

Contraception Update Audio Conference

South Dakota Family Planning
Region VIII Title X

Tuesday, February 8, 2011
10am MST

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Hello!
(and Disclosures)



- ▶ OB/GYN in Denver, CO
- ▶ Special interests: contraception and teen reproductive health.
- ▶ Medical Director, The Young Women's Health Program, RMYC



- ▶ *Eliza Buyers has no significant financial interests or other relationships with industry relative to the topics that will be discussed.*

Learning Objectives

- ▶ Demonstrate how to counsel clients when they start a contraceptive method on how to use the method effectively, common misperceptions and myths, and expected benefits and side effects.
- ▶ Identify additional trouble shooting tips for dealing with common client concerns and common side effects.

Part Two (March 8, 2011)

- ▶ Discuss best practices in client counseling related to contraceptive method selection.
- ▶ Review the Colorado Health Department/Healthy Team Works guideline that incorporates best practices in counseling and providing contraception.
- ▶ Learn where to find additional resources for evidence-based contraceptive care.

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Resources/References



Leading Organizations in Family Planning

- ▶ World Health Organization (WHO)
- ▶ Center for Disease Control (CDC)
- ▶ American College of OB/GYNs (ACOG)
- ▶ Association of Reproductive Health Professionals (ARHP)

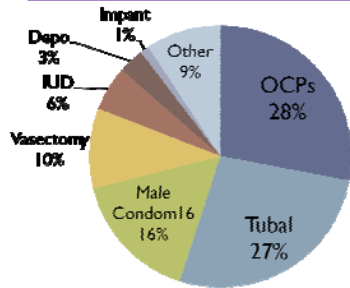
GREAT resources (make it safe and easy!):

- ▶ U.S. Medical Eligibility Criteria (WHO, CDC)
 - ▶ www.cdc.gov/reproductivehealth/unintendedpregnancy/USMEC.htm
- ▶ Contraceptive Technology (Many authors, experts)
- ▶ Health Team Works Contraception Guideline
- ▶ Family Planning Handbook (WHO, John Hopkins)
 - ▶ Free and on-line: www.fphandbook.org



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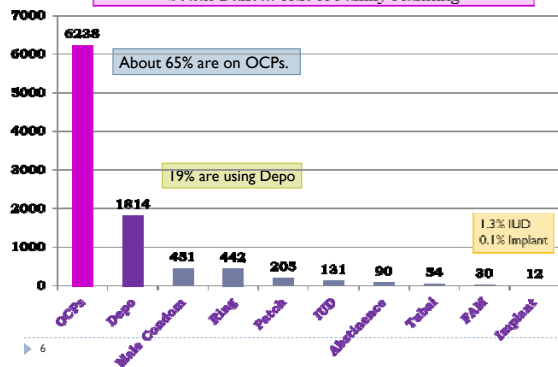
Method Use Among Women Who Practice Contraception in United States 2006-8



Hosmer WD and Jones J. Use of contraception in the United States: 1982-2008. *Vital and Health Statistics, 2010, Series 23, No. 29.*

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Primary Method of Use for Family Planning Clients 2009
South Dakota Title X Family Planning



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Oral Contraceptive Pills (OCPs)

(Aka: COCs, BCPS)

- ▶ **Getting Started**
 - ▶ Quick Start Protocol
 - ▶ Myths/misperceptions
 - ▶ What's in a pill
- ▶ **What to expect**
 - ▶ In the first few weeks
 - ▶ In the first 3-6 months
 - ▶ Any time during OCP use
- ▶ **Common concerns**
 - ▶ Breakthrough bleeding
 - ▶ Amenorrhea
 - ▶ Forgotten Pills



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Oral Contraceptive Pills

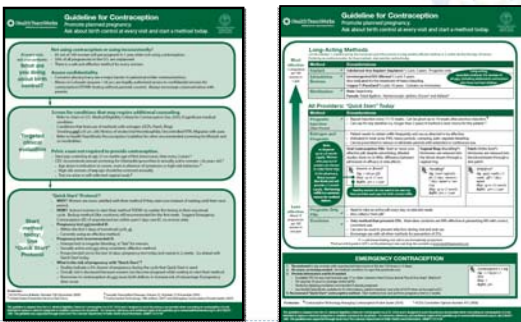
Getting Started: **Quick Start** Protocol

- ▶ Preferred start for OCP/ring/patch/Depo start.
- ▶ Only reason to not use Quick Start: **positive pregnancy test**
- ▶ How to do it: see Health Team Works guideline (next slide)
- ▶ Other considerations
 - ▶ No difference in break-through bleeding compared with traditional/Sunday start.
 - ▶ Risk of undetected ("window") pregnancy: about 3% chance of pregnancy during the cycle that Quick Start is used. Overall, risk is decreased because women can become pregnant while waiting to start their method.
 - ▶ Hormones in contraception do not cause birth defects or increase risk of miscarriage if pregnancy does occur.

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Health Team Works Contraception Guideline

<http://www.healthteamworks.com/guidelines/contraception.html>



HealthTeamWorks

Building Systems. Empowering Excellence.

3 Start method today: Use "Quick Start" Protocol

"Quick Start" Protocol

• **HOW?** Instruct women to start their method TODAY no matter the timing in their menstrual cycle. Backup method (like condoms) still recommended for the first week. Suggest Emergency Contraception (EC) if unprotected sex within past 5 days (see EC on reverse side).

• **Pregnancy test not needed if:**

- » Within the first 5 days of menstrual cycle, or
- » Currently using an effective method.

• **Pregnancy test recommended if:**

- » Unexpected or irregular bleeding, or "late" for menses.
- » Sexually active and *not using consistent, effective method.*
- » If unprotected sex in the last 14 days: pregnancy test today and repeat in 2 weeks. Go ahead with Quick Start today.

Oral Contraceptive Pills

Common Myths/Misperceptions

The following are NOT TRUE:

- ▶ The pill makes you gain weight.
- ▶ The pill makes it harder to get pregnant later on.
- ▶ The pill is dangerous to use.
- ▶ The pill doesn't really work.
- ▶ The pill causes breast cancer.
- ▶ Antibiotics and other medicines interfere with the pill.
- ▶ If I am having any irregular bleeding/spotting the pill isn't really working, or I need a different brand.

Oral Contraceptive Pills

Non-contraceptive benefits

- ▶ Regulate periods
- ▶ Reduce or eliminate periods (extended/continuous use)
- ▶ Reduce pelvic pain
- ▶ Treat PMS
- ▶ Reduce breast pain
- ▶ Clearer skin - 3 months
- ▶ Decreased hair on chin/lip (hirsutism)- 6 months
- ▶ Decreased risk of ovarian cancer and uterine cancer

Oral Contraceptive Pills

Background Information

- ▶ **What is “the pill”?**
 - ▶ Oral pill that contains an Estrogen and Progestin
 - ▶ 50th anniversary- first available in the U.S. in 1960
 - ▶ One of the most studied medications
 - ▶ Differentiate “the pill” from progestin only pills
 - ▶ Nicknames: POPs, “the minipill”
 - ▶ On your formulary: Micronor
- ▶ **Acceptable synonyms and abbreviations for “the pill”**
 - ▶ OCP (oral contraceptive pill)
 - ▶ COC (combined oral contraceptive)
 - ▶ BCP (birth control pill)

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Oral Contraceptive Pills

Differences in Pills: *very few*

What can vary...	Formulary Example(s)
Type of Estrogen Ethinyl Estradiol (EE)	Used in all formulary OCPs
Estrogen Dose 20 – 35 micrograms	Alesse contains 20 ug EE (very low dose) Levora contains 30 ug EE (low dose)
Type of Progestin (8 available) - 3 (or 4) “generations” - some more/less androgenic	(1) Norethindrone: <i>OrthoNovum 7/7/7</i> (2) Levonorgestrel: <i>Levora</i> (more androgenic) (3) Norgestimate: <i>OrthoCyclen</i> (less androgenic)
Progestin Dose Varies	Depends on potency of progestin used
Monophasic Formulation E/P dose same in each pill	Alesse, Levora, Orthocyclen
Triphasic Formulation E+P dose varies each week	<i>OrthoNovum 7/7/7</i> ; <i>Triphasil</i> , <i>Ortho TriCyclen</i>
Regimen (#Active/#Placebo) 21/7, 24/4, 84/7, continuous	All formulary pills: 21/7 Any pill can be used for extended or continuous use

Oral Contraceptive Pills

Differences in Pills: *very few*

- ▶ **Which pill? Differences in side-effects not supported by randomized, double-blinded studies.**
 - ▶ Reassure and educate clients (analogy: toothpaste).
 - ▶ Know cost-effective options- both in/out of your system.
 - ▶ Formulary: pick a few based on big categories
 - ▶ If non-contraceptive benefits or side-effects are of concern, consider less vs. more androgenic/estrogenic

Alesse (Aviane/Lutera)	20ug EE / 0.1mg LNG	Good choice if concern about estrogen effects (breast pain, nausea, headache)
Levora (Nordette)	30ug EE/ 0.15mg LNG	Good choice for extended use Can be more androgenic
OrthoCyclen (Sprintec) <small>18</small>	35ug EE/ 0.25mg Norgestimate	Good choice for estrogen benefits Treat acne, hirsutism Rarely induces amenorrhea

Oral Contraceptive Pills

Getting Started

Key messages for clients and providers:

- ▶ All pill types/brands are great choices.
- ▶ Common side effects do not mean that the pill is harmful or dangerous.
- ▶ **What to expect:**
 - ▶ In the first few weeks
 - ▶ Breast tenderness, mild headaches, nausea (*estrogen*)
 - Reassure and record; take pill before bedtime?
 - ▶ Over the first 3 (even 6 months)
 - ▶ Irregular bleeding and spotting is to be expected.
 - Reassure: if taking pills then still “working.”
 - Can record and follow-up.

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Oral Contraceptive Pills

Common Concerns Any Time During OCP Use

- ▶ **Breakthrough bleeding**
 - Always consider pregnancy test
 - Verify consistent pill use (skipped pills=bleeding)
 - Empower patient: record and follow-up
 - Reassure**
 - ?Switch pills: OK to do- usually luck more than skill; other ideas...
- ▶ **Amenorrhea**
 - Pregnancy test
 - Reassure; can switch pills if desired
- ▶ **Forgotten Pills**
 - Make it simple: 2+ pills missed = 1 week condoms
 - Why not consider another method?

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Depo-Provera

- ▶ **Getting Started: Quick Start Protocol**

What is “Depo”?

- ▶ Depot Medroxyprogesterone Acetate 150mg/1ml
 - ▶ Contains only progestin
 - ▶ Primary mechanism: stops ovulation
 - ▶ Less estrogen -> thinner endometrial lining -> amenorrhea
 - ▶ IM injection every 12 weeks (3 months)
 - ▶ “Grace period” for late shots can be extended to 4 weeks (based on WHO recommendation).

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Depo-Provera
Strong Points

- ▶ Efficacious; (almost) forgettable.
- ▶ **No** estrogen- OK for smokers > 35, classic migraines, hx of clot...
- ▶ Private.
- ▶ With good counseling, high user satisfaction and continuation.
- ▶ Non-contraceptive benefits: at 1 year, 50% with amenorrhea.
- ▶ **No** decrease in efficacy for obese or overweight women.
- ▶ Decreased menstrual symptoms (cramps, moodiness, breast changes).
- ▶ **No** decrease efficacy if on other meds - including enzyme inducers.
- ▶ Fewer grand mal seizures.
- ▶ Fewer sickle cell crises.
- ▶ Less endometriosis pain.

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Depo-Provera
Side Effects & Concerns

Weight Gain

- ▶ Different for each woman and not predictable. (Westhoff, 2003)
 - ▶ Counsel that there are no calories in the Depo.
- ▶ “Early” gainers (5% of body weight at 6 mo) will continue to gain at higher rate. (Le, 2009). Consider asking about increased appetite.

Bone concerns

- ▶ ACOG, August 2009: “Concerns regarding...BMD should neither prevent practitioners from prescribing DMPA nor limit its use to 2 consecutive years.” Client can continue to use (>2y) if best option.
 - ▶ No role for DEXA scans.
 - ▶ Partial or full recovery (like pregnancy, breastfeeding).
 - ▶ No data showing increase fracture risk.

Depression: Conflicting data; NOT a contraindication

Allergic Reaction: very rare

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Depo-Provera
Other Issues

▶ What to expect

- ▶ In the first 3-6 months (1st, 2nd shots)
 - ▶ Anticipate bleeding
- ▶ After 6-9 months
 - ▶ More bleeding -> amenorrhea
- ▶ Can always offer estrogen (usually OCPs) to treat bleeding
 - ▶ Estrogen can help because the bleeding is likely caused by thinned/unstable (hypo-estrogenic) endometrium.



Georgia O'Keefe
Red Hills, Lake George (1927)

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IUDs

▶ Myths/misperceptions

▶ What to expect

- ▶ Choosing an IUD
- ▶ Insertion procedure
- ▶ What to expect with continued use



Georgia O'Keeffe
With Pelvis Series, Red and Yellow (1960)

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IUDs Myths/Misperceptions



▶ Current recommendations (WHO, ACOG)

- ▶ No increased risk of PID* or infertility with use.
- ▶ Not exclusions: history of PID, STDs, or previous ectopic.
 - ▶ **Can screen for STDs at the time of insertion.**
- ▶ Safe for women of any age, including teens and nulliparas.
- ▶ Monogamy is not a pre-requisite for use.
- ▶ Can insert anytime after delivery or abortion.

▶ Women (of any age) are very interested in long-acting, reversible methods...when made aware that they exist!

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IUDs What to expect

- ▶ Insertion requires a pelvic exam with procedure and (of course) patient consent and motivation.

Additional counseling:

Levonorgestrel IUS (Mirena)	Copper T (ParaGard)
Lighter/no periods after 3-6 months Used to treat bleeding/pain	May increase cramps/bleeding (1 st year)
Contains small amount of progestin (local effect: thins endometrium)	No hormones
5 years	10 years

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Implant (Implanon)



- ▶ **What to expect**
 - ▶ Insertion: quick and easy
 - ▶ **Expect amenorrhea or unpredictable, irregular bleeding during entire 3 years of use.**
 - ▶ Does not cause anemia or other health problems.
 - ▶ Does not necessarily “get better” (as with Depo, OCPs, IUDs).
 - ▶ Can offer OCPs or doxycycline to treat bleeding.
 - ▶ For users: convenience and (highest) efficacy should outweigh potential for irregular/unpredictable/not dangerous bleeding.
 - ▶ Obese women: safe to use, counsel that may have slight increased failure rate (i.e., may be higher than 1/1000).

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Ring and Patch

- ▶ **Combined methods (Ring and Patch)**
 - ▶ Contain Estrogen + Progestin (just like pills)
 - ▶ Same instructions/precautions/expectations as OCPs
- ▶ **Patch**
 - ▶ Inform patients who choose this method that there may be a 2-fold increase compared to OCPs (studies vary); estrogen exposure is greater (60% more compared to oral use).
 - ▶ VTE per 100,000 women-years (*Contraceptive Technology*)

Young, general population	Pregnant	OCPs < 50 ug
4-5	48-60	12-20
 - ▶ Obesity: counsel on potential for decreased efficacy for all combined methods, also risk factor for VTE -> **OK if best option.**

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Summary Points



Keith Haring

- ▶ **Quick Start for pills/patch/ring/Depo.**
- ▶ **Recognize/address common misperceptions, myths, and outdated protocols.**
- ▶ **The counseling and support that you provide when a method is initiated predicts user satisfaction (and user continuation).**
 - ▶ Be clear about what to expect.
 - ▶ Side effects usually resolve with use, and are not the same as method failure.
 - ▶ Reassure and follow-up: client can return anytime, any reason.

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