CONTRACEPTION: 2017 UPDATE

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OBJECTIVES

- Understand epidemiology of contraceptive use and unintended pregnancy
- Discuss the role of LARCs including immediate postpartum prior to discharge from hospital
- Understand issues of reproductive justice and coercion with regard to contraceptive choice
- Use US Medical Eligibility (US MEC) and Selected Practice Recommendations (US SPR) to identify candidates for contraceptive methods and best practices for contraceptive use

NO FINANCIAL DISCLOSURES

"I have five dollars that says you won't give me a shot and we'll sweep this little matter under the rug."

ACKNOWLEDGEMENTS

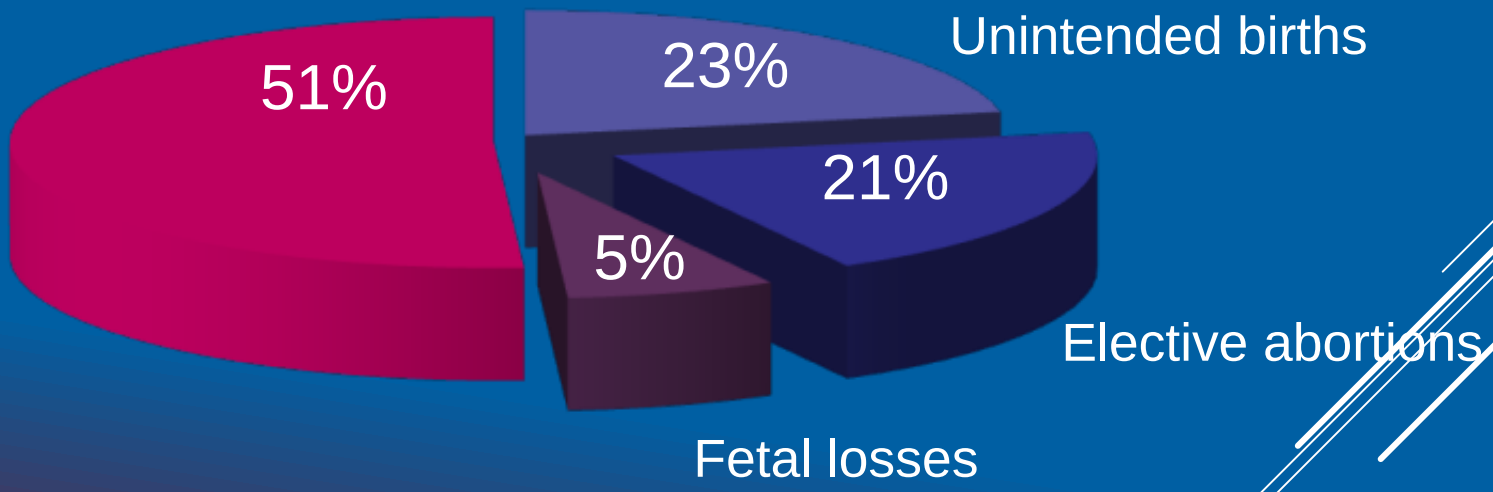
- There are slides from CDC and Association of Reproductive Health Professionals (ARHP) and Eve Espey MD

6.7 MILLION PREGNANCIES PER YEAR

UNINTENDED PREGNANCY IN THE US

Intended: 51%

Unintended 49%



Finer, Zolna. *Contraception.* 2011.

The NEW ENGLAND JOURNAL of MEDICINE

SPECIAL ARTICLE

Declines in Unintended Pregnancy in the United States, 2008–2011

Lawrence B. Finer, Ph.D., and Mia R. Zolna, M.P.H.

ABSTRACT

BACKGROUND

The rate of unintended pregnancy in the United States increased slightly between 2001 and 2008 and is higher than that in many other industrialized countries. National trends have not been reported since 2008.

METHODS

We calculated rates of pregnancy for the years 2008 and 2011 according to women's and girls' pregnancy intentions and the outcomes of those pregnancies. We obtained data on pregnancy intentions from the National Survey of Family Growth and a national survey of patients who had abortions, data on births from the National Center for Health Statistics, and data on induced abortions from a national census of abortion providers; the number of miscarriages was estimated using data from the National Survey of Family Growth.

RESULTS

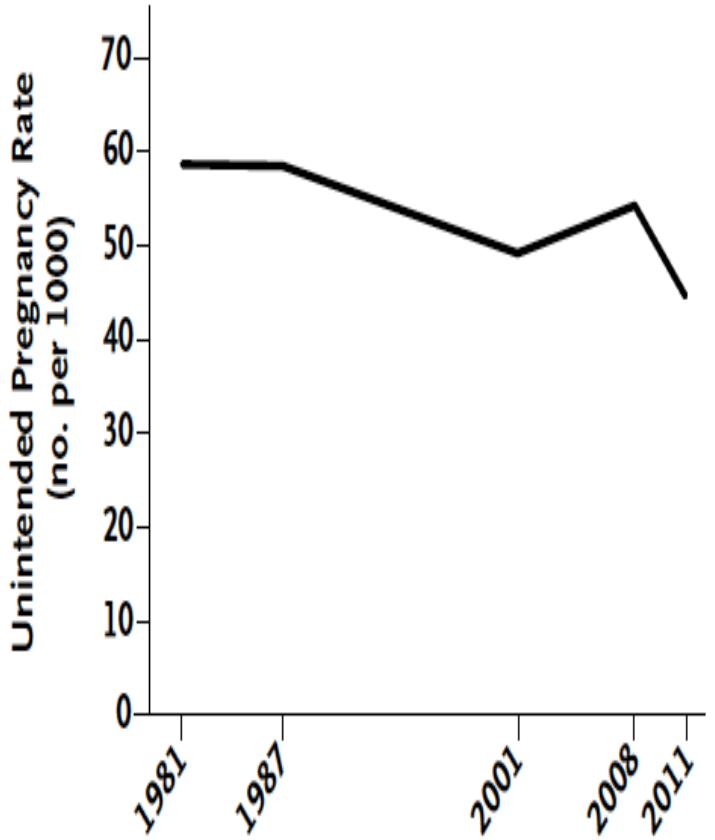
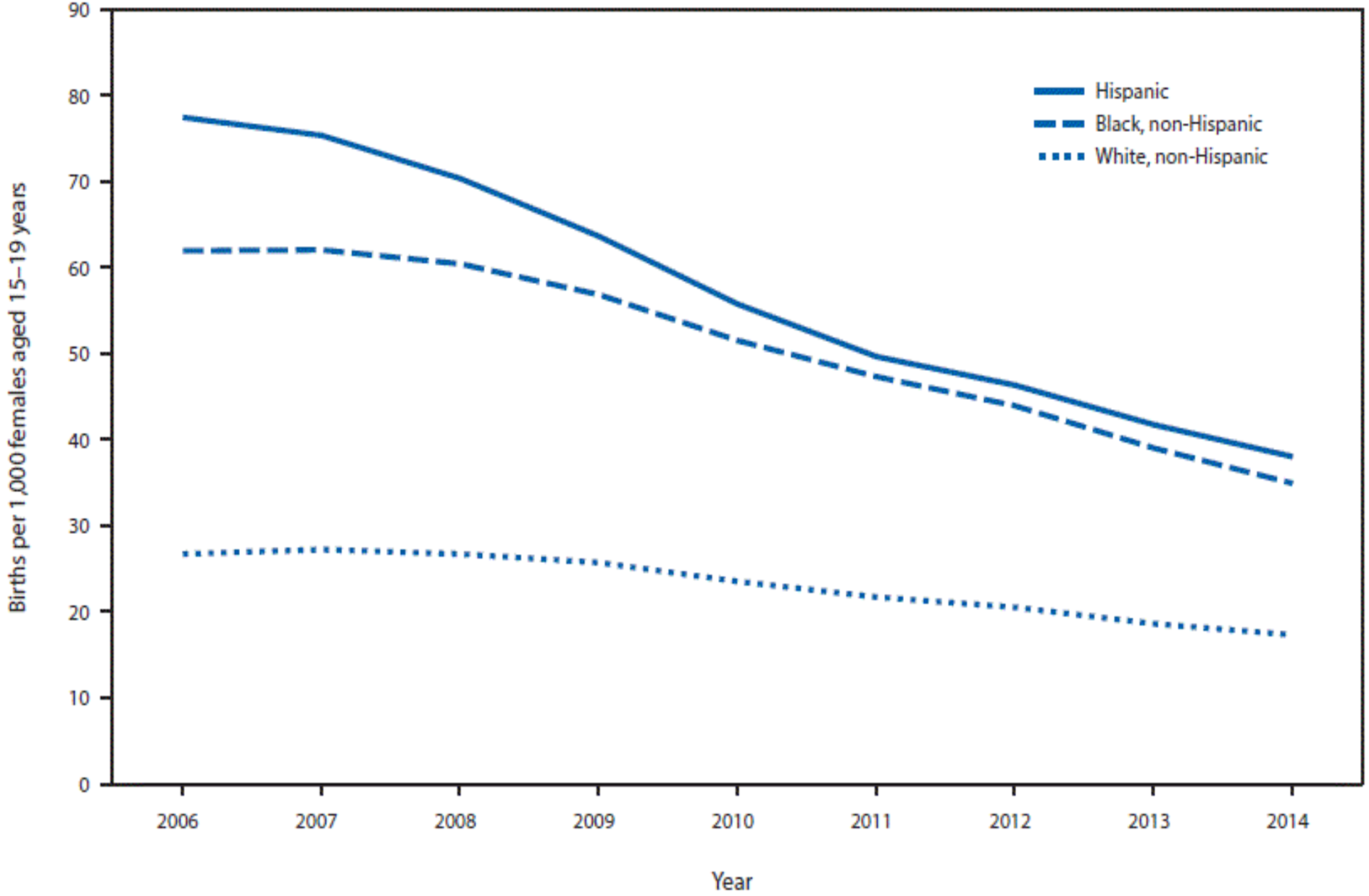


Figure 1. Rates of Unintended Pregnancy, 1981–2011.

Rates are reported as the number of unintended pregnancies per 1000 women and girls 15 to 44 years of age.

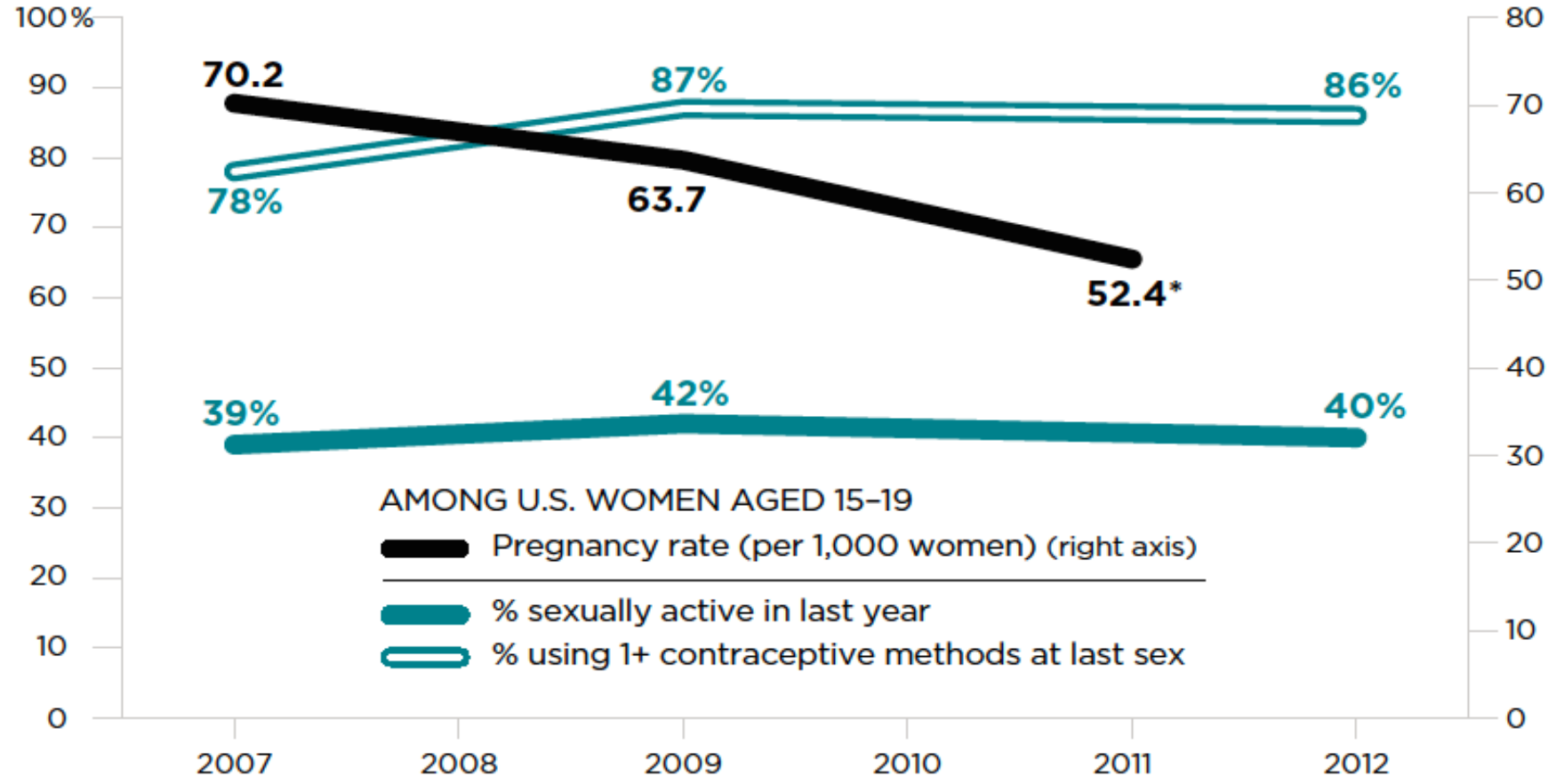
Finer NEJM, 2016

Birth rates for females aged 15–19 years — National Vital Statistics System, United States, 2006–2014



Contraception is Key

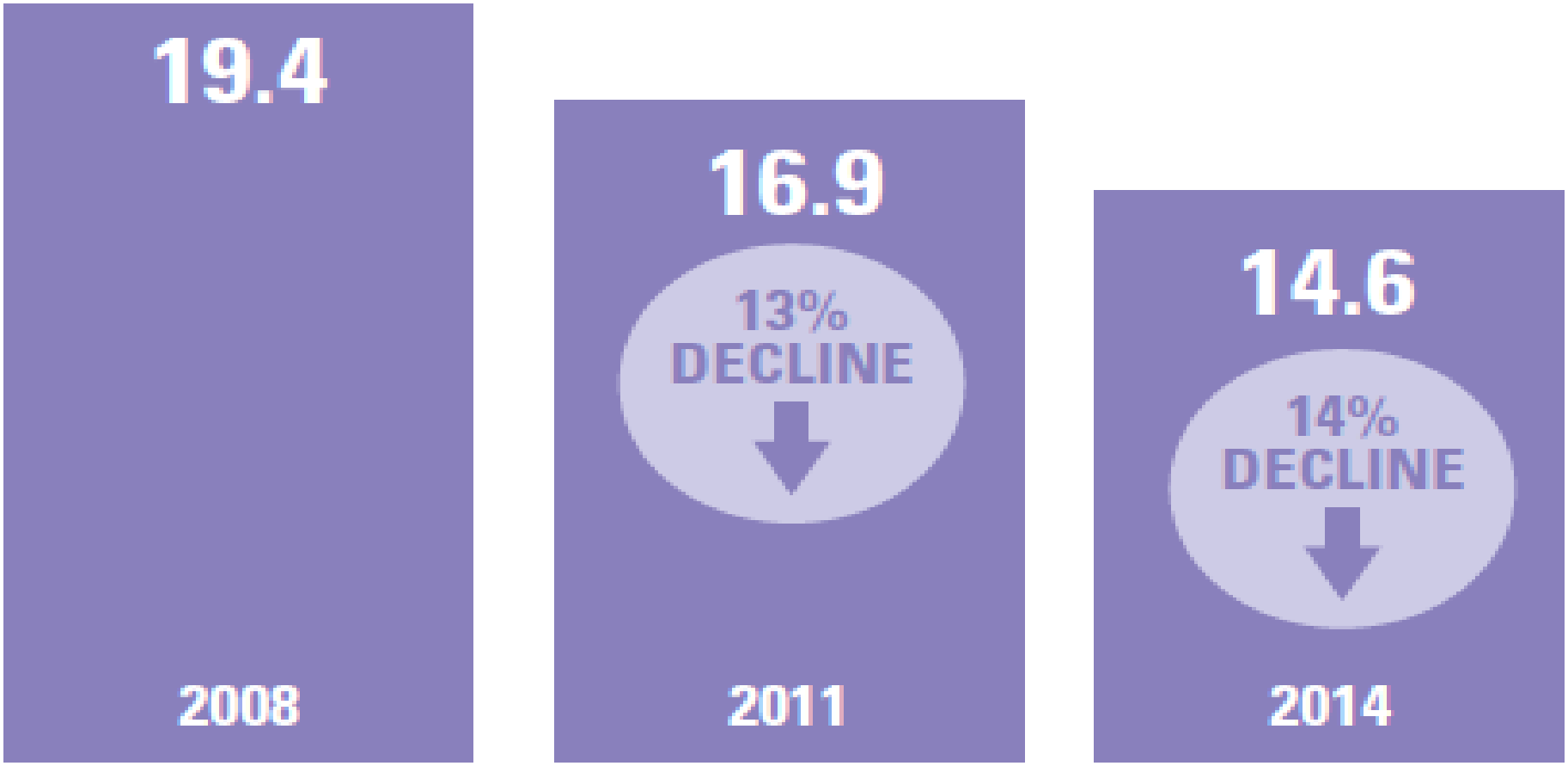
Teen sexual activity remains steady, while improved contraceptive use is likely driving declines in teen pregnancy



*2011 is the most recent year available for teen pregnancy rate

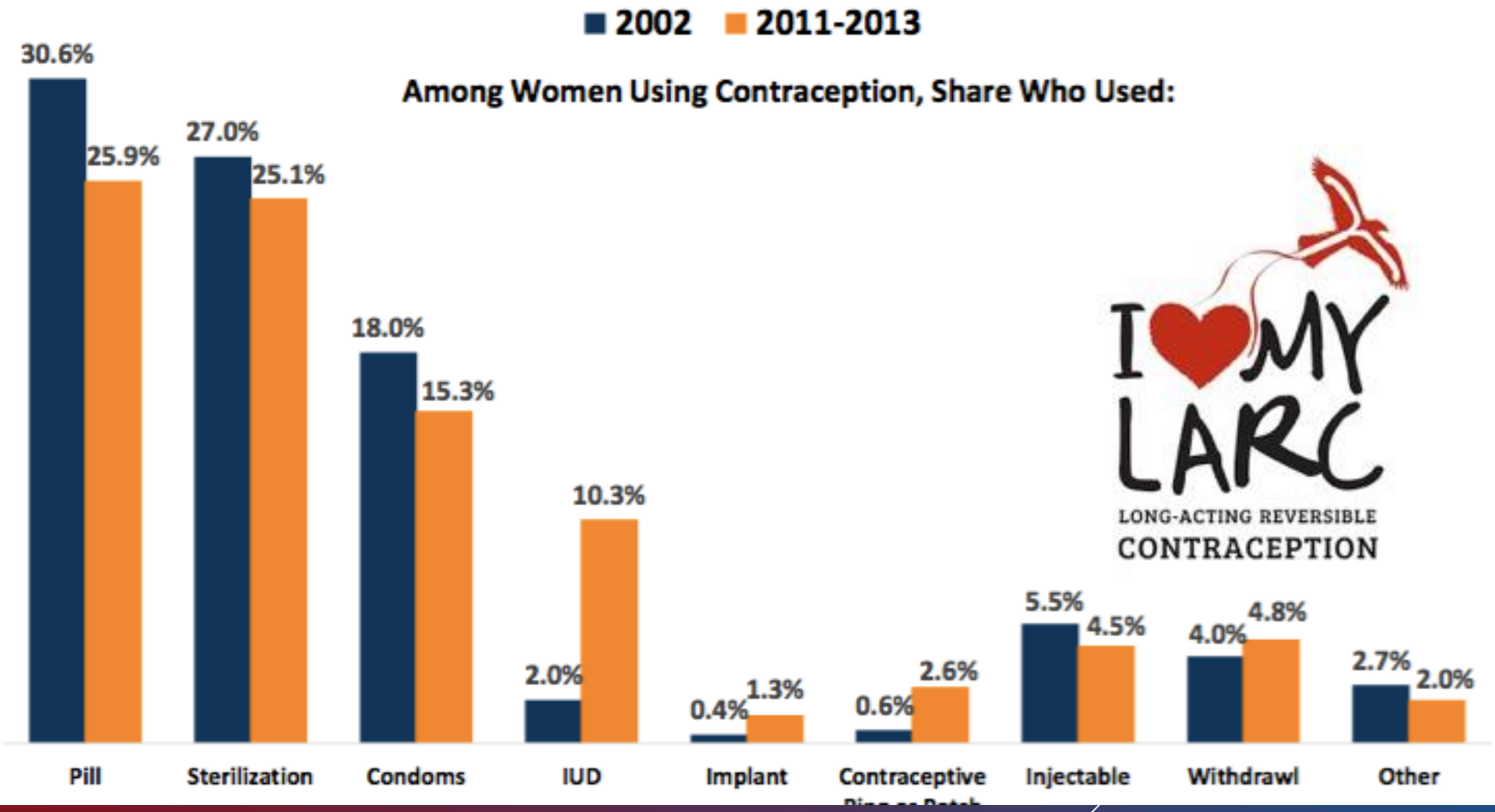
The U.S. abortion rate has declined significantly in recent years.

Abortions per 1,000 women aged 15–44



Source: Guttmacher Institute.

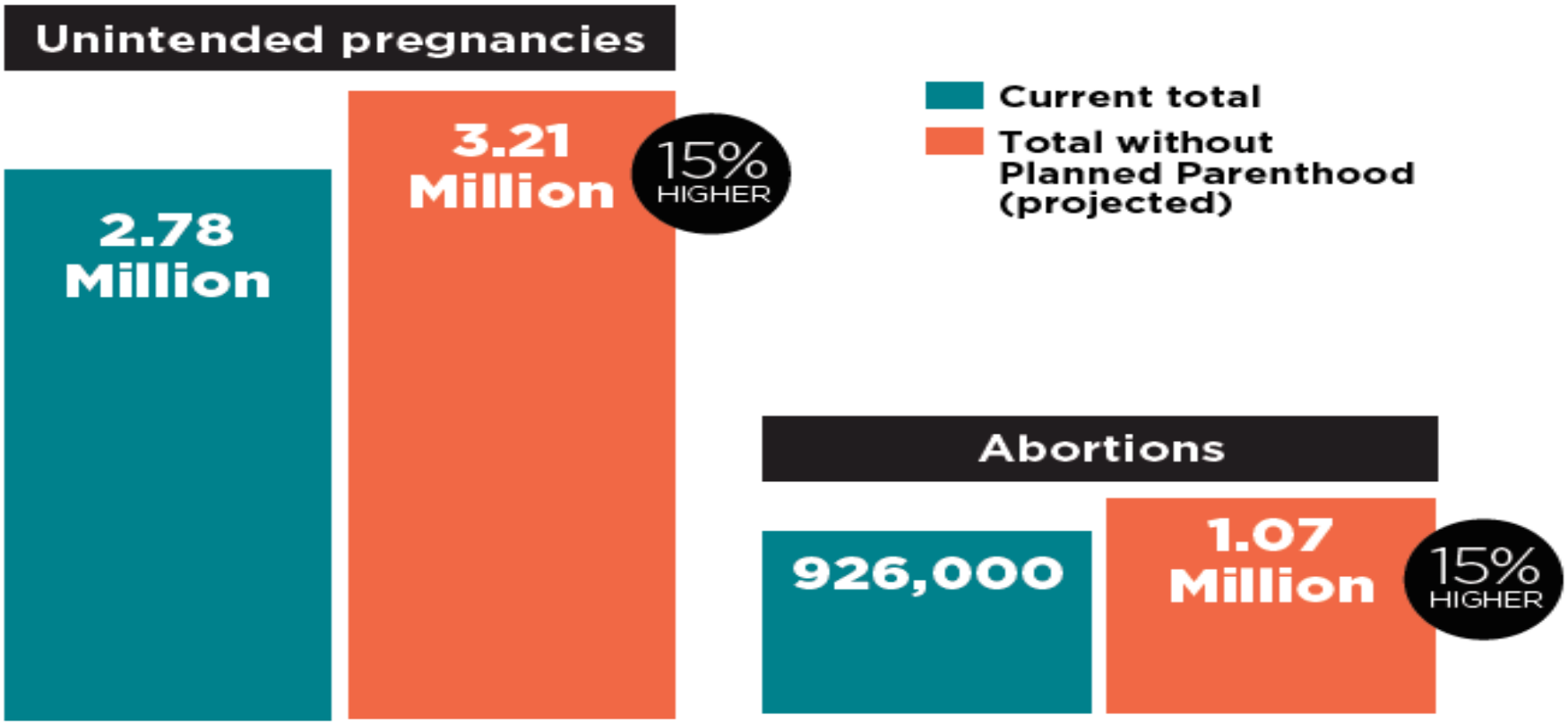
CHANGES IN METHOD USE OVER 10 YEARS



Kaiser Family Foundation 2016

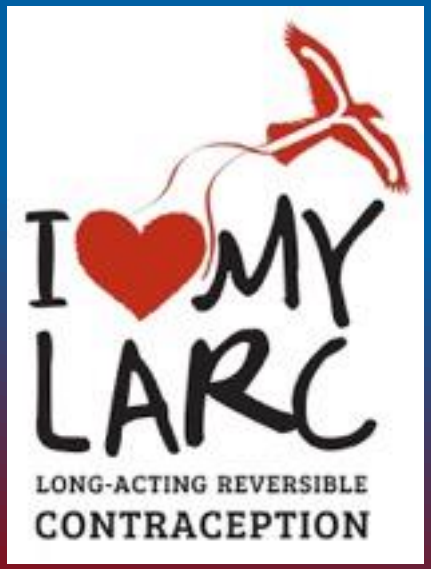
WITHOUT PLANNED PARENTHOOD

Without the contraceptive services provided by Planned Parenthood health centers in 2015, numbers of U.S. unintended pregnancies and abortions would have been 15% higher.



THE CHOICE PROJECT

Large 3 year prospective cohort study of over 9,000 women of reproductive age in the St. Louis area



STUDY INCLUSION CRITERIA

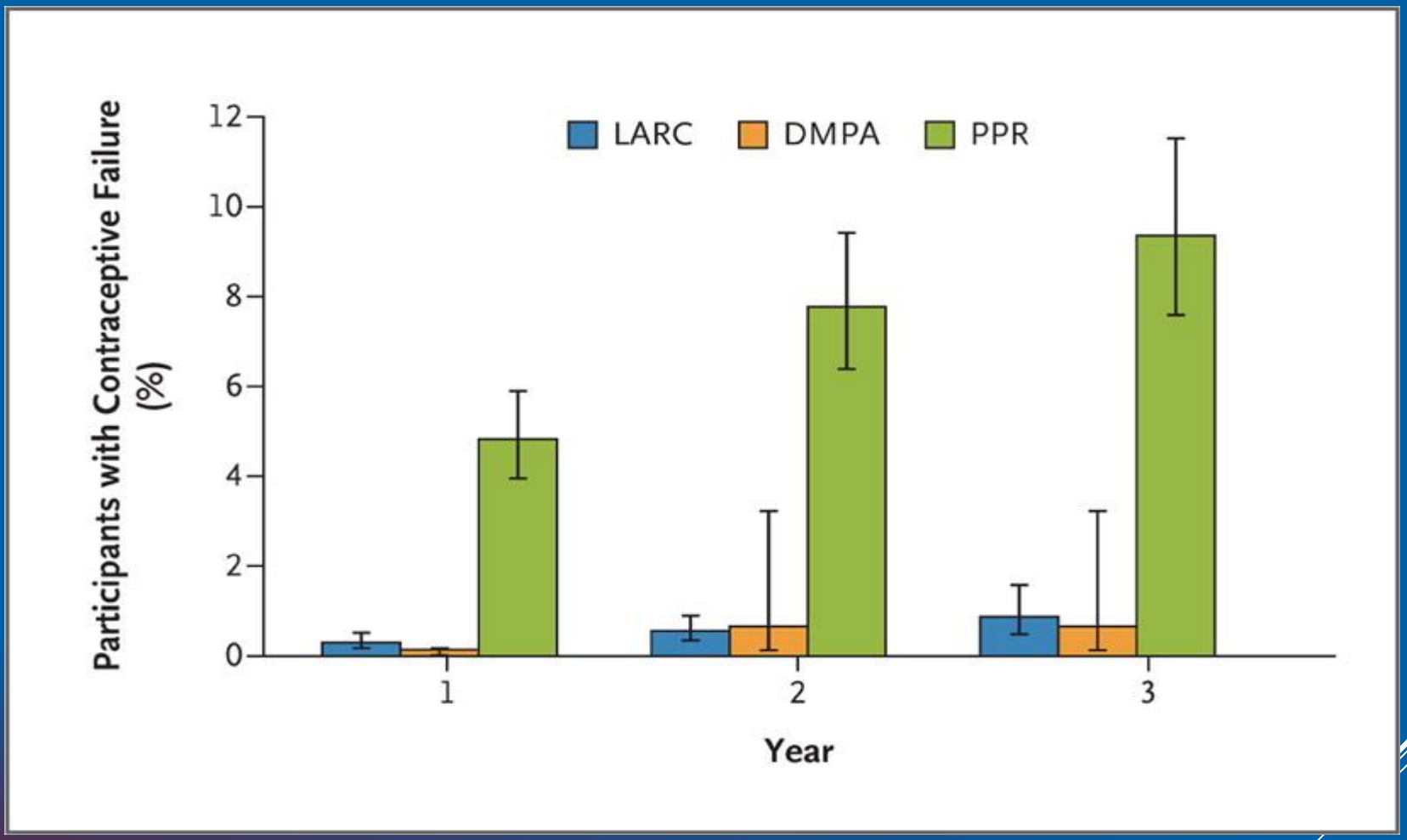
- Women 14-45 years
- Primary residency in STL City or County
- Sexually active with male partner (or soon to be)
- Does not desire pregnancy during next 12 months
- Desires reversible contraception
- Willing to try a new contraceptive method

STUDY DESIGN: PROSPECTIVE COHORT

ELIGIBLE

Exposure	→	Outcome
	2–3 y	
LNG-IUS Cu-IUD Implant DMPA Pills Patch Ring Other		Unintended pregnancy Teen pregnancy Repeat abortion Abortion Continuation Satisfaction STI

Rates of Contraceptive Failures (pregnancies) with LARC, Depo Provera, or Pills/Patch/Ring



Winner B et al. N Engl J Med 2012;366:1998-2007.

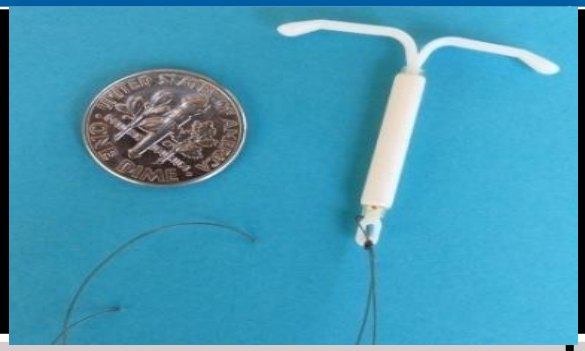
Cumulative Percentage of Participants Who Had a Contraceptive Failure at 1, 2, or 3 Years, According to Contraceptive Method.

BASELINE CHOSEN METHOD

	%
LNG-IUS	46.0
Copper IUD	11.9
Implant	16.9
DMPA	6.9
Pills	9.4
Ring	7.0
Patch	1.8
Other	<1.0

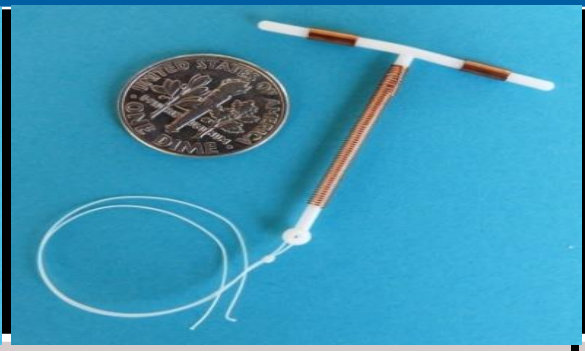
Peipert Obstet & Gynecol 2012

LONG-ACTING REVERSIBLE CONTRACEPTION (LARC)



LNG-IUS

- 99% effective
- 20 mcg levonorgestrel/day
- Up to 5 years



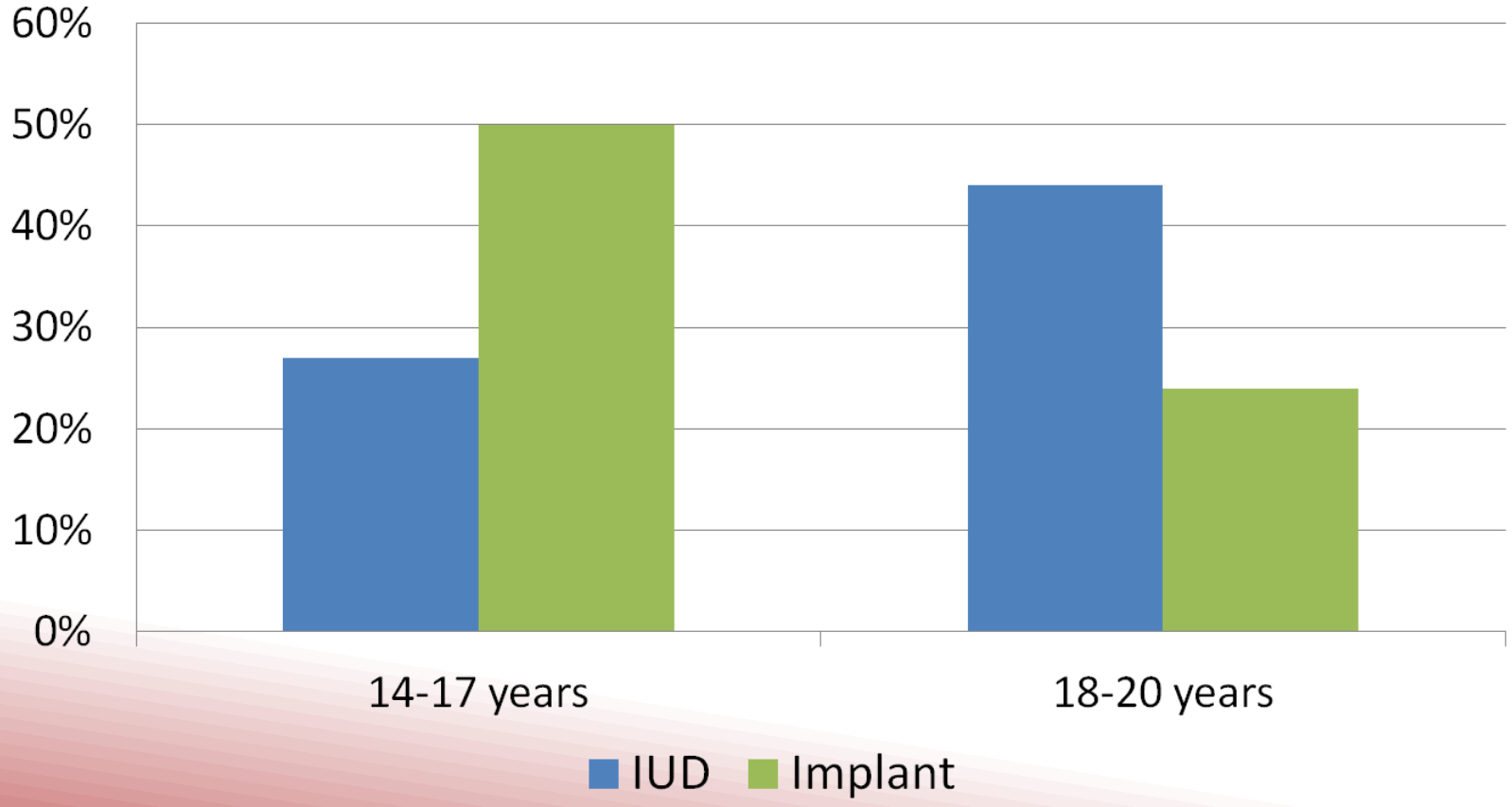
Copper T IUD

- 99% effective
- Copper ions
- Up to 10 years

Subdermal Implant

- 99% effective
- 60 mcg etonogestrel/day
- Up to 3 years

CHOICE OF LARC METHODS AMONG ADOLESCENTS



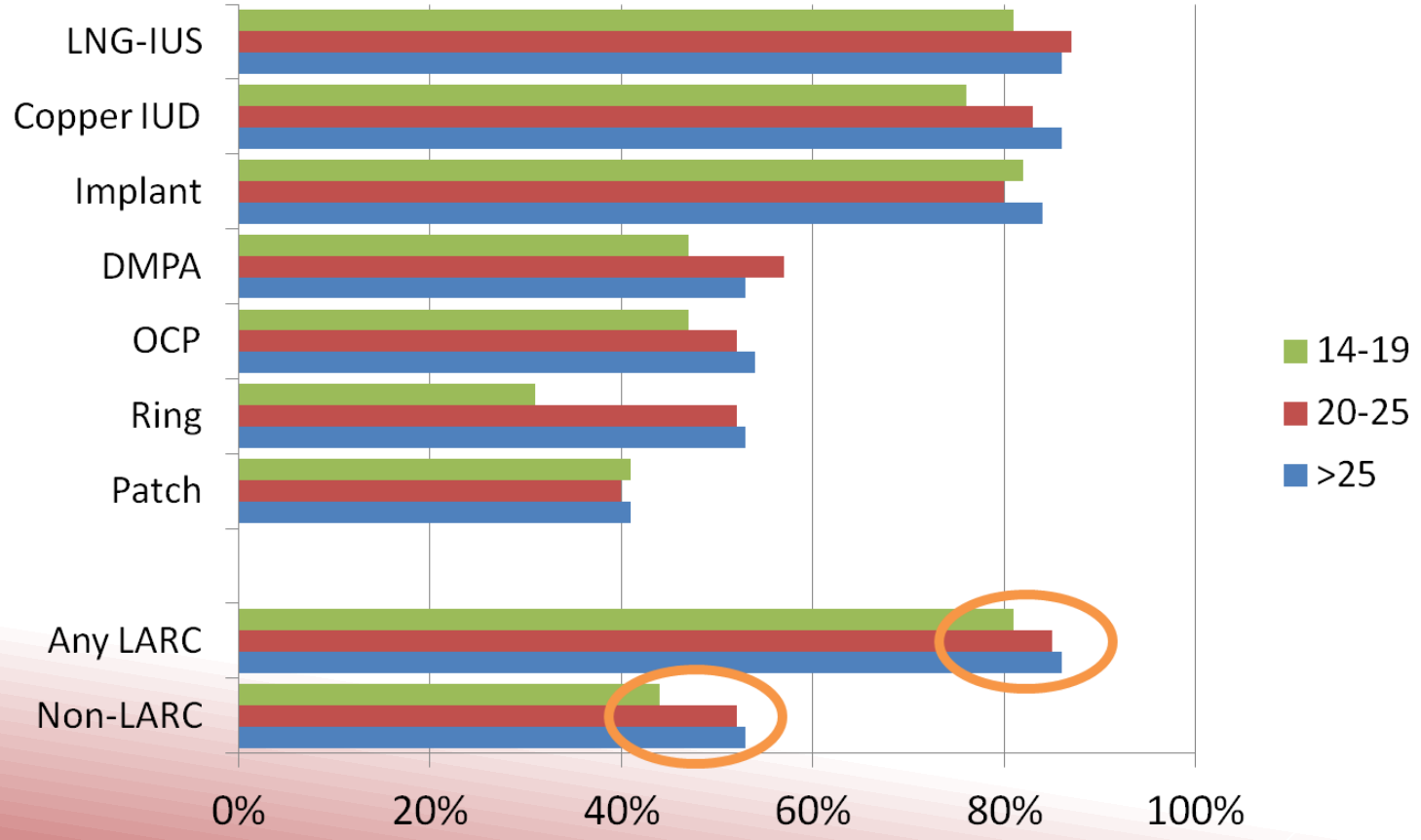
Mestad Contraception 2011

12-MONTH CONTINUATION RATES

EIPERT PEIPERT GYNECOL 2011

Method	Continuation Rate (%)
LNG-IUS	87.5
Copper IUD	84.1
Implant	83.3
Any LARC	86.2
DMPA	56.2
OCPs	55.0
Ring	54.2
Patch	49.5
Non-LARC	54.7

12-MONTH CONTINUATION: ADOLESCENTS COMPARED TO OLDER WOMEN



CHOICE COMPARED TO U.S.

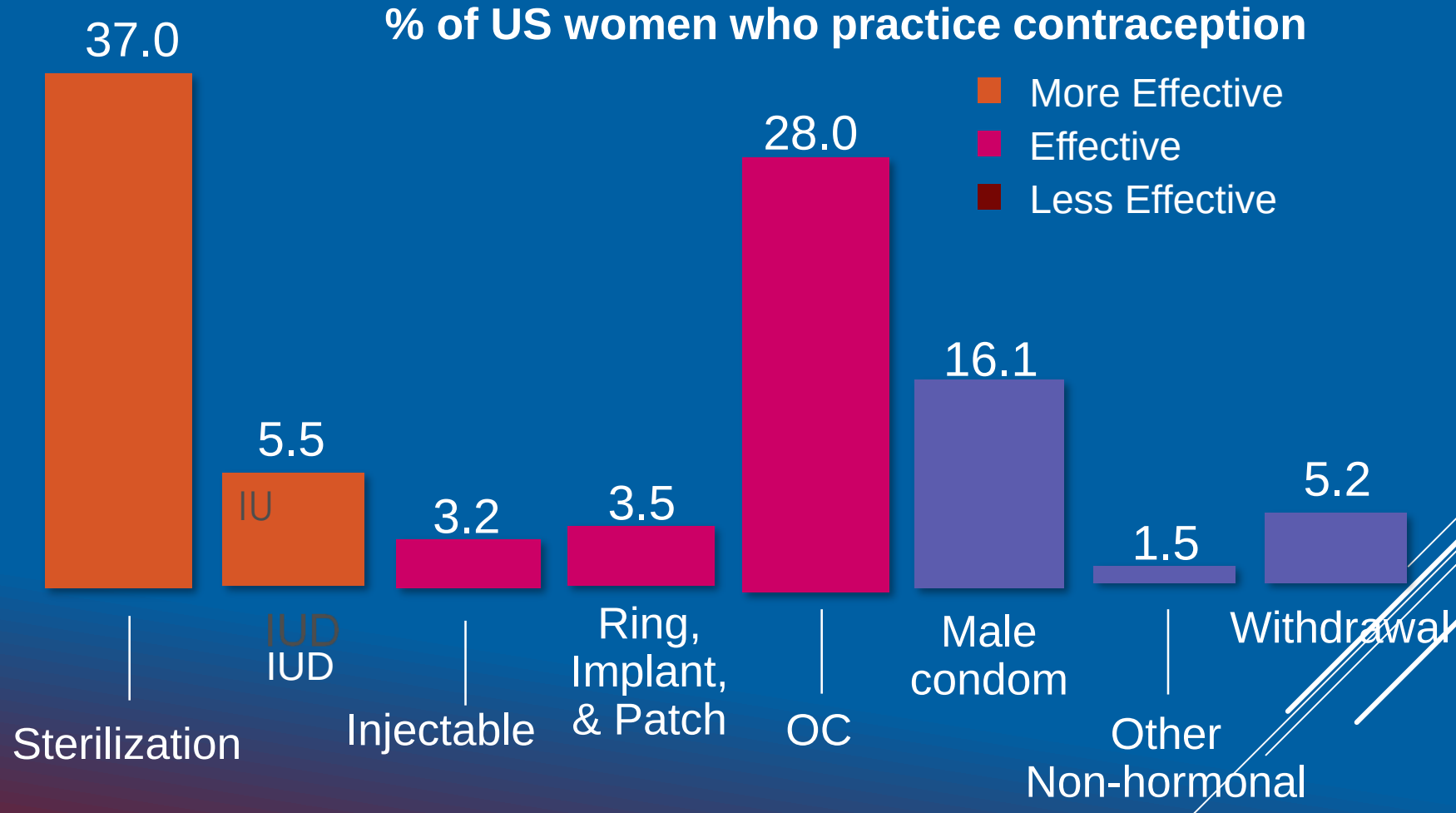
- Teen birth rate (age 15-19 years)
  - 6.3 per 1,000 teens
  - Compared to 34.3 per 1,000 nationally
- Abortion rate (women ages 15-44)
  - 6.0 per 1,000 women
  - Compared to 19.6 per 1,000 nationally
- Unintended pregnancy rate
  - 15.0 per 1,000 women
  - Cumulative: 35.0 per 1,000 women
  - Compared to 52.0 per 1,000 nationally

Peipert Obstet Gynecol 2012

MAIN FINDINGS FROM CHOICE

- LARC methods associated with higher continuation & satisfaction than shorter-acting methods
  - Regardless of age
- LARC methods associated with lower rates of unintended pregnancy
- Increasing LARC use can decrease unintended pregnancy in the population

CONTRACEPTIVE USE IN THE UNITED STATES, 2006–2008



Mosher WD, et al. *Vital Health Stat*. 2010.; Guttmacher 2012.

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

Less than 1 pregnancy per 100 women in a year

6-12 pregnancies per 100 women in a year

18 or more pregnancies per 100 women in a year

LEAST EFFECTIVE

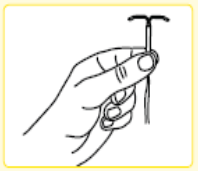
REVERSIBLE

Once in place, little or nothing to do or remember.

Implant

0.05%

Intrauterine Device (IUD)



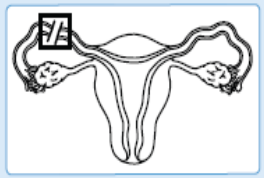
0.2% LNG

0.8% Copper T

PERMANENT STERILIZATION

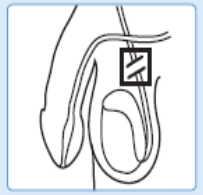
After procedure, little or nothing to do or remember.
Use another method for first 3 months (Hysteroscopic, Vasectomy).

Female (Abdominal, Laparoscopic, and Hysteroscopic)



0.5%

Male (Vasectomy)

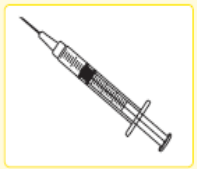


0.15%

REVERSIBLE

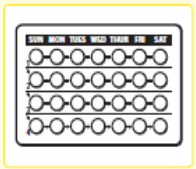
Get repeat injections on time. *Take a pill each day.* *Keep in place, change on time.* *Use correctly every time you have sex.*

Injectable



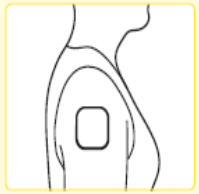
6%

Pill



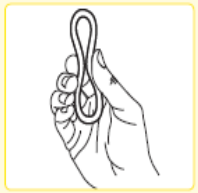
9%

Patch



9%

Ring



9%

Diaphragm

12%

REVERSIBLE

Use correctly every time you have sex.

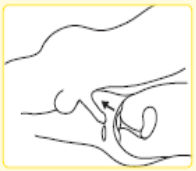
Male Condom

18%

Female Condom

21%

Withdrawal



22%

Sponge

12% Nulliparous Women

24% Parous Women

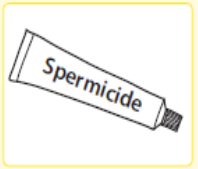
Condoms should always be used to reduce the risk of sexually transmitted infections.

Fertility Awareness-Based Methods

Abstain or use condoms on fertile days.

24%

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 Trussell J. Contraceptive failure in the United States. *Contraception* 2011;83:397–404.

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

LARCS OPTIMAL CONTRACEPTION FOR ALL?

- Would we recommend a hypertensive pill or asthma inhaler that had less than half the efficacy of other medications?
- Should we try and convince all women that a LARC is preferred contraception?
- No! Fertility is not a “disease” and after contraceptive counseling a woman’s preference should be accepted if no contraindications

GOAL OF CONTRACEPTION

- Reduce unintended pregnancy
- Empower women to make the decision that is best for them

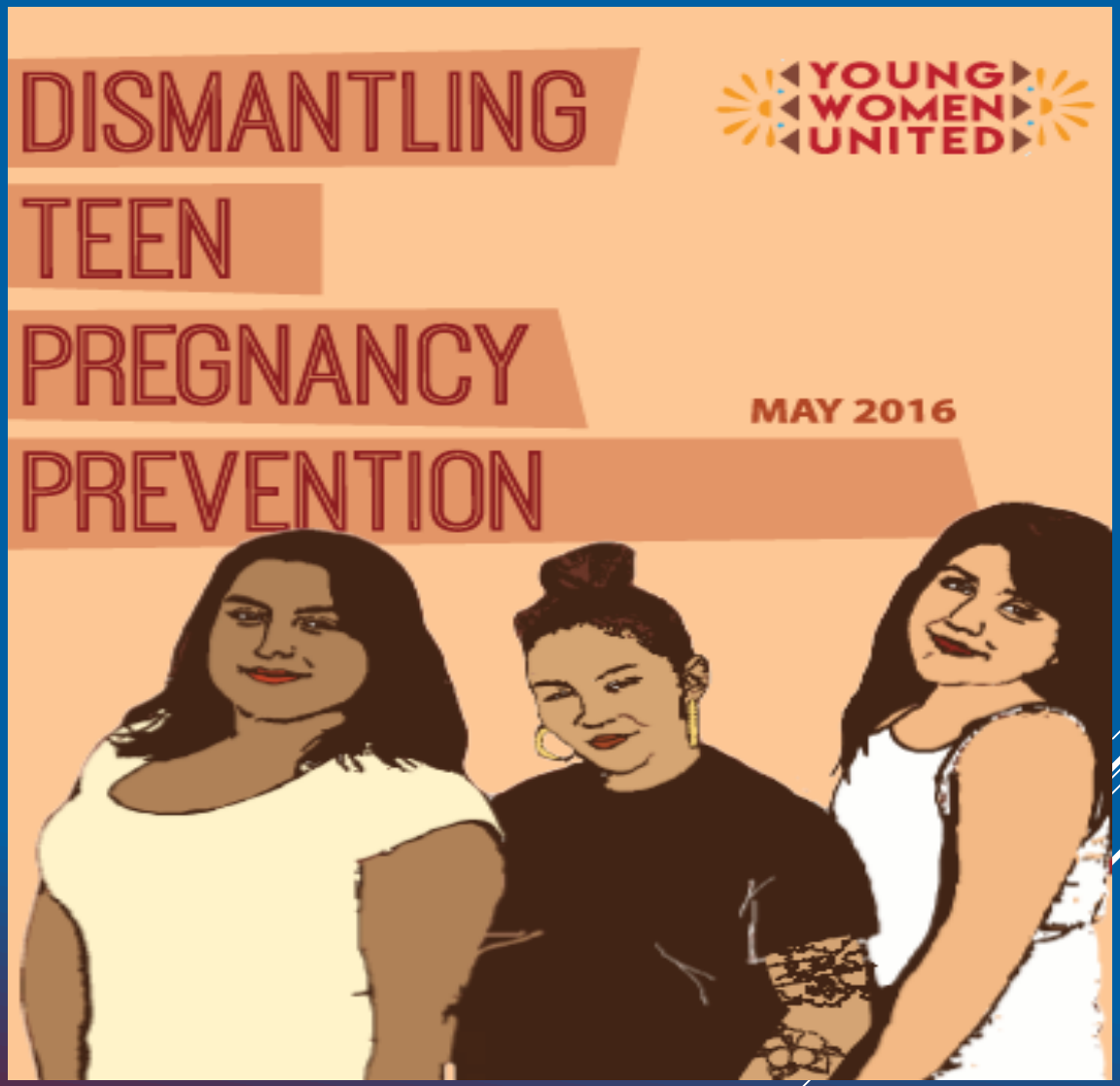
Support reproductive autonomy!

REPRODUCTIVE HEALTHCARE DISPARITIES

They wanted to go with the IUD.. . they kept bringing up over and over again. I was like, it's definitely a no-no. I don't even want to think about it…they said 'It's good, and you know like 90% of the women they love it,' and you know…I was like '100% of me says NO.'"

Yee 2011

HOW ABOUT CAMPAIGN AGAINST TEEN PREGNANCY?



LARC COUNSELING TOPICS

- Effectiveness
- Mechanism of action
- Upfront counseling on changes in menstrual flow
- Return to fertility
- Individual preferences of patient
- Side effects and possible complications
- Insertion and removal procedures
- Instructions on follow-up
- Use of condoms with new partners

Trussell J. *Contraceptive Technology.* 2011. Whitehouse, NJ: N.V. Organon, Oss; 2012

SHARED DECISION MAKING MODEL

- Develop rapport/trust
- Query to identify preferences
- Ask open-ended questions
- Provide information about side effects, effectiveness, and use of method (Upfront)
- Give context about options
- Free of provider bias, non-coercive
- Ensure access to method placement and removal
- Allow time for questions
- "Teach back"

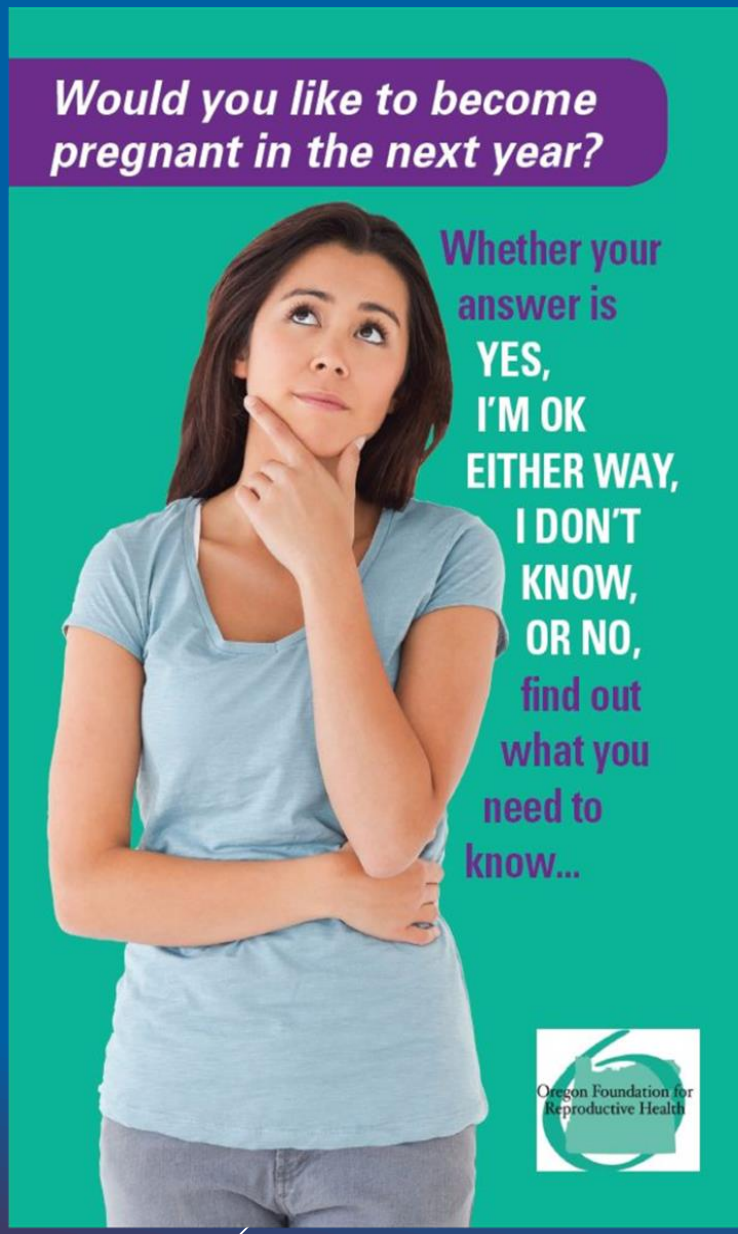
ONE KEY QUESTION

- Well suited for Family Medicine where reproductive

age women may present with unrelated issues

- May prescribe contraception during unrelated visit or schedule back…..or refer to colleagues

- If she desires pregnancy recommend prenatal vitamins with folic acid and offer a preconception visit



Reproductive ambivalence common

Yes

No

All of the above

No Maybe? Yes

*DID **YOU** WANT TO GET PREGNANT?*

NATIONAL SURVEY OF FAMILY GROWTH

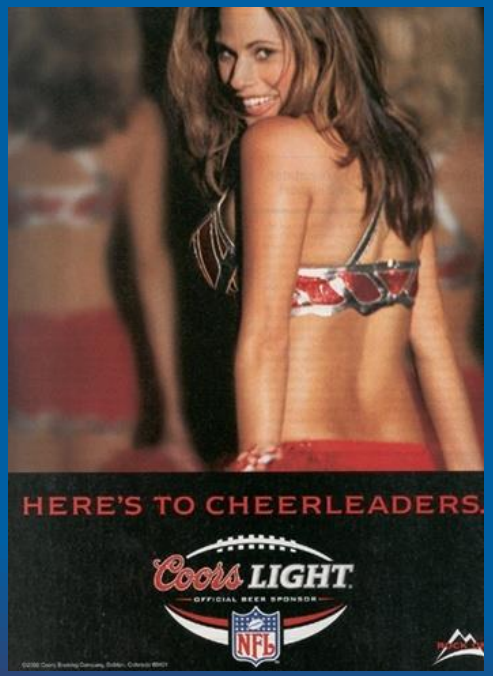
- Women who reported a contraceptive failure:
  - 68% defined pregnancy as unintended
  - 25% of these women felt happy or very happy when they discovered they were pregnant

All of the above

Trussell 1999
Santelli 2003

MISMATCH IN CULTURAL VALUES

OUR MEDIA



OUR MORALS

U.S. MEC: 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

EXAMPLE: SMOKING AND CONTRACEPTIVE USE

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

Cu IUD: Copper IUD;
LNG-IUD: Levonorgestrel IUD;
DMPA: Depo-Medroxyprogesterone Acetate;
POPs: Progestin-only pills;
CHCs: Combined hormonal contraceptives including pills, patch, and ring

Conditions Associated with Increased Risk for Adverse Heath Events as a Result of Pregnancy	
Breast cancer	Hepatocellular adenoma and malignant liver tumors (hepatoma)
Co	
Cys	
Dia reti dis	
Enc	
Epi	2
Hyp > 1	
His	
HIV: not clinically well or not receiving anti-retroviral therapy	Thrombogenic mutations
Ischemic heart disease	Tuberculosis
Gestational trophoblastic disease	

Consider long-acting, highly-effective contraception for these patients

2016 UPDATES TO U.S. MEC 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)

2016 UPDATES TO U.S. MEC: CHANGES TO EXISTING RECOMMENDATIONS

- **Hormonal methods (Implants, DMPA, POP, CHCs)**
  - Migraine headaches
  - Superficial venous disease
  - Women using antiretroviral therapy
  - Women with known dyslipidemia

- **Intrauterine devices (Cu-IUD, LNG-IUD)**
  - Gestational trophoblastic disease
  - Postpartum and breastfeeding women
  - Human immunodeficiency virus
  - Factors related to sexually transmitted diseases

WHY THE MEC??

Can a teen use an IUD?

Can a woman on seizure meds use the patch?

Can a breastfeeding woman use the shot?

Can a diabetic use the pill?

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

Condition	Sub-Condition	CHC		POP		Injection		Implant		LNG-IUD		Cu-IUD	
		I	C	I	C	I	C	I	C	I	C	I	C
Age		Menarche to <40=1		Menarche to <18=1		Menarche to <18=2		Menarche to <18=1		Menarche to <20=2		Menarche to <20=2	
		≥40=2		18-45=1		18-45=1		18-45=1		≥20=1		≥20=1	
				>45=1		>45=2		>45=1					
Anatomic abnormalities	a) Distorted uterine cavity									4		4	
	b) Other abnormalities									2		2	
Anemias	a) Thalassemia	1		1		1		1		1		2	
	b) Sickle cell disease[1]	2		1		1		1		1		2	
	c) Iron-deficiency anemia	1		1		1		1		1		2	
Benign ovarian tumors	(including cysts)	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	
	c) Family history of cancer	1		1		1		1		1		1	
	d) Breast cancer[2]												
	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[3] (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												
	i) non-insulin dependent	2		2		2		2		2		1	
	ii) insulin dependent[4]	2		2		2		2		2		1	
	c) Nephropathy/retinopathy/neuropathy[4]	3/4*		2		3		2		2		1	
	d) Other vascular disease or diabetes of >20 years' duration[4]	3/4*		2		3		2		2		1	

Condition	Sub-Condition	CHC		POP		Injection		Implant		LNG-IUD		Cu-IUD	
		I	C	I	C	I	C	I	C	I	C	I	C
Endometrial cancer[2]		1		1		1		1		4	2	4	2
Endometrial hyperplasia		1		1		1		1		1		1	
Endometriosis		1		1		1		1		1		2	
Epilepsy[4]	(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 ß-hCG levels	1		1		1		1		3		3	
	b) Persistently elevated ß-hCG levels or malignant disease[4]	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*	2*	3*	2*	3*	2*	3*	2*	3*	1*	
History of bariatric surgery[4]	a) Restrictive procedures	1		1		1		1		1		1	
	b) Malabsorptive procedures	COC: 3 P/R: 1		3		1		1		1		1	
History of cholestasis	a) Pregnancy-related	2		1		1		1		1		1	
	b) Past COC-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	
Human immunodeficiency virus (HIV)	High risk	1		1		1*		1		2	2	2	2
	HIV infected (see also Drug Interactions)[4]	1*		1*		1*		1*		2	2	2	2
	AIDS (see also Drug Interactions)[4]	1*		1*		1*		1*		3	2*	3	2*
	Clinically well on therapy	If on treatment, see Drug Interactions								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[5]	4		2		3		2		2		1	
	c) Vascular disease	4		2		3		2		2		1	
Inflammatory bowel disease	(Ulcerative colitis, Crohn's disease)	2/3*		2		2		1		1		1	

Abbreviations: C=continuation of contraceptive method; CHC=combined hormonal contraceptive (pill, patch, and ring); COC=combined oral contraceptive; Cu-IUD=copper-containing intrauterine device; I=initiation of contraceptive method; LNG-IUD=levonorgestrel-releasing intrauterine device; NA=not applicable; POP=progestin-only pill; P/R=patch/ring.

Legend:

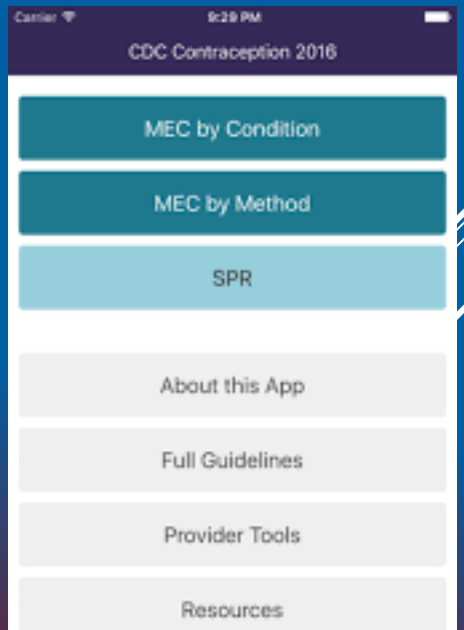
1	No restriction (method can be used)	3	Theoretical or proven risks usually outweigh the advantages
2	Advantages generally outweigh theoretical or proven risks	4	Unacceptable health risk (method not to be used)

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

- CDC coordinated, evidence based contraceptive
  - Characteristics
    - Age
    - Parity
    - Postpartum
  - Diseases
    - Diabetes
    - Migraines

US MEC
US SPR
CDC

US MEC APP—IT'S FREE!



SYLVIA

- 34 year old G3P3 with a history of hypertension and migraines without aura who presents for annual exam and wants birth control pills
- BP 130/78 BMI 29
- PMH:
  - Smokes 12 cigarettes a day
  - HTN on HCTZ 25 mg
  - Regular menstrual cycles
  - Moderate - heavy bleeding, mild dysmenorrhea

HYPERTENSION AND CONTRACEPTION

CONDITION	COC/P/R	POP	DMPA	IMPLANON	IUDS	
					LNG-IUD	Cu-IUD
Adequately Controlled BP	**3**	1	2	1	1	1
Elevated BP 1. Systolic 140–159 mm Hg **or** diastolic 90–99 mm Hg	**3**	1	2	1	1	1
2. Systolic ≥160 mm Hg **or** diastolic ≥100 mm Hg	**4**	2	**3**	2	2	1
3. History of high blood pressure during pregnancy (current BP is normal)	2	1	1	1	1	1

EXAMPLE: SMOKING AND CONTRACEPTIVE USE

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

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

US MEC 2016 RECOMMENDATIONS

Headaches*	CHC	POP	DMPA	Implants	LNG-IUD	Cu-IUD
A. Non-migrainous	1	1	1	1	1	1
B. Migraine						
i. Without aura	2	1	1	1	1	1
ii. With aura	4	1	1	1	1	1

* Clarification: Classification depends on accurate diagnosis of those severe headaches that are migrainous and those headaches that are not

SYSTEMATIC REVIEW: POSTPARTUM VTE

- 3 studies: risk of DVT in PP and non-pregnant women
  - 22 to 84 times higher in PP women
- 3 studies provided weekly data
  - Indicated that risk decreases markedly after first 3 to 4 weeks postpartum
  - Most studies convey no significant increase after 6 weeks

Jackson et al. *Obstetrics and Gynecology* 2011;117:691-703

Postpartum Contraception

- Opportunity to prevent recurrent unintended pregnancy
- Optimal time for 3rd party coverage
- No concern about luteal phase pregnancy

Postpartum contraception

- Postpartum tubal ligation
- Immediate postplacental IUDs
- Nexplanon or depo prior to discharge
- Initiate OCPs/Patch/Ring at 4 week
- Breastfeeding not concern with above
- Referral for vasectomy and Essure

Immediate postplacental IUD

- Disadvantage is higher expulsion rate than interval – about 10 % compared to 2%
- Copper or Levonorgesterol
- More women will wind up with IUD than if wait till 6 weeks postpartum for variety reasons
- New Mexico Medicaid now paying outside of Global

Physical Examination before IUD placement

- General well being and postpartum condition
- Normal temperature
- Assessment of involution of uterus and uterine contractions
- No abnormal bleeding/evidence of infection
- Consider cleaning perineal area, particularly if stool present
- Put on a new pair of sterile gloves

Postplacental manual insertion

- Within TEN minutes of placental delivery
- The cervix is open and limp
- Allows for the passage of a hand
- Placement of the IUD high in the fundus
- Chorioamnionitis and ongoing PPH are contraindications

Immediate Postpartum Instrument Insertion

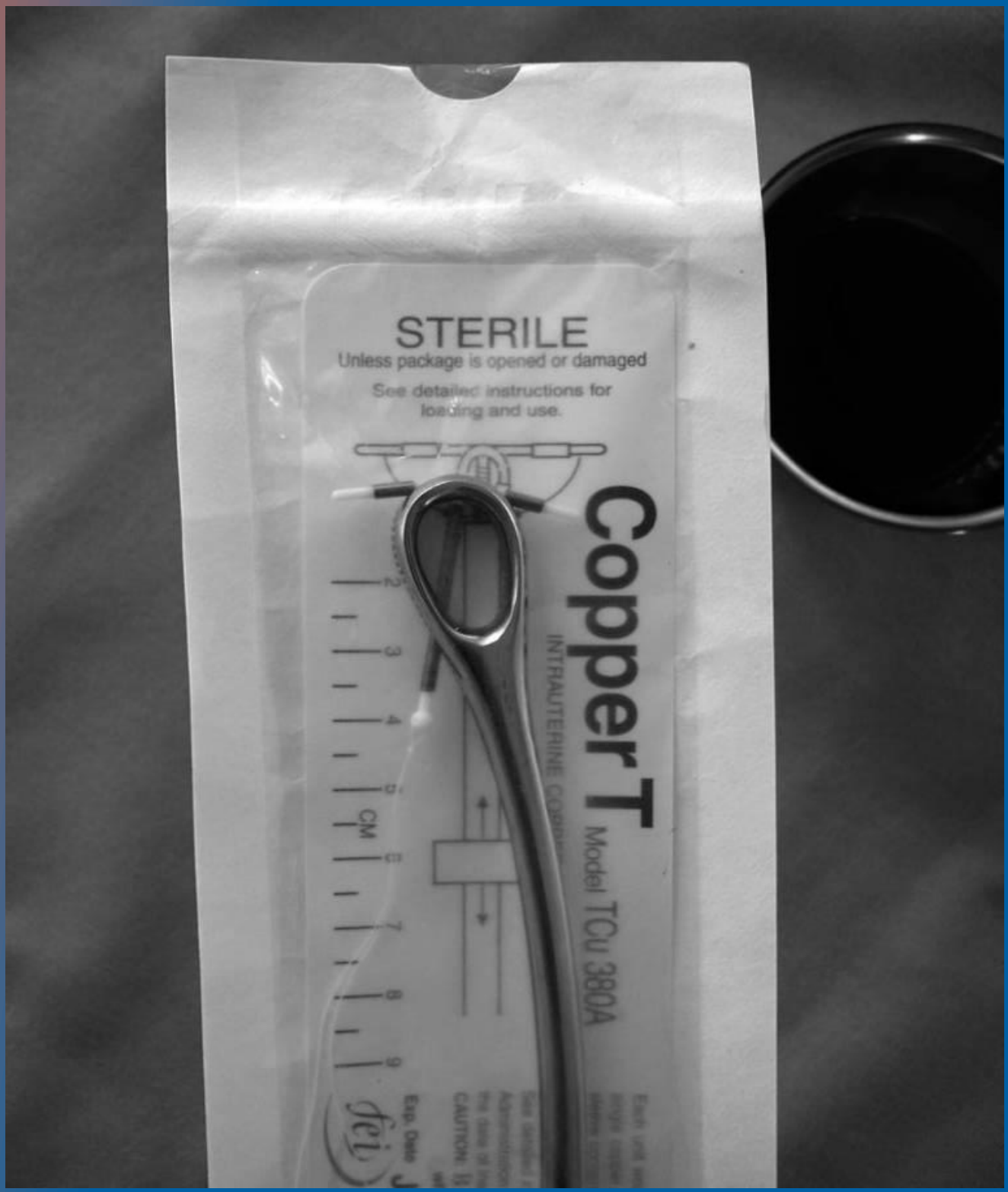
- Possible for up to 48 hours postpartum
- After this, cervix will not be open enough for a painless and easy instrumented insertion
- Rarely done in the United States

Technique for Postplacental IUD

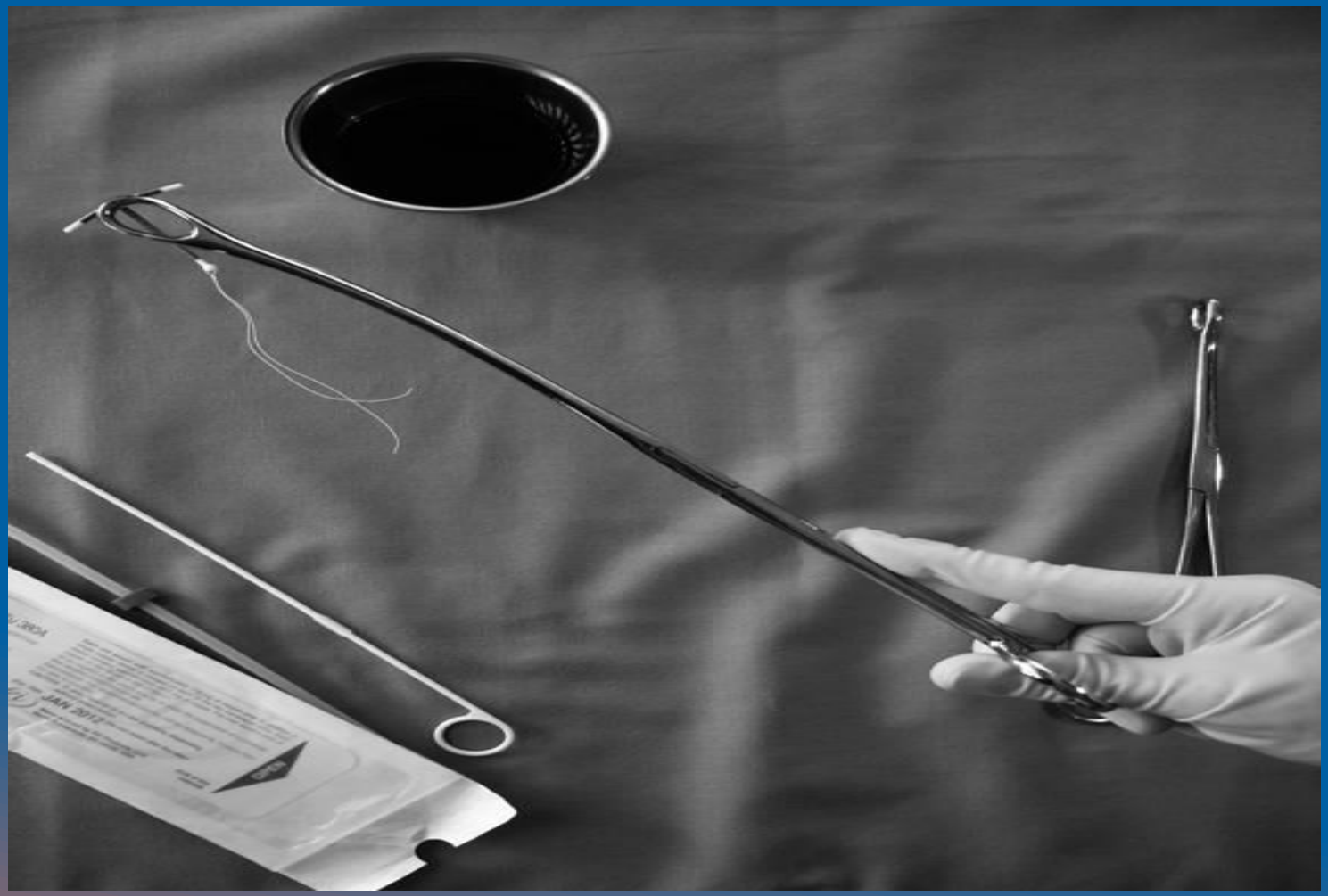
- Immediate postpartum technique with **inserter**
- Ring forceps: Grasp the anterior cervix with a ring forceps and place IUD in second ring Forceps
- Manual placement with hand

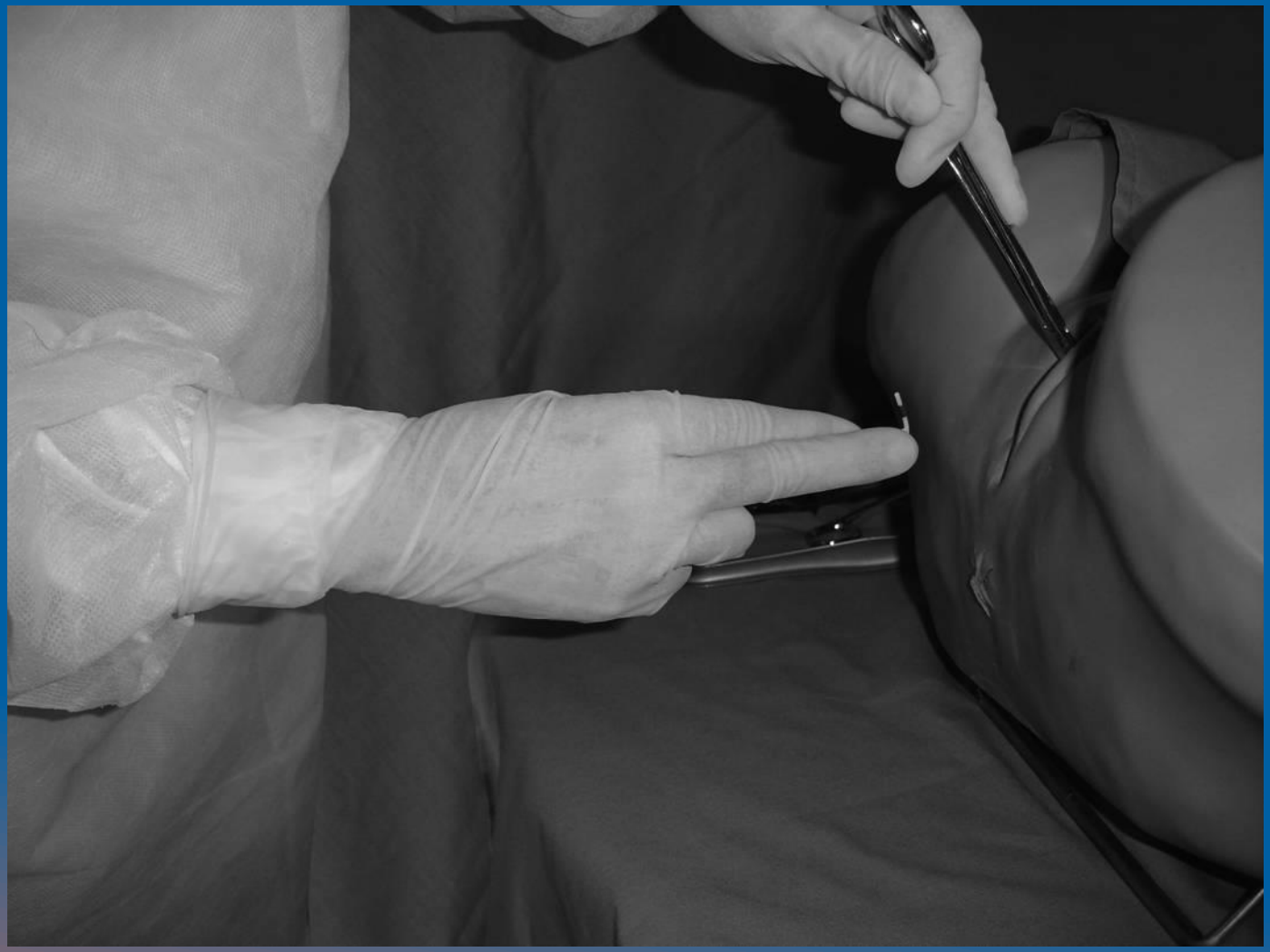
Technique with use of Ring Forceps

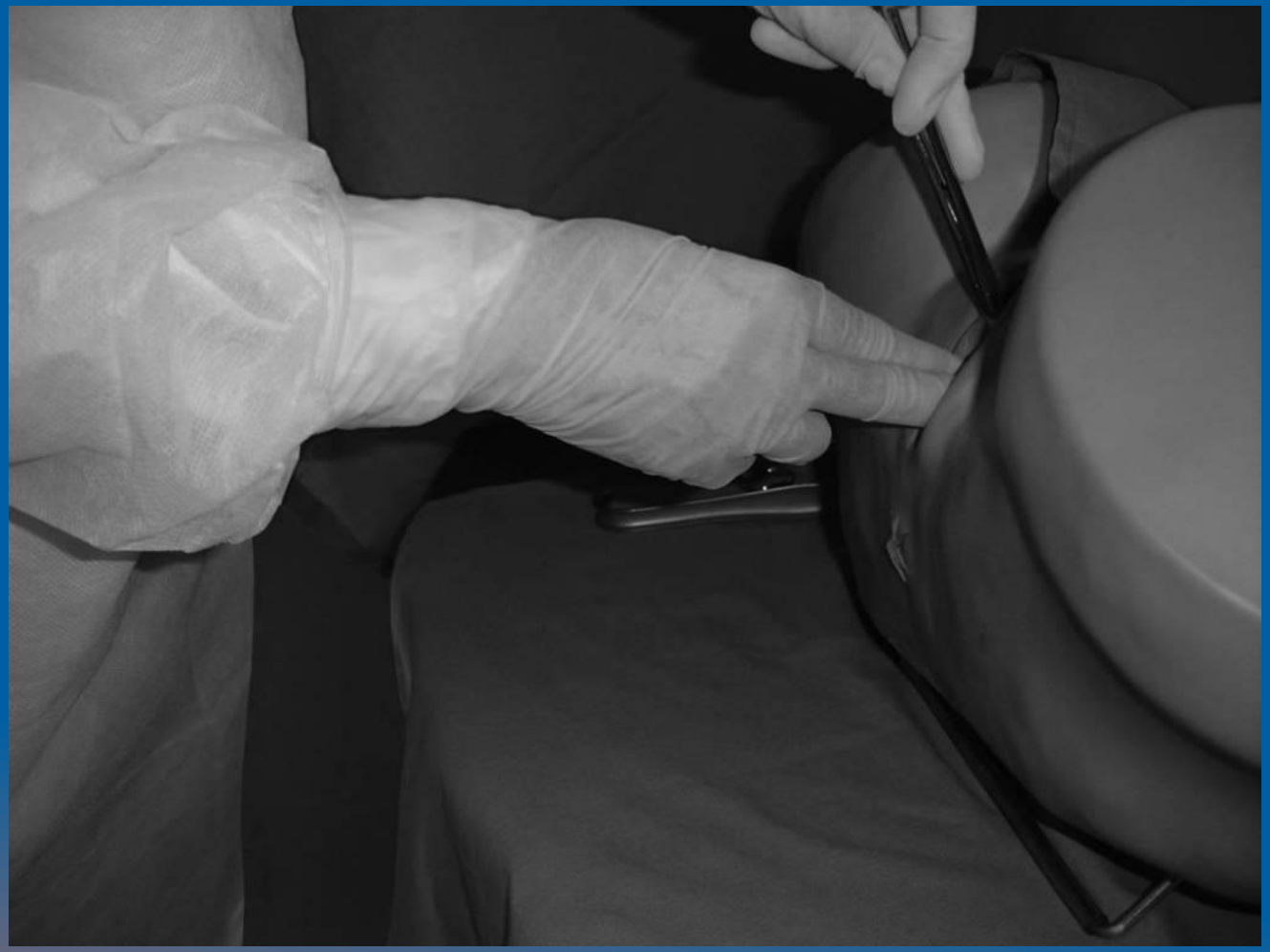
- Visualize and grasp the anterior cervix with a ring forceps
- Place the IUD, loaded in the inserter, in the right hand.
- Place traction on the ring forceps with the left hand and place the loaded IUD in the right hand into the vagina and through the cervix


STERILE
Unless package is opened or damaged
See detailed instructions for loading and use.
Copper T
Model TCu 380A
INTRAUTERINE CONTRACEPTIVE
CM

Insertion with a ring forceps



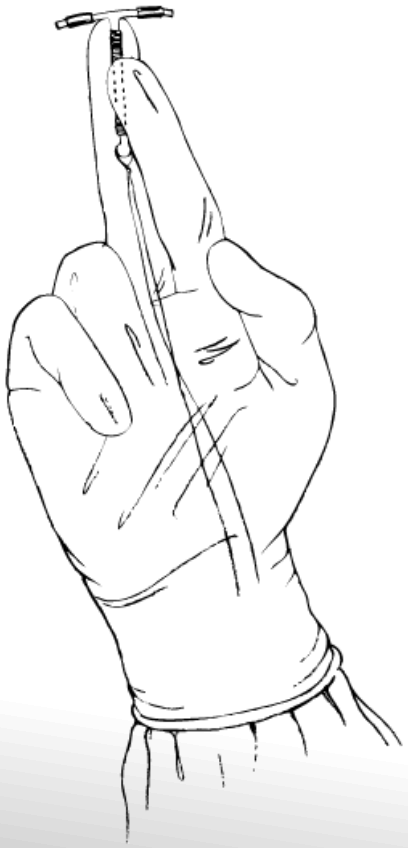




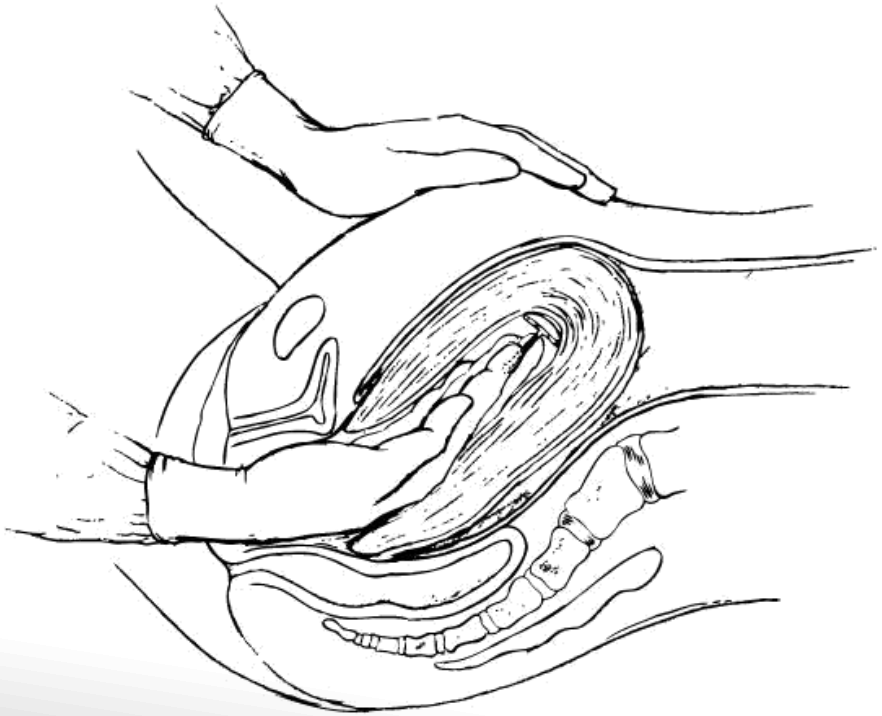
Technique

- Pass the IUD to the fundus
- In the immediate postpartum period, a woman's lower uterine segment is contracted
- Provider may mistakenly believe the IUD is at the fundus when it is only at the turn of the lower uterine segment.
- Exert *slight* pressure to move the IUD past the lower uterine segment and up to the fundus
- Inserting the IUD in the incorrect position may result in an expulsion

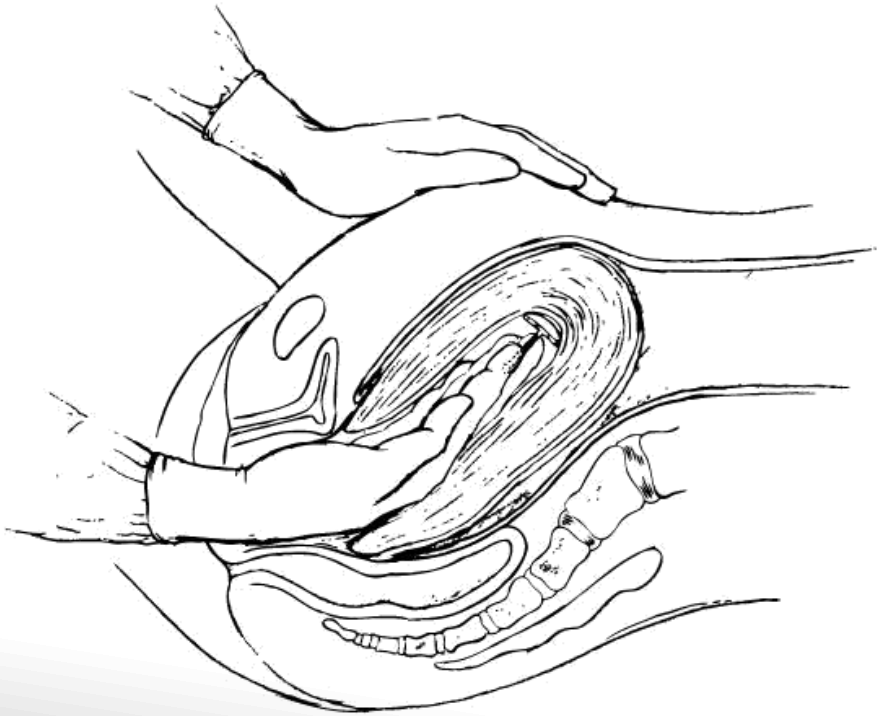
Manual insertion



Pretend the hand is an inserter…



We are recommending manual insertion with use of insertor



Transcesarean Insertion

- **Transcesarean** insertion is defined as one performed following a cesarean delivery, before the uterus incision is sutured.

For transcesarean insertion, as the uterus is open, the IUD can be placed with the inserter

Tips:

- Use “no-touch” technique
- If the IUD comes back through the cervix into the vagina, DO NOT REPLACE! Insert a different one.
- Place the IUD HIGH in the fundus.
- Ultrasound guidance

POSTPARTUM IUD INSERTION

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

- Implant Nexplanon) prio
  - US MEC Category 1 and 2
  - Low rate of removals, similar to those of interval implants

IMMEDIATE PP LARC

Contraception 2016

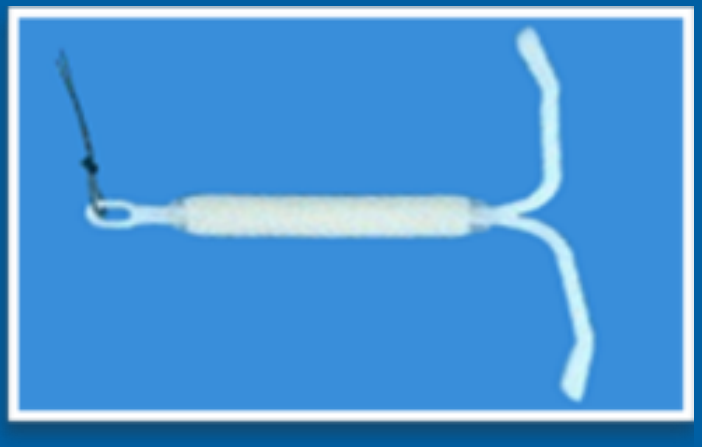
Which IUD do you want?

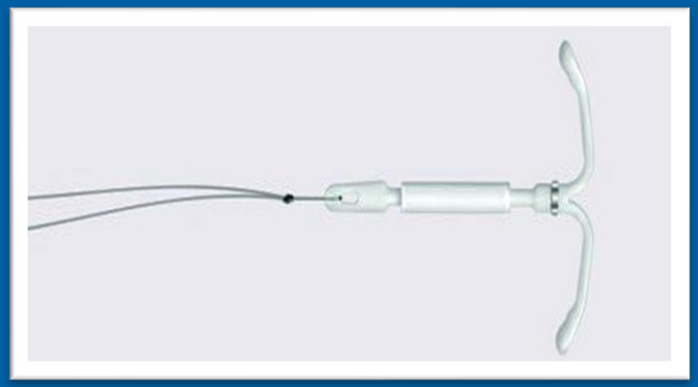
INTRODUCING…. SKYLA, LILETTA, KYLEENA

FIVE IUDS AVAILABLE IN US IN 20178

IUD	FDA use (yrs)	Failure Rate	Content LNG (mg)	Advantages	Disadvantages
Paragard	10	.8%	None	No hormone	Heavy bleeding and cramping
Kyleena	5	.2%	19.5	Smaller frame and insertion tube	Initial irregular bleeding
Liletta	3	.2%	52	Less bleeding	Initial irregular bleeding
Mirena	5	.2%	52	Less bleeding	Initial irregular bleeding
Skyla	3	.4%	13.5	Smaller frame and insertion tube	Irregular bleeding, low rate of amenorrhea

Levonorgesterol IUS





LNG 52 IUS

- Mirena® and Liletta ®
- Release LNG 20 µg/d
- Approved use:
  - Mirena: 5 yrs
  - Liletta: 3 yr. (5-7 yr eventually)

LNG 14 IUS

- Skyla™
- Releases LNG 14 µg/d
- Approved use: 3 yrs

Mirena® PI. 2014; Skyla™ PI. 2013; Liletta™ PI. 2015.

LILETTA UPDATED

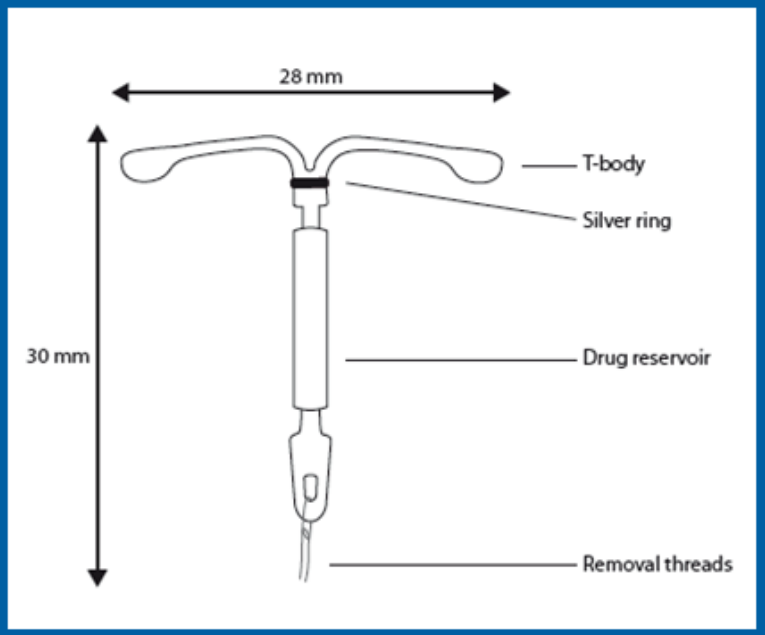
The FDA has approved a new Single-Handed Inserter (SHI) for Liletta®

IUD has not changed

Remains low-cost option for Title X and other safety net programs.

Liletta™ PI. 2016.

KYLEENA: NEW LNG 19.5 IUS



Kyleena ®

- Releases LNG 17.5 µg/d
- Approved use: 5 yrs
- Smaller in size (same as Skyla®)
- Released October 2016

Kyleena™ PI. 2016.

ULIPRISTAL ACETATE

- - First selective progesterone receptor modulator approved by FDA
- - Effective in preventing pregnancy up to 5 days after unprotected sex
- - More effective than ”Plan B”

Glasier AF. *Lancet* 2010;375:555-62.

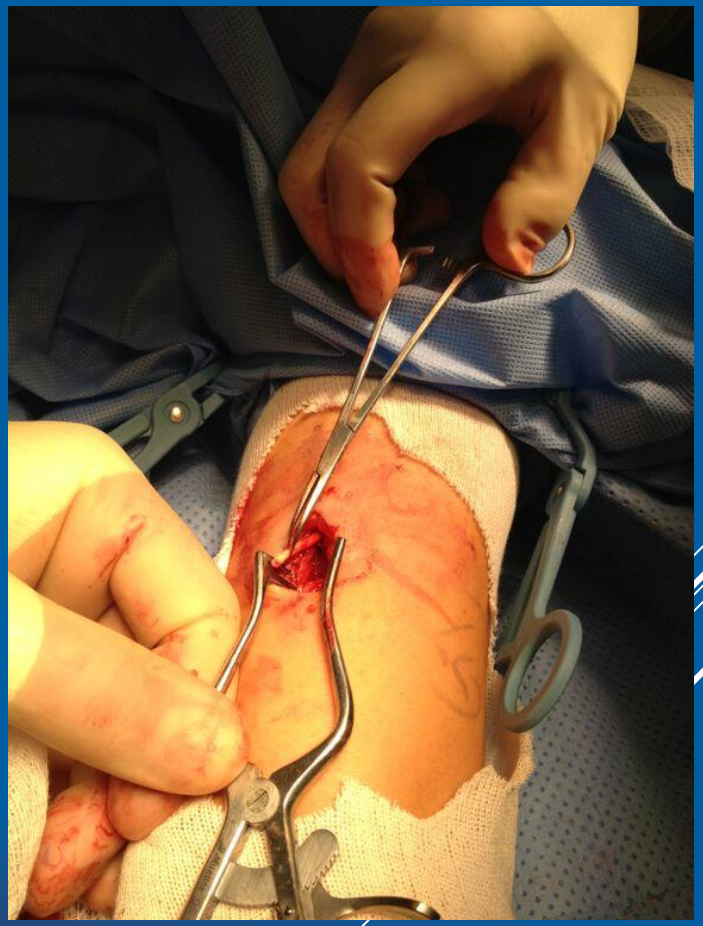
ICE: WEIGHT AND EMERGENCY CONTRACEPTION

- **No woman should be refused or discouraged from using EC based on her weight.**

- LNG EC is often the most accessible, or only, EC option for many women. **Women at higher bodyweights should be advised that LNG EC might be less effective for them**

THE BEST!

Nexplanon

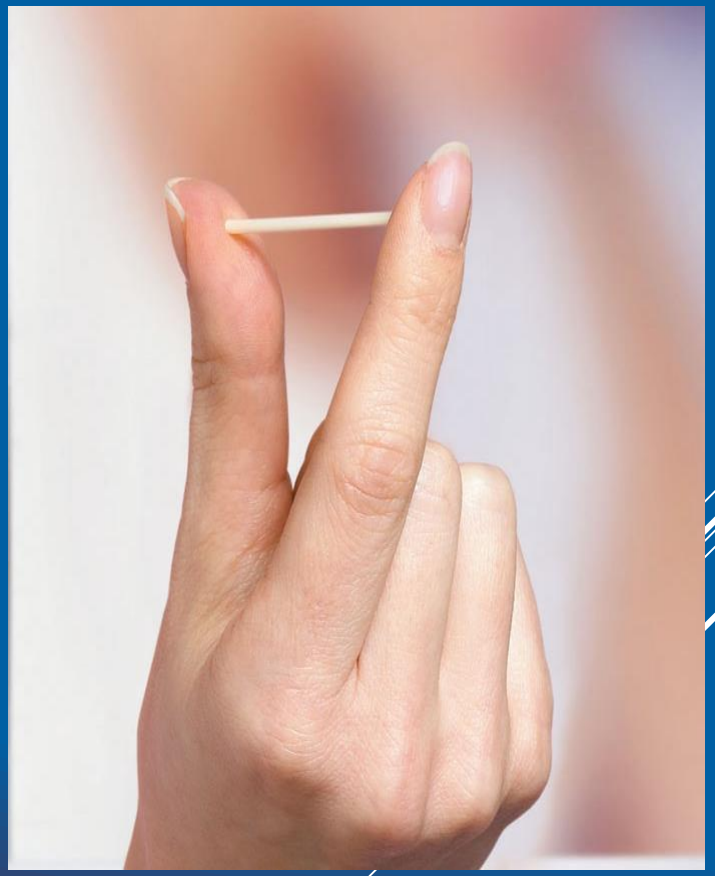


IMPLANON VS. NEXPLANON

	Implanon	Nexplanon
Radiopaque	No	Yes
Requires two hands for insertion	Yes	No
Device may fall out of inserter	Yes	No
Deep insertion possible	Yes	Yes, but less likely?

NEXPLANON ™

- 3 years
- Highly effective
- Few contraindications



IMPLANT: MECHANISM OF ACTION

Mechanism of Action	Implant
Primary	• Suppression of ovulation
Secondary	• Increased viscosity of the cervical mucus • Alterations in the endometrium

IMPLANTS

Advantages

- High efficacy
- Long-term
- Rapid reversibility
- Rapid procedures
- Can use when lactating
- Several non-contraceptive benefits

Disadvantages

- Bleeding irregularities(34%)
- Weight gain (2%)
- Emotional liability (2%)
- Headache (2%)
- Acne (1%)
- Depression (1%)

Trussell J. *Contraceptive Technology.* 2011. NEXPLANON [package insert]. Whitehouse, NJ: N.V. Organon, Oss; 2012

IMPLANT LOCATION

- Non-dominant arm
- Subdermal
- 3-4 inches above the medial epicondyle of the humerus

Trussell J. *Contraceptive Technology*. 2011. NEXPLANON package insert. Curtis KM, Jatlaoui TC, Tepper NK, et al. U.S. Selected Practice Recommendations for Contraceptive Use, 2016. MMWR Recomm Rep 2016; 65:1.

NEXPLANON - BLEEDING

- Bleeding pattern unpredictable
  - ~25% amenorrhea
- No clear trends with time
- Similar bleeding days to cycling women
- Management
  - Counseling and reassurance
  - Estradiol 1-2 mg PO QD for 10-14 days
  - OCs, given for 2-3 cycles, or
  - Ibuprofen 400-800 mg TID for 7-days

CONTRACEPTIVE PRACTICE GUIDANCE

- After placement of an IUD a follow-up visit should be scheduled at

  A. 4-6 weeks to check for the strings and other issues

  B. At one year

  C. No visit scheduled, advise the patient to come in if she experiences problems

US SELECTED PRACTICE RECOMMENDATIONS FOR CONTRACEPTIVE USE, 2016

- *Comprises recommendations that address a select group of common, yet sometimes controversial or complex, issues regarding initiation and use of specific contraceptive methods*
  - How to tell if a women is reasonably not pregnant
  - IUDs and PID
  - Recommended examinations and test before contraceptive initiation
  - **http://www.cdc.gov/reproductivehealth/UnintendedPregnancy/USSPR.htm**

CONCLUSIONS

- Rates of unintended and teen pregnancy falling
- Rates of abortion falling
- Access and use of to contraception including LARCs is primary reason
- Delay in time of sexual debut is lesser factor-abstinence
- Practice shared decision making and avoid reproductive coercion
- Immediate postpartum LARCS now covered by NM Medicaid and IUD prices falling increasing access
- Use CDC Medical Eligbility Criteria (MEC) and Selected Practice Recommendations (SPR) for Contraception :
- FREE MEC/SPR APP :

US MEC
US SPR
CDC