CHALLENGING CONTRACEPTIVE CASES AND NEW RESOURCES

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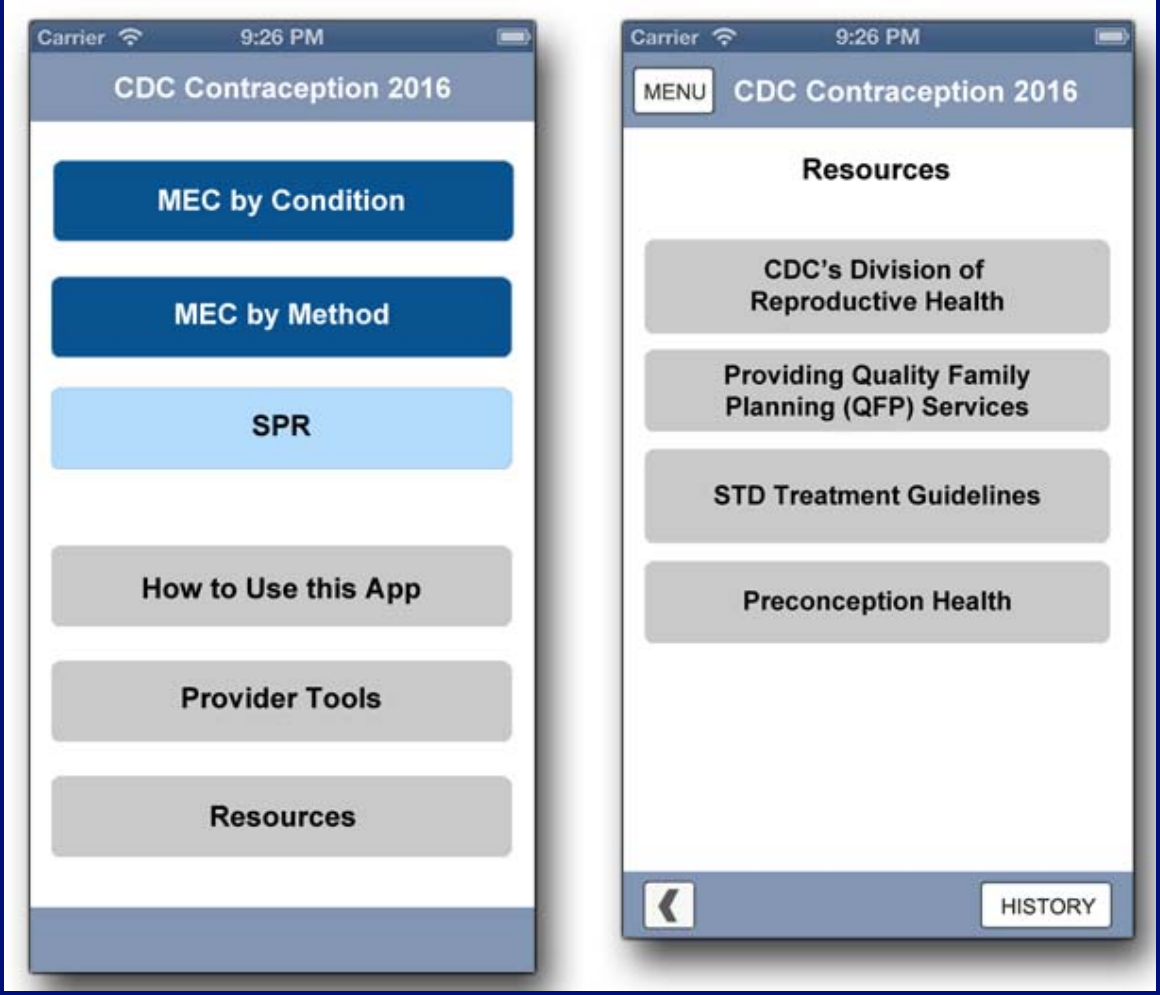
I have no financial disclosures.

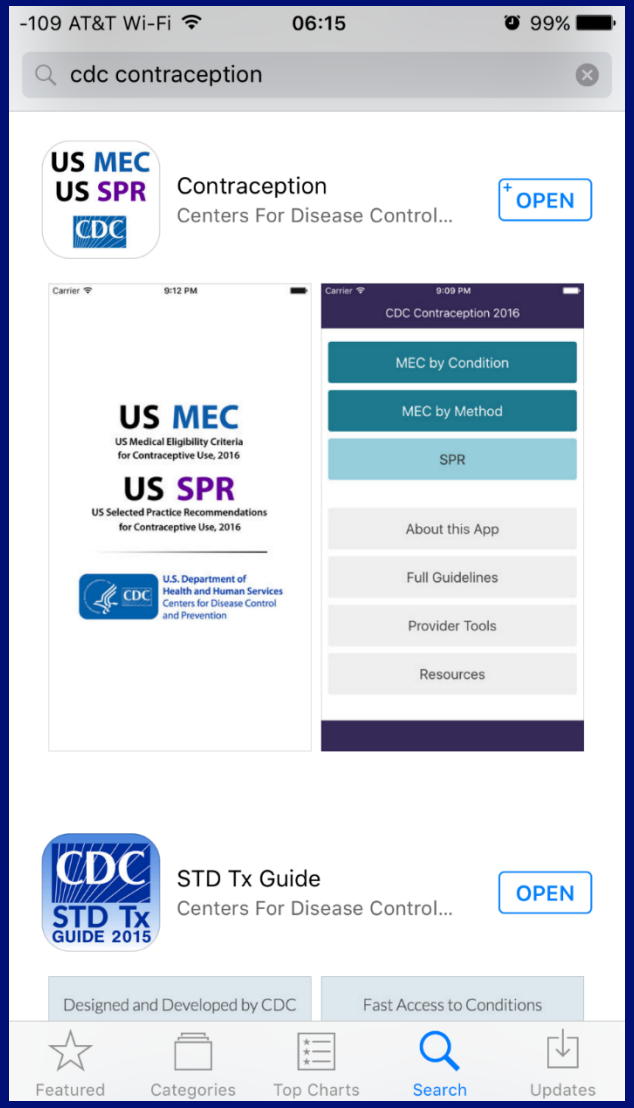
Objectives

- Become familiar with the U.S. Medical Eligibility Criteria for Contraceptive Use, 2016 (U.S. MEC)
- Become familiar with the U.S. Selected Practice Recommendations for Contraceptive Use, 2016 (U.S. SPR)
- Understand the U.S. MEC and U.S. SPR in practice

Takeaway: There's an app for that!



2016 U.S. MEC and SPR App



Methods for initial adaptation of MEC and SPR

- WHO published first MEC in 1996
  - WHO MEC 5th edition was released in 2015
  - CDC published the first U.S. MEC in 2010, adapted from WHO MEC
- WHO published first SPR in 2000
  - WHO SPR 3rd edition was released December 2016
  - CDC published the first U.S. SPR in 2013, adapted from WHO SPR
- CDC and WHO continue to work closely on the development of WHO guidelines

Methods for 2016 U.S. MEC and SPR

- On-going monitoring of published evidence
- Expert meeting in August 2014 to discuss scope
- Expert meeting in August 2015 to review evidence and discuss specific recommendations
  - CDC staff and outside authors conducted independent systematic reviews to inform recommendations
  - These systematic reviews have been published
  - CDC determined final recommendations

US MEC

US Medical Eligibility Criteria for Contraceptive Use, 2016

U.S. Medical Eligibility Criteria for Contraceptive Use, 2016

- **Safe use** of contraceptive methods by women and men with certain characteristics or medical conditions
- Target audience: health-care providers
- Content: more than 1800 recommendations for over 60 conditions
- Purpose: to assist health care providers when they counsel patients about contraceptive use and to serve as a source of clinical guidance

Take Home Messages, U.S. MEC

- Most women can safely use most contraceptive methods
- Certain conditions are associated with increased risk for adverse health events as a result of pregnancy
  - Affected women may especially benefit from highly effective contraception for family planning
- Women, men, and couples should be informed of the full range of methods to decide what will be best for them

Goal of contraception

- REDUCE UNINTENDED PREGNANCY
- EMPOWER WOMEN TO MAKE THE DECISION THAT IS BEST FOR THEM

Did you want to get pregnant?

- Yes
- No
- All of the above ✓

No Maybe? Yes

Not everyone should hear the same message

BOX 2. Conditions associated with increased risk for adverse health events as a result of pregnancy*

- Breast cancer
- Complicated valvular heart disease
- Cystic fibrosis
- Diabetes: insulin dependent; with nephropathy, retinopathy, or neuropathy or other vascular disease; or of >20 years' duration
- Endometrial or ovarian cancer
- Epilepsy
- Hypertension (systolic ≥160 mm Hg or diastolic ≥100 mm Hg)
- History of bariatric surgery within the past 2 years
- HIV: not clinically well or not receiving antiretroviral therapy
- Ischemic heart disease
- Gestational trophoblastic disease
- Hepatocellular adenoma and malignant liver tumors (hepatoma)
- Peripartum cardiomyopathy
- Schistosomiasis with fibrosis of the liver
- Severe (decompensated) cirrhosis
- Sickle cell disease
- Solid organ transplantation within the past 2 years
- Stroke
- Systemic lupus erythematosus
- Thrombogenic mutations
- Tuberculosis

*Long-acting, highly effective contraceptive methods might be the best choice for women with conditions that are associated with increased risk for adverse health events as a result of pregnancy. These women should be advised that sole use of barrier methods for contraception and behavior-based methods of contraception might not be the most appropriate choice because of their relatively higher typical-use rates of failure.

U.S. Medical Eligibility Criteria: Categories

1	

http://www.cdc.gov/mmwr/pdf/rr/rr5904.pdf

U.S. Medical Eligibility Criteria: Categories

1	No restriction for the use of the contraceptive method for a woman with that condition
4	

http://www.cdc.gov/mmwr/pdf/rr/rr5904.pdf

U.S. Medical Eligibility Criteria: Categories

1	No restriction for the use of the contraceptive method for a woman with that condition
4	Unacceptable health risk if the contraceptive method is used by a woman with that condition

http://www.cdc.gov/mmwr/pdf/rr/rr5904.pdf

U.S. Medical Eligibility Criteria: Categories

1	No restriction for the use of the contraceptive method for a woman with that condition
2	Advantages of using the method generally outweigh the theoretical or proven risks
4	Unacceptable health risk if the contraceptive method is used by a woman with that condition

http://www.cdc.gov/mmwr/pdf/rr/rr5904.pdf

U.S. Medical Eligibility Criteria: Categories

1	No restriction for the use of the contraceptive method for a woman with that condition
2	Advantages of using the method generally outweigh the theoretical or proven risks
3	Theoretical or proven risks of the method usually outweigh the advantages – not usually recommended unless more appropriate methods are not available or acceptable
4	Unacceptable health risk if the contraceptive method is used by a woman with that condition

http://www.cdc.gov/mmwr/pdf/rr/rr5904.pdf

Example: Smoking

Condition	Cu-IUD	LNG-IUD	Implants	DMPA	POPs	CHCs
Smoking						
a. Age <35	1	1	1	1	1	2
b. Age ≥35						
i. <15 cigarettes/day	1	1	1	1	1	3
II.≥15 cigarettes/day	1	1	1	1	1	4

U.S. Medical Eligibility Criteria: Clarification

I

C

http://www.cdc.gov/mmwr/pdf/rr/rr5904.pdf

U.S. Medical Eligibility Criteria: Clarification

I

Recommendation about the use of the contraceptive method for a woman with that condition **at the time of contraceptive initiation**

C

http://www.cdc.gov/mmwr/pdf/rr/rr5904.pdf

U.S. Medical Eligibility Criteria: Clarification

I Recommendation about the use of the contraceptive method for a woman with that condition **at the time of contraceptive initiation**

C Recommendation about continuing the use of the contraceptive method for a woman who **develops that condition while using the contraceptive method**

http://www.cdc.gov/mmwr/pdf/rr/rr5904.pdf

Example: Sexually Transmitted Diseases

Condition	Cu-IUD		LNG-IUD		Implants	DMPA	POPs	CHCs
Sexually transmitted diseases	I	C	I	C				
a. Current purulent cervicitis or CT or gonococcal infection	4	2	4	2	1	1	1	1
b. Vaginitis, including Trichomonas and BV	2	2	2	2	1	1	1	1
c. Other factors related to STDs	2	2	2	2	1	1	1	1

USSPR

US Selected Practice Recommendations for Contraceptive Use, 2016

U.S. Selected Practice Recommendations for Contraceptive Use, 2016

- Recommendations for contraceptive management questions
- Target audience: health-care providers
- Purpose: to assist health care providers when they counsel patients on contraceptive use
- Content: Guidance for common contraceptive management topics such as:
  - 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

Take Home Messages, U.S. SPR

- Most women can start most methods anytime
- Few, if any, exams or tests are needed
- Routine follow-up generally not required
- Regular contraception should be started after emergency contraception

Example: U.S. SPR

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

U.S. SPR

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

CONTRACEPTIVE CASES

Case #1

- How can I start hormonal contraception after emergency contraceptive (EC) pills?

Case #2

- My breast cancer patient is interested in an IUD. Your recommendation?

Case #3

- I have endometriosis and I just recently had surgery to remove it.

  If I'm having issues with the pill, will another form of contraception, such as the vaginal ring, cause the same problems?

Case #4

- Can I use a progestin if I have had a blood clot and pulmonary embolism?

Case #5

- What is the best contraceptive method for a woman diagnosed with deep vein thrombosis after knee surgery?

Case #6

- What is the best advice for women about antibiotics and oral contraceptives?

Case #7

- What are the current recommendations for IUDs for women with herpes simplex virus (HSV)?

Case #8

- Is my patient a good candidate for combined pills, the ring, or the patch?

Bonus Case

- **What if everything seems contraindicated?**
  - I am seeing a 30 year old woman with heavy menses who does not want children. She has lupus with antiphospholipid antibodies, chronic kidney disease, thromobocytopenia, and anemia from her lupus. What do you recommend?

Case

Condition	Cu-IUD		LNG-IUD	Implants	DMPA		POPs	CHCs
	I	C			I	C		
SLE + antiphospholipid antibodies								

Case

Condition	Cu-IUD		LNG-IUD	Implants	DMPA		POPs	CHCs
	I	C			I	C		
SLE + antiphospholipid antibodies	1	1	3	3	3	3	3	4

Case

Condition	Cu-IUD		LNG-IUD	Implants	DMPA		POPs	CHCs
	I	C			I	C		
SLE + antiphospholipid antibodies	1	1	3	3	3	3	3	4
Chronic kidney disease								

Case

Condition	Cu-IUD		LNG-IUD	Implants	DMPA		POPs	CHCs
	I	C			I	C		
SLE + antiphospholipid antibodies	1	1	3	3	3	3	3	4
Chronic kidney disease								
SLE + severe thrombocytopenia	3	2	2	2	3	2	2	2

Case

Condition	Cu-IUD		LNG-IUD	Implants	DMPA		POPs	CHCs
	I	C			I	C		
SLE + antiphospholipid antibodies	1	1	3	3	3	3	3	4
Chronic kidney disease								
SLE + severe thrombocytopenia	3	2	2	2	3	2	2	2
Anemia	2		1	1	1		1	1

Case #9

- I am a busy clinician and I am familiar with the U.S. Medical Eligibility Criteria for Contraceptive Use. What recommendations are new or different from previous versions?

THANK YOU!

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2016 U.S. MEC: CHANGES & UPDATES

New Recommendations

- **4 new conditions**
  - Cystic fibrosis
  - Multiple sclerosis
  - Women using selective serotonin reuptake inhibitors (SSRIs)
  - Women using St. John's wort
- **1 new emergency contraception method**
  - Ulipristal acetate (UPA)
- **Revised emergency contraception section**

Cystic Fibrosis

Condition	Cu-IUD	LNG-IUD	Implants	DMPA	POP	CHCs
Cystic Fibrosis						

Cystic Fibrosis

Condition	Cu-IUD	LNG-IUD	Implants	DMPA	POP	CHCs
Cystic Fibrosis	1	1	1	2	1	1

Multiple Sclerosis

Condition	Cu-IUD	LNG-IUD	Implants	DMPA	POPs	CHCs
Multiple Sclerosis						
a. With prolonged immobility						
b. Without prolonged immobility						

Multiple Sclerosis

Condition	Cu-IUD	LNG-IUD	Implants	DMPA	POPs	CHCs
Multiple Sclerosis						
a. With prolonged immobility	1	1	1	2	1	3
b. Without prolonged immobility						

Multiple Sclerosis

Condition	Cu-IUD	LNG-IUD	Implants	DMPA	POPs	CHCs
Multiple Sclerosis						
a. With prolonged immobility	1	1	1	2	1	3
b. Without prolonged immobility	1	1	1	2	1	1

Psychotropic Drugs

Condition	Cu-IUD	LNG-IUD	Implants	DMPA	POP	CHCs
SSRIs						
St. John's Wort						

Psychotropic Drugs

Condition	Cu-IUD	LNG-IUD	Implants	DMPA	POP	CHCs
SSRIs	1	1	1	1	1	1
St. John's Wort						

Psychotropic Drugs

Condition	Cu-IUD	LNG-IUD	Implants	DMPA	POP	CHCs
SSRIs	1	1	1	1	1	1
St. John's Wort	1	1	2	1	2	2

Emergency Contraception

Condition	Cu-IUD	UPA	LNG	COC
History of severe cardiovascular disease	1	2	2	2
Migraine	1	1	1	2
Severe liver disease (including jaundice)	1	2	2	2
Obesity (BMI ≥ 30 kg/m^2)	1	2	2	2
CYP3A4 inducers	1	2	2	2

Changes to Existing Recommendations

- **Systemic hormonal methods**
  - Migraine headaches
  - Superficial venous disease
  - Women using antiretroviral therapy
  - Women with known dyslipidemia

Headaches

Condition	Cu-IUD	LNG IUD	Implants	DMPA	POP	CHCs
Non-migraine	1	1	1	1	1	
Migraine						
Without aura (including menstrual migraine)	1	1	1	1	1	
With aura	1	1	1	1	1	

Headaches

Condition	Cu-IUD	LNG IUD	Implants	DMPA	POP	CHCs
Non-migraine	1	1	1	1	1	1*
Migraine						
Without aura (including menstrual migraine)	1	1	1	1	1	
With aura	1	1	1	1	1	

Headaches

Condition	Cu-IUD	LNG IUD	Implants	DMPA	POP	CHCs
Non-migraine	1	1	1	1	1	1*
Migraine						
Without aura (including menstrual migraine)	1	1	1	1	1	2*
With aura	1	1	1	1	1	

Headaches

Condition	Cu-IUD	LNG IUD	Implants	DMPA	POP	CHCs
Non-migraine	1	1	1	1	1	1*
Migraine						
Without aura (including menstrual migraine)	1	1	1	1	1	2*
With aura	1	1	1	1	1	4*

Superficial Venous Disease

Condition	Cu-IUD	LNG-IUD	Implants	DMPA	POPs	CHCs
Superficial venous disease						
a. Varicose veins						
b. Superficial venous thrombosis (acute or history)						

Superficial Venous Disease

Condition	Cu-IUD	LNG-IUD	Implants	DMPA	POPs	CHCs
Superficial venous disease						
a. Varicose veins	1	1	1	1	1	1
b. Superficial venous thrombosis (acute or history)	1	1	1	1	1	3

Multiple risk factors for atherosclerotic cardiovascular disease

Condition	Cu-IUD	LNG IUD	Implants	DMPA	POP	CHCs
(e.g., older age, smoking, diabetes, hypertension, low HDL, high LDL, or high TG levels)	1					

Multiple risk factors for atherosclerotic cardiovascular disease

Condition	Cu-IUD	LNG IUD	Implants	DMPA	POP	CHCs
(e.g., older age, smoking, diabetes, hypertension, low HDL, high LDL, or high TG levels)	1	2	2		2	

Multiple risk factors for atherosclerotic cardiovascular disease

Condition	Cu-IUD	LNG IUD	Implants	DMPA	POP	CHCs
(e.g., older age, smoking, diabetes, hypertension, low HDL, high LDL, or high TG levels)	1	2	2	3	2	

Multiple risk factors for atherosclerotic cardiovascular disease

Condition	Cu-IUD	LNG IUD	Implants	DMPA	POP	CHCs
(e.g., older age, smoking, diabetes, hypertension, low HDL, high LDL, or high TG levels)	1	2	2	3	2	3/4

Hormonal methods for non-breastfeeding postpartum women

Postpartum (non-breastfeeding)	CHCs	Progestin-only methods
<21 days	4	1
21-42 days		
With other risk factors for VTE	3*	1
Without other risk factors for VTE	2	1
>42 days	1	1

**Clarification: Other risk factors might increase classification to "4"*

Changes to Existing Recommendations

- **Systemic hormonal methods**
  - Migraine headaches
  - Superficial venous disease
  - Women using antiretroviral therapy
  - Women with known dyslipidemia

- **Intrauterine devices**
  - Gestational trophoblastic disease
  - Postpartum and breastfeeding women
  - Human immunodeficiency virus
  - Factors related to sexually transmitted diseases

Gestational Trophoblastic Disease

Gestational Trophoblastic Disease

Condition	LNG-IUD	Cu-IUD
a. Suspected GTD (immediate postevacuation)		
i. Uterine size first trimester		
ii. Uterine size second trimester		
b. Confirmed GTD (during monitoring)		
i. Undetectable β-hCG levels		
ii. Decreasing β-hCG levels		

Gestational Trophoblastic Disease

Condition	LNG-IUD	Cu-IUD
a. Suspected GTD (immediate postevacuation)		
i. Uterine size first trimester	1	1
ii. Uterine size second trimester	2	2
b. Confirmed GTD (during monitoring)		
i. Undetectable β-hCG levels		
ii. Decreasing β-hCG levels		

Gestational Trophoblastic Disease

Condition	LNG-IUD		Cu-IUD	
a. Suspected GTD (immediate postevacuation)				
i. Uterine size first trimester	1		1	
ii. Uterine size second trimester	2		2	
b. Confirmed GTD (during monitoring)	I	C	I	C
i. Undetectable β-hCG levels	1	1	1	1
ii. Decreasing β-hCG levels	2	1	2	1

Gestational Trophoblastic Disease

Condition	LNG-IUD		Cu-IUD	
b. Confirmed GTD (during monitoring)	I	C	I	C
i. Undetectable β-hCG levels	1	1	1	1
ii. Decreasing β-hCG levels	2	1	2	1
iii. Persistent β-hCG levels, no evidence or suspicion of intrauterine disease				
iv. Persistent β-hCG levels, with evidence or suspicion of intrauterine disease				

Gestational Trophoblastic Disease

Condition	LNG-IUD		Cu-IUD	
b. Confirmed GTD (during monitoring)	I	C	I	C
i. Undetectable β-hCG levels	1	1	1	1
ii. Decreasing β-hCG levels	2	1	2	1
iii. Persistent β-hCG levels, no evidence or suspicion of intrauterine disease	2	1	2	1
iv. Persistent β-hCG levels, with evidence or suspicion of intrauterine disease				

Gestational Trophoblastic Disease

Condition	LNG-IUD		Cu-IUD	
b. Confirmed GTD (during monitoring)	I	C	I	C
i. Undetectable β-hCG levels	1	1	1	1
ii. Decreasing β-hCG levels	2	1	2	1
iii. Persistent β-hCG levels, no evidence or suspicion of intrauterine disease	2	1	2	1
iv. Persistent β-hCG levels, with evidence or suspicion of intrauterine disease	4	2	4	2

Postpartum IUD insertion

Postpartum (breastfeeding or non-breastfeeding, including post cesarean section)	LNG-IUD	Cu-IUD
<10 min after delivery of placenta		
Breastfeeding	2	1
Non-breastfeeding	1	1
10 min to <4 weeks	2	2
≥4 weeks	1	1
Postpartum sepsis	4	4

Human Immunodeficiency Virus

Condition	LNG-IUD		Cu-IUD	
	I	C	I	C
High risk for HIV				
HIV infection				
a. Clinically well receiving ARV therapy				
b. Not clinically well or not receiving ARV therapy				

Human Immunodeficiency Virus

Condition	LNG-IUD		Cu-IUD	
	I	C	I	C
High risk for HIV	2	2	2	2
HIV infection				
a. Clinically well receiving ARV therapy	1	1	1	1
b. Not clinically well or not receiving ARV therapy	2	1	2	1

Sexually Transmitted Diseases

Condition	LNG-IUD		Cu-IUD	
	I	C	I	C
a. Current purulent cervicitis or chlamydial infection or gonococcal infection	4	2	4	2
b. Vaginitis (including trichomonas and bacterial vaginosis)	2	2	2	2
c. Other factors related to STDs	2*	2	2*	2

*Clarification: If a woman with risk factors for STDs has not been screened for gonorrhea and chlamydia according to CDC STD treatment guidelines, screening may be performed at the time of IUD insertion and insertion should not be delayed.

2016 U.S. SPR: CHANGES & UPDATES

Major Updates to 2016 U.S. SPR

- New recommendation
  - Using medications to ease IUD insertion
- Update of existing recommendation
  - When to start regular contraception after UPA
- Updates consistent with changes in U.S. MEC 2016

Medications to Ease IUD insertion

- Misoprostol is not recommended for routine use before IUD insertion. Misoprostol might be helpful in select circumstances (e.g., in women with a recent failed insertion)
- Paracervical block with lidocaine might reduce patient pain during IUD insertion.

When to Start Contraception after UPA

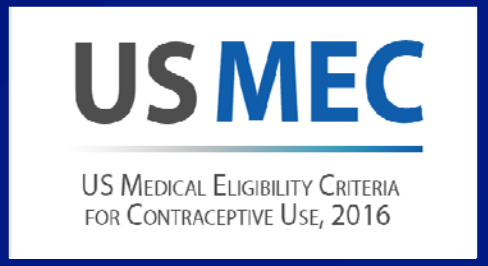
- Start or resume hormonal contraception ≥5 days after UPA.
- For DMPA, implant, LNG-IUD, starting the method at the time of UPA use may be considered; the risk that the regular contraceptive method might decrease the effectiveness of UPA must be weighed against the risk of not starting a regular hormonal contraceptive method.

Outline

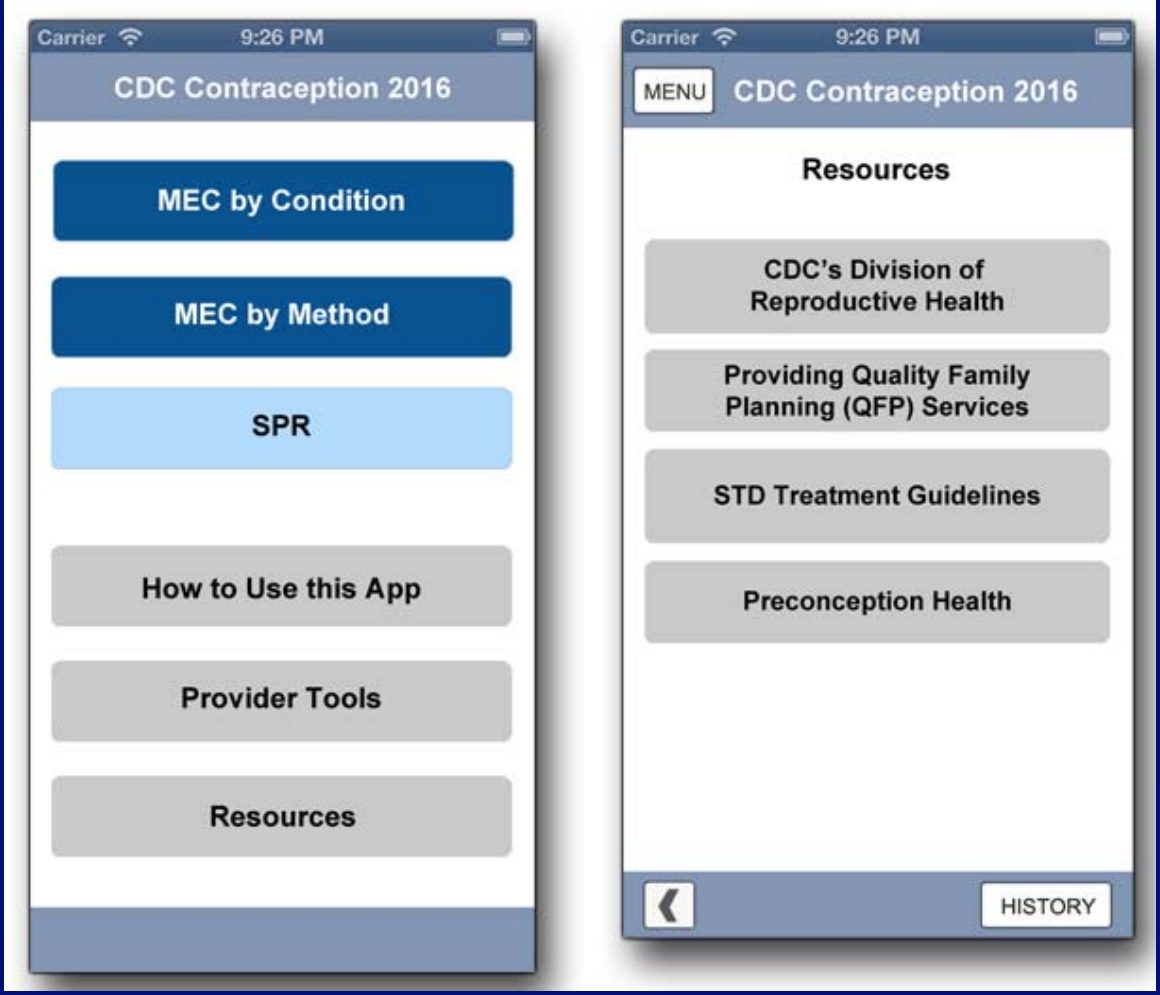
- Background
- 2016 Changes and Updates
- Dissemination and Implementation
- Application

What CDC has done…

- Publication date July 29, 2016
- CDC disseminated to:
  - ACOG
  - Broader group of partners
  - Government delivery system

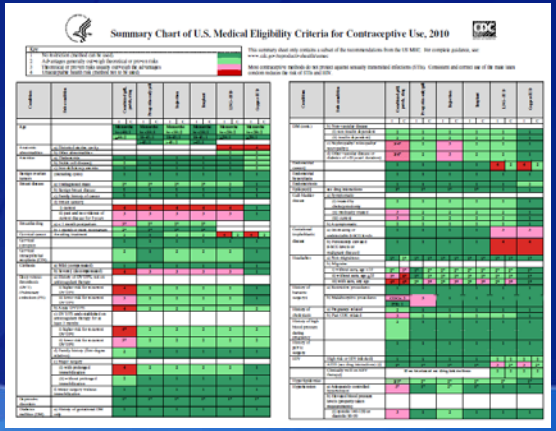


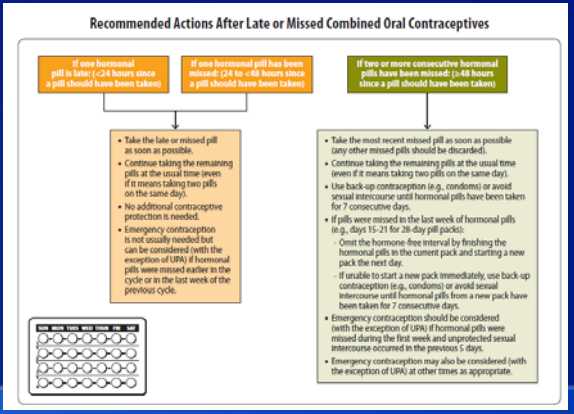
2016 U.S. MEC and SPR App

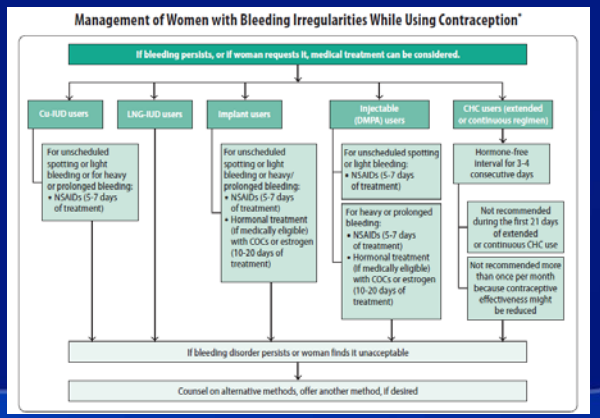


Updated provider tools

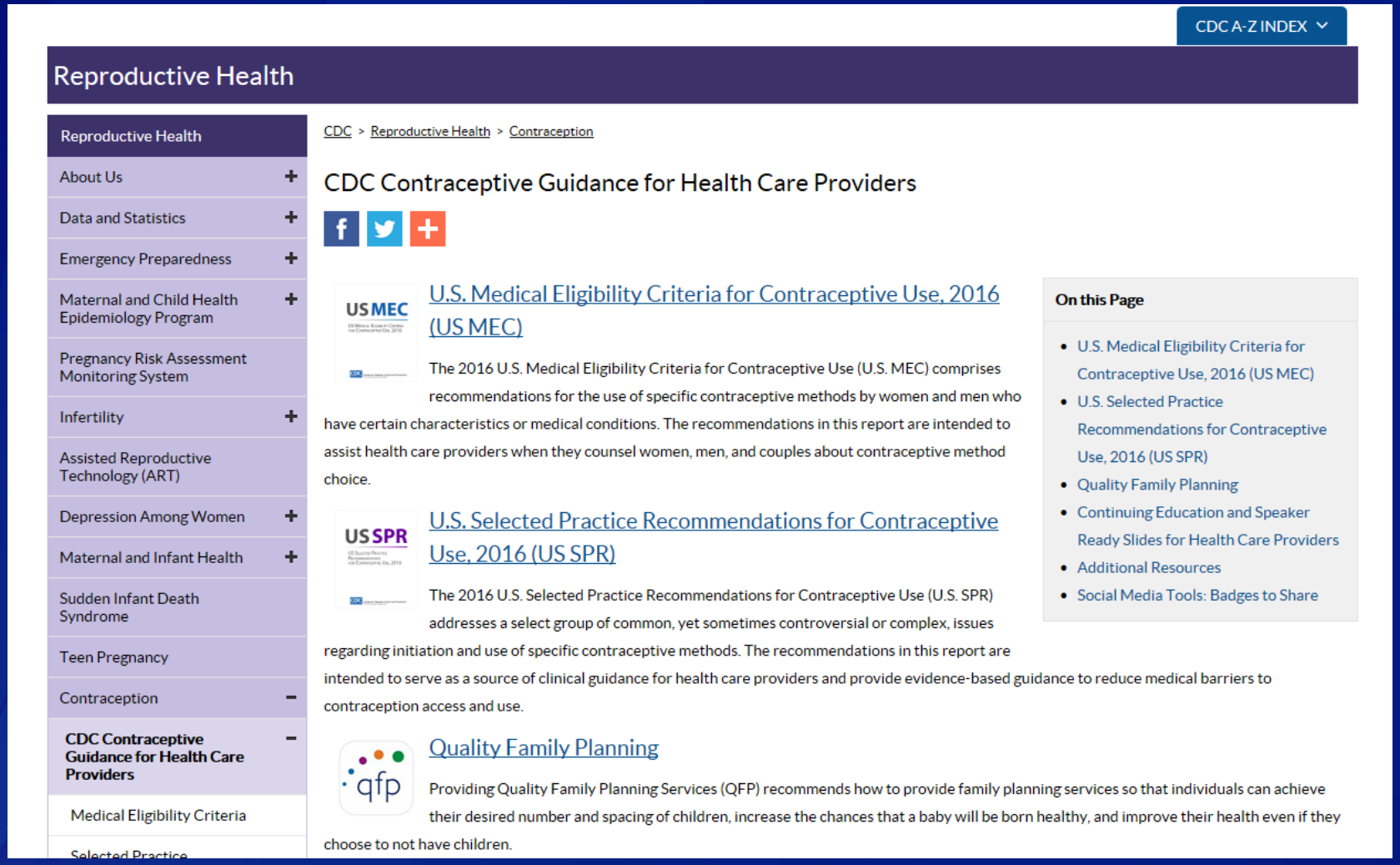
- MEC summary table in English, Spanish
- SPR quick reference charts
  - How to be reasonably certain that a woman is not pregnant
  - When to start contraceptive methods and routine follow up
  - What to do for late, missed or delayed combined hormonal contraception
  - Management of IUD when PID is found
  - Management of women with bleeding irregularities while using contraception







CDC Contraceptive Guidance for Health Care Providers



http://wwwdev.cdc.gov/reproductivehealth/contraception/contraception_guidance.htm

Outline

- Background
- 2016 Changes and Updates
- Dissemination and Implementation
- Application

THANK YOU!

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UNM PALS **REPRODUCTIVE HEALTH MD 505-272-2000**

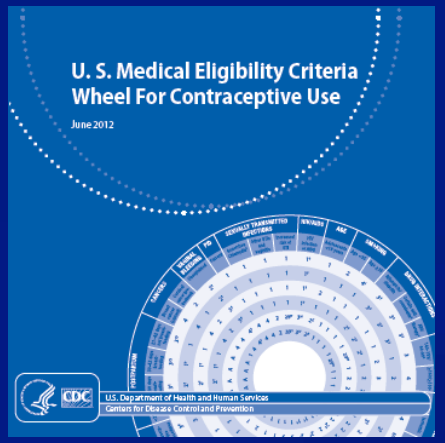
Resources

- **CDC evidence-based family planning guidance documents:**
  http://www.cdc.gov/reproductivehealth/unintendedpregnancy/USMEC.htm

  http://www.cdc.gov/reproductivehealth/unintendedpregnancy/USSPR.htm
  - Sign up to receive alerts!
- **WHO MEC 2015, 5th Edition:**
  http://www.who.int/reproductivehealth/publications/family_planning/Ex-Summ-MEC-5/en/

2. Updating Provider Tools

- MEC Wheel
- Continuing Education Activities
- Speaker-ready slides
- Contraceptive Effectiveness Chart
- Online alerts to receive updates
- eBook for SPR
- Residency training and certification



4. Publications and Media

- MMWR publications July 29, 2016
- Systematic reviews e-published in summer 2016
- Research gaps paper

- Media Inquires