Contraceptive Care for Women with Medical Conditions: the Why’s and the How’s

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Director, Jane Fonda Center
Disclosures

- Woman Care Global
- Ibis Reproductive Health

- Thank you to Carrie Cwiak for some of these slides
Learning Objectives

• List several medical conditions that put a woman at increased risk of adverse events during pregnancy
• Describe the CDC’s guidance on contraceptive provision, including the Medical Eligibility Criteria and Selected Practice Recommendations
• Develop contraceptive care plans for women with common and complex medical conditions
Approach to providing contraception

First: Do no harm.
Approach to providing contraception

Second:
Try to do good.
US Adaptations to WHO guidelines

*Who* can use

*What*

*How to use*

*Contraception effectively*

*How to provide*

*Family planning services*
Always at your fingertips

- www.cdc.gov/reproductivehealth/unintendedpregnancy/USMEC.html
- Sign up for updates
Guidance for contraceptive use
MEC (who can use what)
<table>
<thead>
<tr>
<th>Category</th>
<th>With Clinical Judgement</th>
<th>With Limited Clinical Judgement</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Use method for any circumstance</td>
<td>Use the method</td>
</tr>
<tr>
<td>2</td>
<td>Use the method with increased follow up as needed</td>
<td>Use the method</td>
</tr>
<tr>
<td>3</td>
<td>Not recommended unless no other method available or acceptable</td>
<td>Do not use</td>
</tr>
<tr>
<td>4</td>
<td>Do not use</td>
<td>Do not use</td>
</tr>
</tbody>
</table>
Our Clinical Dilemma
Maternal mortality in US


*Note: Number of pregnancy-related deaths per 100,000 live births per year.
Why are women dying?
Maternal morbidity in the US

Rate of severe maternal morbidity per 10,000 delivery hospitalizations

Overall rate of severe maternal morbidity with blood transfusions
Blood transfusions
Severe maternal morbidity without blood transfusions

www.cdc.gov
BOX 2. Conditions associated with increased risk for adverse health events as a result of unintended pregnancy

- Breast cancer
- Complicated valvular heart disease
- Diabetes: insulin-dependent; with nephropathy/retinopathy/neuropathy or other vascular disease; or of >20 years’ duration
- Endometrial or ovarian cancer
- Epilepsy
- Hypertension (systolic >160 mm Hg or diastolic >100 mm Hg)
- History of bariatric surgery within the past 2 years
- HIV/AIDS
- Ischemic heart disease
- Malignant gestational trophoblastic disease
- Malignant liver tumors (hepatoma) and hepatocellular carcinoma of the liver
- Peripartum cardiomyopathy
- Schistosomiasis with fibrosis of the liver
- Severe (decompensated) cirrhosis
- Sickle cell disease
- Solid organ transplantation within the past 2 years
- Stroke
- Systemic lupus erythematosus
- Thrombogenic mutations
- Tuberculosis
BOX 2: Conditions associated with increased risk for adverse health events as a result of unintended pregnancy.

- [Long-acting, highly effective contraceptive methods may be the best choice](#)
- Sole use of barrier and behavior-based methods [may not be the most appropriate choice](#) because of their relatively higher typical-use rates of failure
Figure 3-1 Comparing typical effectiveness of contraceptive methods

More effective
Less than 1 pregnancy per 100 women in one year

Injectable
- Get repeat injections on time

Pills
- Take a pill each day

Patch, ring
- Keep in place, change on time

Diaphragm
- Use correctly every time you have sex

How to make your method most effective
After procedure, little or nothing to do or remember
Vasectomy: Use another method for first 3 months

Injectable: Get repeat injections on time
Pills: Take a pill each day
Patch, ring: Keep in place, change on time
Diaphragm: Use correctly every time you have sex

Less effective
6-12 pregnancies per 100 women in one year

Condoms, sponge, withdrawal, spermicides: Use correctly every time you have sex

Fertility awareness-based methods: Abstain or use condoms on fertile days.
Newest methods (Standard Days Method and TwoDay Method) may be the easiest to use and consequently more effective

Source: Adapted from WHO 2007

Less effective
6-12 pregnancies per 100 women in one year
Contraceptive Efficacy and Continuation

<table>
<thead>
<tr>
<th>Method</th>
<th>Typical use</th>
<th>Perfect use</th>
<th>Women continuing use at 1 year</th>
</tr>
</thead>
<tbody>
<tr>
<td>No method†</td>
<td>85%</td>
<td>85%</td>
<td>42%</td>
</tr>
<tr>
<td>Spermicides**</td>
<td>29%</td>
<td>18%</td>
<td>43%</td>
</tr>
<tr>
<td>Withdrawal</td>
<td>27%</td>
<td>4%</td>
<td>51%</td>
</tr>
<tr>
<td>Fertility awareness-based methods</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Standard Days method††</td>
<td></td>
<td>5%</td>
<td></td>
</tr>
<tr>
<td>TwoDay method™††</td>
<td></td>
<td>4%</td>
<td></td>
</tr>
<tr>
<td>Ovulation method††</td>
<td></td>
<td>3%</td>
<td></td>
</tr>
<tr>
<td>Sponge</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Parous women</td>
<td>32%</td>
<td>20%</td>
<td>46%</td>
</tr>
<tr>
<td>Nulliparous women</td>
<td>16%</td>
<td>9%</td>
<td>57%</td>
</tr>
<tr>
<td>Diaphragm§†</td>
<td>16%</td>
<td>6%</td>
<td>57%</td>
</tr>
<tr>
<td>Condom††</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female (Reality®)</td>
<td>21%</td>
<td>5%</td>
<td>49%</td>
</tr>
<tr>
<td>Male</td>
<td>15%</td>
<td>2%</td>
<td>53%</td>
</tr>
<tr>
<td>Combined pill and progestin-only pill</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Evra patch®</td>
<td>8%</td>
<td>0.3%</td>
<td>68%</td>
</tr>
<tr>
<td>NuvaRing®</td>
<td>8%</td>
<td>0.3%</td>
<td>68%</td>
</tr>
<tr>
<td>Depo-Provera®</td>
<td>3%</td>
<td>0.3%</td>
<td>56%</td>
</tr>
<tr>
<td>Intrauterine device</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ParaGard® (copper T)</td>
<td>0.8%</td>
<td>0.6%</td>
<td>78%</td>
</tr>
<tr>
<td>Mirena® (LNG-IUS)</td>
<td>0.2%</td>
<td>0.2%</td>
<td>80%</td>
</tr>
<tr>
<td>Implanon®</td>
<td>0.05%</td>
<td>0.05%</td>
<td>84%</td>
</tr>
<tr>
<td>Female sterilization</td>
<td>0.5%</td>
<td>0.5%</td>
<td>100%</td>
</tr>
<tr>
<td>Male sterilization</td>
<td>0.15%</td>
<td>0.10%</td>
<td>100%</td>
</tr>
<tr>
<td>Emergency contraceptive pills***</td>
<td>Not applicable</td>
<td>Not applicable</td>
<td>Not applicable</td>
</tr>
<tr>
<td>Lactational amenorrhea methods††</td>
<td>Not applicable</td>
<td>Not applicable</td>
<td>Not applicable</td>
</tr>
</tbody>
</table>

Top Tier of Effectiveness

Long-Acting Reversible Contraception

• Copper T IUD
• Progestin-only IUD
• Progestin-only implant
Top Tier of Effectiveness

LARC
• 20 times more effective than other reversible methods
• Lowest adverse event rates
• Highest patient satisfaction rates
• Most cost-effective
• Easiest to use
Common Themes in the MEC

- IUDs and implants are typically the safest options
- Other progestin-only and non-hormonal methods are generally safe options
- Estrogen-containing methods can increase cardiovascular complications in women with risk factors
Green Light Conditions

- Gestational hypertension
- Gestational diabetes
- Thyroid disorders
- Mitral valve prolapse
- Varicose veins
- Cervical dysplasia
- Ectopic pregnancy
- Past history of PID
- Non-migraine headaches
- Cholecystectomy
- HIV
- Sickle cell disease
- Benign breast cysts
- Family history of cancer
- Obesity
- Depression
- Adolescence
- Perimenopause
Not in the MEC?

• Why isn’t it there?
  • There is little or no evidence with a certain medical condition

• What do you do?
  • Review the possible complications of the condition
  • Review the common themes for use of methods
  • Resource review (i.e., systematic reviews, Up-to-Date)
  • Consult with another experienced clinician
Clinical Cases:
Women with Medical Conditions
FIGURE 2. Clinical pathway of family planning services for women and men of reproductive age

Determine the need for services among female and male clients of reproductive age
- Assess reason for visit
- Assess source of primary care
- Assess reproductive life plan

Reason for visit is related to preventing or achieving pregnancy
- Contraceptive services
- Pregnancy testing and counseling
- Achieving pregnancy
- Basic infertility services

Initial reason for visit is not related to preventing or achieving pregnancy
- Acute care
- Chronic care management
- Preventive services

If needed, provide services

Assess need for services related to preventing or achieving pregnancy

If services are not needed at this visit, reassess at subsequent visits

Clients also should be provided these services, per clinical recommendations
- Sexually transmitted disease services
- Preconception health services

Clients also should be provided or referred for these services, per clinical recommendations
- Related preventive health services
Our Clinical Dilemma
Chronic Disease

- Contraception
  - Safety of contraceptive use given the condition
  - Non-contraceptive benefits
- Preconception care
  - Likelihood of pregnancy affecting the mother’s health
  - Likelihood of the medical condition affecting the pregnancy.
- For certain conditions,
  - modifying the treatment of the condition
  - avoidance or timing of a potential conception.
- What are her goals? And her understanding of these intersections?
- When appropriate, engage with a maternal-fetal medicine specialist and a provider with expertise in the condition.
Medication Use

• Encourage the simplest effective regimen to optimize her health.
• For women who are using a teratogenic medication
  – If possible, switch to other agents.
  – If not possible, careful counseling should be done indicating the risks, alternatives and a plan for contraception initiated.
  – Counsel regarding what to do with their medication regimen should they conceive.
• Some medications interact with contraceptives
  – Anti-retrovirals
  – Anti-convulsants
  – Rifampin/rifabutin
Lakeisha

• 32 yo para 1 with personal history of a pulmonary embolism with her last pregnancy 3 years ago. She was on lovenox until 6 weeks postpartum. Her doctor told her she “cannot use birth control.”

• Is this true?
Increased Risk of VTE

- Pregnancy alone increases risk of clotting
  - Amplified in postpartum period
- Personal history of VTE further increases risk during pregnancy
- Additional risk factors may increase risk
  - Thrombophilia, cancer, recurrence
- Addition of anticoagulants affects the risk-benefit ratio

Risk of Arterial Events

Myocardial infarction (MI) or cerebrovascular accident (CVA)

• Less common but with more severe sequelae
• Risk doubled with current combined method use
• Not increased with past use

Khader 2003, Lidegaard 2012
Progestin-Only Methods

No increase in cardiovascular events

- No increase in VTE or MI with injection or pills
  - Small increase in CVA if severe HTN
- No increase in CVA, MI with implant, IUD, pills

Lidegaard 2012, Chaktoura 2011, Chakhtoura 2009
## Increased Risk of VTE

<table>
<thead>
<tr>
<th>Condition</th>
<th>Sub-condition</th>
<th>Combined pill, patch, ring</th>
<th>Progestin-only pill</th>
<th>Injection</th>
<th>Implant</th>
<th>LNG-IUD</th>
<th>Copper-IUD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deep venous thrombosis (DVT) / Pulmonary embolism (PE)</td>
<td>a) History of DVT/PE, not on anticoagulant therapy</td>
<td>I</td>
<td>C</td>
<td>I</td>
<td>C</td>
<td>I</td>
<td>C</td>
</tr>
<tr>
<td></td>
<td>i) higher risk for recurrent DVT/PE</td>
<td>4</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>ii) lower risk for recurrent DVT/PE</td>
<td>3*</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>b) Acute DVT/PE</td>
<td>4</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>c) DVT/PE and established on anticoagulant therapy for at least 3 months</td>
<td>4*</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>i) higher risk for recurrent DVT/PE</td>
<td>4*</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>ii) lower risk for recurrent DVT/PE</td>
<td>3*</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>d) Family history (first-degree relatives)</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>e) Major surgery</td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>(i) with prolonged immobilization</td>
<td>4</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>(ii) without prolonged immobilization</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>f) Minor surgery without immobilization</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
</tbody>
</table>
Stacia

- 38 yo para 3 who has had gestational hypertension with all her pregnancies. Her BP today is 150/94. She desires no future fertility and wants to have a regular menstrual period.

- What are her options?
- Are some methods safer for her than others?
Hypertension

- Increases risk of pregnancy-related events
  - Several antihypertensives are contraindicated in pregnancy (ACE-I)
  - Use of COCs may cause a minor increase in BP (Avg 8 mm Hg systolic/6 mm Hg diastolic)
  - WHO case-control study showed an increase in CVA in those with COC use and HTN
## Hypertension

<table>
<thead>
<tr>
<th>Condition</th>
<th>Sub-condition</th>
<th>Combined pill, patch, ring</th>
<th>Progesterin-only pill</th>
<th>Injection</th>
<th>Implant</th>
<th>LNG-IUD</th>
<th>Copper-IUD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hypertension</td>
<td>a) Adequately controlled hypertension</td>
<td>3*</td>
<td>1*</td>
<td>2*</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>b) Elevated blood pressure levels (properly taken measurements)</td>
<td></td>
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<td></td>
</tr>
<tr>
<td></td>
<td>(i) Systolic 140-159 or diastolic 90-99</td>
<td>3</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>(ii) Systolic ≥160 or diastolic ≥100‡</td>
<td>4</td>
<td>2</td>
<td>3</td>
<td>2</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>c) Vascular disease</td>
<td>4</td>
<td>2</td>
<td>3</td>
<td>2</td>
<td>2</td>
<td>1</td>
</tr>
</tbody>
</table>
Irene

• 42 yo para 2 ab 2 with migraines diagnosed as a teen. Started on COCs back then for recurrent ovarian cysts. She did not have migraines for two years while on propranolol, but recently stopped and now has aura. She wants to continue her COCs.
  • Can she safely do so?
  • What are better options for her?
Migraine Headaches

• Ensure diagnosis of migraine headache
  – Typically unilateral, throbbing, with photophobia, phonophobia, nausea
  – Auras are neurologic symptoms that precede the headache

• Those with migraines have 2-3.5 risk of ischemic stroke above baseline

• Combined methods further increase risk 2-4 fold above those with migraines not using combined contraceptives
# Migraines

<table>
<thead>
<tr>
<th>Headaches</th>
<th>1</th>
<th>1</th>
<th>1</th>
<th>1</th>
<th>1</th>
<th>1</th>
<th>1*</th>
</tr>
</thead>
<tbody>
<tr>
<td>a) Nonmigraine (mild or severe)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>b) Migraine</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>i) Without aura (includes menstrual migraine)</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2*</td>
</tr>
<tr>
<td>ii) With aura</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>4*</td>
</tr>
</tbody>
</table>
Caitlin

• 17 yo gravida 0 with diabetes mellitus, requiring insulin for glucose control. Has a hard time keeping up with her insulin regimen. Currently being evaluated for new onset proteinuria.

• What methods are you going to discuss first?
• What if she wants to use the patch?
Diabetes Mellitus

• Increases maternal and fetal risks during pregnancy
• Inconsistent or no evidence that any method affects glucose metabolism or insulin requirements
  • Any changes in non-diabetic women are clinically insignificant
  • Obese non-diabetic women may have minor effects
  • Diabetic women may have minor effects

# Diabetes

<table>
<thead>
<tr>
<th>Condition</th>
<th>Sub-condition</th>
<th>Combined pill, patch, ring</th>
<th>Progestin-only pill</th>
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<th>Implant</th>
<th>LNG–IUD</th>
<th>Copper–IUD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diabetes mellitus (DM)</td>
<td>a) History of gestational DM only</td>
<td>I</td>
<td>C</td>
<td>I</td>
<td>C</td>
<td>I</td>
<td>C</td>
</tr>
<tr>
<td></td>
<td>b) Non-vascular disease</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diabetes mellitus (cont.)</td>
<td>(i) non-insulin dependent</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>(ii) insulin dependent‡</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>c) Nephropathy/ retinopathy/ neuropathy‡</td>
<td>3/4*</td>
<td>2</td>
<td>3</td>
<td>2</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>d) Other vascular disease or diabetes of &gt;20 years' duration‡</td>
<td>3/4*</td>
<td>2</td>
<td>3</td>
<td>2</td>
<td>2</td>
<td>1</td>
</tr>
</tbody>
</table>
Yasmeen

• 23 yo para 1 who gained 40 pounds during her pregnancy. She is 6 weeks postpartum and is breastfeeding. Her BMI is 32. She desires another pregnancy in two years. She is hesitant to use contraception because she is afraid of further weight gain.
  • How do you counsel her?
Obesity

Increased risk of:

– Maternal complications:
  • Preeclampsia, VTE, increased glucose levels, cesarean section

– Fetal complications:
  • Fetal loss, birth defects, IUGR, increase in childhood obesity

## Obesity

<table>
<thead>
<tr>
<th>Condition</th>
<th>Sub-condition</th>
<th>Combined pill, patch, ring</th>
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<th>Injection</th>
<th>Implant</th>
<th>LNG-IUD</th>
<th>Copper-IUD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Obesity</td>
<td>a) ≥30 kg/m² body mass index (BMI)</td>
<td>I C</td>
<td>I C</td>
<td>I C</td>
<td>I C</td>
<td>I C</td>
<td>I C</td>
</tr>
<tr>
<td>Obesity</td>
<td>b) Menarche to &lt; 18 years and ≥ 30 kg/m² BMI</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Breastfeeding (see also Postpartum)</th>
<th>a) &lt;1 month postpartum</th>
<th>b) 1 month or more postpartum</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>3*</td>
<td>2*</td>
</tr>
<tr>
<td></td>
<td>2*</td>
<td>1*</td>
</tr>
</tbody>
</table>

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EMORY UNIVERSITY SCHOOL OF MEDICINE
I had a patient today requesting a Paragard IUD. She is 31, hypertensive, chronic kidney disease was close to having to go on dialysis (had a shunt placed in arm) but kidney function improved to not needing it. Hgb was 7.3 on 4/17 and today 6.1. Also has hx of blood clot in arm. Gave a hx of heavy bleeding but then says period is 3 days and sometimes may skip a month and not have a period. I did not insert the Paragard, today would like to see Hgb improve. Was in hosp last week after an allergic reaction of some type most likely seasonal environmental. What should be the lower limit on HGB?
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Considerations

• Excellent to discuss non-estrogen methods, including LARC
• Her anemia may be due to chronic kidney disease vs. HMB
• Women with iron deficiency anemia (and other anemias), heavy/prolonged bleeding can use any method of contraception
• IUDs impact bleeding, and potentially anemia differently
  – LNG IUDs can decrease menstrual bleeding and improve anemia
  – Cu IUDs can increase menstrual blood loss, but a systematic review found no clinically significant change in hemoglobin among women up to 5 years follow-up
  – There is no need from a contraceptive perspective to screen for anemia prior to placement of an IUD
• Each person/uterus is different
### How to Be Reasonably Certain That a Woman is Not Pregnant

A health-care provider can be reasonably certain that a woman is not pregnant if she has no symptoms or signs of pregnancy and meets any one of the following criteria:
- is ≤7 days after the start of normal menses
- has not had sexual intercourse since the start of last normal menses
- has been correctly and consistently using a reliable method of contraception
- is ≤7 days after spontaneous or induced abortion
- is within 4 weeks postpartum
- is fully or nearly fully breastfeeding (exclusively breastfeeding or the vast majority [≥85%] of feeds are breastfeeding), amenorrheic, and <6 months postpartum

### When to Start Using Specific Contraceptive Methods

<table>
<thead>
<tr>
<th>Contraceptive method</th>
<th>When to start (if the provider is reasonably certain that the woman is not pregnant)</th>
<th>Additional contraception (i.e., back up) needed</th>
<th>Examinations or tests needed before initiation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Copper-containing IUD</td>
<td>Anytime</td>
<td>Not needed</td>
<td>Bimanual examination and cervical inspection²</td>
</tr>
<tr>
<td>Levonorgestrel-releasing IUD</td>
<td>Anytime</td>
<td>If &gt;7 days after menses started, use back-up method or abstain for 7 days.</td>
<td>Bimanual examination and cervical inspection²</td>
</tr>
<tr>
<td>Implant</td>
<td>Anytime</td>
<td>If &gt;5 days after menses started, use back-up method or abstain for 7 days.</td>
<td>None</td>
</tr>
<tr>
<td>Injectable</td>
<td>Anytime</td>
<td>If &gt;7 days after menses started, use back-up method or abstain for 7 days.</td>
<td>None</td>
</tr>
<tr>
<td>Combined hormonal contraceptive</td>
<td>Anytime</td>
<td>If &gt;5 days after menses started, use back-up method or abstain for 7 days.</td>
<td>Blood pressure measurement</td>
</tr>
<tr>
<td>Progestin-only pill</td>
<td>Anytime</td>
<td>If &gt;5 days after menses started, use back-up method or abstain for 2 days.</td>
<td>None</td>
</tr>
</tbody>
</table>

### Abbreviations:
- BMI = body mass index
- IUD = intrauterine device
- STD = sexually transmitted disease
- U.S. MEC = U.S. Medical Eligibility Criteria for Contraceptive Use

1. Weight (BMI) measurement is not needed to determine medical eligibility for any methods of contraception because all methods can be used (U.S. MEC 1) or generally can be used (U.S. MEC 2) among obese women. However, measuring weight and calculating BMI (weight [kg]/height [m²]) at baseline might be helpful for monitoring any changes and counseling women who might be concerned about weight change perceived to be associated with their contraceptive method.

2. Most women do not require additional STD screening at the time of IUD insertion. If a woman with risk factors for STDs has not been screened for gonorrhea and chlamydia according to CDC's STD Treatment Guidelines (http://www.cdc.gov/std/treatment), screening can be performed at the time of IUD insertion, and insertion should not be delayed. Women with current purulent cervicitis or chlamydial infection or gonococcal infection should not undergo IUD insertion (U.S. MEC 4).
Screening Prior to Initiation

- Unnecessary tests may be a barrier
- Recommendations address exams and tests needed prior to initiation
  - **Class A** = essential and mandatory
  - **Class B** = contributes substantially to safe and effective use, but implementation may be considered within context
  - **Class C** = does not contribute substantially to safe and effective use of the contraceptive method
# Exams and tests prior to initiation

<table>
<thead>
<tr>
<th>Examination or test</th>
<th>Contraceptive method and class</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>LNG and Cu-IUD</td>
</tr>
<tr>
<td>Blood pressure</td>
<td>C</td>
</tr>
<tr>
<td>Weight (BMI)</td>
<td><em>†</em></td>
</tr>
<tr>
<td>Clinical breast examination</td>
<td>C</td>
</tr>
<tr>
<td>Bimanual examination and cervical inspection</td>
<td>A</td>
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<tr>
<td>Laboratory test</td>
<td></td>
</tr>
<tr>
<td>Glucose</td>
<td>C</td>
</tr>
<tr>
<td>Lipids</td>
<td>C</td>
</tr>
<tr>
<td>Liver enzymes</td>
<td>C</td>
</tr>
<tr>
<td>Hemoglobin</td>
<td>C</td>
</tr>
<tr>
<td>Thrombogenic mutations</td>
<td>C</td>
</tr>
<tr>
<td>Cervical cytology (Papanicolaou smear)</td>
<td>C</td>
</tr>
<tr>
<td>STD screening with laboratory tests</td>
<td><em>§</em></td>
</tr>
<tr>
<td>HIV screening with laboratory tests</td>
<td>C</td>
</tr>
</tbody>
</table>
From the field

- 40 yo, BMI 36, normal-borderline BP, who has von Willebrand's Disease. She wants birth control. Has history of ovarian cysts. The patient does not want a Mirena IUD because she had a ParaGard several years back, had pain, and pulled out the Paragard herself. She wants Depo Provera, but I worry that the von Willebrand's may cause the bleeding expected with Depo Provera to be worse, also with Nexplanon. Would progestin only pills be the best option for this patient?
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Considerations

• Does she have “multiple risk factors for arterial disease”?
• Previous pain with an IUD does not preclude future use
• LNG IUDs can reduce pain and bleeding, but some women will experience ovarian cysts (what are these cysts?)
• DMPA inhibits ovulation and leads to amenorrhea over time in most women
• POPs are very time sensitive and missing pills increases risk of break through bleeding and pregnancy
In Summary

Contraception is generally safer than pregnancy in women with chronic medical conditions

• A detailed discussion of her reproductive goals is imperative.
• Evidence-based resources are available to assist
• Most women are eligible for one of the LARC methods
• Avoid additional risk with contraceptive use if possible
• Closer and multidisciplinary follow-up may be indicated
QUESTIONS?
References

• Allen, Cwiak. Contraception For The Medically Challenging Patient, 2014
• CDC’S Medical Eligibility Criteria. http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5904a1.htm?s_cid=rr5904a1_w
• CDC’S Selected Practice Recommendations For Contraceptive Use http://www.cdc.gov/mmwr/pdf/rr/rr62e0614.pdf
• CDC’S Quality Family Planning https://www.cdc.gov/mmwr/pdf/rr/rr6304.pdf