Choosing The Right Contraception: Adolescence through Menopause

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Tacoma Family Medicine Rural/OB Fellows
May 14, 2015
Why is this important?

• ~50% of pregnancies unintended

• ~50% of unintended pregnancies with no contraception use

• Higher rates in young, minorities, & lower SES

• Unintended pregnancies = higher risk for mother and baby
Objectives

1. Summarize CDC’s 2013 “US Selected Practice Recommendations of Contraceptive Use”

2. Identify new options for contraception

3. Incorporate use of contraceptive guidelines into current clinical practice
Goals of CDC SRP 2013 Publication

- Overview of all contraceptives, efficacy and timing of initiation
- Algorithm for late or missed contraceptive
- Management of bleeding irregularities
- Management of IUD with PID
- Guidelines to ensure patient is not pregnant
- Regular contraception after emergency contraceptive use
- Determine when contraception is no longer needed
# 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

<table>
<thead>
<tr>
<th>Method</th>
<th>Effectiveness</th>
<th>Use Instructions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Implant</td>
<td>0.05%</td>
<td>Once in place, little or nothing to do or remember.</td>
</tr>
<tr>
<td>Intrauterine Device (IUD)</td>
<td>0.2% LNG, 0.8% Copper T</td>
<td>Get repeat injections on time.</td>
</tr>
<tr>
<td><strong>Permanent Sterilization</strong></td>
<td></td>
<td>Use another method for first 3 months (Hysteroscopic, Vasectomy).</td>
</tr>
<tr>
<td>Female (Abdominal, Laparoscopic, and Hysteroscopic)</td>
<td>0.5%</td>
<td>Take a pill each day.</td>
</tr>
<tr>
<td>Male (Vasectomy)</td>
<td>0.15%</td>
<td>Keep in place, change on time.</td>
</tr>
</tbody>
</table>

## Reversible

<table>
<thead>
<tr>
<th>Method</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Injectable</td>
<td>6%</td>
<td>Use correctly every time you have sex.</td>
</tr>
<tr>
<td>Pill</td>
<td>9%</td>
<td>Use correctly every time you have sex.</td>
</tr>
<tr>
<td>Patch</td>
<td>9%</td>
<td>Use correctly every time you have sex.</td>
</tr>
<tr>
<td>Ring</td>
<td>9%</td>
<td>Use correctly every time you have sex.</td>
</tr>
<tr>
<td>Diaphragm</td>
<td>12%</td>
<td>Use correctly every time you have sex.</td>
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## Least Effective

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<tr>
<td>Male Condom</td>
<td>18%</td>
<td>Use correctly every time you have sex.</td>
</tr>
<tr>
<td>Female Condom</td>
<td>21%</td>
<td>Use correctly every time you have sex.</td>
</tr>
<tr>
<td>Withdrawal</td>
<td>22%</td>
<td>Use correctly every time you have sex.</td>
</tr>
<tr>
<td>Sponge</td>
<td>12% Nulliparous Women, 24% Parous Women</td>
<td>Use correctly every time you have sex.</td>
</tr>
</tbody>
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## Fertility Awareness-Based Methods

**JANUARY**

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
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<th>4</th>
<th>5</th>
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Abstain or use condoms on fertile days: 24%

Spermicide: 28%

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

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Our Approach To Every Patient

1. Establish patient goals and knowledge of options

2. Evaluate for contraindications

3. Offer the most effective option
Case #1

• 16 years old

• Newly sexually active

• Chlamydia diagnosed by school nurse 2 weeks ago

• GOAL: Go to college, not be pregnant
Birth Control = PILLS!
Contraceptive Use in the U.S.

Percent of users 2006-2008 (15-44 years old)

# Effectiveness of Family Planning Methods

*The percentages indicate the number of 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**
  - **Implant**
    - 0.05%
  - **Intrauterine Device (IUD)**
    - 0.2% LNG
    - 0.8% Copper T

## REVERSIBLE
- **Injectable**
  - 6%
- **Pill**
  - 9%
- **Patch**
  - 9%
- **Ring**
  - 9%
- **Diaphragm**
  - 12%

## LEAST EFFECTIVE
- **Male Condom**
  - 18%
- **Female Condom**
  - 21%
- **Withdrawal**
  - 22%
- **Sponge**
  - 12% Nulliparous Women
  - 24% Parous Women
- **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 Trussel & Contraceptive failure in the United States. Contraception 2011;83:397–404.

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

**Continuing Medical Education**

**MultiCare Women & Children’s Grand Rounds**
Comparative Effectiveness

Percent of women with unintended pregnancy in the first year of use

- **Perfect**
- **Typical**

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<td>Condoms</td>
<td>2</td>
<td>18</td>
</tr>
<tr>
<td>Pill/ Patch/ Ring</td>
<td>0.3</td>
<td>9</td>
</tr>
<tr>
<td>DMPA</td>
<td>0.2</td>
<td>6</td>
</tr>
<tr>
<td>Copper IUD</td>
<td>0.6</td>
<td>0.8</td>
</tr>
<tr>
<td>LNG-IUS</td>
<td>0.2</td>
<td>0.2</td>
</tr>
<tr>
<td>Implanon</td>
<td>0.05</td>
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Adapted from Trussell J. Contracept. 2011; 83(5)
Case #1- Contraceptive Options

• Emergency Contraception
• IUD
• Nexplanon
• Depo
• Pills
• Vaginal Ring
• Condoms
EC: Not needed, menstruating currently

IUD: declines, never had pelvic exam, recent STI

Nexplanon: Sounds good

Depo: Hates injections, does not want q3 months

Pills: Cannot remember to take vitamin daily

Ring: Uncomfortable with vaginal placement

Condoms: knows to use them to prevent STI, will use in future
Case #1

Insert Nexplanon TODAY

Implant: Etonogesterel 68 mg, FDA approved 3 yr (<1/100 UP/yr)

1. If not “reasonably sure” pt is not pregnant
   - Place anyway. Repeat preg test in 2-4 weeks
   - Depo, pills or condoms and return when menstruating

2. Discuss importance of regular condom use and STI testing
How to Be Reasonably Certain a Woman is not Pregnant

- < 7 days from start of normal menses
- No intercourse since start of normal menses
- Correctly & consistently using reliable contraception
- < 7 days from spontaneous or induced abortion
- Within 4 weeks post partum
- Fully/near fully (>85%) breastfeeding, amenorrheic & <6 months postpartum
Nexplanon Initiation:

Backup method not needed if:
1. Within first 5 days of menstrual bleeding
2. <1 mo PP or <6 mo PP if amenorrheic and BF >85% of time
3. <7 days post abortion

OK in pts with HTN, DM, Obesity, Cancer, and HIV

No physical exam or lab tests needed prior to insertion

No necessary follow up needed until 3 years
# Timing of Initiation

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Appendix B CDC SPR for Contraceptive Use, When to start using Specific Contraceptive Methods
Nexplanon Counseling: Side Effects

- Unscheduled bleeding or amenorrhea is common
  - 34% infrequent spotting
  - 7% frequent bleeding & 18% prolonged bleeding
  - 22% have amenorrhea

- Heavy bleeding not common; look for other etiology
  - Medications, STIs, Fibroids, Polyps, or pregnancy

- Irregular Bleeding:
  - NSAIDs
  - COC or estrogen for 10-20 days
  - Alternative LARC
Case #1
TAKE HOME POINTS

Every teen deserves a thorough evaluation

– Sexual History
– Assess need for contraception & risk of STI
– Arrangement for contraceptive counseling
– Consider highly effective LARC method
SEXUAL HISTORY

Partners

Practices

Protection from STDs

Past history of STDs

Prevention of pregnancy
### Progestin Implant

**What is the implant?**
The implant is a thin plastic tube about the size of a paper matchstick. It is inserted under the skin of your upper arm. It prevents pregnancy by releasing a small amount of progestin (a hormone). It works for 3 years. After 3 years, you can get a new implant if you want one.

**How well does it work?**
The implant works better than the pill, the patch, the ring, and the shot. It prevents pregnancy in 99% of women who use it.

**Is it safe?**
Yes.

**How is it inserted?**
After numbing your skin, a medical provider inserts the implant under the skin of your upper arm. This takes a few minutes. It is done in the office or clinic.

**How is it removed?**
A medical provider numbs your skin and makes a small cut to remove the implant. This takes a few minutes. The implant can be removed at any time. It is removed in the office or clinic.

**What are the benefits?**
The implant is safe, effective, and easy to use. Once you have it, it works on its own – you don’t have to do anything. You can use it while breastfeeding. It’s great for many women who can’t use birth control pills, patch, or ring.

**What are the side effects?**
The implant causes periods to change. Most women have off-and-on spotting. Spotting may last until the implant is removed. A few women have mood changes, weight gain, headache, acne, and/or skin changes in the upper arm. Most side effects go away when the implant is removed.

**Can people see it?**
Most people can’t see it, but you can feel it if you touch the skin over the implant.

**How much does it cost?**
Insertion costs $400-800, and removal costs $75-150. Most insurance plans cover the implant.

**Does it protect against HIV and other sexually transmitted infections?**
No, it does NOT protect you from sexually transmitted infections. Unless you and your partner have sex only with each other, you should use a condom every time you have sex (even with the implant in place).

**Is it easy to get pregnant after the implant is removed?**
Most women get pregnant quickly after a medical provider removes the implant.
Case #2

- 26 yo female
- Hx of 3 spont abortions
- Last SAB 2 days ago
- BMI 51
- Type II DM (HgAc1 9)
- HTN, BP: 145/86
- PCOS, heavy irregular cycles
- Currently using Patch
- GOAL: no more pregnancies
Case #2

- **EC:** Not needed, just had miscarriage

- **IUD:** Like idea of >99% effective, sick of miscarriages

- **Nexplanon:** doesn’t want abnormal spotting

- **Depo:** Worried about the weight gain

- **Pills:** MEC category 3-4 with uncontrolled diabetes and HTN

- **Patch:** Less efficacy >90 kg, larger risk of blood clots, doesn’t stick well often, same risk with HTN and DM

- **Ring:** Better option but same risk with HTN and DM

- **Condoms:** Low efficacy alone but necessary for STI prevention
Case #2: Obesity and Contraception

- IUDs: Highly effective regardless of weight
- Nexplanon: No change in efficacy
- Depo: No change in efficacy. Less wt gain in obese pts
- Pills: Effective with perfect use, treats PCOS
- Patch: Much less effective if >90kg
- Ring: Poorly studied but thought to be effective
Medical Eligibility Criteria (MEC)

- Category 1: no restrictions
- Category 2: benefits outweigh the risks
- Category 3: risks outweigh the benefits
- Category 4: unacceptable health risks
Medical Eligibility Criteria (MEC) Free App: “CDC Contraception”

**Summary of Classifications for Hormonal Contraceptive Methods and Intrauterine Devices**

**Condition: OBESITY**

**Category:**

- a. >30 kg/m² BMI
  - COC/P/R - 2 (details)
  - POP - 1 (details)
  - DMPA - 1 (details)
  - Implants - 1 (details)
  - LNG-IUD - 1 (details)
  - Cu-IUD - 1 (details)

- b. Menarche to <18 yrs and >30 kg/m² BMI
  - COC/P/R - 2 (details)
  - POP - 1 (details)
  - DMPA - 2 (details)
  - Implants - 1 (details)
  - LNG-IUD - 1 (details)
  - Cu-IUD - 1 (details)
Case #2 - HTN and DM

- All LARCs and sterilization: Category 1 and 2

- Depo: category 3 with multiple CV Risk factors, vascular disease and BP >160/100

- Pills, Patch, Ring (PPR): Category 3 and 4
  - Risk factors: >35 yo, smoking, both diseases
  - BP >160/100: Category 4, stop OCP: may improve BP
  - DM alone for >20 yrs or complications
Case #2

Inserted a Mirena IUD in office in a week after confirmed complete SAB
Types of Intrauterine Devices

A. Levonorgesteral (progesterone)
   - Mirena IUD (52 mg LNG), FDA approved 5yr (7)
   - Skyla IUD (13.5 mg LNG), FDA approved 3 yr

B. Copper IUD (no hormone)
   - FDA approved 10 yr (12)
   - Also effective for emergency contraception
Breaking News!
April 2015

Liletta™
(levonorgestrel-releasing intrauterine system) 52 mg

Generic Mirena
Same size, amount of hormone, & duration of efficacy
$50
IUD Timing of Initiation

• Copper IUD: < 5 days can be used as EC, not pregnant, immediately post-partum/post-abortion

• LNG-IUD: not pregnant, No back up needed if <7 days from LMP

• STI Screening per CDC Guidelines. If not done, do at the time of insertion.
IUD Advantages

• Single motivational act for insertion
• Long duration and high degree of efficacy
• Easily reversible
• Little systemic hormonal effects
• Excellent safety profile
Cost-effectiveness

Cost of female contraceptive methods at 5 years

- Cervical cap
- Spermicide
- Diaphragm
- Sterilization
- Pill
- Injection
- Copper IUD
- LNG-IUS

Thousands in dollars

IUDs and Pelvic Inflammatory Disease

- Incidence same for IUD users & general population
- Increased risk in only 1st month, d/t preexisting STI
- Long term decreases risk
Keep your IUD with PID!

- Treat PID.*
- Counsel about condom use.
- IUD does not need to be removed.

**Woman wants to continue IUD.**

- Reassess in 24-48 hours.
- **Clinical improvement**
  - Continue IUD.
- **No clinical improvement**
  - Continue antibiotics.
  - Consider removal of IUD.
  - Offer another contraceptive method.
  - Offer emergency contraception.

**Woman wants to discontinue IUD.**

- Remove IUD after beginning antibiotics.
- **Offer another contraceptive method.**
- **Offer emergency contraception.**

*Abbreviations: Cu-IUD = copper-containing IUD; IUD = intrauterine device; LNG-IUD = levonorgestrel-releasing IUD; PID = pelvic inflammatory disease.*

* Treat according to CDC’s STD Treatment Guidelines (available at http://www.cdc.gov/std/treatment).*
Risks/Side Effects

1. Uterine perforation with insertion (1/1000)
2. Infection in first 20 days
3. Expulsion (5%)
4. Amenorrhea with Mirena (20% by 12 mo)
5. Unscheduled bleeding
   - Mirena: spotting or light bldg for first 3-6 months
   - Paraguard: same to heavier menstruation
Management of Bleeding Irregularities

If bleeding persists, or if the woman requests it, medical treatment can be considered.

- **Cu IUD users**
  - For unscheduled spotting or light bleeding or for heavy or prolonged bleeding:
    - NSAIDs (5–7 days of treatment)

- **LNG-IUD users**
  - For unscheduled spotting or light bleeding or heavy or prolonged bleeding:
    - NSAIDs (5–7 days of treatment)
    - Hormonal treatment (if medically eligible) with COCs or estrogen (10–20 days of treatment)

- **Implant users**
  - For unscheduled spotting or light bleeding:
    - NSAIDs (5–7 days of treatment)
    - Hormonal treatment (if medically eligible) with COCs or estrogen (10–20 days of treatment)

- **Injectable (DMPA) users**
  - For unscheduled spotting or light bleeding:
    - NSAIDs (5–7 days of treatment)
    - Hormonal treatment (if medically eligible) with COCs or estrogen (10–20 days of treatment)

- **CHC users (extended or continuous regimen)**
  - Hormone-free interval for 3–4 consecutive days
  - Not recommended during the first 21 days of extended or continuous CHC use
  - Not recommended more than once per month because contraceptive effectiveness might be reduced

If bleeding disorder persists or woman finds it unacceptable

Counsel on alternative methods and offer another method, if desired.
Case #2
TAKE HOME POINTS

– Effective birth control is life saving for women with medical complications, at risk for high risk pregnancy
– Birth control side effects can be helpful/treatment
– Use resources to guide contraception choice and management
Case #3

- 36 yo woman
- 1 day s/p uncomplicated delivery of 4th child
- GOAL: No more pregnancies
Case #3

- IUD: Does not want “anything” in uterus
- Nexplanon: No, heard bad stories of breaking
- Depo: No, does not want to see doctor this often
- Pills: No, got pregnant with last 2 children on pill
- Condoms: No, hates them
- Natural family planning: Knows this won’t work
- Tubal ligation: Likes this idea
- Vasectomy: Partner declines
Case #3

1. Female (0.5% failure rate)
   - Tubal ligation: laparoscopic or laparotomy. Immediate efficacy.
   - Essure: Hysteroscopy. 3 mo to confirm.

2. Male (0.15% failure rate)
   - Vasectomy. Must verify lack azoospermia, check 8-16 wks
ESSURE

- Office based procedure
- Permanent, non-surgical **transcervical sterilization** procedure
- Best placed after ~4 weeks of progesterone only contraception
- Can not be done while menstruating
- Need for 3 month hysterosalpingogram to confirm efficacy
Case #3

On discharge from hospital:
- given Depo injection (declined Minipill)
- referred to OB/Gyn consultant
- signed DSHS Sterilization Consent (30 days in WA)

Six weeks later:
- underwent day surgery with laparoscopic tubal ligation
Case #3
TAKE HOME POINTS

Start discussing birth control options and preferences during pregnancy care

Postpartum contraception management is part of effective pregnancy care

Offer a bridge for contraception if leaving hospital postpartum with future contraception plans
Case #4

• 44 yo woman

• New partner with unprotected intercourse last night

• Has not been using any contraception

• No significant medical history

• GOAL: No pregnancy
Case #4

- **EC:** NEED IT!

- **IUD:** Copper for EC. Will take her through menopause

- **Tubal ligation/Essure:** Does not want surgery or fu

- **Nexplanon/Depo:** Hates needles

- **Pills:** Feels “too old” for pills

- **Ring:** Sounds weird

- **Condoms:** Knows she should use them to protect from STI
EMERGENCY CONTRACEPTIVES:
Prevent fertilization; do not end pregnancy

1. Pills
   a. **Ella (Ulipristal):** Progesterone agonist/antagonist. Take within 5 days, works best on day 4-5. Delays ovulation. Medium efficacy (>90%). Rx.

   b. **Plan B:** Progesterone. Inhibits ovulation, thickens cervical mucus, endometrial changes. Take within 72 hours (5 days EBM). Medium-low efficacy (88%). OTC.

   c. **OCP** (Emergency Contraception website: [www.not-2-late.com](http://www.not-2-late.com)) Low efficacy (~75%). Rx.

2. **Copper IUD:** Up to 5 days, ~99% effective. Provider insertion. Inhibits sperm movement, lasts 10 yrs.
Case #4

Cu IUD inserted TODAY as emergency and long term contraceptive

Take Home Points:
1. Don’t assume women over 40 can’t get pregnant
2. Offer effective contraception through menopause
3. STI screening at IUD insertion
Case # 5

• 24 yo, never pregnant, healthy

• Had spotting with Nexplanon

• GOAL: Wants pill to help with acne (friend recommended)

• Which pill to start with?
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Appendix B CDC SPR for Contraceptive Use, When to start using Specific Contraceptive Methods
Choosing a Combined Oral Contraceptive (COC)

- Start with a mid-dose estrogen: 25-35 mcg
- Adjust based on side effects or indications
- Lower estrogen = greater breakthrough bleeding
- Higher Androgen Activity = less effect on libido
- Lower Androgen Activity = treats hyperandrogenism
Pill, Patch or Ring Initiation

• Anytime one is reasonably sure patient is not pregnant– anytime in menstrual cycle

• No significant maternal or fetal morbidity or mortality with pill/patch/ring use in pregnancy

• Consider starting OCP then recheck preg test in 2-4 weeks or give EC, then start OCP
Late or Missed Pill

FIGURE 2. Recommended actions after late or missed combined oral contraceptives. CDC SPR for Contraception Use

If one hormonal pill is late: (<24 hours since a pill should have been taken)
- Take the late or missed pill as soon as possible.
- Continue taking the remaining pills at the usual time (even if it means taking two pills on the same day).
- No additional contraceptive protection is needed.
- Emergency contraception is not usually needed but can be considered if hormonal pills were missed earlier in the cycle or in the last week of the previous cycle.

If one hormonal pill has been missed: (24 to <48 hours since a pill should have been taken)
- Take the most recent missed pill as soon as possible. (Any other missed pills should be discarded.)
- Continue taking the remaining pills at the usual time (even if it means taking two pills on the same day).
- Use back-up contraception (e.g., condoms) or avoid sexual intercourse until hormonal pills have been taken for 7 consecutive days.
- If pills were missed in the last week of hormonal pills (e.g., days 15–21 for 28-day pill packs):
  - Omit the hormone-free interval by finishing the hormonal pills in the current pack and starting a new pack the next day.
  - If unable to start a new pack immediately, use back-up contraception (e.g., condoms) or avoid sexual intercourse until hormonal pills from a new pack have been taken for 7 consecutive days.
- Emergency contraception should be considered if hormonal pills were missed during the first week and unprotected sexual intercourse occurred in the previous 5 days.
- Emergency contraception may also be considered at other times as appropriate.

If two or more consecutive hormonal pills have been missed: (≥48 hours since a pill should have been taken)
- Take the most recent missed pill as soon as possible. (Any other missed pills should be discarded.)
- Continue taking the remaining pills at the usual time (even if it means taking two pills on the same day).
- Use back-up contraception (e.g., condoms) or avoid sexual intercourse until hormonal pills have been taken for 7 consecutive days.
- If pills were missed in the last week of hormonal pills (e.g., days 15–21 for 28-day pill packs):
  - Omit the hormone-free interval by finishing the hormonal pills in the current pack and starting a new pack the next day.
  - If unable to start a new pack immediately, use back-up contraception (e.g., condoms) or avoid sexual intercourse until hormonal pills from a new pack have been taken for 7 consecutive days.
- Emergency contraception should be considered if hormonal pills were missed during the first week and unprotected sexual intercourse occurred in the previous 5 days.
- Emergency contraception may also be considered at other times as appropriate.
Case #5

Started medium-dose OCP today

Take Home Points:

1. Give the BC she wants, ensuring she knows the options

2. OCP’s are COMPLICATED. Follow algorithms for troubleshooting side effects, missed doses, etc

3. Give a year worth of refills with no strings attached

4. Give a prescription/instructions for EC
Our Approach To Every Patient

1. Establish patient goals and knowledge of options

2. Evaluate for possible contraindications

3. Offer the most effective option
THE BIRTH CONTROL THAT WORKS BEST...

IS THE ONE THE PATIENT WANTS!
Questions?
References

ACOG Practice Bulletin #121, "Long-Acting Reversible Contraception: Implants and Intrauterine Devices,“

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Walsh T et al., Randomized controlled trial of prophylactic antibiotics before insertion of intrauterine devices, Lancet, 1998, 351(9108):1005-1008

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Sivin I, et al. Prolonged intrauterine contraception: a seven-year randomized study of the levonorgestrel 20 mcg/day (LNg 20) and the Copper T380 Ag IUDS. Contraception. 1991; 44 (5): 473-80.
CME for webstream viewers only.

Please cut and paste following web address into your browser to return to the Women and Children’s Webpage to access the evaluation form.

http://www.multicare.org/women-childrens-grand-rounds/

Complete and submit evaluation form by Saturday, 05/16/15, in order to receive a certificate of completion.

Please make sure to print your name and email address on evaluation form.