. Changes in lipid profile and haemostatic markers were limited, and most changes remained within normal values *(419, 422–430)*. |
| i) non-insulin dependent | 2 | 2 | 2 | 2 | |
| ii) insulin dependent | 2 | 2 | 2 | 2 | |
| c) Nephropathy/retinopathy/ neuropathy | 3/4 | 3/4 | 3/4 | 3/4 | **Clarification**: The category should be assessed according to the severity of the condition. |
| d) Other vascular disease or diabetes of > 20 years' duration | 3/4 | 3/4 | 3/4 | 3/4 | **Clarification**: The category should be assessed according to the severity of the condition. |

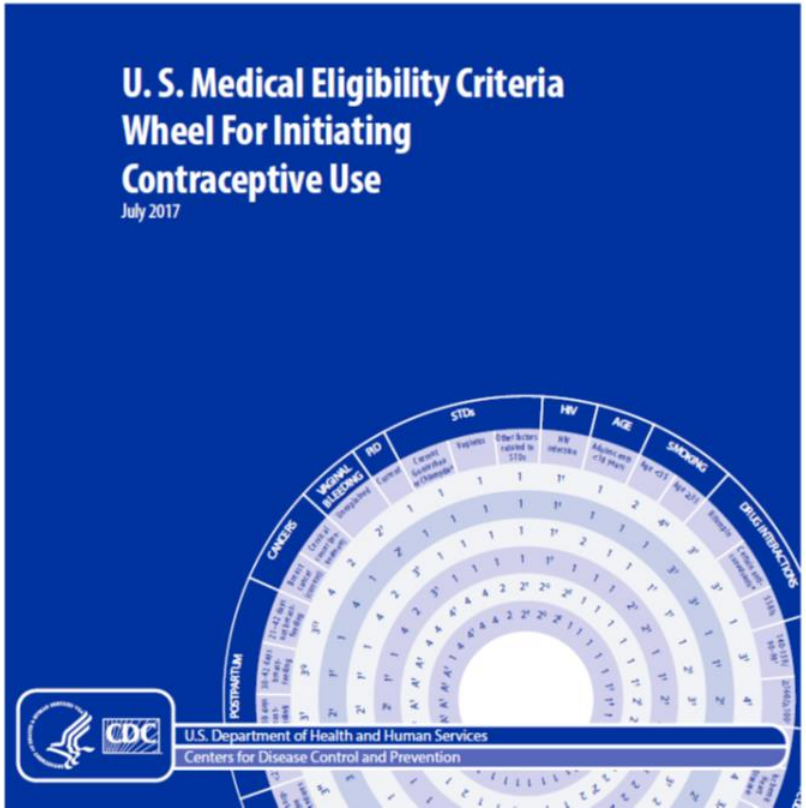
# Combined Hormonal Contraceptive use (CHC)

| CONDITION | CATEGORY I = initiation, C = continuation | | | | CLARIFICATIONS/EVIDENCE |
|---|---|---|---|---|---|
| | COC | P | CVR | CIC | |
| THYROID DISORDERS | | | | | |
| a) Simple goitre | 1 | 1 | 1 | 1 | |
| b) Hyperthyroid | 1 | 1 | 1 | 1 | |
| c) Hypothyroid | 1 | 1 | 1 | 1 | |
| GASTROINTESTINAL CONDITIONS | | | | | |
| GALL BLADDER DISEASE* | | | | | |
| a) Symptomatic | | | | | |
| i) treated by cholecystectomy | 2 | 2 | 2 | 2 | |
| ii) medically treated | 3 | 3 | 3 | 2 | |
| iii) current | 3 | 3 | 3 | 2 | |
| b) Asymptomatic | 2 | 2 | 2 | 2 | |
| HISTORY OF CHOLESTASIS* | | | | | |
| a) Pregnancy related | 2 | 2 | 2 | 2 | |
| b) Past-COC related | 3 | 3 | 3 | 2 | |

# Combined Hormonal Contraceptive use (CHC)

| CONDITION | CATEGORY I = initiation, C = continuation | | | | | | | | CLARIFICATIONS/EVIDENCE |
|---|---|---|---|---|---|---|---|---|---|
| | COC | | P | | CVR | | CIC | | |
| VIRAL HEPATITIS | I | C | I | C | I | C | I | C | |
| a) Acute or flare | 3/4 | 2 | 3/4 | 2 | 3/4 | 2 | 3 | 2 | **Clarification**: The category should be assessed according to the severity of the condition. |
| b) Carrier | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | **Evidence**: Data suggest that in women with chronic hepatitis, COC use does not increase the rate or severity of cirrhotic fibrosis, nor does it increase the risk of hepatocellular carcinoma *(431, 432)*. For women who are carriers, COC use does not appear to trigger liver failure or severe dysfunction *(408, 433, 434)*. Evidence is limited for COC use during active hepatitis *(435, 436)*. |
| c) Chronic | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | |
| CIRRHOSIS | | | | | | | | | |
| a) Mild (compensated) | 1 | | 1 | | 1 | | 1 | | |
| b) Severe (decompensated) | 4 | | 4 | | 4 | | 3 | | |
| LIVER TUMOURS* | | | | | | | | | |
| a) Benign | | | | | | | | | |
| i) focal nodular hyperplasia | 2 | | 2 | | 2 | | 2 | | **Evidence**: There is limited, direct evidence that hormonal contraceptive use does not influence either progression or regression of liver lesions among women with focal nodular hyperplasia *(437–439)*. |
| ii) hepatocellular adenoma | 4 | | 4 | | 4 | | 3 | | |
| b) Malignant (hepatoma) | 4 | | 4 | | 4 | | 3/4 | | |

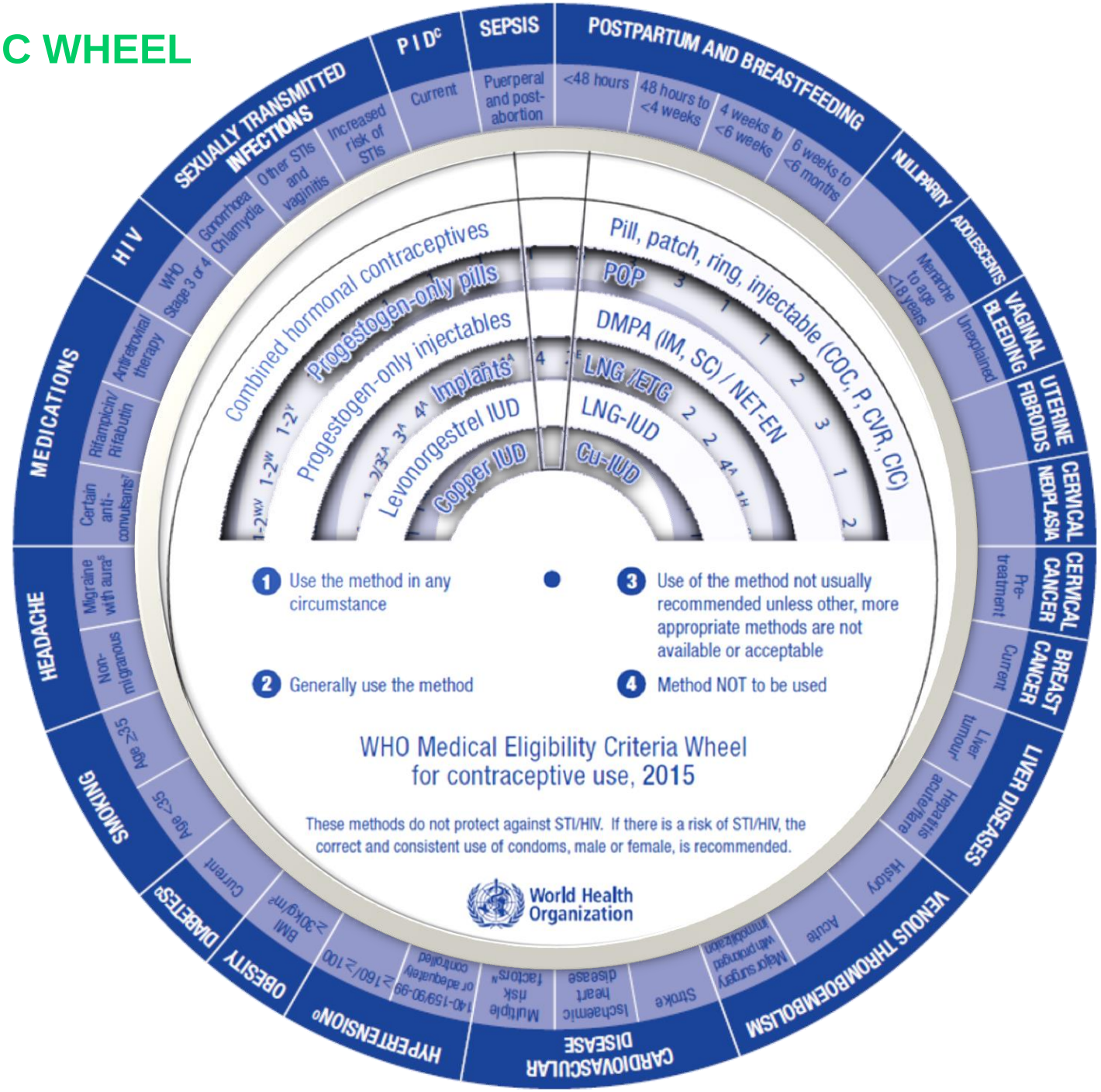
# WHO - MEC WHEEL 2015




## U.S. Medical Eligibility Criteria Wheel for Contraceptive Use (MEC)

The *U.S. Medical Eligibility Criteria Wheel for Contraceptive Use (MEC)* is available for order on the CDC On-Demand website.

# WHO – MEC WHEEL 2015



# WHO – MEC WHEEL 2015

## Conditions that are category 1 and 2 for all methods (method can be used)

**Reproductive Conditions:** Benign breast disease or undiagnosed mass • Benign ovarian tumours, including cysts • Dysmenorrhoea • Endometriosis • History of gestational diabetes • History of high blood pressure during pregnancy • History of pelvic surgery, including caesarean delivery • Irregular, heavy or prolonged menstrual bleeding (explained) • Past ectopic pregnancy • Past pelvic inflammatory disease • Post-abortion (no sepsis) • Postpartum ≥ 6 months

**Medical Conditions:** Depression • Epilepsy • HIV asymptomatic or mild clinical disease (WHO Stage 1 or 2) • Iron-deficiency anaemia, sickle-cell disease and thalassaemia • Malaria • Mild cirrhosis • Schistosomiasis (bilharzia) • Superficial venous disorders, including varicose veins • Thyroid disorders • Tuberculosis (non-pelvic) • Uncomplicated valvular heart disease • Viral hepatitis (carrier or chronic)

**Other:** Adolescents • Breast cancer family history • Venous thromboembolism (VTE) family history • High risk for HIV • Surgery without prolonged immobilization • Taking antibiotics (excluding rifampicin/rifabutin)

With few exceptions, all women can safely use emergency contraception, barrier and behavioural methods of contraception, including lactational amenorrhoea method; for the complete list of recommendations, please see the full document.

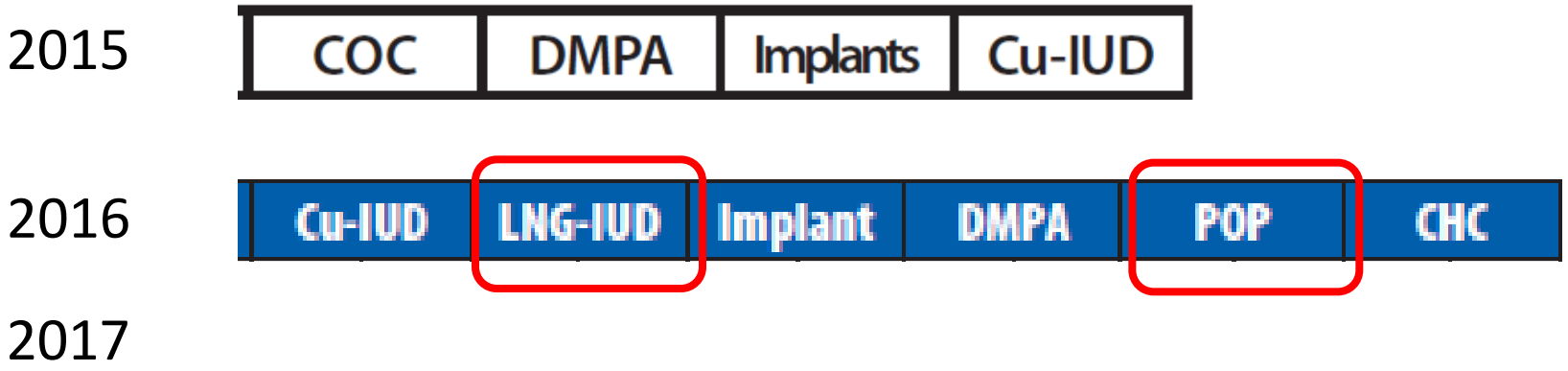
"Combined" is a combination of ethinyl estradiol & a progestogen.

**CIC**: combined injectable contraceptive **COC**: combined oral contraceptive pill
**Cu-IUD**: copper intrauterine device **CVR**: combined contraceptive vaginal ring
**DMPA (IM, SC)**: depot medroxyprogesterone acetate, intramuscular or subcutaneous
**ETG**: etonogestrel **LNG**: levonorgestrel **LNG-IUD**: levonorgestrel intrauterine device
**NET-EN**: norethisterone enanthate **P**: combined contraceptive patch
**POP**: progestogen-only pill

# US MEC

## US Medical Eligibility Criteria for Contraceptive Use, 2016

# 2016 Quick Reference Chart for the U.S. MEC(Medical Eligibility Criteria) for Contraceptive Use method




| Key: | |
|---|---|
| 1 No restriction (method can be used) | 3 Theoretical or proven risks usually outweigh the advantages |
| 2 Advantages generally outweigh theoretical or proven risks | 4 Unacceptable health risk (method not to be used) |

# Summary Chart of U.S. Medical Eligibility Criteria for Contraceptive Use

Centers for Disease Control and Prevention
National Center for Chronic Disease Prevention and Health Promotion

| Condition | Sub-Condition | Cu-IUD | | LNG-IUD | | Implant | | DMPA | | POP | | CHC | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | I | C | I | C | I | C | I | C | I | C | I | C |
| Hypertension | a) Adequately controlled hypertension | 1* | | 1* | | 1* | | 2* | | 1* | | 3* | |
| | b) Elevated blood pressure levels (*properly taken measurements*) | | | | | | | | | | | | |
| | i) Systolic 140-159 or diastolic 90-99 | 1* | | 1* | | 1* | | 2* | | 1* | | 3* | |
| | ii) Systolic ≥160 or diastolic ≥100‡ | 1* | | 2* | | 2* | | 3* | | 2* | | 4* | |
| | c) Vascular disease | 1* | | 2* | | 2* | | 3* | | 2* | | 4* | |
| Inflammatory bowel disease | (*Ulcerative colitis, Crohn's disease*) | 1 | | 1 | | 1 | | 2 | | 2 | | 2/3* | |
| Ischemic heart disease‡ | Current and history of | 1 | | 2 | 3 | 2 | 3 | 3 | | 2 | 3 | 4 | |
| Known thrombogenic mutations‡ | | 1* | | 2* | | 2* | | 2* | | 2* | | 4* | |
| Liver tumors | a) Benign | | | | | | | | | | | | |
| | i) Focal nodular hyperplasia | 1 | | 2 | | 2 | | 2 | | 2 | | 2 | |
| | ii) Hepatocellular adenoma‡ | 1 | | 3 | | 3 | | 3 | | 3 | | 4 | |
| | b) Malignant‡ (hepatoma) | 1 | | 3 | | 3 | | 3 | | 3 | | 4 | |
| Malaria | | 1 | | 1 | | 1 | | 1 | | 1 | | 1 | |
| Multiple risk factors for atherosclerotic cardiovascular disease | (e.g., older age, smoking, diabetes, hypertension, low HDL, high LDL, or high triglyceride levels) | 1 | | 2 | | 2* | | 3* | | 2* | | 3/4* | |
| Multiple sclerosis | a) With prolonged immobility | 1 | | 1 | | 1 | | 2 | | 1 | | 3 | |
| | b) Without prolonged immobility | 1 | | 1 | | 1 | | 2 | | 1 | | 1 | |
| Obesity | a) Body mass index (BMI) ≥30 kg/m² | 1 | | 1 | | 1 | | 1 | | 1 | | 2 | |
| | b) Menarche to <18 years and BMI ≥ 30 kg/m² | 1 | | 1 | | 1 | | 2 | | 1 | | 2 | |
| Ovarian cancer‡ | | 1 | | 1 | | 1 | | 1 | | 1 | | 1 | |
| Parity | a) Nulliparous | 2 | | 2 | | 1 | | 1 | | 1 | | 1 | |
| | b) Parous | 1 | | 1 | | 1 | | 1 | | 1 | | 1 | |
| Past ectopic pregnancy | | 1 | | 1 | | 1 | | 1 | | 2 | | 1 | |
| Pelvic inflammatory disease | a) Past | | | | | | | | | | | | |
| | i) With subsequent pregnancy | 1 | 1 | 1 | 1 | 1 | | 1 | | 1 | | 1 | |
| | ii) Without subsequent pregnancy | 2 | 2 | 2 | 2 | 1 | | 1 | | 1 | | 1 | |
| | b) Current | 4 | 2* | 4 | 2* | 1 | | 1 | | 1 | | 1 | |
| Peripartum cardiomyopathy‡ | a) Normal or mildly impaired cardiac function | | | | | | | | | | | | |
| | i) <6 months | 2 | | 2 | | 1 | | 1 | | 1 | | 4 | |
| | ii) ≥6 months | 2 | | 2 | | 1 | | 1 | | 1 | | 3 | |
| | b) Moderately or severely impaired cardiac function | 2 | | 2 | | 2 | | 2 | | 2 | | 4 | |
| Postabortion | a) First trimester | 1* | | 1* | | 1* | | 1* | | 1* | | 1* | |
| | b) Second trimester | 2* | | 2* | | 1* | | 1* | | 1* | | 1* | |
| | c) Immediate postseptic abortion | 4 | | 4 | | 1* | | 1* | | 1* | | 1* | |
| Postpartum (*nonbreastfeeding women*) | a) <21 days | | | | | 1 | | 1 | | 1 | | 4 | |
| | b) 21 days to 42 days | | | | | | | | | | | | |
| | i) With other risk factors for VTE | | | | | 1 | | 1 | | 1 | | 3* | |
| | ii) Without other risk factors for VTE | | | | | 1 | | 1 | | 1 | | 2 | |
| | c) >42 days | | | | | 1 | | 1 | | 1 | | 1 | |
| Postpartum (*in breastfeeding or non-breastfeeding women, including cesarean delivery*) | a) <10 minutes after delivery of the placenta | | | | | | | | | | | | |
| | i) Breastfeeding | 1* | | 2* | | | | | | | | | |
| | ii) Nonbreastfeeding | 1* | | 1* | | | | | | | | | |
| | b) 10 minutes after delivery of the placenta to <4 weeks | 2* | | 2* | | | | | | | | | |
| | c) ≥4 weeks | 1* | | 1* | | | | | | | | | |
| | d) Postpartum sepsis | 4 | | 4 | | | | | | | | | |

| Condition | Sub-Condition | Cu-IUD | | LNG-IUD | | Implant | | DMPA | | POP | | CHC | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | I | C | I | C | I | C | I | C | I | C | I | C |
| Pregnancy | | 4* | | 4* | | NA* | | NA* | | NA* | | NA* | |
| Rheumatoid arthritis | a) On immunosuppressive therapy | 2 | 1 | 2 | 1 | 1 | | 2/3* | | 1 | | 2 | |
| | b) Not on immunosuppressive therapy | 1 | | 1 | | 1 | | 2 | | 1 | | 2 | |
| Schistosomiasis | a) Uncomplicated | 1 | | 1 | | 1 | | 1 | | 1 | | 1 | |
| | b) Fibrosis of the liver‡ | 1 | | 1 | | 1 | | 1 | | 1 | | 1 | |
| Sexually transmitted diseases (STDs) | a) Current purulent cervicitis or chlamydial infection or gonococcal infection | 4 | 2* | 4 | 2* | 1 | | 1 | | 1 | | 1 | |
| | b) Vaginitis (*including trichomonas vaginalis and bacterial vaginosis*) | 2 | 2 | 2 | 2 | 1 | | 1 | | 1 | | 1 | |
| | c) Other factors relating to STDs | 2* | 2 | 2* | 2 | 1 | | 1 | | 1 | | 1 | |
| Smoking | a) Age <35 | 1 | | 1 | | 1 | | 1 | | 1 | | 2 | |
| | b) Age ≥35, <15 cigarettes/day | 1 | | 1 | | 1 | | 1 | | 1 | | 3 | |
| | c) Age ≥35, ≥15 cigarettes/day | 1 | | 1 | | 1 | | 1 | | 1 | | 4 | |
| Solid organ transplantation‡ | a) Complicated | 3 | 2 | 3 | 2 | 2 | | 2 | | 2 | | 4 | |
| | b) Uncomplicated | 2 | | 2 | | 2 | | 2 | | 2 | | 2* | |
| Stroke‡ | History of cerebrovascular accident | 1 | | 2 | | 2 | 3 | 3 | | 2 | 3 | 4 | |
| Superficial venous disorders | a) Varicose veins | 1 | | 1 | | 1 | | 1 | | 1 | | 1 | |
| | b) Superficial venous thrombosis (acute or history) | 1 | | 1 | | 1 | | 1 | | 1 | | 3* | |
| Systemic lupus erythematosus‡ | a) Positive (or unknown) antiphospholipid antibodies | 1* | 1* | 3* | | 3* | | 3* | 3* | 3* | | 4* | |
| | b) Severe thrombocytopenia | 3* | 2* | 2* | | 2* | | 3* | 2* | 2* | | 2* | |
| | c) Immunosuppressive therapy | 2* | 1* | 2* | | 2* | | 2* | 2* | 2* | | 2* | |
| | d) None of the above | 1* | 1* | 2* | | 2* | | 2* | 2* | 2* | | 2* | |
| Thyroid disorders | Simple goiter/ hyperthyroid/hypothyroid | 1 | | 1 | | 1 | | 1 | | 1 | | 1 | |
| Tuberculosis‡ (*see also Drug Interactions*) | a) Nonpelvic | 1 | 1 | 1 | 1 | 1* | | 1* | | 1* | | 1* | |
| | b) Pelvic | 4 | 3 | 4 | 3 | 1* | | 1* | | 1* | | 1* | |
| Unexplained vaginal bleeding | (suspicious for serious condition) before evaluation | 4* | 2* | 4* | 2* | 3* | | 3* | | 2* | | 2* | |
| Uterine fibroids | | 2 | | 2 | | 1 | | 1 | | 1 | | 1 | |
| Valvular heart disease | a) Uncomplicated | 1 | | 1 | | 1 | | 1 | | 1 | | 2 | |
| | b) Complicated‡ | 1 | | 1 | | 1 | | 1 | | 1 | | 4 | |
| Vaginal bleeding patterns | a) Irregular pattern without heavy bleeding | 1 | | 1 | 1 | 2 | | 2 | | 2 | | 1 | |
| | b) Heavy or prolonged bleeding | 2* | | 1* | 2* | 2* | | 2* | | 2* | | 1* | |
| Viral hepatitis | a) Acute or flare | 1 | | 1 | | 1 | | 1 | | 1 | | 3/4* | 2 |
| | b) Carrier/Chronic | 1 | | 1 | | 1 | | 1 | | 1 | | 1 | 1 |
| **Drug Interactions** | | | | | | | | | | | | | |
| Antiretroviral therapy All other ARV's are 1 or 2 for all methods. | Fosamprenavir (FPV) | 1/2* | 1* | 1/2* | 1* | 2* | | 2* | | 2* | | 3* | |
| Anticonvulsant therapy | a) Certain anticonvulsants (phenytoin, carbamazepine, barbiturates, primidone, topiramate, oxcarbazepine) | 1 | | 1 | | 2* | | 1* | | 3* | | 3* | |
| | b) Lamotrigine | 1 | | 1 | | 1 | | 1 | | 1 | | 3* | |
| Antimicrobial therapy | a) Broad spectrum antibiotics | 1 | | 1 | | 1 | | 1 | | 1 | | 1 | |
| | b) Antifungals | 1 | | 1 | | 1 | | 1 | | 1 | | 1 | |
| | c) Antiparasitics | 1 | | 1 | | 1 | | 1 | | 1 | | 1 | |
| | d) Rifampin or rifabutin therapy | 1 | | 1 | | 2* | | 1* | | 3* | | 3* | |
| SSRIs | | 1 | | 1 | | 1 | | 1 | | 1 | | 1 | |
| St. John's wort | | 1 | | 1 | | 2 | | 1 | | 2 | | 2 | |

**Updated in 2017.** This summary sheet only contains a subset of the recommendations from the U.S. MEC. For complete guidance, see: http://www.cdc.gov/reproductivehealth/unintendedpregnancy/USMEC.htm. Most contraceptive methods do not protect against sexually transmitted diseases (STDs). Consistent and correct use of the male latex condom reduces the risk of STDs and HIV.

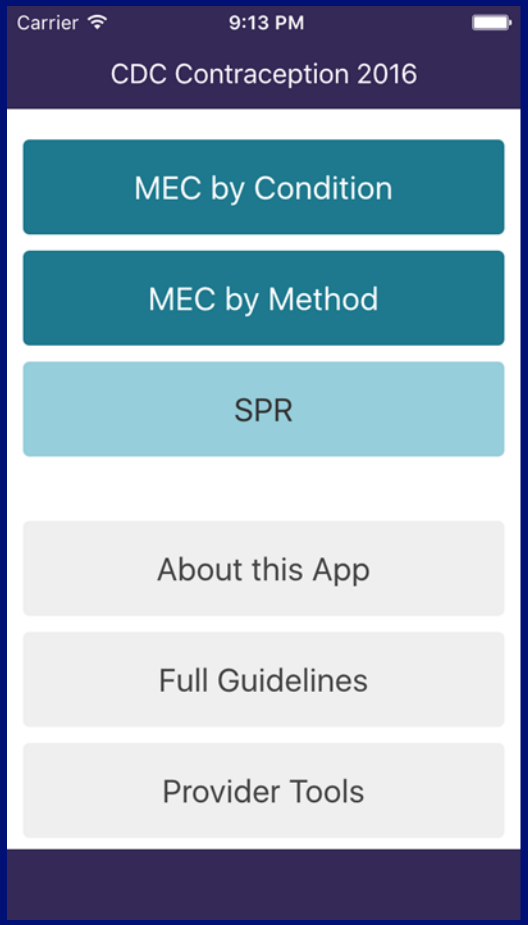
CS266008-A

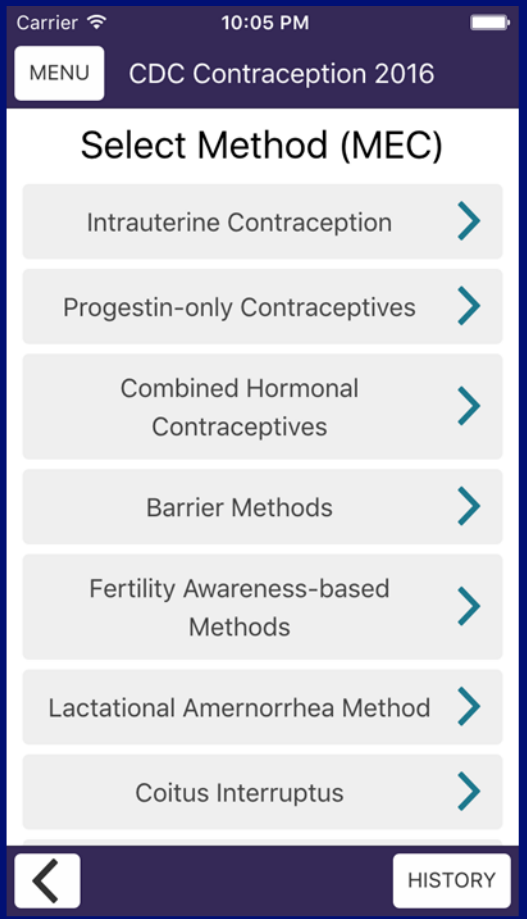
*MEC (Medical Eligibility Criteria)*

*SPR (Selected Practice Recommendations )*

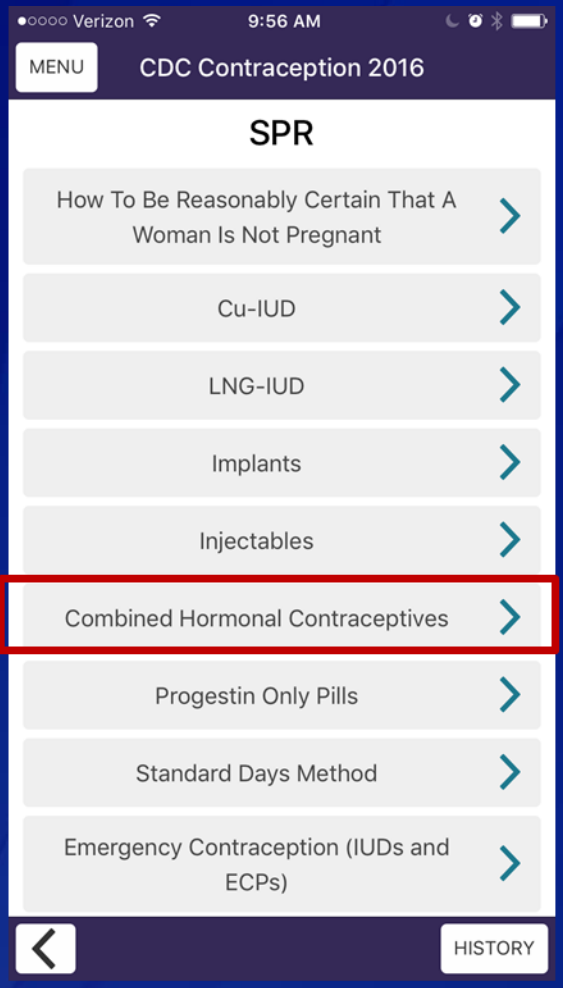
in everyday practice : APP

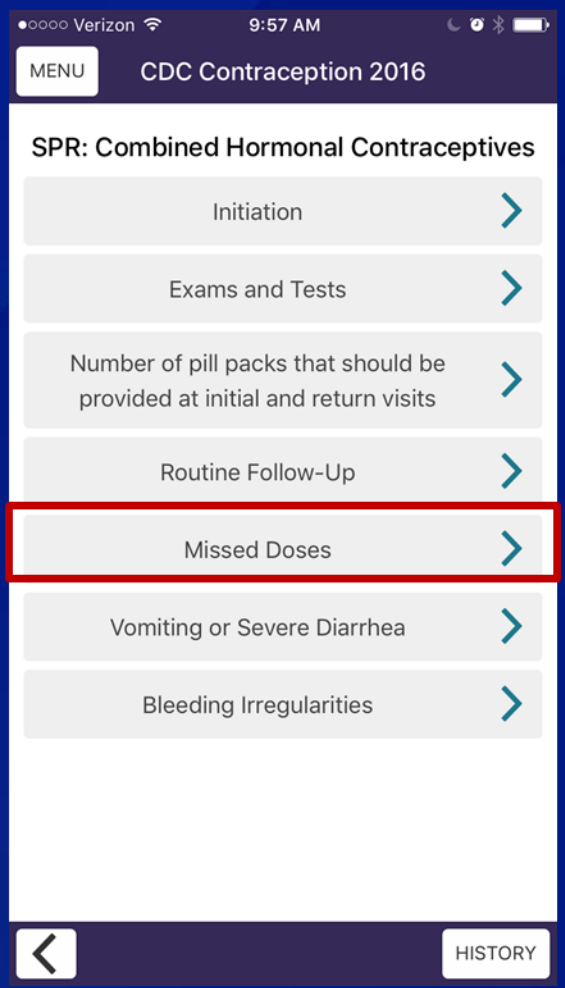
# 2016 U.S. MEC and SPR App

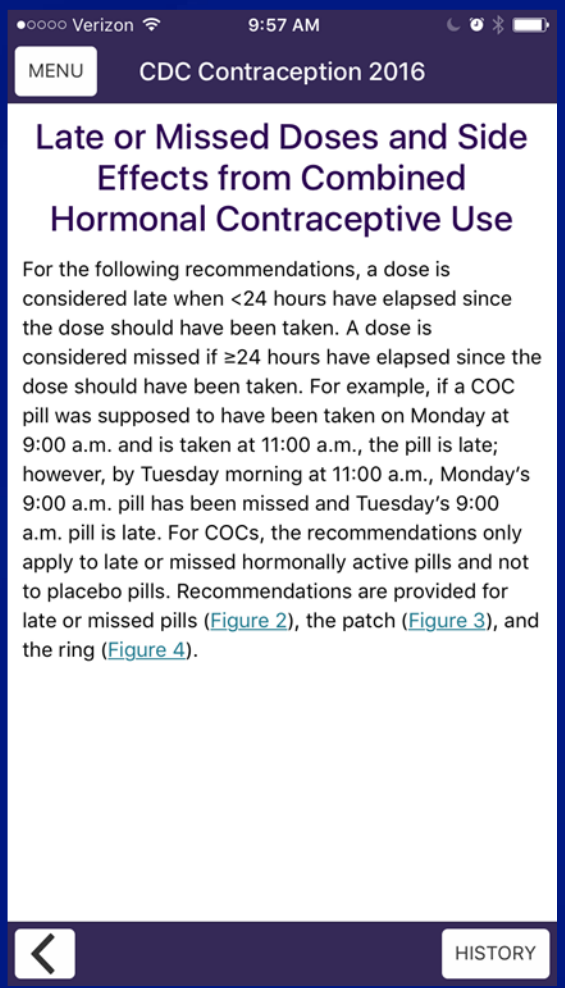



# Using the U.S. SPR App



# 사전피임제(복합경구피임제) 사용 여성을 위한 체크리스트

이름 | 나이 만 세 | 키 cm | 체중 kg | 혈압 mmHg

| | 질 문 | 의사 확인사항 | 추가검사 | WHO 카테고리 |
|---|---|---|---|---|
| 1 | 마지막 생리시작일이 언제인가요?<br>( 년 월 일) | 현재 임신 여부, 임신 가능성 여부 | 임신검사 | |
| 2 | 몸소에 생리 주기는 규칙적인가요?<br>□ 예( )일 간격 □ 아니오 | 현재 임신 여부, 임신 가능성 여부 | 초음파검사 | |
| 3 | 몸소에 생리통이 있나요?<br>□ 없다<br>□ 있다 (□참을 수 있는 정도 / □진통제로 조절 가능 / □진통제로 조절 안됨) | 생리통이 심한 경우 부인과 질환 확인 | 초음파검사 | |
| 4 | 몸소에 월경전증후군이 있나요?<br>□ 없다<br>□ 있다 (□유방통 □복부팽만 □두통 □부종 □우울, 짜증, 불안 □수면장애 □식욕 변화) | | | |
| 5 | 몸소에 생리량은 어느 정도인가요?<br>□ 적다(소형패드) □ 보통이다(중형패드) □ 많다(대형패드) □ 아주 많다(외출불가) | 부종 이상일 경우 부인과 질환 확인 | 초음파검사 | |
| 6 | 최근 출산 경험이 있나요?<br>□ 예 □ 아니오 | 분만 후 21일 미만이며 혈전위험인자 없음<br>분만 후 21일 미만이며 혈전위험인자 있음<br>분만 후 21일-42일이며 혈전위험인자 있음 | | 3<br>4<br>3 |
| 7 | 현재 모유수유 중인가요?<br>□ 예 □ 아니오 | 모유수유 중이고 분만 후 6주 미만<br>모유수유 중이고 분만 후 6주 이상 6개월 미만 | | 4<br>3 |
| 8 | 향후 1년 이내에 임신할 계획이 있나요?<br>□ 예 □ 아니오 | 단기 또는 장기 피임법 선택 | | |
| 9 | 몸소 사용했던 피임법은 무엇인가요?<br>□ 없다 □ 경구 피임제 □ 콘돔 □ 구리루프 □ 미레나 □ 임플라논<br>□ 자연주기법 □ 질외사정 □ 기타( ) | 피임 경험과 지식 확인 | | |
| 10 | 흡연을 하나요?<br>□ 예(하루 개비) □ 아니오 | 35세 이상 하루 15개비 미만<br>35세 이상 하루 15개비 이상 | | 3<br>4 |
| 11 | 뇌졸중, 심근경색, 다리 또는 폐의 혈전을 경험한 적이 있나요?<br>□ 예 □ 아니오 | 뇌졸중, 심근경색 과거력<br>여러 혈전위험인자(고령, 흡연, 당뇨, 고혈압) | | 4<br>3/4 |
| 12 | 고혈압, 당뇨병, 고지혈증이 있거나, 과거에 있었던 적이 있나요?<br>□ 예 □ 아니오 | 고혈압 과거력 또는 잘 조절되는 고혈압<br>혈압 160/100mmHg 이상<br>혈압 140-159/90-99mmHg<br>고지혈증 단독<br>합병증을 동반한 당뇨병 또는 20년 이상 지속 | | 3<br>4<br>3<br>2<br>3/4 |
| 13 | 유방암을 진단받은 적이 있거나 유방의 종양이 있나요?<br>□ 예 □ 아니오 | 유방암 과거력<br>현재 유방암으로 치료 중<br>양성 유방 종양 또는 유방암 가족력 | | 3<br>4<br>1 |
| 14 | 간이나 쓸개 관련 질환 또는 황달이 있나요?<br>□ 예 □ 아니오 | 간암을 포함한 간세포종양 또는 급성 간염<br>중증 간경화증<br>경증 간경화증<br>증상이 있는 약물 치료 중인 담낭질환 | | 4<br>4<br>1<br>3 |
| 15 | 전신성홍반성루푸스를 앓고 있나요?<br>□ 예 □ 아니오 | 항인지질항체 양성<br>심각한 혈소판감소증, 면역억제치료 중 | | 4<br>2 |
| 16 | 골반염이나 질염, 성매개성 감염을 앓은 적이 있나요?<br>□ 예 □ 아니오 | 골반염, 성매개성감염, 에이즈(HIV) | | |
| 17 | 반복적으로 심한 두통이나 편두통이 있으며, 두통 전에 밝은 섬광이 보인 적이 있나요?<br>□ 예 □ 아니오 | 전조증상 있음<br>전조증상 없으나 35세 이상 | | 4<br>3 |
| 18 | 장기간 움직일 수 없는 큰 수술이 예정되어 있나요?<br>□ 예 □ 아니오 | 장기간 움직일 수 없는 큰 수술<br>움직일 수 있는 큰 수술 | | 4<br>2 |
| 19 | 현재 복용하고 있는 약물을 모두 적어주세요. (특히, 항결핵약, 항전간제) | Rifampicin, Rifabutin<br>항전간제<br>HIV 항바이러스제 | | 3<br>3<br>3 |

WHO 카테고리 1: 사용가능, 2: 일반적으로 사용, 3: 일반적으로 추천되지 않음, 4: 사용불가

발행 | 식품의약품안전처 자문

# 구피임제) 복용 안내서

래장애 증상의 치료
치료
증의 치료
없는 월경과다

※ 2-5번의 효능효과는 제품마다 다를 수 있습니다.

합니다. 만일 늦게 복용을 시작한다면 복용 후 첫 7일간은 임신
니다.

개 정제의 마지막 복용 후 2~3일 이내에 시작됩니다. 새로운 포장을
의 경우 호르몬 정제의 마지막 복용 후 3일 이내에 소퇴성 출혈이
수도 있습니다. 사상성 28일 정제의 경우 마지막 정제를 복용하는
소퇴성 출혈이 시작될 수도 있습니다. 출혈과 상관없이 지속적으로

약 정제를 복용한 다음 날 이 약의 복용을 시작합니다. 질링 또는
을 시작합니다. 프로게스테론 단일 성분을 함유한 피임제(주사,
체론 단일 제제(임플란트, 자궁내장치는 제거일부터, 주사는 다음
습니다. 그러나 모든 경우에 복용 후 첫 7일간 별도의 피임법(예:

장관 증상, 편두통, 우울감, 부종, 콘택트렌즈 불편감등이 있을 수

심혈관계 부작용 위험이 증가하므로 반드시 금연을 하여야 합니다.

이상) 경우 • 장기간 움직일 수 없는 수술, 장거리 비행이 예정된 경우
는 약물을 복용하는 경우
문해야 합니다. 혈전색전증 발생 빈도는 0.1% 미만으로 매우 드물지만(임신으로
다.

**폐색전증**

인불명의 기침(혈액이 나올 수도 있음)
규칙적인 심장박동
증 또는 어지러움
증가되는 날카로운 흉통

# *Thank you for your attention!*