Contraceptive Updates and Recommendations

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MCH Public Health Webinar
June 24, 2013

Learning Objectives

- Review updates to the U.S. Medical Eligibility Criteria (MEC)
- Describe CDC’s new U.S. Selected Practice Recommendations for Contraceptive Use (SPR)
- Identify recommendations for contraceptive use for women with contraceptive management issues
Disclosures

- Merck Pharmaceuticals
- Teva Women’s Health
- Some recommendations may be inconsistent with prescribing information

U.S. Medical Eligibility Criteria
A Success Story!
Quick Question

Are you currently using the U.S. Medical Eligibility Criteria for Contraceptive Use (MEC) in clinical practice?

Yes

No

U.S. Selected Practice Recommendations

Just Released!!
Quick Question

Have you heard of the Selected Practice Recommendations for Contraceptive Use (SPR)?

Yes
No

How to find CDC’s contraception guidance

Provider tools
U.S. Medical Eligibility Criteria

U.S. Medical Eligibility Criteria for Contraceptive Use
US Medical Eligibility Criteria for Contraceptive Use

How to use the US MEC

<table>
<thead>
<tr>
<th>Condition</th>
<th>Sub-condition</th>
<th>Combined pill, patch, ring</th>
<th>Prescription-only pill</th>
<th>Injection</th>
<th>Implant</th>
<th>LNG IUD</th>
<th>Copper IUD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sexually transmitted infections</td>
<td>a) Current primary syphilis or chlamydial infection or gonorrhea</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>b) Other STIs (excluding HIV and syphilis)</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>c) Vaginitis (excluding trichomonas vaginitis and bacterial vaginitis)</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>d) Increased risk of STI</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>2</td>
</tr>
</tbody>
</table>

(I) = Initiation

(C) = Continuation
US Medical Eligibility Criteria: Categories

<table>
<thead>
<tr>
<th>1</th>
<th>No restriction for the use of the contraceptive method for a woman with that medical condition</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>Advantages of using the method generally outweigh the theoretical or proven risks</td>
</tr>
<tr>
<td>3</td>
<td>Theoretical or proven risks of the method usually outweigh the advantages – or that there are no other methods that are available or acceptable to the women with that medical condition</td>
</tr>
<tr>
<td>4</td>
<td>Unacceptable health risk if the contraceptive method is used by a woman with that medical condition</td>
</tr>
</tbody>
</table>

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

Quick Question

Are you aware that the CDC produces interim contraceptive guidance when new evidence becomes available and a change in recommendations is warranted?

Yes
No
What’s happened since the US MEC was released?

- Keeping guidance up to date:
  - UPDATE: Combined methods for postpartum women
  - UPDATE: Hormonal contraception and HIV

Update: Combined methods for postpartum women (pills, patch, ring)

CDC, MMWR, 2011; 60(878-883)
Clinical scenario

A 30 y.o. female is s/p c-section, ready to be discharged from hospital and desires contraception with combined hormonal pills. She does not wish to breastfeed. When is the soonest time it would be safe to initiate her birth control pills?

A. Immediately postpartum
B. 21 days (3 weeks) postpartum
C. 42 days (6 weeks) postpartum

Systematic review

- 3 studies directly compared postpartum risk of venous thromboembolism (VTE) to non-pregnant women
  - Risk (probability) is 22 to 84 times as high in postpartum women than non-pregnant women
- Rate ratio comparing postpartum risk of venous thromboembolism (VTE) to non-pregnant women calculated for 3 studies
  - Rate Ratio: 2.5 to 21.5 in postpartum women

Jackson, Obstet Gynecol, 2011;117:691.
Previous US MEC guidance for CHCs in the postpartum period

<table>
<thead>
<tr>
<th>Postpartum (non-breastfeeding)</th>
<th>Category</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;21 days</td>
<td>3</td>
</tr>
<tr>
<td>≥21 days</td>
<td>1</td>
</tr>
</tbody>
</table>

Update: Combined methods for postpartum women

### Postpartum (non-breastfeeding) Category Clarification

<table>
<thead>
<tr>
<th>Time Period</th>
<th>Category</th>
<th>Clarification</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;21 days</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>21-42 days</td>
<td></td>
<td></td>
</tr>
<tr>
<td>With other risk factors</td>
<td>3</td>
<td>Other risk factors might increase classification to “4”</td>
</tr>
<tr>
<td>Without other risk factors</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>&gt;42 days</td>
<td>1</td>
<td></td>
</tr>
</tbody>
</table>

Other risk factors: previous VTE, thrombophilia, immobility, transfusion at delivery, BMI ≥ 30, age ≥ 35 years, smoking, preeclampsia, postcesarean delivery, postpartum hemorrhage

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Update: Combined methods for postpartum women

### Postpartum (breastfeeding) MEC Category

<table>
<thead>
<tr>
<th>Time Period</th>
<th>MEC Category</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;21 days</td>
<td>4</td>
</tr>
<tr>
<td>21-&lt;30 days</td>
<td></td>
</tr>
<tr>
<td>With other risk factors for VTE (such as age ≥ 35, previous VTE, thrombophilia, immobility, transfusion at delivery, BMI ≥ 30, post cesarean delivery, preeclampsia, or smoking)</td>
<td>3</td>
</tr>
<tr>
<td>Without other risk factors for VTE</td>
<td>3</td>
</tr>
<tr>
<td>30-42 days</td>
<td></td>
</tr>
<tr>
<td>With other risk factors for VTE (such as age ≥ 35, previous VTE, thrombophilia, immobility, transfusion at delivery, BMI ≥ 30, post cesarean delivery, preeclampsia, or smoking)</td>
<td>3</td>
</tr>
<tr>
<td>Without other risk factors for VTE</td>
<td>2</td>
</tr>
<tr>
<td>&gt; 42 days</td>
<td>2</td>
</tr>
</tbody>
</table>
Update: Hormonal contraception and HIV

CDC, MMWR, 2012; 64(449-452)

<table>
<thead>
<tr>
<th>Condition</th>
<th>CHC</th>
<th>POP</th>
<th>DMPA</th>
<th>Implants</th>
</tr>
</thead>
<tbody>
<tr>
<td>High risk for HIV</td>
<td>1</td>
<td>1</td>
<td>1†</td>
<td></td>
</tr>
<tr>
<td>HIV infection</td>
<td>1*</td>
<td>1*</td>
<td>1*</td>
<td>1*</td>
</tr>
<tr>
<td>AIDS</td>
<td>1*</td>
<td>1*</td>
<td>1*</td>
<td>1*</td>
</tr>
</tbody>
</table>

* Clarification: Drug interactions might exist between hormonal contraceptives and antiretroviral drugs; refer to the section on drug interactions.
† Clarification: See next slide.
Clarification for progestin-only injectables among women at high risk of HIV

Some studies suggest that women using progestin-only injectable contraception might be at increased risk for HIV acquisition; other studies do not show this association. CDC reviewed all available evidence and agreed that the data were not sufficiently conclusive to change current guidance. However, because of the inconclusive nature of the body of evidence on possible increased risk for HIV acquisition, women using progestin-only injectable contraception should be strongly advised to also always use condoms (male or female) and take other HIV preventive measures. Expansion of contraceptive method mix and further research on the relationship between hormonal contraception and HIV infection are essential. These recommendations will be continually reviewed in light of new evidence.

United States (U.S.) Adaptation of World Health Organization (WHO) Selected Practice Recommendations for Contraceptive Use (SPR)
World Health Organization
Family Planning Guidance

Guidance for guides

Guidance for providers

U.S. Adaptation of WHO SPR

- **2010:**
  - Talked to key family planning providers in US
  - Identified WHO recs to consider adapting, new clinical questions to consider adding
- **2010-2011:**
  - Conducted systematic reviews of evidence
- **2011:**
  - Expert meeting
  - Presented evidence, discussed and drafted US recs
- **2012-2013:**
  - Finalize US SPR
U.S. Adaptation of WHO SPR

- Much of the guidance is same or very similar to WHO SPR
  - Addresses issues related to use of contraceptives
    - Examinations and tests recommended prior to contraceptive method use
    - Timing of initiation of the contraceptive method
    - Follow up
    - Addressing problems that come up during use
      - Missed pills
      - Side effects, such as unscheduled bleeding during contraceptive method use
  - Does not address guidance on every aspect of provision and management of contraceptive method use

- MEC summary chart is included

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U.S. Adaptation of WHO SPR

- New guidance in US SPR
  - Recommendations on patch and ring
  - How to start regular contraception after taking emergency contraceptive pills
  - Management of bleeding irregularities among women using extended or continuous CHCs
  - When a woman can rely on female sterilization for contraception
  - When a woman can stop contracepting
U.S. SPR Organization

• Organized by contraceptive method
  – Methods presented in order of effectiveness (highest to lowest)
  – Each section provides
    • Recommendation
    • Comments and evidence
      – Comments about the recommendations
      – Brief summary of the scientific evidence on which recommendation is based

Systematic reviews behind the U.S. SPR recommendations

Contraception, Vol 87, May 2013
Clinical Scenario

Clinical scenario

Gina is a 19 y.o. G1P1 comes to your office for her 6-week postpartum visit desiring contraception and wants to have the levonorgestrel IUD (LNG-IUD)

Do you need to do any exams or tests before Gina has her IUD placed?

If so, which exams and which tests?
Evidence: STI screening

- **Women with and without IUD**
  - No difference in PID rates among women at low risk of STI

- **STI screening at time of insertion**
  - STI at time of Insertion: 0%-5% rate of PID
  - No STI at time of Insertion: 0%-2% rate of PID

Tepper et al. Contraception, 2013

### National STI Screening Guidelines

<table>
<thead>
<tr>
<th>When to Screen</th>
<th>Recommendation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Routine care</td>
<td>Women ≤ 25 years annually; High-risk women &gt; 25 years</td>
</tr>
<tr>
<td>Pregnancy</td>
<td>Screen at the first prenatal visit; Retest in the 3rd trimester if ≤25 years or &gt; 1 sex partner If positive, retest within 3-6 months-3rd trimester</td>
</tr>
<tr>
<td>Postpartum care</td>
<td>If not screened during pregnancy, screen women ≤ 25 years or high risk women &gt; 25 years</td>
</tr>
</tbody>
</table>

2010 CDC; 2005 and 2008 USPSTF; 2005 AAP; 2008 AAP; 2007 ACOG
**U.S. MEC Recommendation: STIs**

<table>
<thead>
<tr>
<th>Condition</th>
<th>LNG-IUD</th>
<th>Copper IUD</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>I</td>
<td>C</td>
</tr>
<tr>
<td>Current purulent cervicitis or chlamydial</td>
<td>4</td>
<td>2^</td>
</tr>
<tr>
<td>infection or gonorrhea</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Increased risk of STIs</td>
<td>2/3*</td>
<td>2</td>
</tr>
</tbody>
</table>

*Clarification: If a woman has a very high individual likelihood of exposure to gonorrhea or chlamydia infection, the condition is a category 3

(I) = Initiation

(C) = Continuation

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**U.S. SPR**

Exams and tests prior to initiation

- **Unnecessary tests may be barrier to starting**
  - Coming back for a second (or more) visit to receive test results
  - STI can be acquired between time test was done and results are known

- **Recommendations address exams and test needed prior to initiation**
  - Class A = essential and mandatory
  - Class B = contributes substantially to safe and effective use, but implementation may be considered within the public health and/or service context
  - Class C = does not contribute substantially to safe and effective use of the contraceptive method
## Exams and tests prior to initiation (Appendix C)

<table>
<thead>
<tr>
<th>Examination or test</th>
<th>Cu-IUD and LNG-IUD</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Examination</strong></td>
<td></td>
</tr>
<tr>
<td>Blood pressure</td>
<td>C</td>
</tr>
<tr>
<td>Weight</td>
<td>+</td>
</tr>
<tr>
<td>Clinical breast examination</td>
<td>C</td>
</tr>
<tr>
<td>Bimanual examination and cervical inspection</td>
<td>A</td>
</tr>
<tr>
<td><strong>Laboratory test</strong></td>
<td></td>
</tr>
<tr>
<td>Glucose</td>
<td>C</td>
</tr>
<tr>
<td>Lipids</td>
<td>C</td>
</tr>
<tr>
<td>Liver Enzymes</td>
<td>C</td>
</tr>
<tr>
<td>Hemoglobin</td>
<td>C</td>
</tr>
<tr>
<td>Thrombogenic mutations</td>
<td>C</td>
</tr>
<tr>
<td>Cervical cytology (Pap smear)</td>
<td>C</td>
</tr>
<tr>
<td>STD screening with laboratory tests</td>
<td>*</td>
</tr>
<tr>
<td>HIV screening with laboratory tests</td>
<td>C</td>
</tr>
</tbody>
</table>

### Footnotes (Appendix C)

- * = Most women do not require additional STD screening at the time of IUD insertion if they have already been screened according to CDC’s STD Treatment Guidelines. If screening according to guidelines has not been done, screening can be performed at the time of IUD insertion and insertion should not be delayed. Women with purulent cervicitis or current chlamydial infection or gonorrhea should not undergo IUD insertion (MEC 4). Women who have a very high individual likelihood of STD exposure (e.g., those with a currently infected partner) generally should not undergo IUD insertion (MEC 3). For these women, IUD insertion should be delayed until appropriate testing and treatment occurs.

- + = Weight (BMI) measurement is not needed to determine medical eligibility for any methods of contraception because all methods can be used (MEC 1) or generally can be used (MEC 2) among obese women. However, measuring weight and calculating BMI at baseline might be helpful for monitoring any changes and counseling women who might be concerned about weight change perceived to be associated with their contraceptive method.
Clinical scenario

Gina is 19 y.o. G1P1 comes to your office for her 6-week postpartum visit desiring contraception and wants to have the levonorgestrel IUD (LNG-IUD)

Do you need to do any exams or tests before Gina has her IUD placed?

Yes, she needs a pelvic exam prior to insertion and STD risk assessment to determine if currently infected

No, for STD screening if she has already obtained STD screening according to national guidelines during pregnancy.

Next steps

- Work with partners on dissemination and implementation
  - Office of Population Affairs/Title X Clinics
  - Medical Professional Organizations
- Keeping guidance up to date
- Develop provider tools
- Address research gaps (Folger et al., Contraception, May 2013)
Summary

• The CDC has produced two evidence-based guidelines related to contraceptive use
  – Medical Eligibility Criteria for Contraceptive Use (Who can use the method)
  – Selected Practice Recommendations for Contraceptive Use (How to use the method)
  – Both documents were adapted from the World Health Organization

• Recommendation updates will occur approximately every 4 years
  – Interim guidance will be released sooner if new evidence warrants a recommendation change

Resources

• CDC reproductive health:

• WHO reproductive health:
  – http://www.who.int/reproductive-health/family_planning/index.html

• Association of Reproductive Health Professionals (ARHP)
  – arhp.org

• Reproductive Health Access Project
  – http://www.reproductiveaccess.org/
THANK YOU!

Questions?
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