Best Practices for Contraceptive Counseling: A Primer for the Primary Care Pediatrician

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Primary Teen Pregnancy Prevention:
Let's Talk About Sex

- Half of adolescents are engaging in sexual activity[1]

- Unintended Teen Pregnancies[2]
  - 46% due to non-use of contraception
  - 54% due to contraceptive failure
    - Effectiveness of method
    - Consistent and correct use
- Pediatricians are important providers of sexual health and contraception education[3,4]

Martinez et al, 2011; Santelli et al., 2006; Ott et al, 2011; Jones et al, 2011

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At the session's end, participants will be able to …

- Identify talking points and tools for contraceptive counseling in the primary care setting
- List the steps for obtaining Long-Acting Reversible Contraceptives (LARCs)
- Identify appropriate patients for co-management with a contraception specialist

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Case: Angela

- Angela is a 16-year-old young in the office for a well adolescent exam

- You review the confidentiality and consent rules with her and her mother
  - In MD*, DC, and VA: All teens have the right to confidential reproductive health services including contraception and STI testing/treatment
  - Privacy extends to the medical record, but may not be kept by EOBs

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Sexual History Taking

- Frame some questions in the third person
  - "Are you noticing that your peers/friends are starting to have sex?"
- Be concrete:
  - "Have you ever had sex?"
  - "Do you use condoms 100% or less than 100% of the time?"
- Be aware of judgmental questions and behaviors:
  - "you don't have unprotected sex, do you?"
  - shaking your head as you ask questions
- Acknowledge positive behaviors:
  - establishing healthy relationships
  - proper use of contraceptives and safer sex methods
- Screen for intimate partner violence
  - "Has your partner ever forced you to do something sexually that you did not want to do, or tried to get you pregnant when you didn't want to be?"

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Case: Angela

- Angela has had sex three times with her current boyfriend and used condoms during two of those three encounters.
- After discussion with Angela, she would like to read more about available contraceptive options.
- She plans to discuss this with her mother.
- What resources do you provide her?

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Long Acting Reversible Contraception (LARC): The Implant and IUDs

- LARC methods should be considered first-line contraceptive choices for adolescents
- Counsel about LARC methods at all visits with sexually active adolescents
- Providers should help make IUDs and the contraceptive implant accessible to adolescents

AAP (2014) and ACOG (2012) Recommendations

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HOW WELL DOES BIRTH CONTROL WORK?

What is your chance of getting pregnant?

Really, really well

The Implant (Nexplanon)

Works, hassle-free, for up to... 3 years

IUD (Skyla)

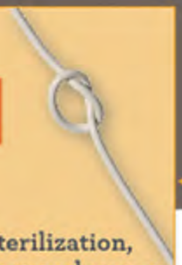
Works, hassle-free, for up to... 3 years

IUD (Mirena)

Works, hassle-free, for up to... 5 years

IUD (ParaGard)

Works, hassle-free, for up to... 12 years



Sterilization, for men and women

Works, hassle-free, for up to... Forever

Less than 1 in 100 women

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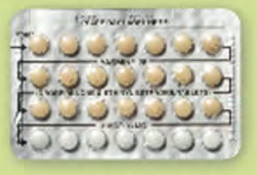

The Pill

For it to work best, use it... Every. Single. Day.

The Patch

For it to work best, use it... Every week

The Ring

For it to work best, use it... Every month

The Shot (Depo-Provera)

For it to work best, use it... Every 3 months

6-9 in 100 women, depending on method

Not as well

Pulling Out

Fertility Awareness

Diaphragm

Condoms, for men or women

For each of these methods to work, you or your partner have to use it every single time you have sex.

12-24 in 100 women, depending on method

FYI, without birth control, over 90 in 100 young women get pregnant in a year.

www.YoungWomensHealth.org

Ask Us | Health Guides | Guías de la Salud | Quizzes | Parents | Clinicians

Center for Young Women's Health

General Health | Sexual Health | Gynecology | Medical Conditions

Pros and Cons of Different Contraceptive Methods

Here's a list of the many available types of contraception, and the pros and cons of using each.

Minimum effectiveness: 95%
Birth Control Pills

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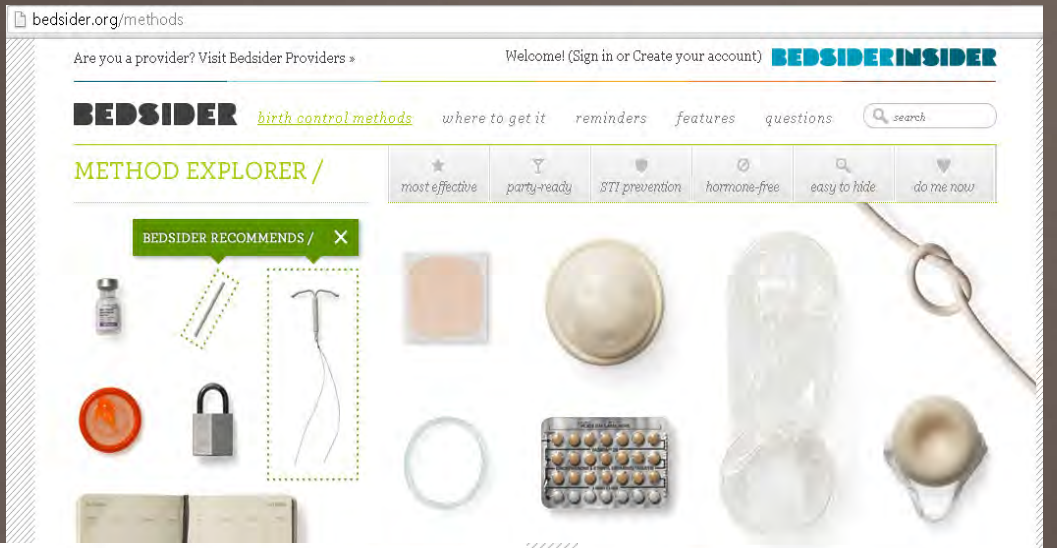
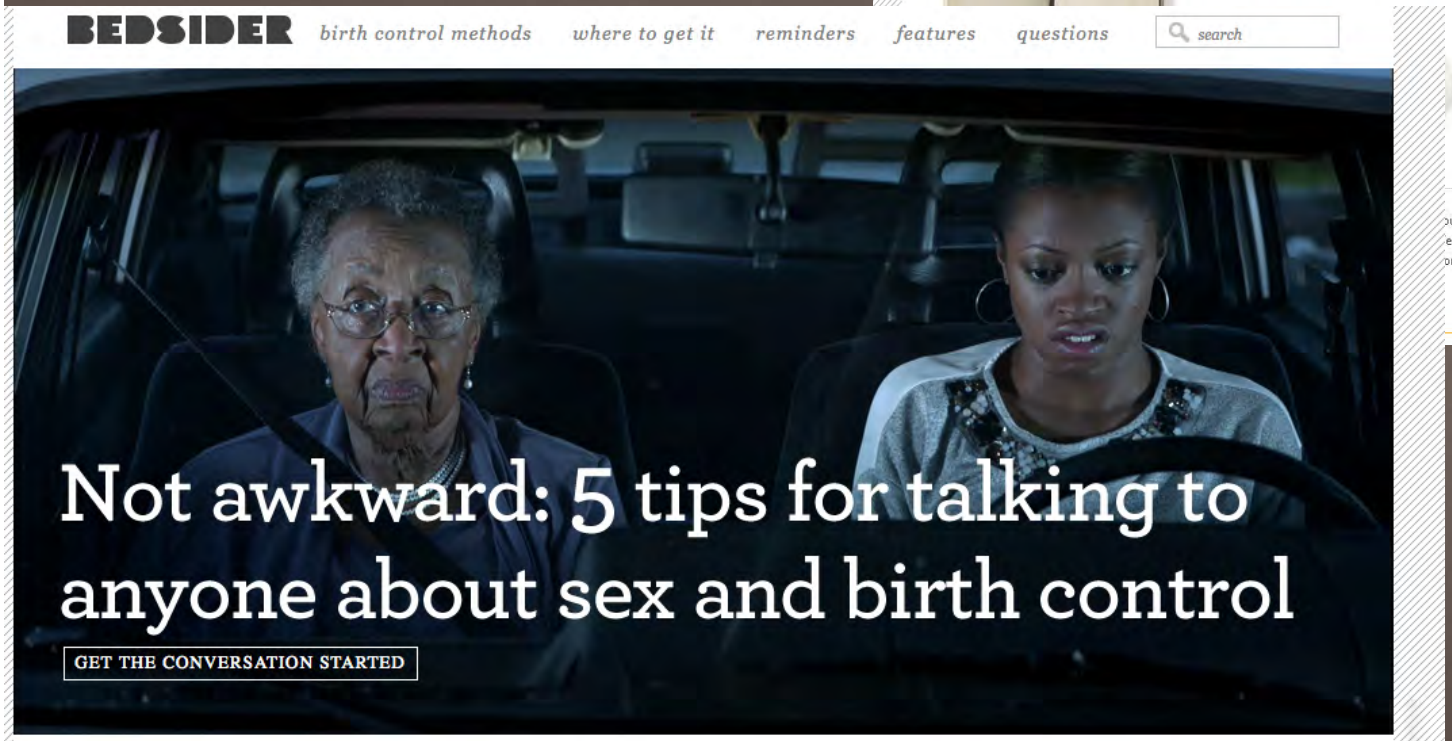
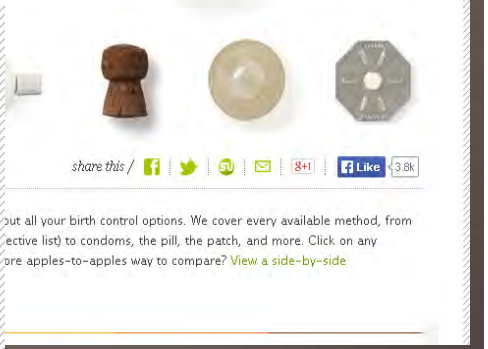
Also… www.YoungMensHealthSite.org

www.bedsider.org







GET COVERED

REAL STORIES

FRISKY FRIDAY

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Case: Angela, age 16 years

- Angela returns for an appointment to start hormonal birth control.
- Angela was thinking about starting "the pill"
- What questions do you ask before beginning contraception counseling?

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Case: Angela, age 16 years

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- What questions do you ask before beginning contraception counseling?

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Case: Medical Eligibility Screening

- Angela has migraines (without aura) controlled with topiramate 50mg BID.
- She does not think anyone in her family has a history of blood clots.

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Medical Eligibility Screening

Higher risk for hormonal contraception:

- History of blood clots, thrombophilia or high risk for DVT
- Active liver disease/hepatitis
- History of breast cancer
- Migraines with aura
- History of stroke (e.g., in sickle cell disease)
- Uncontrolled HTN (>160/100)
- DM with end organ damage
- Precancerous cervical changes
- Interfering medications: antiepileptics, HIV meds, rifampin, oral antifungals, St. John's Wort

Not an issue:

- Obesity
- IBD
- Smoking <35 years old
- Migraines without aura
- Ovarian cysts
- Postpartum >6 weeks
- Fhx of VTE

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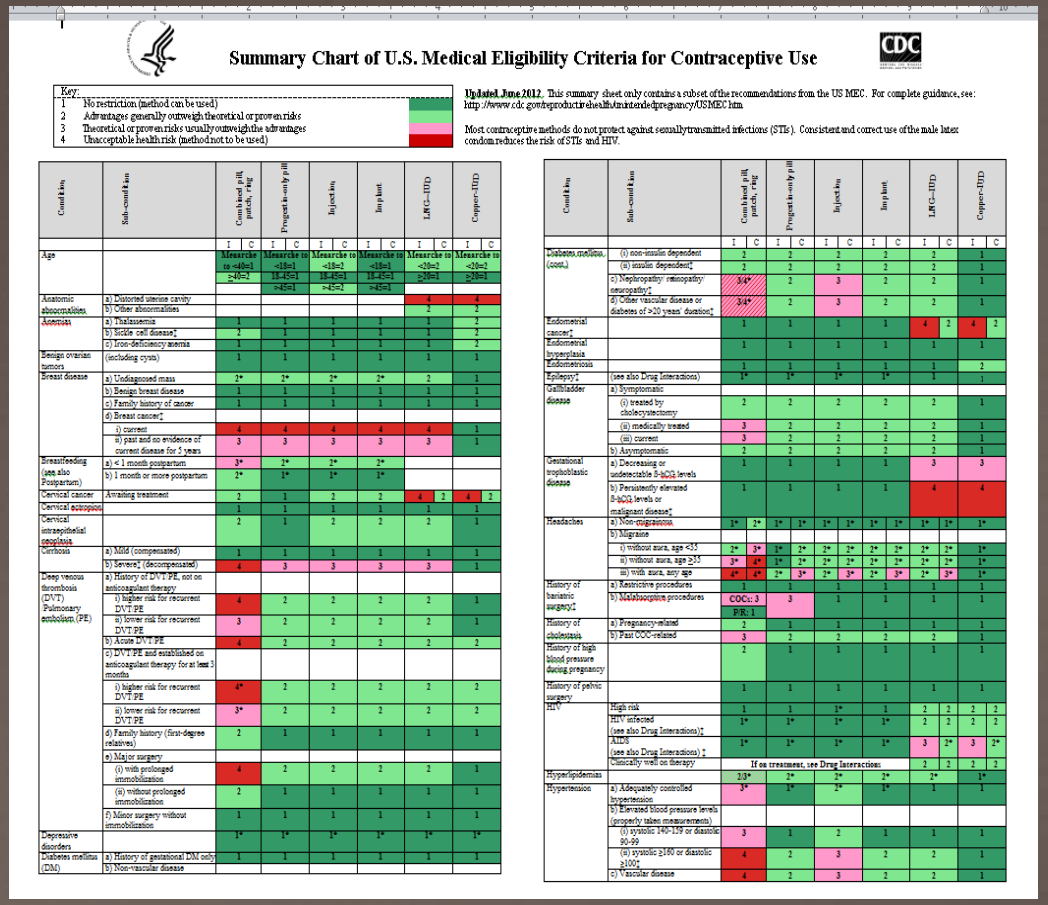
Medical Eligibility Criteria for Contraceptive Use 2010

www.CDC.gov



Summary Chart of U.S. Medical Eligibility Criteria for Contraceptive Use

Key:
1 No restriction (method can be used)
2 Advantages generally outweigh theoretical or proven risks
3 Theoretical or proven risks usually outweigh the advantages
4 Unacceptable health risk (method not to be used)

Updated June 2012. This summary sheet only contains a subset of the recommendations from the US MEC. For complete guidance, see: http://www.cdc.gov/reproductivehealth/unintendedpregnancy/USMEC.htm

Most contraceptive methods do not protect against sexually transmitted infections (STIs). Consistent and correct use of the male latex condom reduces the risk of STIs and HIV.

Condition	Sub-condition	Combined pill, patch, ring		Progestin-only pill		Injection		Implant		LNG-IUD		Copper-IUD	
		I	C	I	C	I	C	I	C	I	C	I	C
Age		Menarche to <40=1 ≥40=2		Menarche to <18=1 18-45=1 >45=1		Menarche to <18=2 18-45=1 >45=1		Menarche to <18=1 18-45=1 >45=1		Menarche to <20=2 ≥20=1		Menarche to <20=1 ≥20=1	
Anatomic abnormalities	a) Distorted uterine cavity									4		4	
	b) Other abnormalities									2		2	
Anemias	a) Thalassemia	1	1	1	1	1	1	1	1	1	1	2	
	b) Sickle cell disease[‡]	2	1	1	1	1	1	1	1	2	1	2	
	c) Iron-deficiency anemia	1	1	1	1	1	1	1	1	1	1	2	
Benign ovarian tumors	(including cysts)	1	1	1	1	1	1	1	1	1	1	1	
Breast disease	a) Undiagnosed mass	2*	2*	2*	2*	2	1						
	b) Benign breast disease	1	1	1	1	1	1	1	1	1	1	1	
	c) Family history of cancer	1	1	1	1	1	1	1	1	1	1	1	
	d) Breast cancer[‡]												
	i) current	4	4	4	4	4	1						
	ii) past and no evidence of current disease for 5 years	3	3	3	3	3	1						
Breastfeeding (see also Postpartum)	a) < 1 month postpartum	3*	2*	2*	2*								
	b) 1 month or more postpartum	2*	1*	1*	1*								
Cervical cancer	Awaiting treatment	2	1	2	2	4	2	4	2				
Cervical ectropion		1	1	1	1	1	1						
Cervical intraepithelial neoplasia		2	1	2	2	2	1						
Cirrhosis	a) Mild (compensated)	1	1	1	1	1	1						
	b) Severe[‡] (decompensated)	4	3	3	3	3	1						
Deep venous thrombosis (DVT)/ Pulmonary embolism (PE)	a) History of DVT/PE, not on anticoagulant therapy												
	i) higher risk for recurrent DVT/PE	4	2	2	2	2	1						
	ii) lower risk for recurrent DVT/PE	3	2	2	2	2	1						
	b) Acute DVT/PE	4	2	2	2	2	2						
	c) DVT/PE and established on anticoagulant therapy for at least 3 months												
	i) higher risk for recurrent DVT/PE	4*	2	2	2	2	2						
	ii) lower risk for recurrent DVT/PE	3*	2	2	2	2	2						
	d) Family history (first-degree relatives)	2	1	1	1	1	1						
	e) Major surgery												
	(i) with prolonged immobilization	4	2	2	2	2	1						
	(ii) without prolonged immobilization	2	1	1	1	1	1						
	f) Minor surgery without immobilization	1	1	1	1	1	1						
Depressive disorders		1*	1*	1*	1*	1*	1*						
Diabetes mellitus (DM)	a) History of gestational DM only	1	1	1	1	1	1						
	b) Non-vascular disease												

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		I	C	I	C	I	C	I	C	I	C	I	C
Diabetes mellitus (cont.)	(i) non-insulin dependent	2		2		2		2		2		1	
	(ii) insulin dependent[‡]	2		2		2		2		2		1	
	c) Nephropathy/ retinopathy/ neuropathy[‡]	3/4*		2		3		2		2		1	
	d) Other vascular disease or diabetes of >20 years' duration[‡]	3/4*		2		3		2		2		1	
Endometrial cancer[‡]		1		1		1		1		4	2	4	2
Endometrial hyperplasia		1		1		1		1		1		1	
Endometriosis		1		1		1		1		1		2	
Epilepsy[‡]	(see also Drug Interactions)	1*		1*		1*		1*		1		1	
Gallbladder disease	a) Symptomatic												
	(i) treated by cholecystectomy	2		2		2		2		2		1	
	(ii) medically treated	3		2		2		2		2		1	
	(iii) current	3		2		2		2		2		1	
	b) Asymptomatic	2		2		2		2		2		1	
Gestational trophoblastic disease	a) Decreasing or undetectable β-hCG levels	1		1		1		1		3		3	
	b) Persistently elevated β-hCG levels or malignant disease[‡]	1		1		1		1		4		4	
Headaches	a) Non-migrainous	1*	2*	1*	1*	1*	1*	1*	1*	1*	1*	1*	
	b) Migraine												
	i) without aura, age <35	2*	3*	1*	2*	2*	2*	2*	2*	2*	2*	1*	
	ii) without aura, age ≥35	3*	4*	1*	2*	2*	2*	2*	2*	2*	2*	1*	
	iii) with aura, any age	4*	4*	1*	3*	2*	3*	2*	3*	2*	3*	1*	
History of bariatric surgery[‡]	a) Restrictive procedures	1		1		1		1		1		1	
	b) Malabsorptive procedures	COCs: 3 P/R: 1		3		1		1		1		1	
History of cholestasis	a) Pregnancy-related	2		1		1		1		1		1	
	b) Past OCC-related	3		2		2		2		2		1	
History of high blood pressure during pregnancy		2		1		1		1		1		1	
History of pelvic surgery		1		1		1		1		1		1	
HIV	High risk	1		1		1*		1		2	2	2	2
	HIV infected (see also Drug Interactions)[‡]	1*		1*		1*		1*		2	2	2	2
	AIDS (see also Drug Interactions) [‡]	1*		1*		1*		1*		3	2*	3	2*
	Clinically well on therapy	If on treatment, see Drug Interaction								2	2	2	2
Hyperlipidemias		2/3*		2*		2*		2*		2*		1*	
Hypertension	a) Adequately controlled hypertension	3*		1*		2*		1*		1		1	
	b) Elevated blood pressure levels (properly taken measurements)												
	(i) systolic 140-159 or diastolic 90-99	3		1		2		1		1		1	
	(ii) systolic ≥160 or diastolic ≥100[‡]	4		2		3		2		2		1	
	c) Vascular disease	4		2		3		2		2		1	

iPhone/ iPad App

New Mobile Tool Available for CDC's U.S. Medical Eligibility Criteria for Contraceptive Use, 2010

Download the U.S. MEC application for iPhone/iPad from the iTunes App Store.

CDC has a new app which provides guidance for healthcare providers on the safety of contraceptive methods for people with certain medical conditions. The app is developed from the *U.S. Medical Eligibility Criteria for Contraceptive Use, 2010* that includes more than 60 characteristics and medical conditions that may affect people seeking family planning services.

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		I	C	I	C	I	C	I	C	I	C	I	C
Headaches	a) Non-migrainous	1*	2*	1*	1*	1*	1*	1*	1*	1*	1*	1*	
	b) Migraine												
	i) without aura, age <35	2*	3*	1*	2*	2*	2*	2*	2*	2*	2*	1*	
	ii) without aura, age ≥35	3*	4*	1*	2*	2*	2*	2*	2*	2*	2*	1*	
	iii) with aura, any age	4*	4*	2*	3*	2*	3*	2*	3*	2*	3*	1*	
Drug Interactions													
Anticonvulsant therapy	a) Certain anticonvulsants (phenytoin, carbamazepine, barbiturates, primidone, topiramate, oxcarbazepine)	3*		3*		1		2*		1		1	
	b) Lamotrigine	3*		1		1		1		1		1	

Key:	
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http://www

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Condition	Sub-condition	Combined pill, patch, ring		Progestin-only pill		Injection		Implant		LNG-IUD		Copper-IUD	
		I	C	I	C	I	C	I	C	I	C	I	C
Deep venous thrombosis (DVT) /Pulmonary embolism (PE)	a) History of DVT/PE, not on anticoagulant therapy												
	i) higher risk for recurrent DVT/PE	4		2		2		2		2		1	
	ii) lower risk for recurrent DVT/PE	3		2		2		2		2		1	
	b) Acute DVT/PE	4		2		2		2		2		2	
	c) DVT/PE and established on anticoagulant therapy for at least 3 months												
	i) higher risk for recurrent DVT/PE	4*		2		2		2		2		2	
	ii) lower risk for recurrent DVT/PE	3*		2		2		2		2		2	
	d) Family history (first-degree relatives)	2		1		1		1		1		1	
	e) Major surgery												

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Case: Angela

- Angela is thinking about starting “the pill.”
- What other questions do you ask before beginning contraception counseling?
- What other contraceptive options do you discuss with her?

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Shared Decision Making in Choosing a Method

- How far in the future might you want to have a child (again)?
- What is important to the patient in selecting a contraceptive method?
  - Efficacy?
  - Control in starting and stopping?
  - Frequency of administration?
  - Discreetness?
    - "Do we need to keep contraception use private from your parents or partners?"
    - "Does your partner support your decision about when or if you want to become pregnant?"
  - Side effects?

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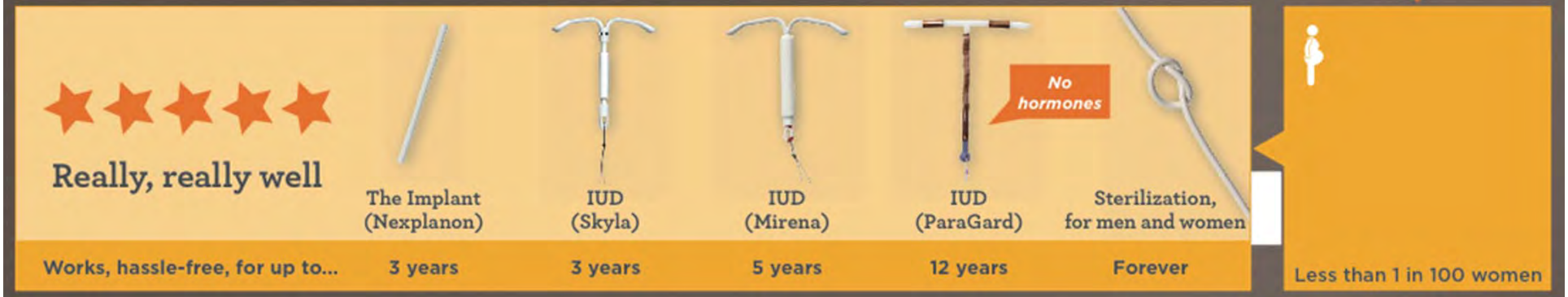
First Tier Efficacy



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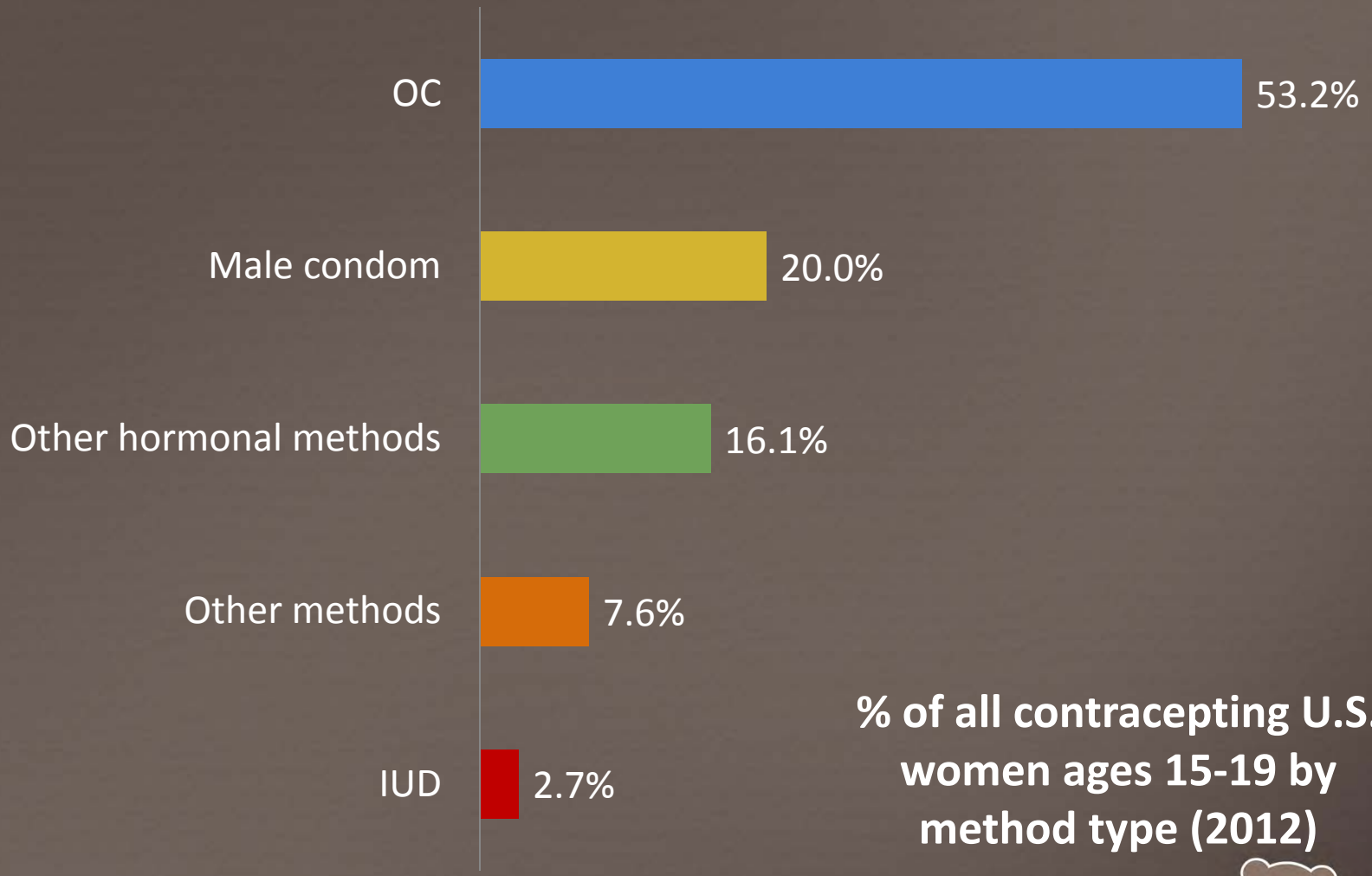
Contraceptive CHOICE and Continuation rates

Females aged 14-19 years (n=1099), Contraceptive CHOICE Project

Method	% Choosing Method	Continuation Rate (%)
LARC	69.3%	81%
Levonorgestrel IUS	30%	80.6%
Copper IUD	5%	75.6%
Implant	34.3%	82.2%
Non-LARC	30.6%	44%
DMPA	10.2%	47.3%
OCPs	13.3%	46.7%
Patch	2%	40.9%
Ring	5.1%	31%

Adolescent Contraceptive Use



% of all contracepting U.S. women ages 15-19 by method type (2012)

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Barriers to LARC provision

- Patient knowledge
- Patient preference
- Concern about safety
  - Risk of PID
  - Nulliparous, adolescent, not monogamous
- Provider not trained in insertion
- LARC not available
- Cost

Tyler, Obstet Gynecol 2012;119:762
Madden, Contraception 2010;81:112.
Whitaker, Contraception 2008;78:211.
Mestad, Contraception 2011;84:493.

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Shared Decision Making in Choosing a Method: **Implant**

- How far in the future might you want to have a child (again)?
  - **≥3 years**

- What is important to the patient in selecting a contraceptive method?
  - Efficacy? **99.8%**
  - Control in starting and stopping? **Ask for a 6 month commitment for bleeding pattern; small incision to remove; no delay in fertility return**
  - Frequency of administration? **Can be replaced same day every 3 years**
  - Discreetness? **Not visible; palpable only**
  - Side effects? **Progestin-only; no impact on bone density; few discontinue due to weight gain; unpredictable bleeding pattern; only slight burning of lidocaine with insertion**

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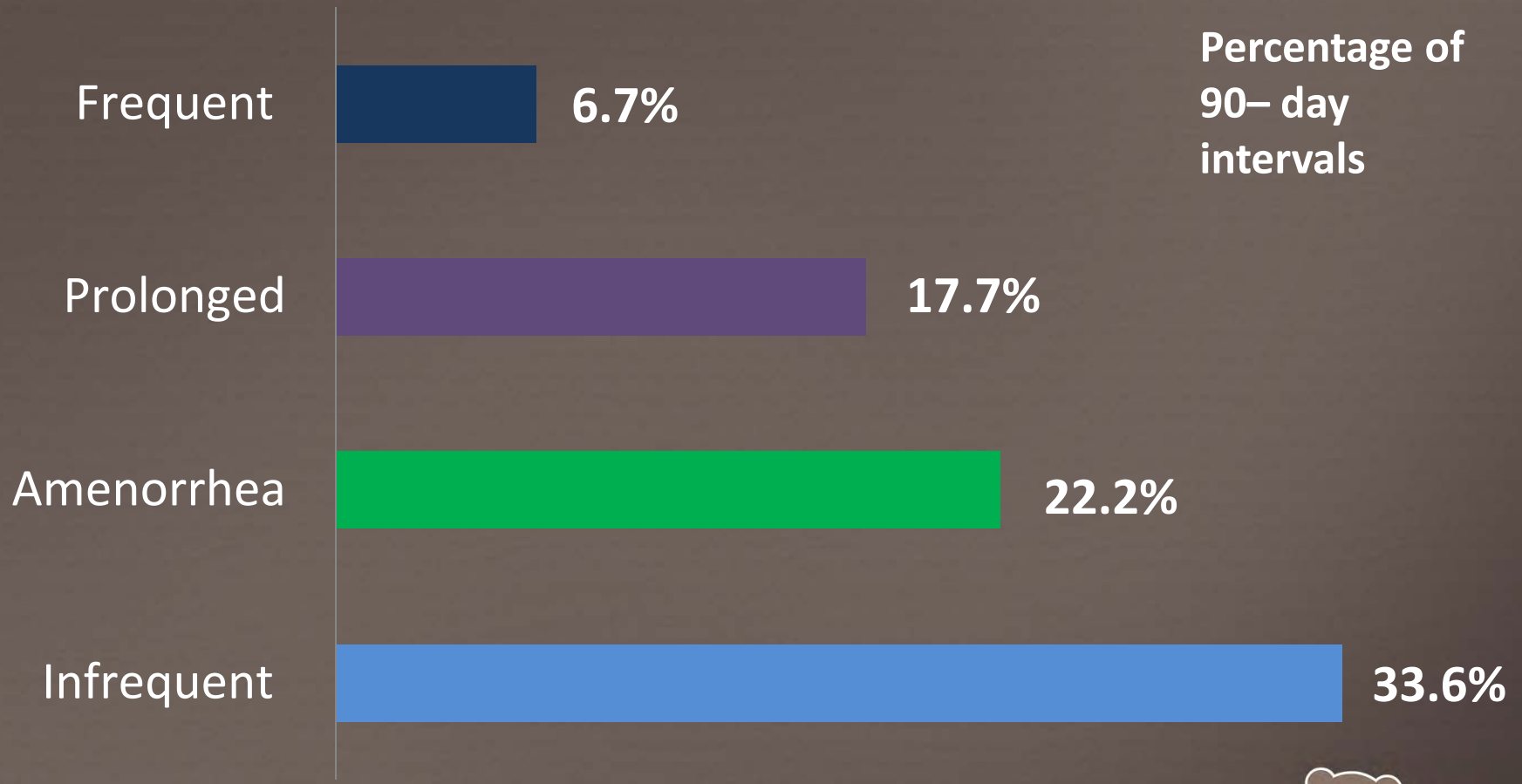
Bleeding Patterns with Implant

First 2 Years



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Shared Decision Making in Choosing a Method: Levonorgestrel IUD

- How far in the future might you want to have a child (again)?
  - **≥3 years**

- What is important to the patient in selecting a contraceptive method?
  - Efficacy? **99.2%**
  - Control in starting and stopping? **Office placement/removal; no delay in fertility return**
  - Frequency of administration? **3-5 years**
  - Discreetness? **Not visible; string palpable in vagina**
  - Side effects? **Cramping with insertion; Progestin-only: no impact on bone density; 50% amenorrhea within 2 years**

Copper IUD: heavier cramps and bleeding; doesn't stop ovulation; but lasts 10 years

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Safety of IUDs for Teens

- **IUDs and age <20: US Medical Eligibility Criteria Class 2**
- **IUDs and Expulsion**
  - Evidence shows slightly increased risk of expulsion in younger women (5-22%)
- **IUDs and infertility**
  - No evidence that IUDs cause later infertility
  - Infertility associated with gonorrhea and Chlamydia
- **IUDs and STIs**
  - No evidence that IUDs increase risk of STI acquisition
  - Women with current cervicitis, chlamydial infection, gonorrhea should not start an IUD (US MEC 4)
  - Women with a very high individual likelihood of exposure to chlamydial infection or gonorrhea generally should not start an IUD (US MEC 3)

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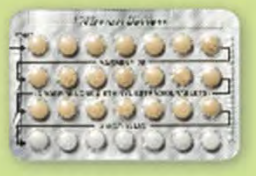
Second Tier Efficacy
92-96%

★★★ O.K.					
For it to work best, use it...	The Pill	The Patch	The Ring	The Shot (Depo-Provera)	6-9 in 100 women, depending on method
	Every. Single. Day.	Every week	Every month	Every 3 months	

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Shared Decision Making in Choosing a Method: Depot Medroxyprogesterone Acetate (DMPA)

- How far in the future might you want to have a child (again)?
  - **≥3-12 months**
- What is important to the patient in selecting a contraceptive method?
  - Efficacy? **94%**
  - Control in starting and stopping? **Office placement; fertility may take 9-12 months to resume**
  - Frequency of administration? **3 months**
  - Discreetness? **May need to pick up from pharmacy first**
  - Side effects? **Progestin-only: temporary osteopenia; unpredictable bleeding; weight gain**

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DMPA Side Effects

- Menstrual disturbances
  - Incidence 70%
  - Decreases with each injection
- Weight Gain
  - 4-5 pounds over those with IUD
  - May be more in obese
- Bone Mineral Density
  - Loss greatest in first 2 years
  - Regained when DMPA stopped, especially in adolescents
- Delay in return to fertility
  - Median 9-10 months to conception

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Shared Decision Making in Choosing a Method: Combined estrogen-progestin Vaginal Ring

- How far in the future might you want to have a child (again)?
  - **≥1 month**

- What is important to the patient in selecting a contraceptive method?
  - Efficacy? **91%**
  - Control in starting and stopping? **Patient dependent; may take out for 3hrs; no delay in fertility return**
  - Frequency of administration? **3 weeks in, 1 wk out**
  - Discreetness? **May be noticed during sex**
  - Side effects? **Vaginal irritation**

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Shared Decision Making in Choosing a Method: Combined estrogen-progestin Patch

- How far in the future might you want to have a child (again)?
  - **≥1 week**
- What is important to the patient in selecting a contraceptive method?
  - Efficacy? **91%**
  - Control in starting and stopping? **Patient dependent; no delay in fertility return**
  - Frequency of administration? **weekly**
  - Discreetness? **Visible on skin**
  - Side effects? **Skin irritation from adhesive; theoretic risk of VTE higher due to bypass of liver filtration**

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Shared Decision Making in Choosing a Method: Combined estrogen-progestin oral pill

- How far in the future might you want to have a child (again)?
  - **≥1 week**
- What is important to the patient in selecting a contraceptive method?
  - Efficacy? **91%**
  - Control in starting and stopping? **Patient dependent; no delay in fertility return**
  - Frequency of administration? **Daily**
  - Discreetness? Ensure pill storage accessible
  - Side effects? Consider pill at night if nausea; mood changes and

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Standard Counseling on Safety

- Review serious but rare side effects
  - High blood pressure
  - Formation of blood clots
- Instruct patient to stop medication and notify provider immediately with any of the following ACHES symptoms:
  - **A**bdominal Pain (severe)
  - **C**hest Pain
  - **H**eadache (severe)
  - **E**ye problems, visual disturbances
  - **S**evere localized leg pain (calf or thigh)
- Review disadvantages
  - Condoms still required for STI protection
  - Few months for body to equilibrate hormones
  - Potential for benign liver masses

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Case: Angela

- Angela now wants to get the DMPA injection (Depo-Provera®) until she can be referred to get the Implant placed

- Do you need to perform any exam or test?

Do Not Defer Contraception Initiation

- **Pelvic exam:** Not necessary unless…
  - she has STI symptoms
  - provider is going to place IUD

- **Pap smear:** Every 3 years starting at age 21years age, unless immunocompromised

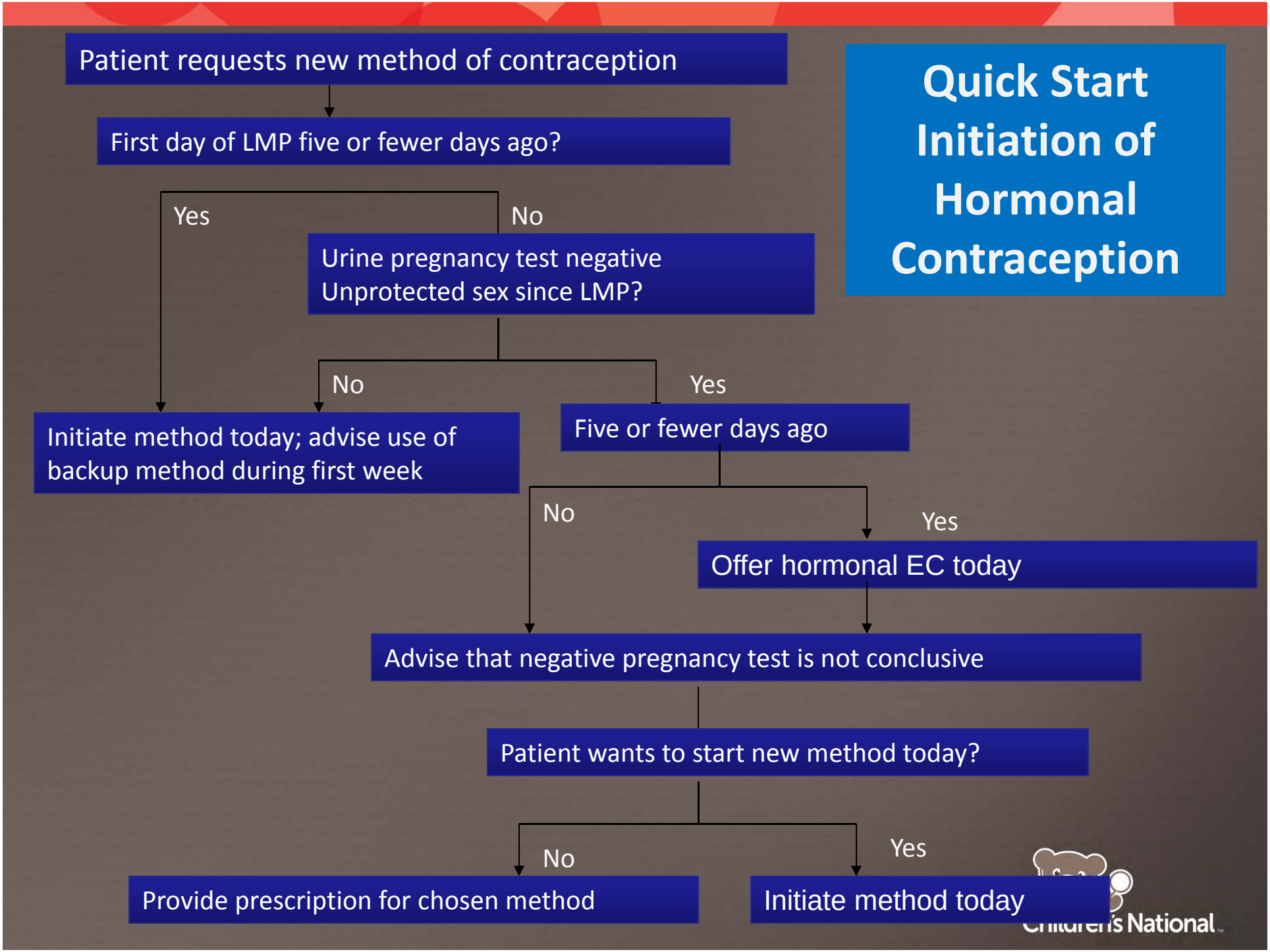
ACOG, 2009

Children's National

Case: Angela

- Angela informs you that she last had unprotected sex two weeks ago.
- Her urine pregnancy test is negative.
- Her LMP was 3 weeks ago.
- When can you give her the first injection?

Quick Start Initiation of Hormonal Contraception



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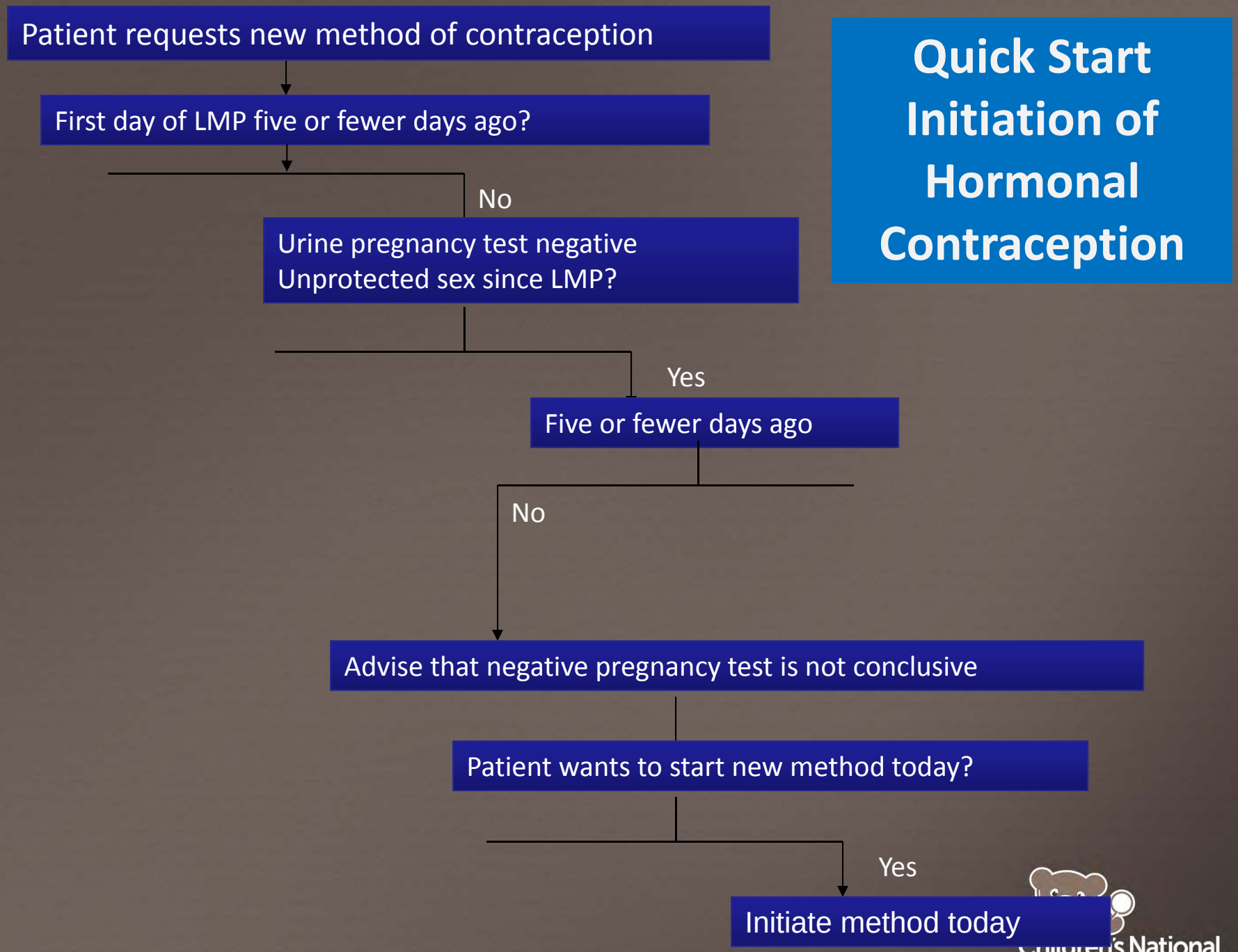
Quick Start Initiation of Hormonal Contraception



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The Pregnant Teenager

- Counseling:
  - Determine teen's intentions and thoughts
  - Provide education regarding all options
  - Provide referrals for prenatal care, adoption information, and/or termination services
  - Ensure you have a way to reach the teen confidentially
  - Discuss to whom she can disclose this (parent, partner, etc)
  - Schedule follow up

- Medical:
  - Determine last menstrual period
  - Do complete STI testing
  - Start Prenatal vitamins
  - Review medication list, make changes as appropriate
  - Counsel against alcohol/drugs/smoking

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Benefits Beyond Contraception-
Consider co-management with a specialist

- Menstrual regulation for hygienic assistance
- Dysmenorrhea and menorrhagia control
- Functional ovarian cyst prevention
- Cancer risk (neutral to favorable)
- PCOS treatment
- Acne and Hirsutism improvement
- Endometriosis treatment

…and other benefits with extended cycling

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Appropriate patients for co-management with a contraception specialist

- Implant placement
- IUD placement
- Patients with complex medication regimens or medical problems:
  - Seizure disorder
  - Uncontrolled hypertension
  - HIV
  - Lupus
  - DVT history

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Referrals

- Implant Placement, Contraception and Menstrual Co-Management

  Adolescent Health Center, 202-476-5464, ages 12-21 years
  - Nexplanon placement: same day placement possible; ideal for patient to be informed about method in advance
  - Have patient specify "nexplanon" or "implant placement" to ensure they are scheduled with the correct providers
  - Drs. Bokor, Malcolm, Woodward, Someshwar, & Addison (all ♀)
  - No IUD placements at this time

- IUD Placements
  - Under anesthesia (implants, too), Children's National Gynecologic Surgery Division, Dr. Gomez-Lobo, 202-877-4099
  - Not under anesthesia, Washington Hospital Center GYN, Dr. Gomez-Lobo, 202-877-4099

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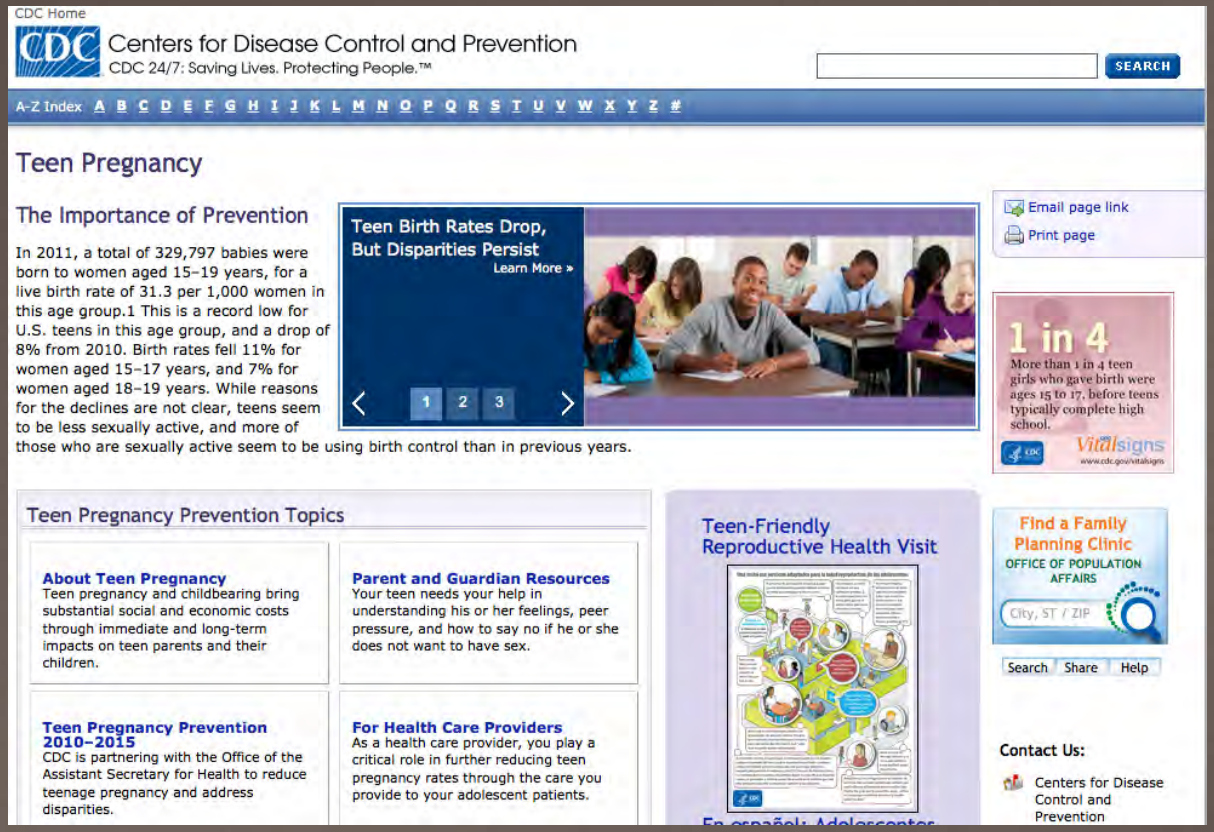
Resources

LARC Webinars

The LARC Program offers *free* accredited live monthly webinars addressing a wide range of topics related to the provision of Long-Acting Reversible Contraception (LARC). Please visit the ACOG Webinar Registration Site to register for our upcoming webinars.

www.ACOG.org



www.CDC.gov/teenpregnancy

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Resources

- AAP Policy Statement Contraception for Adolescents. Sept 2014 http://pediatrics.aappublications.org/content/134/4/e1244.full
- Guttmacher Institute http://www.guttmacher.org/statecenter/
- ACOG.org
- Bedsider.org
- YoungWomensHealth.org
- National Compaign to Prevent Teen and Unintended Pregnancy http://thenationalcampaign.org/
- Bixby Center for Global Reproductive Health http://bixbycenter.ucsf.edu

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