CONTRACEPTION IN PRIMARY CARE

36th Annual Update in Primary Care

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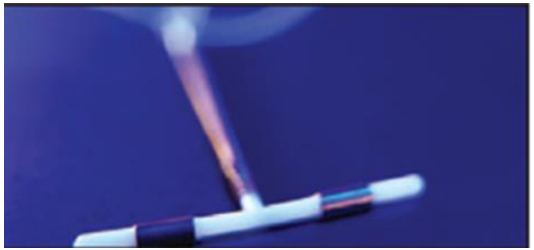
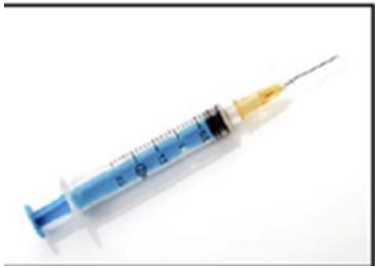
10/21/2023

LEARNING OBJECTIVES

- Evaluate comparative effectiveness of forms of contraception
- Review how to initiate contraception methods
- Review how to identify contraindications for contraception
- Discuss how to improve access to contraception
- Review long-acting reversible contraception (LARC) and emergency contraception





CONTRACEPTION AND PATIENT CHOICE

MEDICAL COLLEGE OF WISCONSIN

EFFECTIVENESS OF FAMILY PLANNING METHODS*

*The percentages indicate the number out of every 100 women who experienced an unintended pregnancy within the first year of typical use of each contraceptive method.

MOST EFFECTIVE

Less than 1 pregnancy per 100 women in a year

6-12 pregnancies per 100 women in a year

18 or more pregnancies per 100 women in a year

LEAST EFFECTIVE

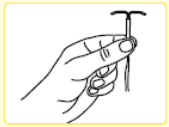
REVERSIBLE

Once in place, little or nothing to do or remember.

Implant

0.05%

Intrauterine Device (IUD)



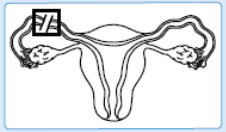
0.2% LNG

0.8% Copper T

PERMANENT STERILIZATION

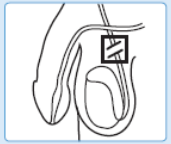
After procedure, little or nothing to do or remember.
Use another method for first 3 months (Hysteroscopic, Vasectomy).

Female (Abdominal, Laparoscopic, and Hysteroscopic)



0.5%

Male (Vasectomy)

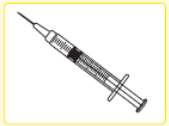


0.15%

REVERSIBLE

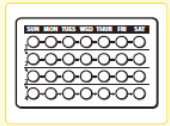
Get repeat injections on time. | *Take a pill each day.* | *Keep in place, change on time.* | *Use correctly every time you have sex.*

Injectable



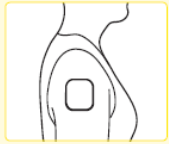
6%

Pill



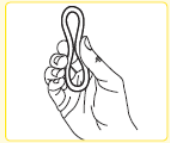
9%

Patch



9%

Ring



9%

Diaphragm

12%

REVERSIBLE

Use correctly every time you have sex.

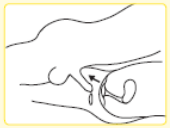
Male Condom

18%

Female Condom

21%

Withdrawal



22%

Sponge

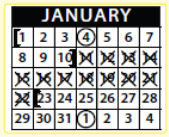
12% Nulliparous Women

24% Parous Women

Condoms should always be used to reduce the risk of sexually transmitted infections.

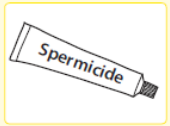
Fertility Awareness-Based Methods

Abstain or use condoms on fertile days.



24%

Spermicide



28%

Other Methods of Contraception: (1) **Lactational Amenorrhea Method (LAM):** is a highly effective, temporary method of contraception; and (2) **Emergency Contraception:** emergency contraceptive pills or a copper IUD after unprotected intercourse substantially reduces risk of pregnancy.

Adapted from World Health Organization (WHO) Department of Reproductive Health and Research, Johns Hopkins Bloomberg School of Public Health/Center for Communication Programs (CCP). Knowledge for health project. Family planning: a global handbook for providers (2011 update). Baltimore, MD; Geneva, Switzerland: CCP and WHO; 2011; and Trussell J. Contraceptive failure in the United States. *Contraception* 2011;83:397–404.

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

HOW TO START CONTRACEPTION

MEDICAL COLLEGE OF WISCONSIN

CONSIDER A CASE

A 22 year old woman presents to discuss contraception options. Today is Thursday, October 12th and her last period started on October 1st. She has not had any sexual activity since her last period. She elects to start the combined hormonal contraceptive pill. When should she take her first dose?

A. Wait until she starts her next menstrual cycle and use condoms until then
B. Start the pill pack on Sunday and use condoms until then
C. Take the first pill of the pill pack today – no other contraception needed
D. Take the first pill of the pill pack today and use condoms for next 7 days

THE U.S. SELECTED PRACTICE RECOMMENDATIONS FOR CONTRACEPTIVE USE (SPR)

- Adapted from WHO guidelines, expert review of evidence, CDC determined final recommendations
- Purpose: a source of clinical guidance for contraceptive counseling
  - How to be reasonably certain that a woman is not pregnant
  - When to start contraception
  - Medically indicated exams and tests
  - Follow-up and management of problems

CDC materials are open domain, including a slide set available for presentations, found at: US Selected Practice Recommendations for Contraceptive Use, 2016 (US SPR) | CDC

WHEN CAN I START CONTRACEPTION?

Quick start method means **Start Contraception Now!**

- For most patients no need to delay based on menstrual cycle
  - (though may need backup contraception)
- Using the “quick start” method is safe and effective
- Low chance of patient already being pregnant when following guidelines (next slide)
- Quick start method reduces risk of becoming pregnant
- No increased risk for adverse outcomes (congenital anomalies, neonatal death, infant death) among infants exposed in utero to COCs
- Starting CHCs on different days of the cycle does not affect bleeding or cause other side effects

Brahmi, Contraception, 2013.
Bracken, Obstet Gynecol. 1990;76:552-7

How to Be Reasonably Certain That a Woman is Not Pregnant

A health-care provider can be reasonably certain that a woman is not pregnant if she has no symptoms or signs of pregnancy and meets any one of the following criteria:

- is ≤7 days after the start of normal menses
- has not had sexual intercourse since the start of last normal menses
- has been correctly and consistently using a reliable method of contraception
- is ≤7 days after spontaneous or induced abortion
- is within 4 weeks postpartum
- is fully or nearly fully breastfeeding (exclusively breastfeeding or the vast majority [≥85%] of feeds are breastfeeds), amenorrheic, and <6 months postpartum

CDC, SPR

WHAT TESTING SHOULD BE DONE?

- Pre-contraception testing guidance is included in the SPR
- Most contraception requires no testing**,** if there is reasonable certainty the patient is not pregnant
- Pregnancy testing is not needed if criteria are met for reasonable certainty of not being pregnant
- CDC does recommend a pregnancy test prior to IUD insertion if uncertain pregnancy status
- For other contraception, benefits of starting contraception outweigh risks, could get a follow up pregnancy test in a few weeks after initiation (CDC)

How To Be Reasonably Certain a Woman Is Not Pregnant - US SPR | CDC

Examination or test	Contraceptive method and class							
Examination	**LNG and Cu-IUD**	**Implant**	**Injectable**	**CHC**	**POP**	**Condom**	**Diaphragm or cervical cap**	**Spermicide**
Blood pressure	C	C	C	A*	C	C	C	C
Weight (BMI)	—†	—†	—†	—†	—†	C	C	C
Clinical breast examination	C	C	C	C	C	C	C	C
Bimanual examination and cervical inspection	A	C	C	C	C	C	A	C
Laboratory test								
Glucose	C	C	C	C	C	C	C	C
Lipids	C	C	C	C	C	C	C	C
Liver enzymes	C	C	C	C	C	C	C	C
Hemoglobin	C	C	C	C	C	C	C	C
Thrombogenic mutations	C	C	C	C	C	C	C	C
Cervical cytology (Papanicolaou smear)	C	C	C	C	C	C	C	C
STD screening with laboratory tests	—§	C	C	C	C	C	C	C
HIV screening with laboratory tests	C	C	C	C	C	C	C	C

Class A: Essential and mandatory

Class C: Does not contribute substantially to safe and effective use of the contraceptive method

CDC, SPR

WHAT IS THE EVIDENCE FOR BP MEASUREMENT PRIOR TO CHC?

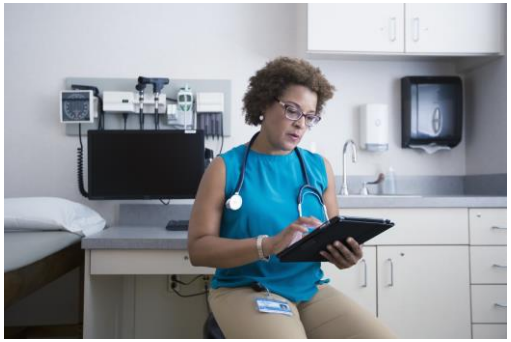
- Women who did not have blood pressure check prior to CHC initiation had higher odds of MI and ischemic stroke than women who had blood pressure check
- No evidence identified on other hormonal methods

Reference: Tepper, Contraception 2013

Slide adapted from US Selected Practice Recommendations for Contraceptive Use, 2016 (US SPR) | CDC

WHAT IS THE EVIDENCE FOR NOT NEEDING PELVIC EXAMS FOR CHCS?

- No conditions for which CHCs would be unsafe that would be detected by pelvic exam
- 2 studies: Delayed versus immediate pelvic exam before contraception
  - No difference in risk factors for cervical neoplasia, incidence of STDs, incidence of abnormal Pap smears, or incidence of abnormal wet mounts.
- Take-away: pelvic exams are not needed before starting combined hormonal contraception



Reference: Tepper, Contraception 2013
Slide adapted from US Selected Practice Recommendations for Contraceptive Use, 2016 (US SPR) | CDC

HEALTH POLICY SIDEBAR

FDA NEWS RELEASE

FDA Approves First Nonprescription Daily Oral Contraceptive

Share | Tweet | Linkedin | Email | Print

For Immediate Release: July 13, 2023

Español

Today, the U.S. Food and Drug Administration approved Opill (norgestrel) tablet for nonprescription use to prevent pregnancy— the first daily oral contraceptive approved for use in the U.S. without a prescription. Approval of this progestin-only oral contraceptive pill provides an option for consumers to purchase oral contraceptive medicine without a prescription at drug stores, convenience stores and grocery stores, as well as online.

The timeline for availability and price of this nonprescription product is determined by the manufacturer. Other approved formulations and dosages of other oral contraceptives will remain available by prescription only.

- FDA has approved OTC contraceptive pill
- Progestin only pill
- No pre-initiation testing is needed per CDC prior to starting a progestin only pill

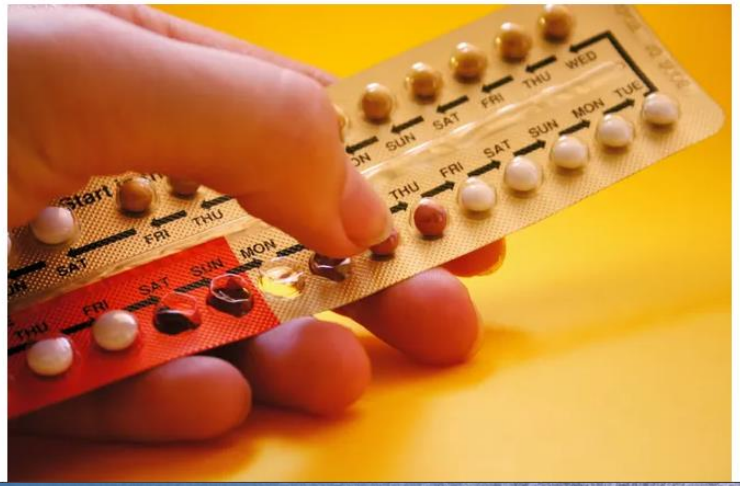
HEALTH POLICY SIDEBAR

POLITICS

Wisconsin pharmacists could prescribe birth control under a new bill. Here's what you need to know.

Alex Groth
Milwaukee Journal Sentinel

Published 10:21 a.m. CT June 22, 2023 | **Updated 7:01 p.m. CT June 28, 2023**



- Bill has passed the Wisconsin Assembly to allow pharmacist prescribed CHC – pill and patch
- Patient undergoes a questionnaire and BP screening
- Bill goes to Senate and then Governor for approval

When to Start Using Specific Contraceptive Methods

Contraceptive method	When to start (if the provider is reasonably certain that the woman is not pregnant)	Additional contraception (i.e., back up) needed	Examinations or tests needed before initiation[1]
Copper-containing IUD	Anytime	Not needed	Bimanual examination and cervical inspection[2]
Levonorgestrel-releasing IUD	Anytime	If >7 days after menses started, use back-up method or abstain for 7 days.	Bimanual examination and cervical inspection[2]
Implant	Anytime	If >5 days after menses started, use back-up method or abstain for 7 days.	None
Injectable	Anytime	If >7 days after menses started, use back-up method or abstain for 7 days.	None
Combined hormonal contraceptive	Anytime	If >5 days after menses started, use back-up method or abstain for 7 days.	Blood pressure measurement
Progestin-only pill	Anytime	If >5 days after menses started, use back-up method or abstain for 2 days.	None

CDC, SPR

WHO CAN TAKE WHICH CONTRACEPTION?

MEDICAL COLLEGE OF WISCONSIN

WHAT IS THE U.S. MEDICAL ELIGIBILITY CRITERIA FOR CONTRACEPTIVE USE, 2016?

- Recommendations for the safe use of contraceptive methods for people with certain characteristics or medical conditions
- Purpose: to assist health care providers when they counsel patients about contraceptive use
- Content: more than 1800 recommendations for over 60 conditions

Slide adapted from US Selected Practice Recommendations for Contraceptive Use, 2016 (US SPR) | CDC

Sample MEC page

Condition	Sub-Condition	Cu-IUD		LNG-IUD		Implant	DMPA	POP	CHC
		I	C	I	C	I C	I C	I C	I C
Age		Menarche to <20 yrs:2		Menarche to <20 yrs:2		Menarche to <18 yrs:1	Menarche to <18 yrs:2	Menarche to <18 yrs:1	Menarche to <40 yrs:1
		≥20 yrs:1		≥20 yrs:1		18-45 yrs:1	18-45 yrs:1	18-45 yrs:1	≥40 yrs:2
						>45 yrs:1	>45 yrs:2	>45 yrs:1	
Anatomical abnormalities	a) Distorted uterine cavity	4		4					
	b) Other abnormalities	2		2					
Anemias	a) Thalassemia	2		1		1	1	1	1
	b) Sickle cell disease‡	2		1		1	1	1	2
	c) Iron-deficiency anemia	2		1		1	1	1	1
Benign ovarian tumors	(*including cysts*)	1		1		1	1	1	1
Breast disease	a) Undiagnosed mass	1		2		2*	2*	2*	2*
	b) Benign breast disease	1		1		1	1	1	1
	c) Family history of cancer	1		1		1	1	1	1
	d) Breast cancer‡								
	i) Current	1		4		4	4	4	4
	ii) Past and no evidence of current disease for 5 years	1		3		3	3	3	3
Breastfeeding	a) <21 days postpartum					2*	2*	2*	4*
	b) 21 to <30 days postpartum								
	i) With other risk factors for VTE					2*	2*	2*	3*
	ii) Without other risk factors for VTE					2*	2*	2*	3*
	c) 30-42 days postpartum								
	i) With other risk factors for VTE					1*	1*	1*	3*
	ii) Without other risk factors for VTE					1*	1*	1*	2*
	d) >42 days postpartum					1*	1*	1*	2*
Cervical cancer	Awaiting treatment	4	2	4	2	2	2	1	2
Cervical ectropion		1		1		1	1	1	1
Cervical intraepithelial neoplasia		1		2		2	2	1	2
Cirrhosis	a) Mild (*compensated*)	1		1		1	1	1	1
	b) Severe‡ (*decompensated*)	1		3		3	3	3	4
Cystic fibrosis‡		1*		1*		1*	2*	1*	1*
Deep venous thrombosis (DVT)/Pulmonary embolism (PE)	a) History of DVT/PE, not receiving anticoagulant therapy								
	i) Higher risk for recurrent DVT/PE	1		2		2	2	2	4
	ii) Lower risk for recurrent DVT/PE	1		2		2	2	2	3
	b) Acute DVT/PE	2		2		2	2	2	4
	c) DVT/PE and established anticoagulant therapy for at least 3 months								
	i) Higher risk for recurrent DVT/PE	2		2		2	2	2	4*
	ii) Lower risk for recurrent DVT/PE	2		2		2	2	2	3*
	d) Family history (*first-degree relatives*)	1		1		1	1	1	2
	e) Major surgery								
	i) With prolonged immobilization	1		2		2	2	2	4
	ii) Without prolonged immobilization	1		1		1	1	1	2
	f) Minor surgery without immobilization	1		1		1	1	1	1
Depressive disorders		1*		1*		1*	1*	1*	1*

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)

HOW TO INTERPRET THE MEC

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*	

Key:	
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BACK TO OUR CASE

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MEC by Co

MEC by M

SPR

About this

Full Guide

Provider

SPR

Cu-IUD

LNG-IUD

Implants

Injectables

Combined Hormonal Contraceptives

SPR: Combined Horm
Contraceptives

Initiation

Exams and Tests

Number of Pill Packs that Shou
Provided at Initial and Return V

Routine Follow-Up

Late or Missed Doses

Initiation of Combined Hormonal Contraceptives

Timing

- Combined hormonal contraceptives can be initiated at any time if it is reasonably certain that the woman is not pregnant (Box 2).

Need for Back-Up Contraception

- If combined hormonal contraceptives are started within the first 5 days since menstrual bleeding started, no additional contraceptive protection is needed.
- If combined hormonal contraceptives are started >5 days since menstrual bleeding started, the woman needs to abstain from sexual intercourse or use additional contraceptive protection for the next 7 days.

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ACCESSING CONTRACEPTION

MEDICAL COLLEGE OF WISCONSIN

BARRIERS TO CONTRACEPTION

- Provide 1 year of refills of contraception (90 day prescriptions!)
- Don't require unnecessary apts or exams
- Consider telehealth

Table 2. Difficulties Related to Obtaining or Refilling a Prescription for Hormonal Contraception Among Women Who Had Ever Tried (*N* = 1385)

	n	*Weighted %*	*95% CI*
Cost barriers or lack of insurance coverage	182	13.5	11.2–16.1
Challenges related to obtaining an appointment or getting to a clinic	179	13.4	11.2–16.0
Clinician required clinic visit, exam, or Pap smear before providing refill	156	12.7	10.5–15.2
Not having a regular doctor or clinic	123	10.0	8.0–12.3
Difficulty accessing a pharmacy	51	3.5	2.5–4.8
Other reason	46	3.6	2.4–5.3

CI, confidence interval.

Grindlay K, Grossman D. Prescription birth control access among U.S. women at risk of unintended pregnancy. J Womens Health. 2016; 25(3):249-254.

LONG ACTING REVERSIBLE CONTRACEPTION (LARC)

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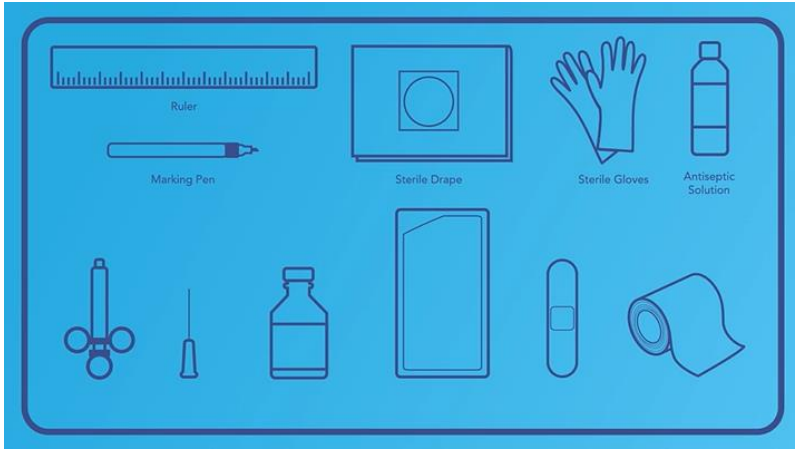
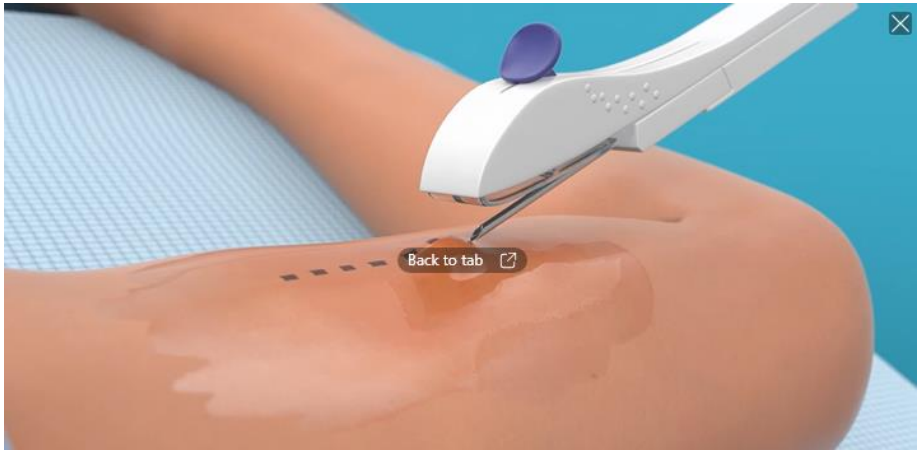
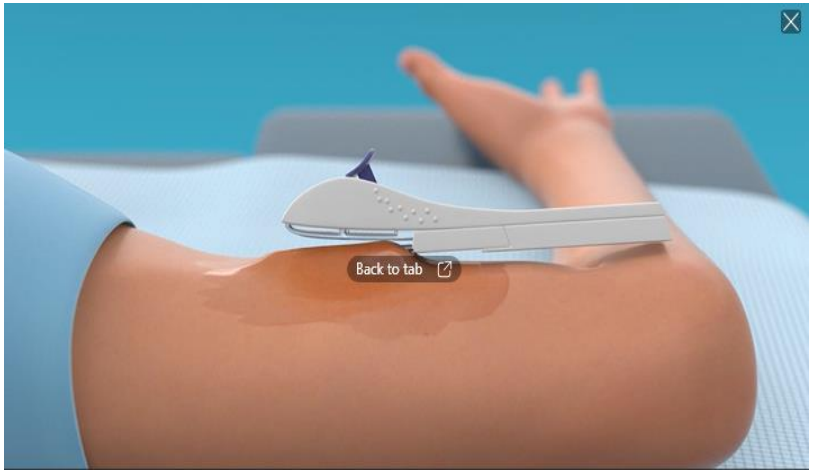
LONG ACTING REVERSIBLE CONTRACEPTION

- IUD and implant insertion is within the scope of primary care
- Manufacturers provide free training for providers
- Training less than 2 hours
- ACOG provides excellent videos
  LARC Video Series | ACOG





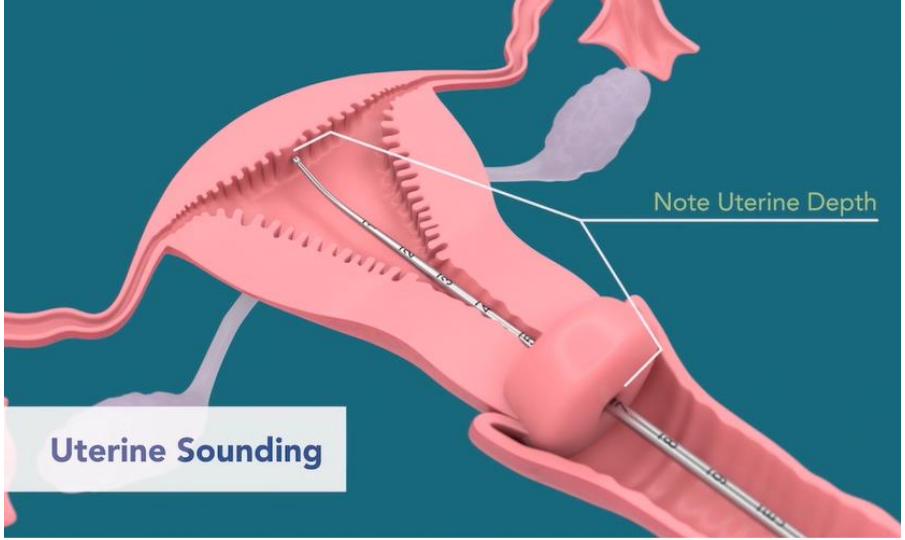


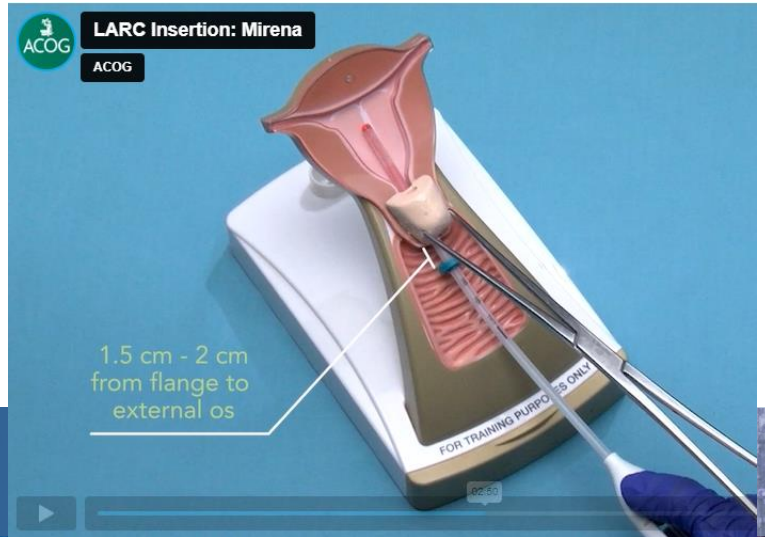
ACOG
The American College of Obstetricians and Gynecologists

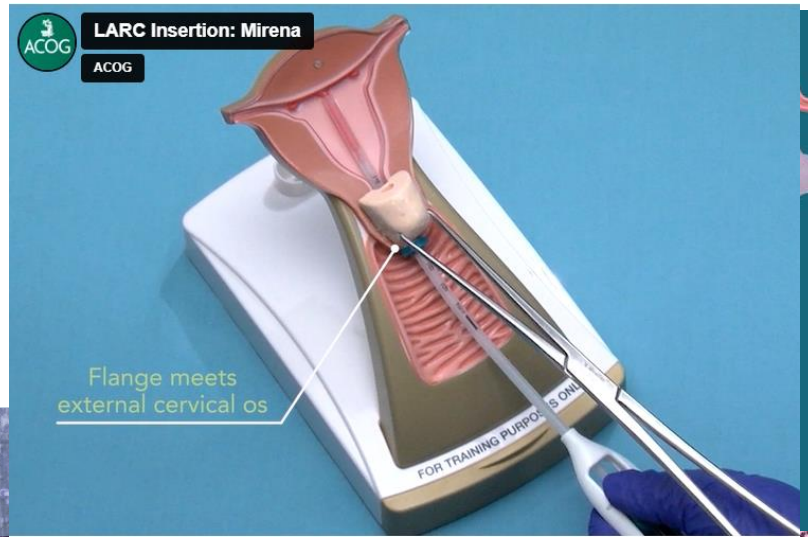
IMPLANT TIPS

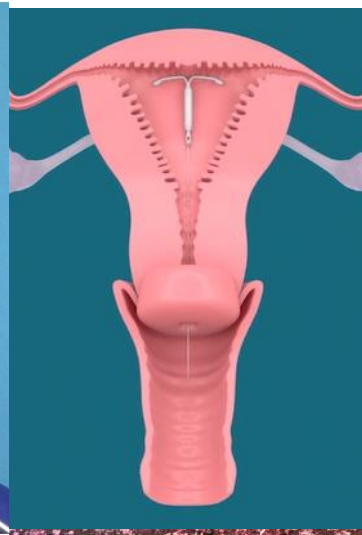
- Easy insertion
  - Make sure patient is fully anesthetized – around 5 minutes
  - Make sure needle is fully inserted prior to deploying device
- Implant can stay for up to 5 years with high effectiveness (approved for 3 years)
- Possible complications – infection, migration
- Possible side effects - mood swings, weight gain, acne, headache
- Biggest side effect is usually abnormal bleeding – some women discontinue implant
- Failure rate in 1st year of insertion is 0.05%


ACOG
The American College of Obstetricians and Gynecologists
Tenaculum Placement

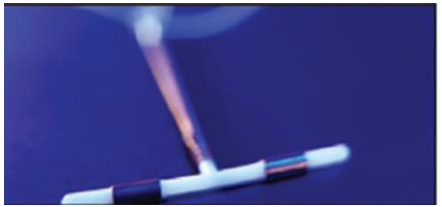

Note Uterine Depth
Uterine Sounding


LARC Insertion: Mirena
ACOG
1.5 cm - 2 cm
from flange to
external os


LARC Insertion: Mirena
ACOG
Flange meets
external cervical os



IUD TIPS



- Copper IUD can stay for 10 years (and has no hormones)
- Mirena and Liletta can now stay in 8 years with good efficacy
- Kyleena can stay 5 years and Skyla can stay 3 years
- Pregnancy test should be done if not reasonably sure patient is not pregnant
- Pain control is important: pre-medication with nsaids, paracervical block with lidocaine may decrease pain with insertion of IUD (CDC)
- Good to have a spare device with you if possible
- Possible side effects: irregular bleeding, cramping/pelvic pain, acne, headache
- Possible benefits: amenorrhea or decreased severity of menstruation (hormonal IUD)
- Failure rate in 1st year is 0.2%

EMERGENCY CONTRACEPTION

MEDICAL COLLEGE OF WISCONSIN

FOUR OPTIONS FOR EC AVAILABLE IN THE US

ALL CAN BE TAKEN WITHIN 5 DAYS OF INTERCOURSE EPISODE, ASAP

- Intrauterine device - Copper intrauterine device (Cu-IUD)

- Emergency contraceptive pills (ECPs)
  - Levonorgestrel (LNG – “plan B”) in a single or split dose
  - Ulipristal acetate (UPA) available in a single dose (30 mg)
    - UPA has been shown more effective than LNG when 3-5 days post-intercourse
    - UPA may more effective than LNG in obese women
  - Estrogen/progestin in 2 doses
    - less effective than UPA or LNG and associated with more side effects

Slide adapted from US Selected Practice Recommendations for Contraceptive Use, 2016 (US SPR) | CDC

ADVANCE PROVISION OF EMERGENCY CONTRACEPTION PILLS (ECP)

- An advance supply of emergency contraception may be provided
- Any use of ECP was 2 – 7x more common in people who received advance script
- Studies have not shown a significant reduction in unintended pregnancy for those who received advance ECP
- In the majority of studies, rates of contraceptive use, pregnancy rates, and STD incidence did not differ between those who received advance script and those who did not
- Evidence supports the safety of prescribing advance ECP

Emergency Contraception - US SPR | CDC

TAKE-AWAYS

- Discuss relative effectiveness of contraception when counseling on options
- Use the CDC Selected Practice Recommendations (SPR) for information on initiating or changing contraception
- Use the CDC Medical Eligibility Criteria (MEC) for safe prescribing for people with chronic medical conditions
- Do not require unnecessary exams or testing prior to starting contraception
- Consider providing long acting reversible contraception as it is safe and highly effective
- Prescribe emergency contraception to patients, including advance prescriptions

THANK YOU!

- Thank you to Drs. Theresa Maatman, Amy Farkas, Cecilia Scholcoff and Jake Decker for giving me feedback on this presentation

- Please feel free to contact me with questions at Rbernard@mcw.edu