Workshop in Contraception

McGill Annual Refresher
November 28, 2018
Cleve Ziegler, M.D

Disclosure

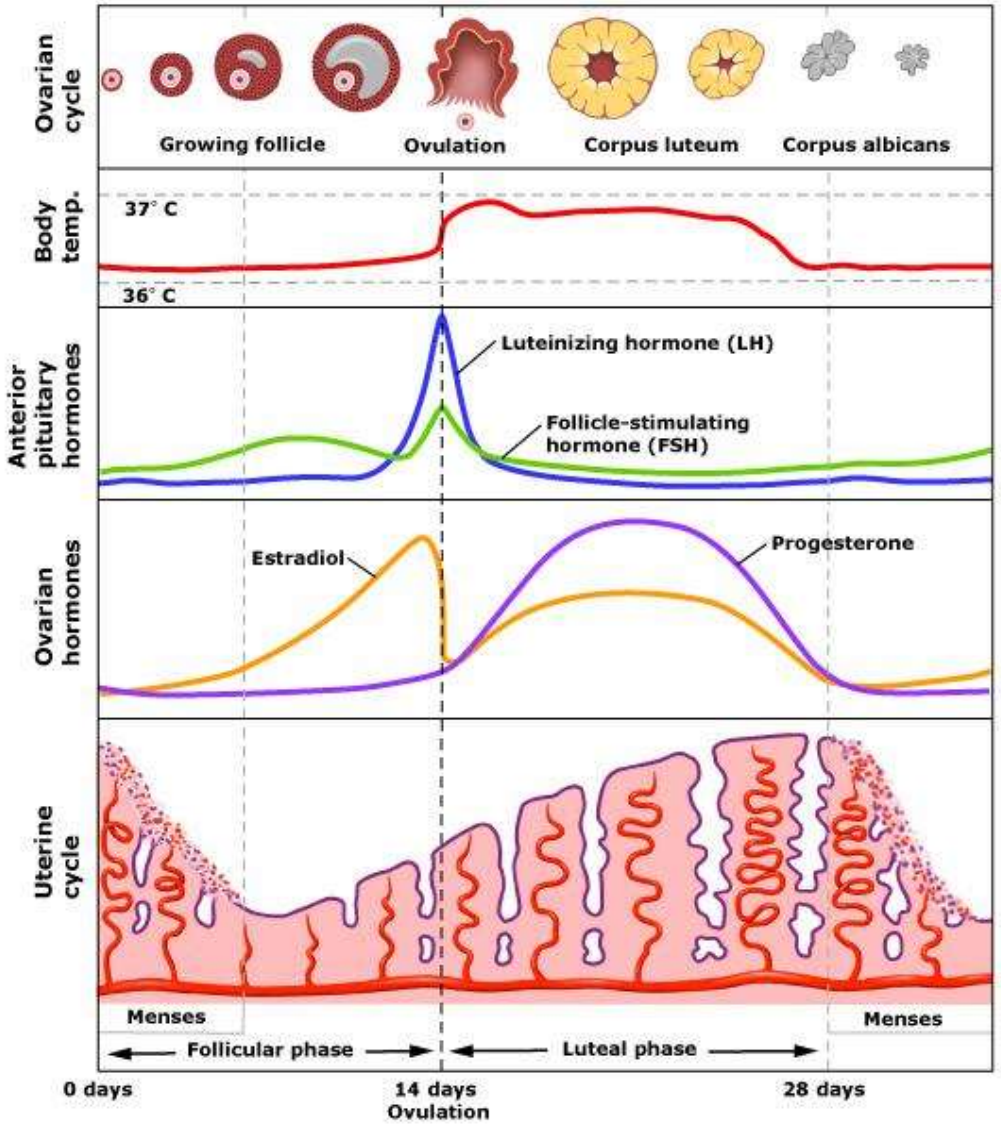
- CME Speaker:
- Bayer, Schering-Plough (Merck), Bayer, Wyeth (Pfizer)

- Advisory Board:
- Bayer, GSK, Schering-Plough (Merck)

Learning Objectives

- 1. L'evolution de la contraception modern
- 2. Connaitre les tendencies et l'innocuite de la Nouvelle Norme
- 3. Questions/reponses

Menstruation:Normal Physiology



Menstruation:Good or Bad?

- Ridding the body of toxins
- Sign of fertility and femininity
- Physiological anemia and reduction in cardiovascular disease

- Dysmenorrhea
- Menorrhagia
- Endometriosis
- Ovarian cancer
- Breast cancer
- Premenstrual syndrome
- Migraine headache
- Epilepsy

Normal Physiological Process

Pathological Entity

Menstrual Disorders:Cost

- Affects 250,000 Canadian women /year
- 10-15% of ER visits in women 15-44
- 40% require regular analgesics
- 25% reduction in productivity during menses
- Economic cost 8-10% of total wages
- 20% of women with abnormal bleeding undergo hysterectomy

Attitudes Towards Menstruation

- Culture
- Age
- Parity
- Economic Status
- Educational level
- Presence/absence of menstrual associated symptoms

Menstruation:Ethnic Preferences

Cultural Preferences

Geographic Trends

Preferred Frequency of Menses

	Age category (years)					
	Dutch women			Italian women (without menstruation-related symptoms)		
	15-19 (n=322)	25-34 (n=325)	45-49 (n=324)	20-29 (n=22)	30-39 (n=171)	40-49 (n=77)
Monthly	30	35	32	9 (41%)	78 (46%)	31 (40%)
Every 3 months	35	24	10	10 (45%)	36 (21%)	15 (19%)
Every 6 months	6	6	4	2 (9%)	7 (4%)	2 (3%)
Yearly	3	4	5	0 (0%)	1 (<1%)	2 (3%)
Never	26	31	51	1 (5%)	49 (28%)	27 (35%)

den Tonkelaar I *et al*. *Contraception* 1999; 59(6):357-62.
Ferrero S *et al*. *Contraception* 2006; 73(5):537-41.


BIRTH CONTROL EFFECTIVENESS
CONDOMS
99%
BIRTH CONTROL PILLS
99%
crocs
100%
VIA @MENSHUMOR

Address Risks Caused by Unplanned Changes in Methc

Unintended Pregnancies Each Year

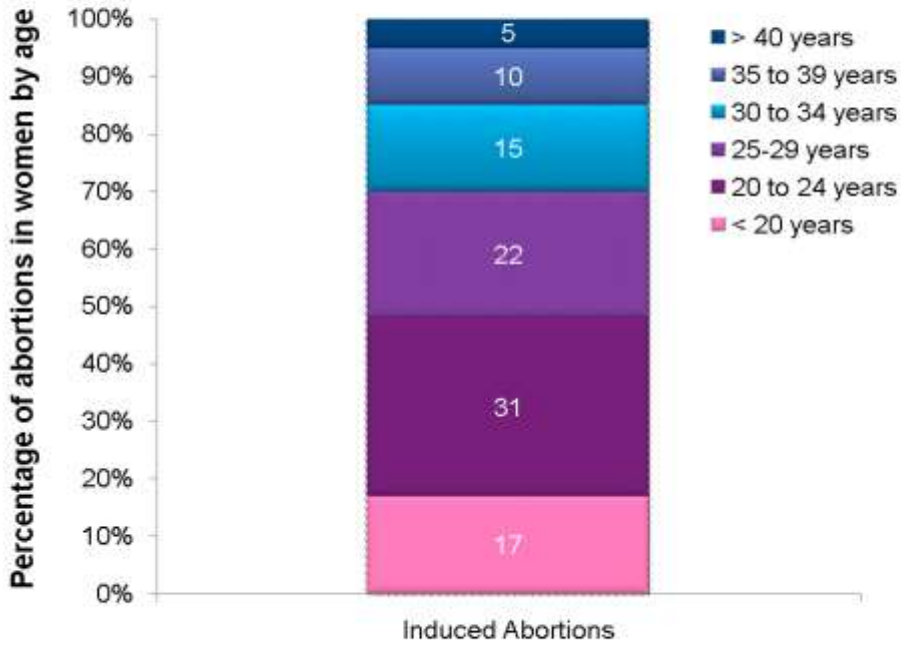
50%

Unintended Pregnancies Using Contraception

20%

Finer LG. *Perspect Sex Reprod Health.* 2006; Moreau C. *Contraception*. 2007. Frost JJ. *In Brief*. 2008.

Induced abortions by age in Canada



70% of induced abortions are among young women <30 years

Statistics Canada, Pregnancy Outcomes 2005, Catalogue no. 82-224-X

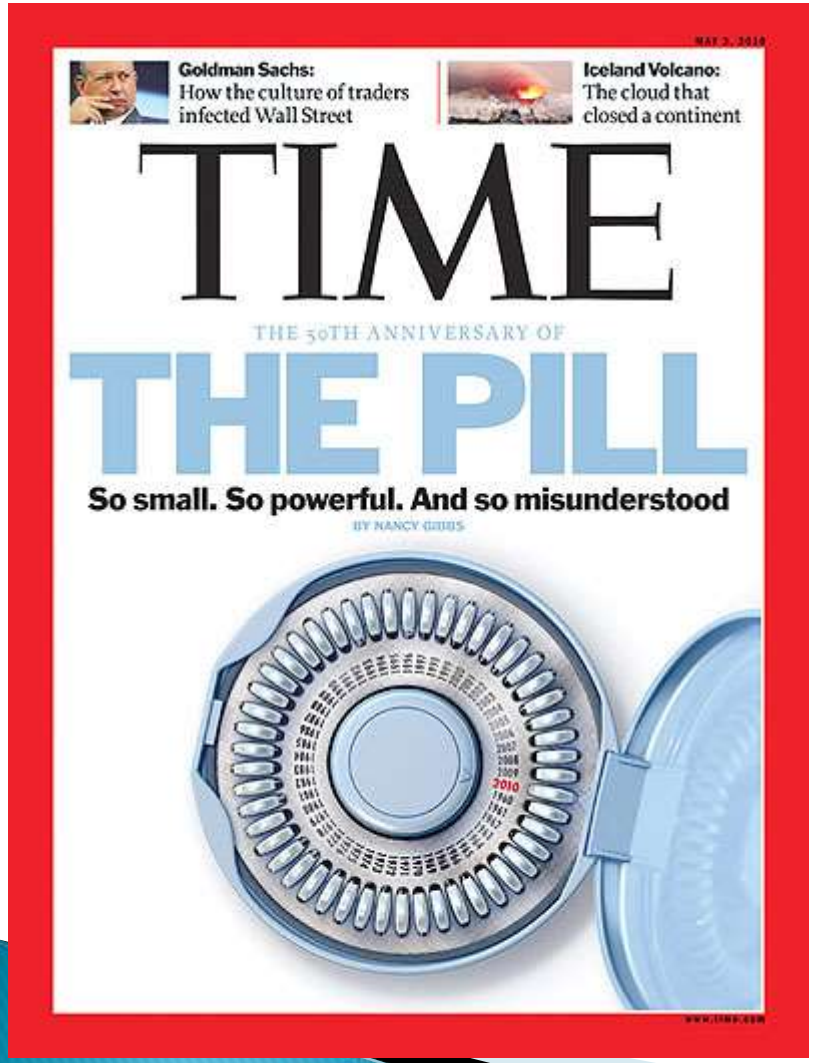
Oregon greenlights pharmacist-prescribed birth control

By Marilyn Malara
Jan. 2, 2016 at 10:24 AM

Birth control pills in Oregon can now be prescribed by a pharmacist thanks to a law that began January 1. Oregon is the first state to implement the change, while reports say

Health Canada Approval August 2015

"Love, Sex, Freedom and the Paradox of the Pill"



"Arriving at a moment of social
and political upheaval,
the Pill became a handy proxy
for wider trends:
the rejection of tradition,
the challenge to institutions,
the redefinition of women's roles"

Nancy Gibbs,
Time Executive Editor

Time Magazine, May 3, 2010.

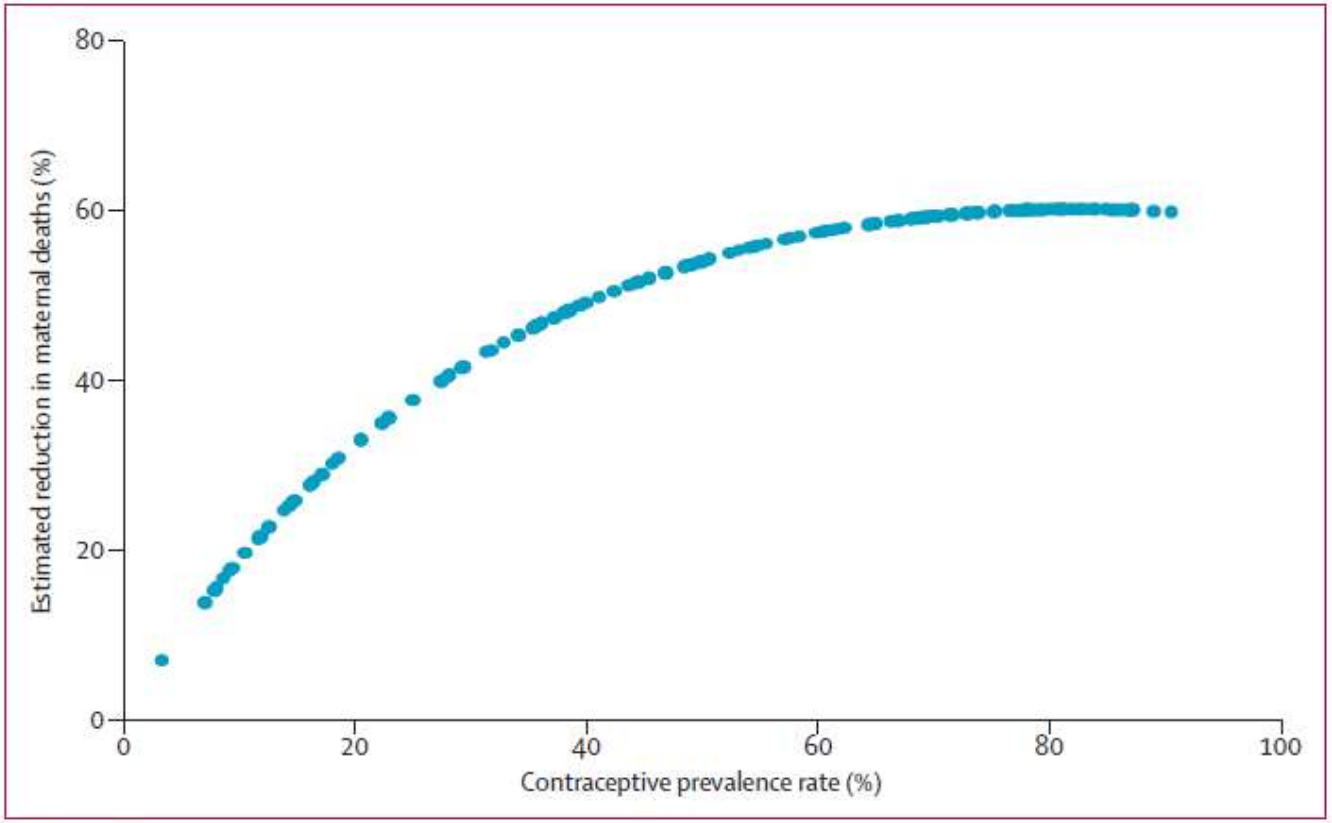
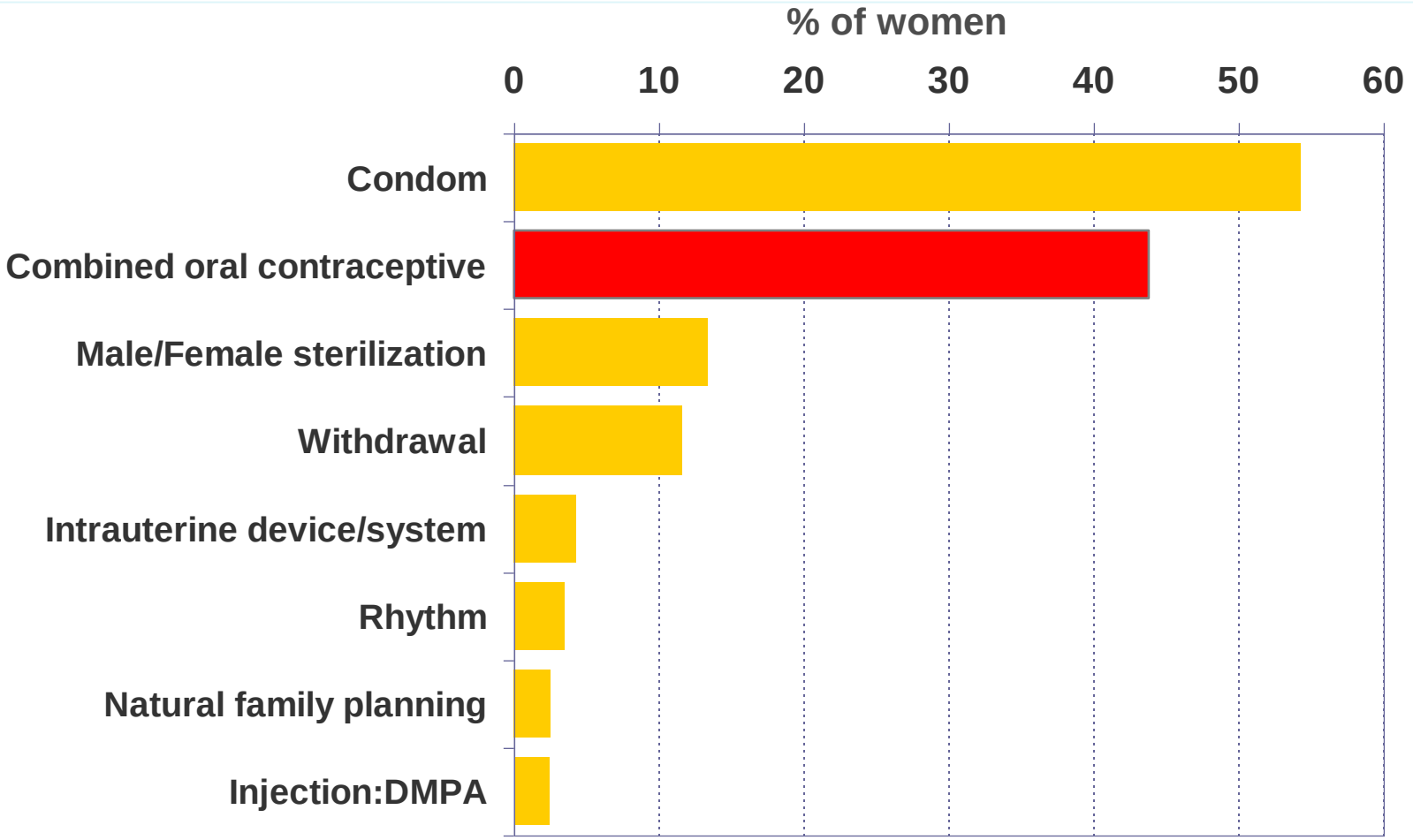


Figure 3: **Contraceptive prevalence rate and estimated maternal mortality reduction**

Most Commonly Used Contraceptive Methods by Canadian Women



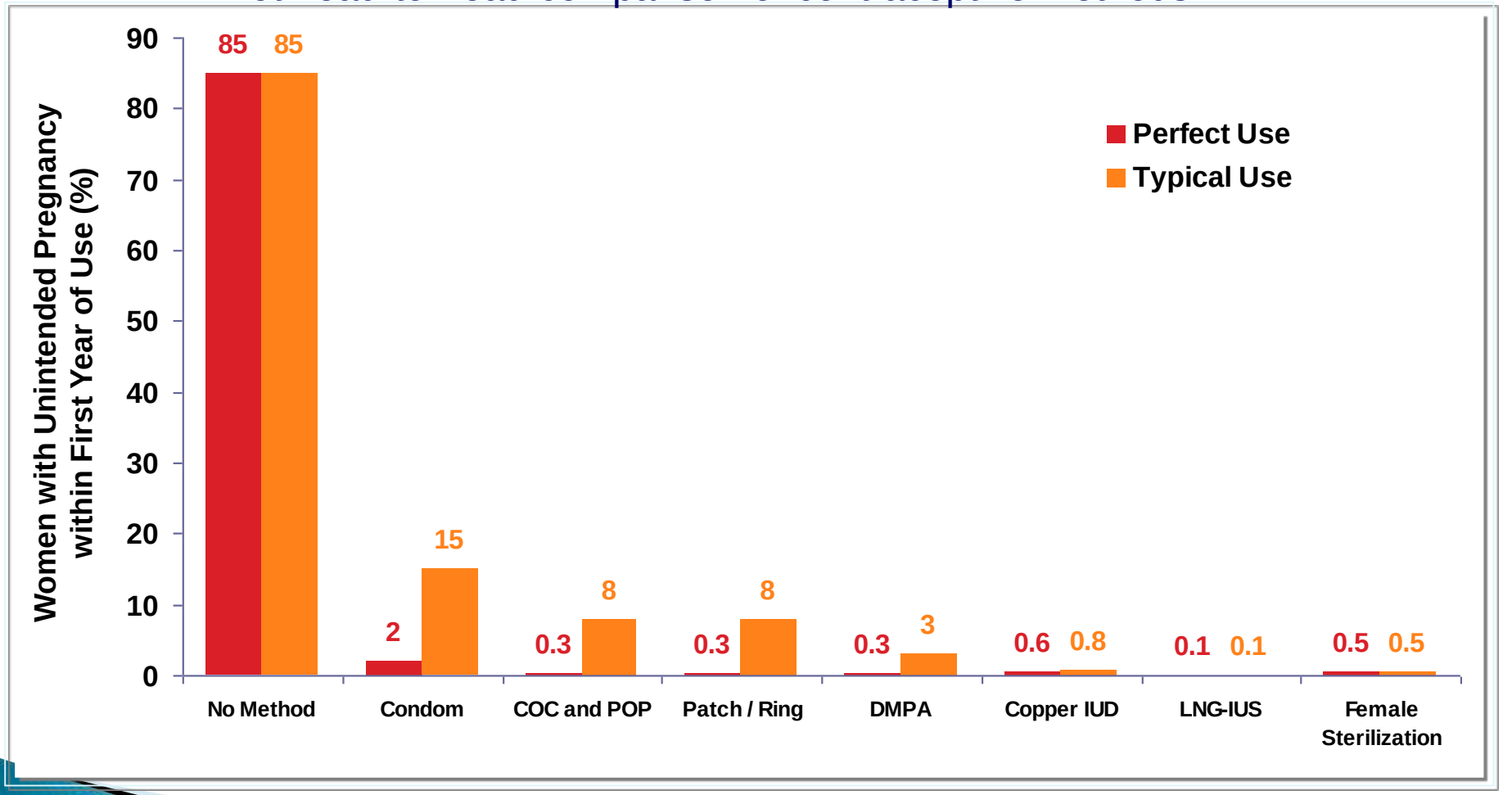
Column totals may exceed 100% as women were allowed to choose more than one method.
Base: Women aged 15-50 who have had vaginal intercourse in the previous 6 months, n=2,341

DMPA=depot medroxyprogesterone

Back et al. J Obstet Gynaecol Can 2009;31(7):627–640.

Unintended Pregnancy in First Year of Contraceptive Use*

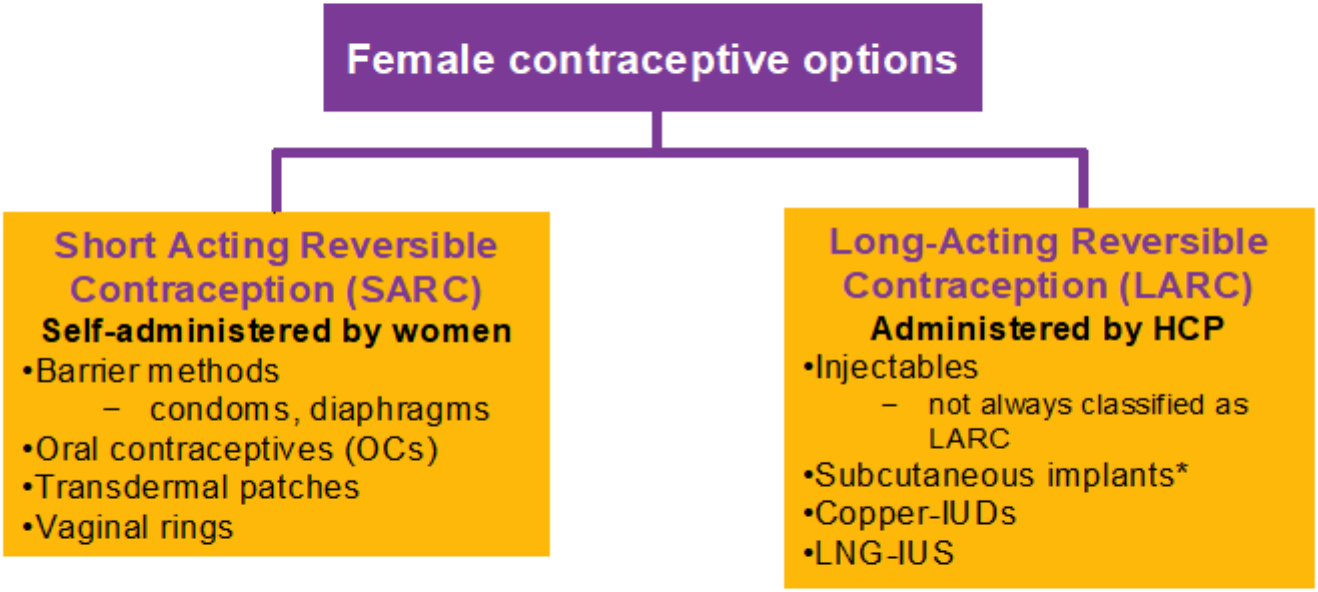
*not head-to-head comparison of contraceptive methods



COC=combined oral contraceptive; POP= progestin only pill; DMPA=depot medroxyprogesterone; LNG-IUS=levonorgestrel releasing intrauterine system

Trussell J. Contraception 2004; 70: 89-96.

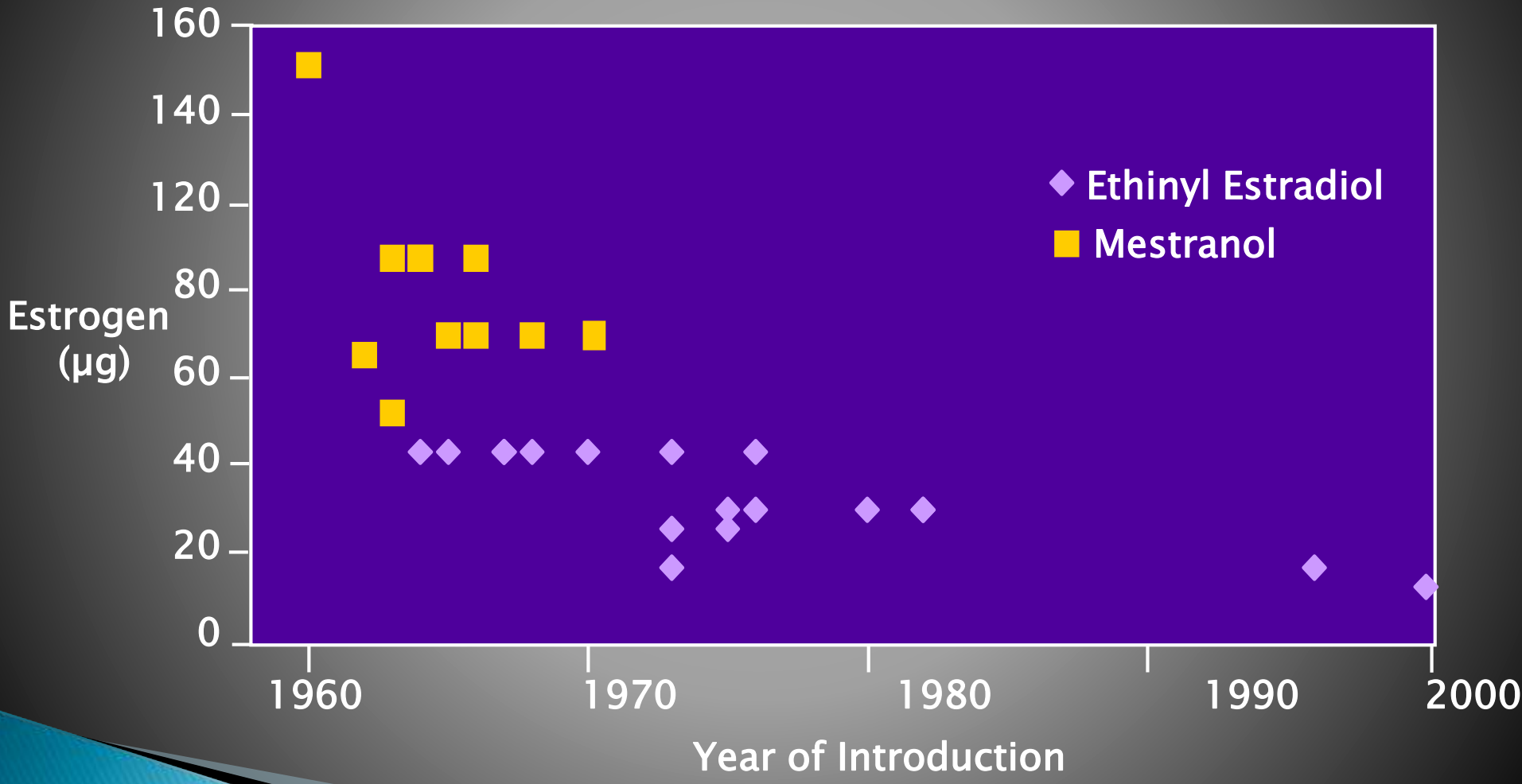
Duration of use for reversible methods



HCP, healthcare provider; LARC, long acting reversible contraception; SARC, short acting reversible contraception; OC, oral contraceptive.; IUD, intrauterine device; LNG-IUS, levonorgestrel intrauterine system

*Not available in Canada

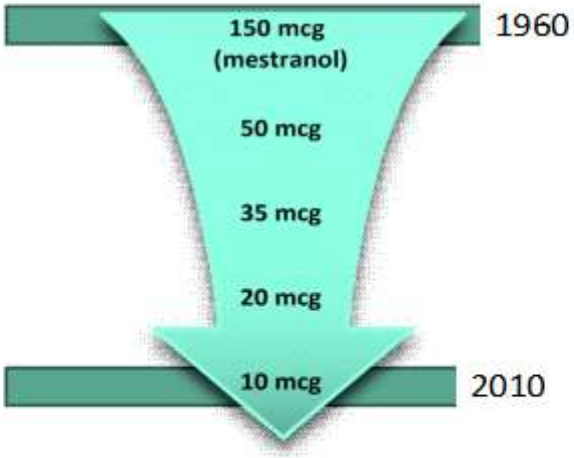
Change in Estrogen and Dose



Thorneycroft IH. *Infert Clin North Am.* 2000;11:515–529.

A Historical Perspective: Estrogen in COC's

Over time, the amount of estrogen in COCs has decreased significantly



Evolution of Progestins

Progesterone → **17α-Spirolactone**

- **YASMIN®** (Drospirenone/EE)

Progesterone → **17 α-Hydroxyprogesterone**

- **DIANE®-35*** (Cyproterone acetate/EE)
- **Depo-Provera** (Medroxyprogesterone acetate)

Testosterone → **19-Nortestosterone**

Estranes

- **Ortho 1/35** (Norethindrone/EE)

Gonanes

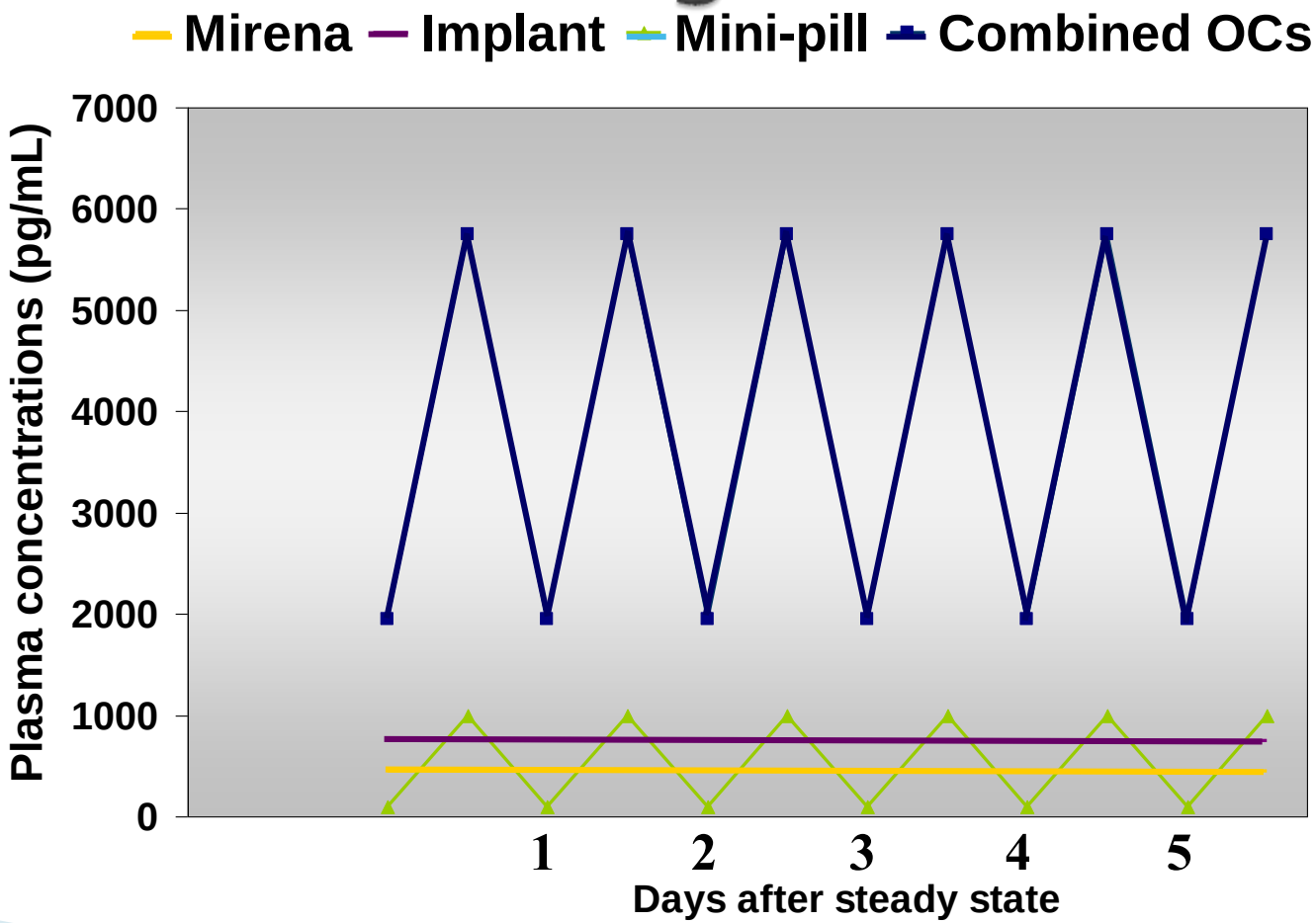
- **Alesse, Triphasil, TRIQUILAR®** (Levonorgestrel/EE)
- **Evra** (Norelgestromin†/EE)
- **Marvelon, Linessa** (Desogestrel/EE)
- **MIRENA®** (Levonorgestrel)
- **NuvaRing** (Etonogestrel†/EE)
- **Tri-Cyclen, Tri-Cyclen Lo** (Norgestimate/EE)

†Active metabolite
*Indicated for severe acne

Non-Androgenic → **Androgenic**

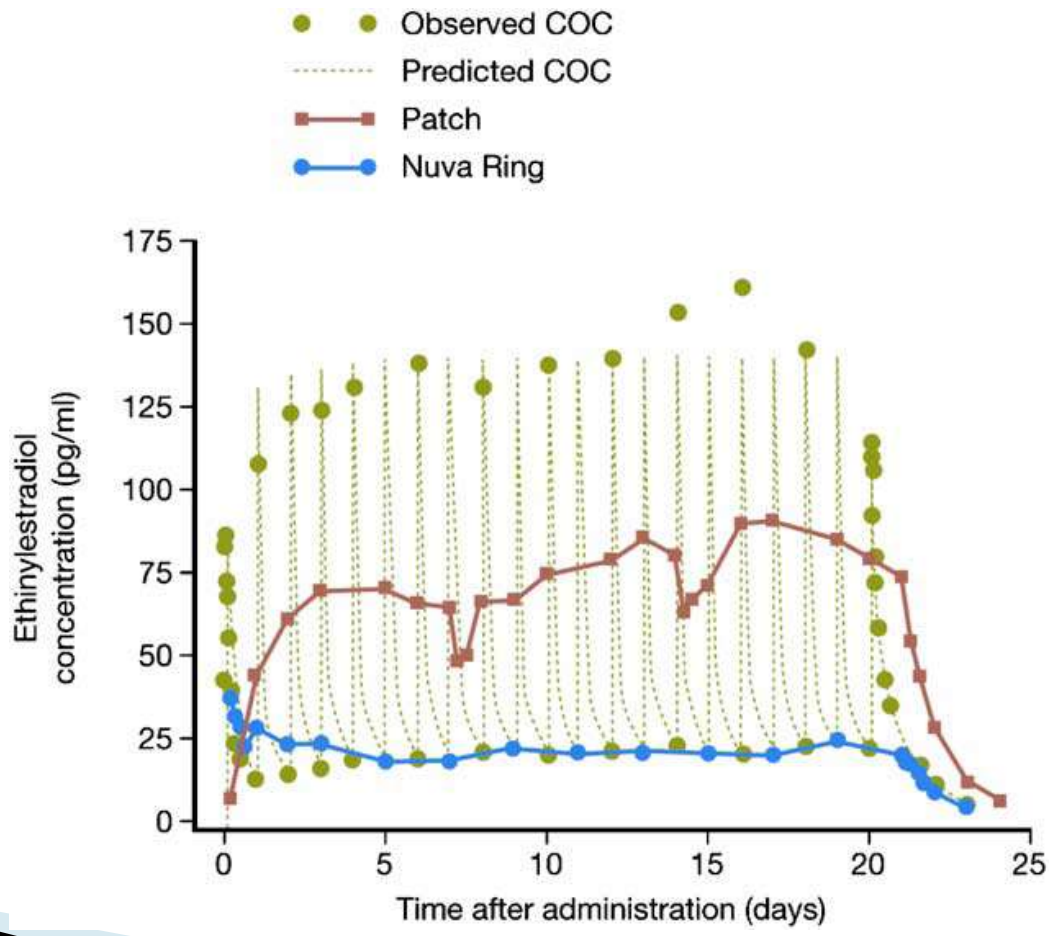
Adapted from Rapkin AJ et al. Expert ... Pharmacother 2007;8:989-99.

Plasma Concentrations of Levonorgestrel



Nilsson et al. Acta Endocrinol 1980;93:380
Diaz et al. Contraception 1987;35:551

Serum Hormonal Levels:Pill,Patch and Ring



Cycle Control:Definition

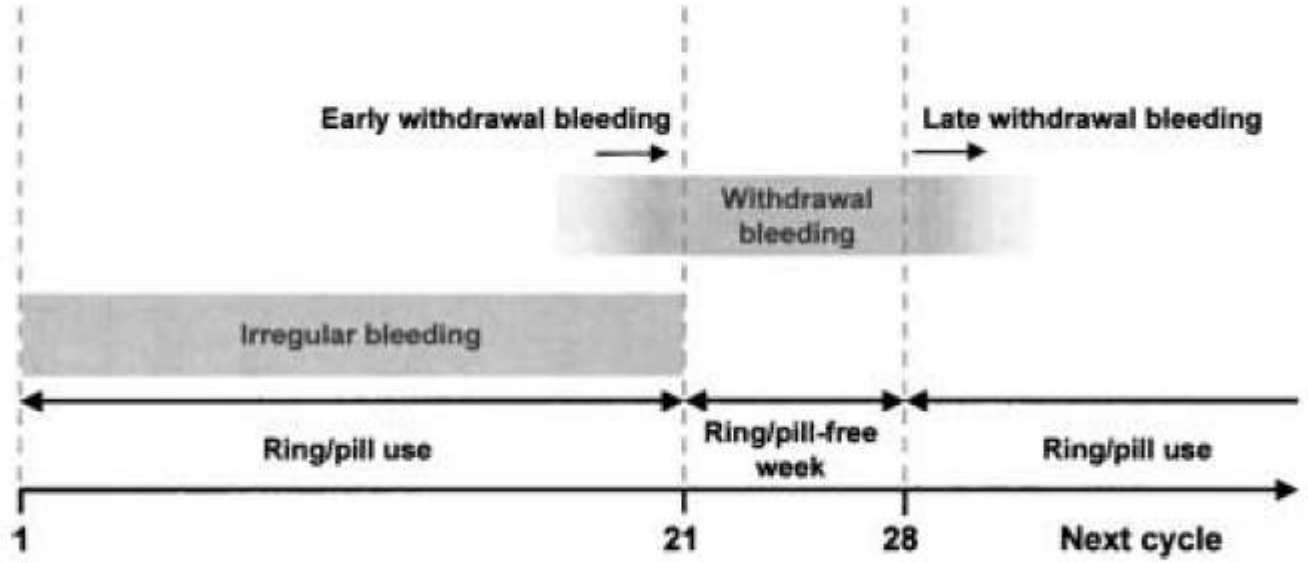
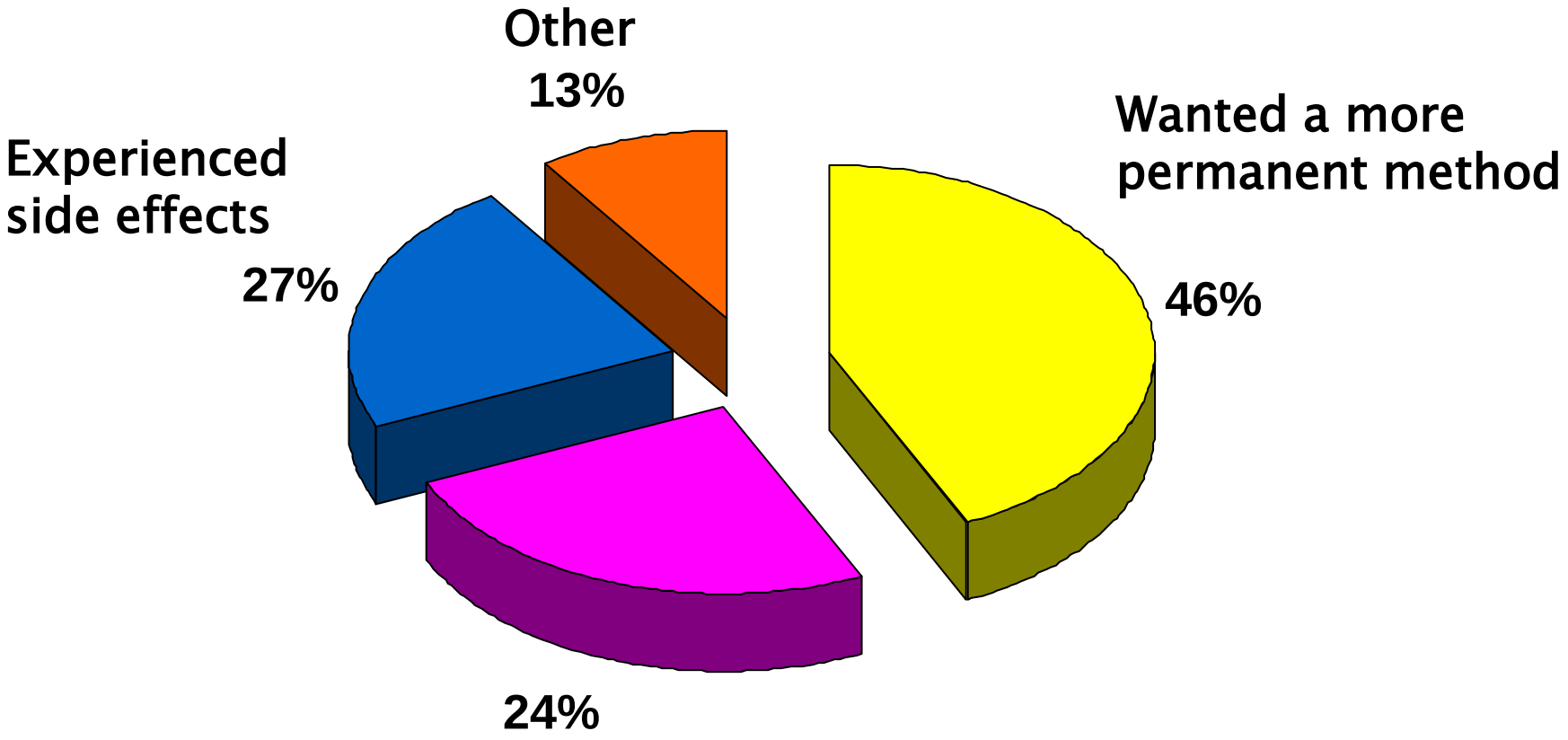


Fig 1. Parameters of cycle control.

Reasons for discontinuation of oral contraception



Fisher WA et al. The Canadian Journal of Human Sexuality 1999;8(3):161-216.

Extended Use
Hormonal Contraception

Definition: "Extended" oral contraception refers to the use of combined hormonal contraceptives for extended periods of time (greater than 2 consecutive 21 days) with planned HFIs.

Guilbert E *et al. J Obstet Gynaecol Can* 2007; 29(7 Suppl 2):S1-32.

BMJ

RESEARCH

Mortality among contraceptive pill users: cohort evidence from Royal College of General Practitioners' Oral Contraception Study

Philip C Hannaford, Grampian Health Board chair of primary care,[1] Lisa Iversen, research fellow,[1] Tatiana V Macfarlane, senior research fellow,[2] Alison M Elliott, senior research fellow,[1] Valerie Angus, data manager,[3] Amanda J Lee, professor of medical statistics[4]

Table 2 | Risk of death among ever and never users of oral contraceptives in full dataset

Cause of death	ICD-8 codes	Never users		Ever users		Adjusted relat
		Observed rate (No)	Standardised rate*	Observed rate (No)	Standardised rate*	risk† (95% C
All causes	000-999, all E codes	462.16 (1747)	417.45	349.62 (2864)	365.51	0.88 (0.82 to 0.
All cancers	140-209	205.29 (776)	194.55	160.16 (1312)	165.45	0.85 (0.78 to 0.
Large bowel and rectum	153-154	21.16 (80)	20.05	11.84 (97)	12.41	0.62 (0.46 to 0.
Gallbladder/liver	155-156	3.17 (12)	3.12	1.83 (15)	2.03	0.65 (0.30 to 1.
Lung	162	26.45 (100)	26.08	31.49 (258)	31.70	1.22 (0.96 to 1.
Melanoma	172	2.65 (10)	2.67	1.95 (16)	1.95	0.73 (0.33 to 1.
Breast	174	44.44 (168)	43.91	38.09 (312)	39.41	0.90 (0.74 to 1.
Invasive cervix	180	3.70 (14)	4.02	5.62 (46)	5.38	1.34 (0.74 to 2.
Uterine body	182	5.03 (19)	4.47	1.59 (13)	1.94	0.43 (0.21 to 0.
Ovary	183	19.84 (75)	18.04	9.16 (75)	9.47	0.53 (0.38 to 0.
Main gynaecological	180, 182, 183	28.57 (108)	26.51	16.36 (134)	16.80	0.63 (0.49 to 0.
CNS-pituitary	191, 1943	5.03 (19)	4.47	3.42 (28)	3.74	0.84 (0.47 to 1.
Site unknown	199	22.22 (84)	20.50	17.21 (141)	18.02	0.88 (0.67 to 1.
Other cancers	140-209, except above	51.59 (195)	47.19	37.96 (311)	39.39	0.83 (0.70 to 1.
All circulatory diseases	390-458	132.54 (501)	115.18	93.14 (763)	99.15	0.86 (0.77 to 0.
Ischaemic heart disease	410-414	64.02 (242)	57.41	41.02 (336)	42.85	0.75 (0.63 to 0.
Other heart	420-429	15.34 (58)	11.90	9.03 (74)	10.12	0.85 (0.60 to 1.
Cerebrovascular disease	430-438	32.54 (123)	27.86	27.71(227)	29.19	1.05 (0.84 to 1.
Other circulatory	390-409, 440-458	20.63 (78)	18.02	15.38 (126)	16.98	0.94 (0.71 to 1.
All digestive disease	520-577	18.25 (69)	16.53	15.38 (126)	15.67	0.95 (0.71 to 1.
Liver disease	570-573	5.56 (21)	5.48	7.20 (59)	7.20	1.32 (0.80 to 2.
Violence	800-999, E800-999	13.49 (51)	12.86	19.04 (156)	19.20	1.49 (1.09 to 2.
Suicide	E950-959	4.50 (17)	4.79	6.10 (50)	6.03	1.26 (0.73 to 2

Understanding Risk: Cardiovascular Adverse Events

Most serious cardiovascular adverse events associated with all COCs

Venous thrombo-embolism

Stroke

Myocardial infarction

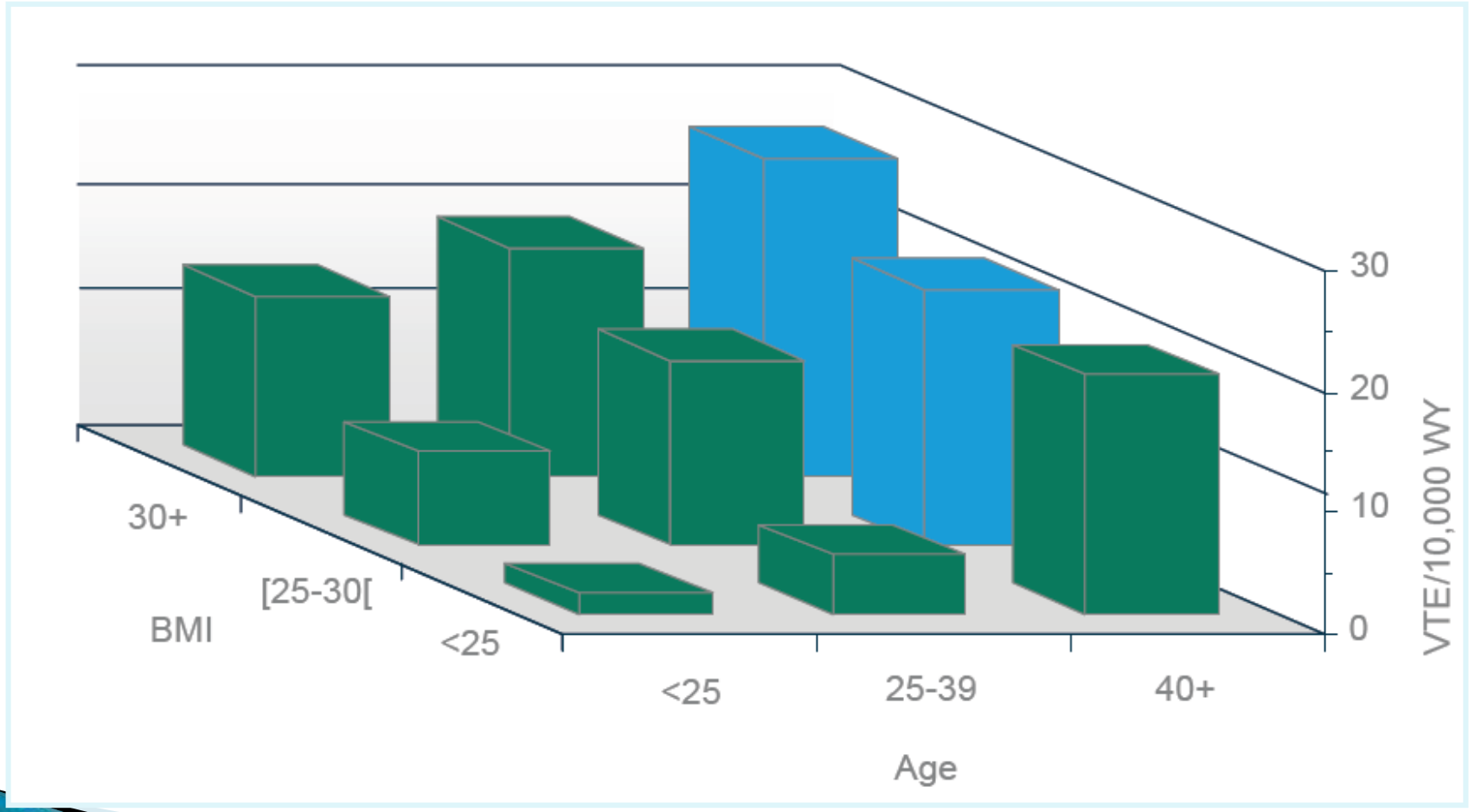
Farley et al., Contraception 1996; 57(3)211-30.

AEFI Frequency Terminology

Very common*	≥ 1/10	≥ 10%
Common (frequent)	≥ 1/100 and < 1/10	≥ 1% and < 10%
Uncommon (infrequent)	≥ 1/1,000 and < 1/100	≥ 0.1% and < 1 %
Rare	≥ 1/10,000 and < 1/1,000	≥ 0.01% and < 0.1%
Very rare*	< 1/10,000	< 0.01%

* Optional categories

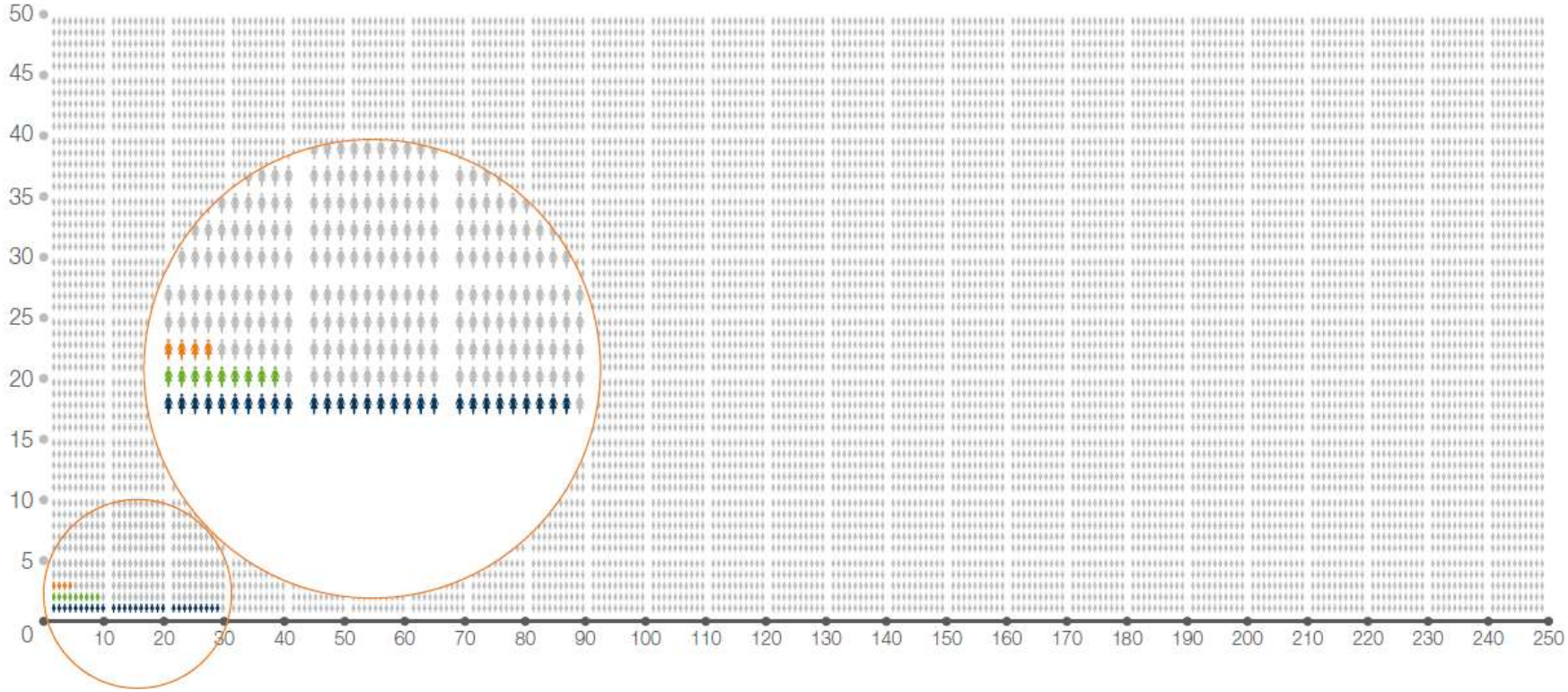
Increased Impact of Age and BMI on VTE Incidence in COC Users*



BMI: body mass index
*Risk estimates based on 115 VTEs in 116,708 WY of exposure
Dinger, EURAS Study. Presentation EC Prague 2008.

Putting the VTE Risk into Context

10,000 Woman-Years:



- Non-pregnant women not using any EE containing COCs (4.4/10,000 woman-years)
- Women using low dose EE containing COCs (8.9/10,000 woman-years)
- Pregnant women (29.5/10,000 woman-years)

Dinger et al., Contraception 2007; 75(5):344-54.

Part 3: Literature on VTE: EURAS, Ingenix, MEGA, Danish National Registry

VTE and Estrogen Dose

Table 4 | The risk of venous thrombosis associated with different doses of ethinylestradiol in monophasic oral contraceptives. Data are odds ratios adjusted for age (95% CI) unless stated otherwise

Ethinylestradiol dose (μg)	Percentage use among controls*	Levonorgestrel	Gestodene	Desogestrel
20	11.2	1.1 (0.4 to 3.1)	0.3 (0.2 to 0.7)	0.7 (0.4 to 1.2)
30†	84.4	1	1	1
50	4.4	2.2 (1.3 to 3.7)	—	—

*In total, 51 women used a monophasic preparation with 20 μg ethinylestradiol, 385 women used one with 30 μg, and 20 used one with 50 μg (total 456).
†Reference category is the most commonly used dose of oestrogen among controls.

VTE and Progestin Type

Table 3 | Risk of venous thrombosis associated with different types of progestogens in combined oral preparations. Data are numbers (percentages) unless stated otherwise

Type of progestogen	Thrombosis patients (n=1524)	Controls (n=1760)	Odds ratio (95% CI)*
Levonorgestrel†	485 (31.9)	373 (21.2)	3.6 (2.9 to 4.6)
Gestodene†	119 (7.8)	67 (3.8)	5.6 (3.7 to 8.4)
Desogestrel†	289 (19.0)	108 (6.2)	7.3 (5.3 to 10.0)
Lynestrenol†	44 (2.9)	19 (1.1)	5.6 (3.0 to 10.2)
Norethisterone	11 (0.7)	7 (0.4)	3.9 (1.4 to 10.6)
Cyproterone acetate	125 (8.2)	62 (3.5)	6.8 (4.7 to 10.0)
Norgestimate	9 (0.6)	4 (0.2)	5.9 (1.7 to 21.0)
Drospirenone	19 (1.2)	14 (0.8)	6.3 (2.9 to 13.7)
No oral contraceptive (reference)	421 (27.7)	1102 (62.8)	1

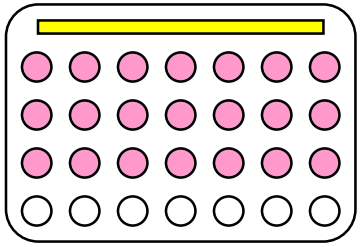
The Oral Contraceptive

21/7 Phasic

21/7 Phasic

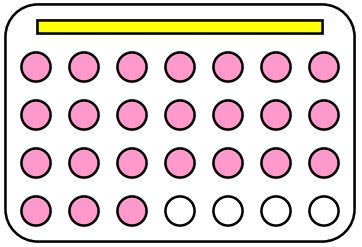
What's the Difference in OC Dosing Regimens?

Cyclic Regimen: 21/7



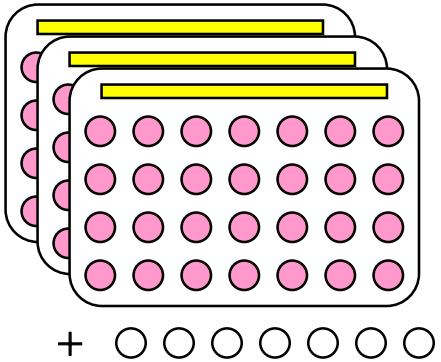
21 active pills
7 placebo pills

Cyclic Regimen: 24/4



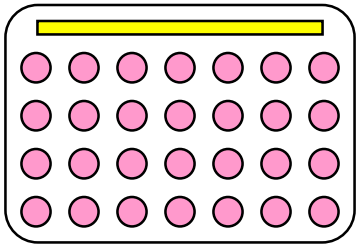
24 active pills
4 placebo pills

Extended Regimen: 84/7



84 active pills
7 placebo pills

Continuous Regimen:



365 active pills
No placebo pills

X13 pill packs

Canadian Consensus Guideline on Continuous [illegible]tended Hormonal Contraception, *JOGC 2007*; 195:S1-S32.

The EVRA Transdermal System

Confronting the Legal Risks of Prescribing the Contraceptive Patch With Ongoing Litigation

John Y. Phelps, MD, JD, LLM and Mae Ellen Kelver, MD

Recent changes in U.S. Food and Drug Administration (FDA) labeling and news reports of lawsuits resulting in million-dollar settlements understandably may deter gynecologists from prescribing the transdermal contraceptive patch Ortho Evra (Ortho-McNeil Pharmaceutical, Inc., Titusville, NJ). Gynecologists who, with all good intentions, prescribe an FDA-approved drug such as the contraceptive patch potentially could find themselves liable for an adverse drug reaction. Although much of the current focus by plaintiff attorneys and the news media is on the contraceptive patch, no prescription contraceptive method is without medical risks to the patient or legal risks to the prescribing gynecologist. The purpose of this commentary is to provide an overview of the medical–legal controversies and pitfalls in prescribing the contraceptive patch as well as to outline how gynecologists can avert legal liability by providing proper informed consent. Despite FDA labeling changes and ongoing litigation, with proper informed consent, the contraceptive patch still may be the best choice for many patients who prefer the convenience of a weekly patch over a daily oral contraceptive. Also, regardless of the contraceptive option chosen, the principles of providing and documenting proper informed consent in medical records are applicable not only to providing quality care to patients, but also to protecting the legal interests of the prescribing gynecologist. By documenting proper informed consent in medical records, gynecologists should feel more at ease in prescribing the contraceptive method that best fits their individual patients' needs, even in the presence of ongoing litigation.

(Obstet Gynecol 2009;113:712–6)

From the Department of Obstetrics and Gynecology, Division of Reproductive Endocrinology and Infertility, The University of Texas Medical Branch, Galveston, Texas.

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Financial Disclosure
The authors did not report any potential conflicts of interest.

In January 2008, the U.S. Food and Drug Administration (FDA) revised the labeling for the Ortho Evra (Ortho-McNeil Pharmaceutical, Inc., Titusville, NJ) weekly transdermal contraceptive patch, stating that users of the patch may be at higher risk of developing venous thromboembolism.[1] This followed a lawsuit recently settled for $1.25 million against Ortho-McNeil Pharmaceutical, Inc., a subsidiary of Johnson & Johnson, that was entered into federal court in Ohio for complications arising from its weekly transdermal contraceptive patch.[2] This lawsuit was filed on behalf of a 14-year-old girl who died of a pulmonary embolism several weeks after beginning use of the contraceptive patch.[2] Currently, it is estimated that there are more than 2,400 lawsuits filed against Johnson & Johnson for injuries allegedly stemming from use of the contraceptive patch.[2] The legal basis of the lawsuits includes claims for strict product liability, breach of express and implied warranties, implied warranty of merchantability, negligence, consumer fraud, and common-law fraud for its product. Among other allegations, all these claims allege that the contraceptive patch was defectively designed and that users of the patch received inadequate warnings regarding the patch's side effects and safety profile.[3] More specifically, the lawsuits allege Johnson & Johnson failed to give adequate warning of the transdermal contraceptive patch's known dangerous propensity to cause blood clots. The lawsuits follow a study that concluded there was a more than twofold increase in the risk of venous thromboembolism associated with use of the transdermal contraceptive system.[4]

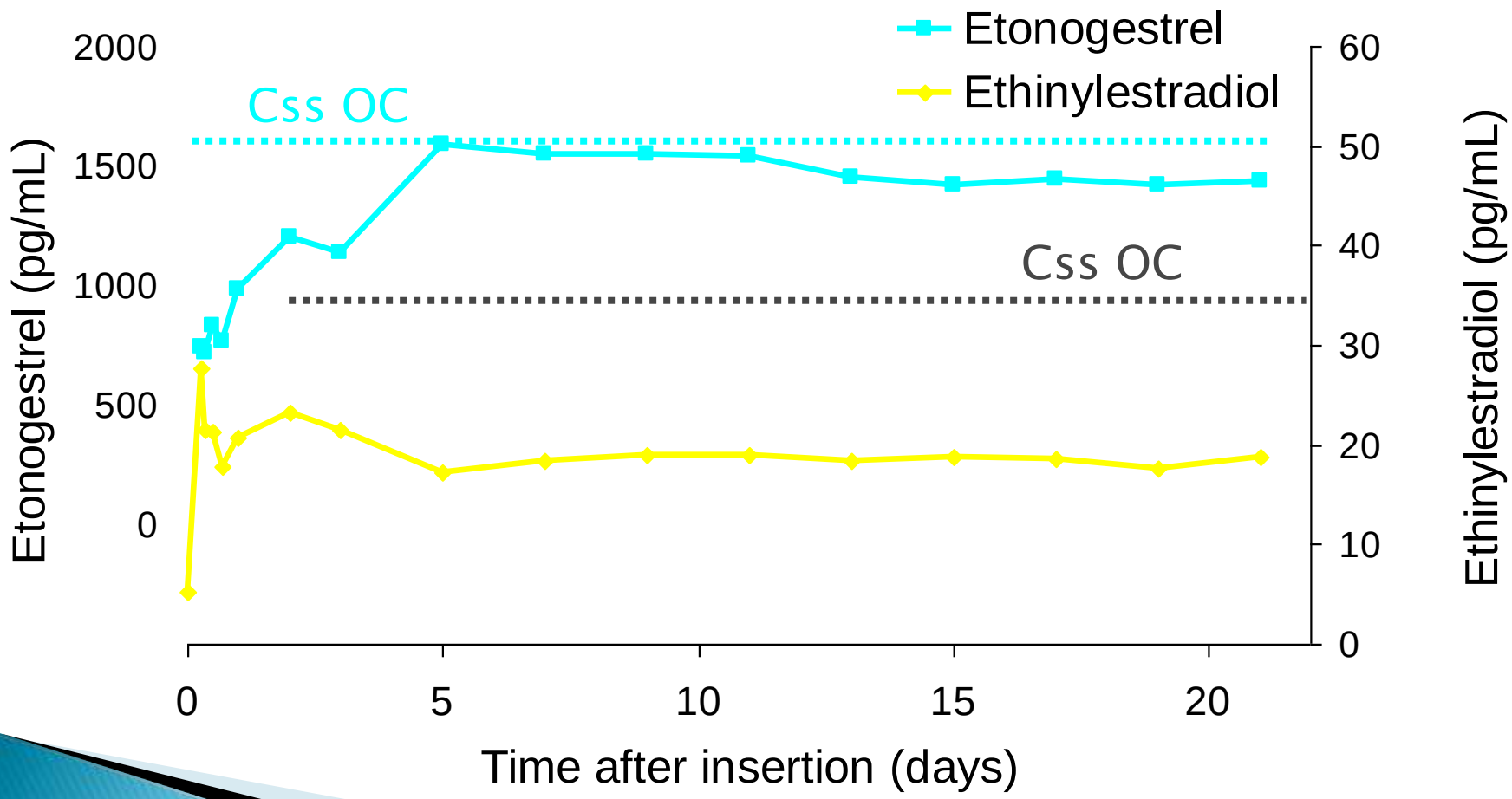
Understandably, the prescribing practices of gy-

NuvaRing

- 1 ring per cycle
- Regimen:
  - 3 weeks of ring-use
  - 1 ring-free week
- Daily release:
  - 15 µg ethinylestradiol
  - 120 µg etonogestrel

Pharmacokinetic profile

NuvaRing and 30 EE/150 DSG COC



Timmer & Mulders, Clin Pharmacokinet, 2000;39:233-42

The NEW ENGLAND JOURNAL of MEDICINE

ORIGINAL ARTICLE

Effectiveness of Long-Acting Reversible Contraception

Brooke Winner, M.D., Jeffrey F. Peipert, M.D., Ph.D., Qiuhong Zhao, M.S., Christina Buckel, M.S.W., Tessa Madden, M.D., M.P.H., Jenifer E. Allsworth, Ph.D., and Gina M. Secura, Ph.D., M.P.H.

ABSTRACT

BACKGROUND

The rate of unintended pregnancy in the United States is much higher than in other developed nations. Approximately half of unintended pregnancies are due to contraceptive failure, largely owing to inconsistent or incorrect use.

METHODS

We designed a large prospective cohort study to promote the use of long-acting reversible contraceptive methods as a means of reducing unintended pregnancies in our region. Participants were provided with reversible contraception of their choice at no cost. We compared the rate of failure of long-acting reversible contraception (intrauterine devices [IUDs] and implants) with other commonly prescribed contraceptive methods (oral contraceptive pills, transdermal patch, contraceptive vaginal ring, and depot medroxyprogesterone acetate [DMPA] injection) in the overall cohort and in groups stratified according to age (less than 21 years of age vs. 21 years or older).

From the Department of Obstetrics and Gynecology, Washington University School of Medicine, St. Louis. Address reprint requests to Dr. Peipert at the Department of Obstetrics and Gynecology, Division of Clinical Research, Washington University School of Medicine in St. Louis, 4533 Clayton Ave., Campus Box 8219, St. Louis, MO 63110, or at peipertj@wustl.edu.

N Engl J Med 2012;366:1998-2007.

Back to The Future:Depo-provera

Two categories of intrauterine contraception (IUC)

COPPER IUD

- Copper IntraUterine Device (copper IUD)
- 3.2cm piece of polyethylene often shaped like a T
- Copper coil wound round stalk and, sometimes, horizontal parts
- Two monofilament threads hang from uterus through cervix into vagina

LNG-IUS

- LevoNorGestrel-releasing IntraUterine System (LNG-IUS)
- 3.2cm piece of polyethylene shaped like a T
- Cylindrical reservoir around stalk contains 52 mg levonorgestrel
- Two monofilament threads hang from uterus through cervix into vagina

[1]Black et al. J Obstet Gyencol Can 2004; 143: 219-254
[2]Mirena Product Monograph, Bayer Inc. July 20, 2012
[3] Nova T Product Leaflet, Bayer Inc. January 26, 2007

Mirena

- Intrauterine system (IUS)
- Releases up to 20 µg/day o levonorgestrel (progestin)
- No estrogen
- 5 years of treatment

Indications

- Contraception

What is Jaydess®?

Jaydess® is:

- The smallest LNG-IUS available[1]
- Inserted using the smallest diameter insertion tube for an IUS (3.80 mm)[2]
- The lowest dose LNG-IUS available (initial *in vivo* release rate: 10 µg/day*)
- Approved for 3 years' maximum duration of use[1]

- Characteristics in common with Mirena®:
  - Estrogen-free
  - Mainly locally acting; minimal systemic exposure to levonorgestrel[1]

Jaydess®

IUS, intrauterine system;
LNG-IUS, levonorgestrel intrauterine system
*initial release rate, 3-4 weeks after insertion

1. Jaydess® Product Monograph, Bayer Inc. June 18, 2013;
2. Gemzell-Danielsson et al. Fertil Steril 2012; 97: 616-622.

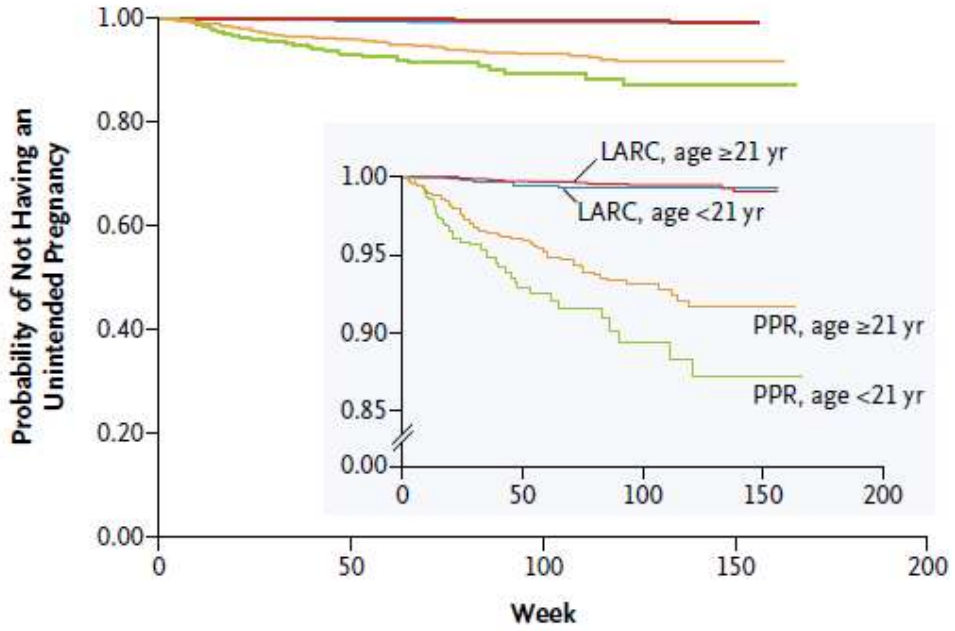


Figure 2. Probability of Not Having an Unintended Pregnancy, According to Contraceptive Method and Age.

Survival curves show the probability of not having an unintended pregnancy, stratified according to age group. LARC methods were the most effective, and failure rates did not vary according to age (P=0.49). PPR methods were less effective, and failure rates in participants younger than 21 years old were twice as great as in women 21 years of age or older (P=0.02).

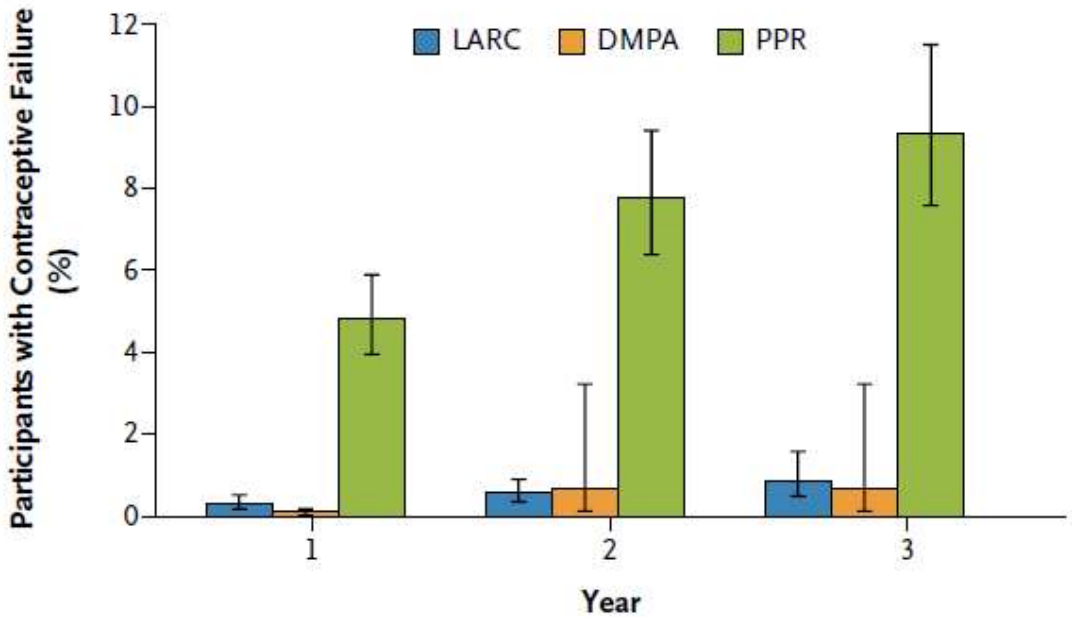


Figure 1. Cumulative Percentage of Participants Who Had a Contraceptive Failure at 1, 2, or 3 Years, According to Contraceptive Method.

Bars depict the cumulative percentage of participants who had a contraceptive failure with long-acting reversible contraception (LARC), depot medroxyprogesterone acetate (DMPA), or pill, patch, or ring (PPR) at 1, 2, or 3 years. Participants using PPR had significantly more unintended pregnancies than those using LARC ($P<0.001$) or DMPA ($P<0.001$).

Original Research

Cancer Risk in Women Using the Levonorgestrel-Releasing Intrauterine System in Finland

Tuuli Soini, MD, Ritva Hurskainen, MD, Seija Grénman, MD, Johanna Mäenpää, MD, Jorma Paavonen, MD, and Eero Pukkala, PhD

The American College of
Obstetricians and Gynecologists
WOMEN'S HEALTH CARE PHYSICIANS

COMMITTEE OPINION

Number 539 • October 2012 *(Replaces Committee Opinion No. 392, December 2007)*

Committee on Adolescent Health Care
Long-Acting Reversible Contraception Working Group

This document reflects emerging clinical and scientific advances as of the date issued and is subject to change. The information should not be construed as dictating an exclusive course of treatment or procedure to be followed.

Adolescents and Long-Acting Reversible Contraception: Implants and Intrauterine Devices

ABSTRACT: Long-acting reversible contraception (LARC)—intrauterine devices and the contraceptive implant—are safe and appropriate contraceptive methods for most women and adolescents. The LARC methods are top-tier contraceptives based on effectiveness, with pregnancy rates of less than 1% per year for perfect use and typical use. These contraceptives have the highest rates of satisfaction and continuation of all reversible contraceptives. Adolescents are at high risk of unintended pregnancy and may benefit from increased access to LARC methods.

PEDIATRICS®
OFFICIAL JOURNAL OF THE AMERICAN ACADEMY OF PEDIATRICS

Contraception for Adolescents

COMMITTEE ON ADOLESCENCE

Pediatrics; originally published online September 29, 2014;
DOI: 10.1542/peds.2014-2299

RECOMMENDATIONS

1. Pediatricians should counsel about and ensure access to a broad range of contraceptive services for their adolescent patients. This includes educating patients about all contraceptive methods that are safe and appropriate for them and describing the most effective methods first.
2. Pediatricians should be able to educate adolescent patients about LARC methods, including the progestin implant and IUDs. Given the efficacy, safety, and ease of use, LARC methods should be considered first-line contraceptive choices for adolescents. Some pediatricians may choose to acquire the skills to provide these methods to adolescents. Those who do not should identify health care providers in their communities to whom patients can be referred.
3. Despite increased attention to adverse effects, DMPA and the contraceptive patch are highly effective methods of contraception that are much safer than pregnancy. Pedia-

The American College of
Obstetricians and Gynecologists
WOMEN'S HEALTH CARE PHYSICIANS

COMMITTEE OPINION SUMMARY

Number 642 • October 2015

(Replaces Committee Opinion Number 450, December 2009)

For a comprehensive overview of these recommendations, the full-text version of this Committee Opinion is available at http://dx.doi.org/10.1097/AOG.0000000000001106.

Scan this QR code with your smart phone to view the full-text version of this Committee Opinon.

Committee on Gynecologic Practice
Long-Acting Reversible Contraception Working Group

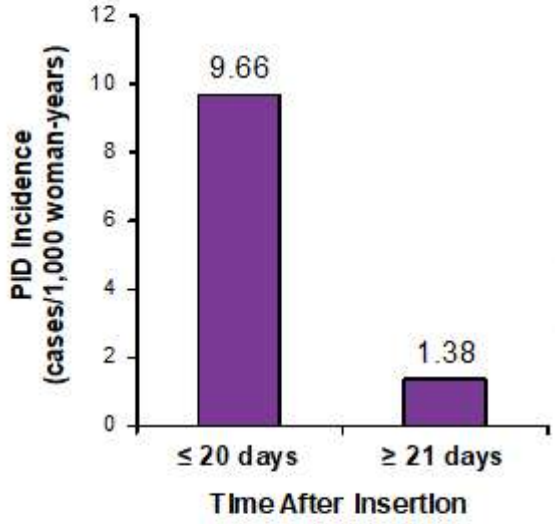
This document reflects emerging clinical and scientific advances as of the date issued and is subject to change. The information should not be construed as dictating an exclusive course of treatment or procedure to be followed.

Increasing Access to Contraceptive Implants and Intrauterine Devices to Reduce Unintended Pregnancy

ABSTRACT: Unintended pregnancy persists as a major public health problem in the United States. Although lowering unintended pregnancy rates requires multiple approaches, individual obstetrician–gynecologists may contribute by increasing access to contraceptive implants and intrauterine devices. Obstetrician–gynecologists should encourage consideration of implants and intrauterine devices for all appropriate candidates, including nulliparous women and adolescents. Obstetrician–gynecologists should adopt best practices for long-acting reversible contraception insertion. Obstetrician–gynecologists are encouraged to advocate for coverage and appropriate payment and reimbursement for every contraceptive method by all payers in all clinically appropriate circumstances.

Myth # 1: IUDs Cause PID

PID associated with insertion of IUC



WHO randomized controlled trial data

22,908 IUC insertions

51,399 woman-years of follow-up

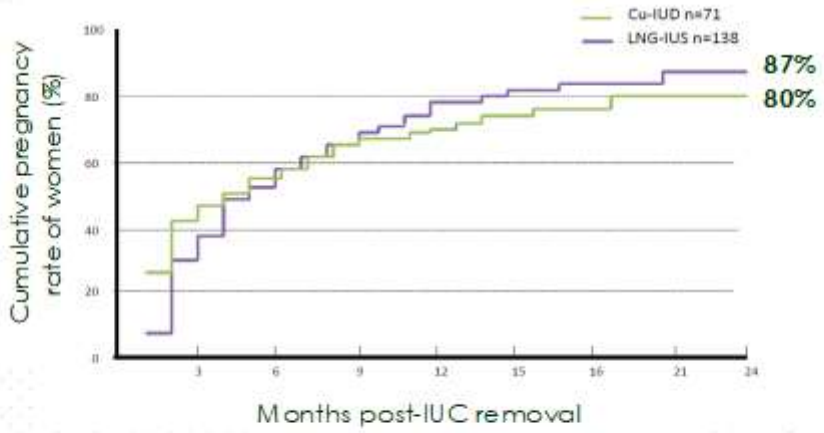
PID overall rate 1.58/1000 WY

IUC – Intrauterine contraception
PID – Pelvic inflammatory disease
WHO – World Health Organization
WY – Woman-years

1. Farley et al. Lancet 1992; 339: 785-788.
2. ACOG Practice on Practice Bulletins. Obstet Gynecol 2005; 105: 223-232.
3. Black et al. J Obstet Gynaecol Can 2004; 26: 219-254.

Myth #2 : IUDs Cause Infertility

IUC does not alter the course of future fertility



Cu-IUD, copper intrauterine device
IUC, intrauterine contraception
LNG-IUS, levonorgestrel intrauterine system

Andersson et al Contraception 1992; 46:575-584

Nulliparous women: SOGC guidelines

MYTH

"Nulliparous women cannot use IUDs."

FACT

"Nulliparity is not a contraindication to IUD use. In carefully selected nulliparous women, IUDs may be successfully used."

IUD, Intrauterine device
SOGC, Society of Obstetricians and Gynecologists of Canada

Black A et al. SOGC Clinical Practice Guidelines. J Obstet Gynaecol Can. 2004; 143: 219-254.

Implanon

Implanon