Contraceptive Update 2015:
The New CDC MEC Guidelines and More

R. Mimi Secor, DNP, FNP-BC, NCMP, FAANP
Onset, Massachusetts

R. Mimi Secor, DNP, FNP-BC, NCMP, FAANP
- Nurse Practitioner for 37 years
- Newton Wellesley ObGyn, Newton, MA
- DNP, 8/2015 Rocky Mtn University, Provo, UT
- 2013 Lifetime Achievement Award, MCNP (Mass)
- NEW! 3rd edition
- Visiting Scholar, Boston College
- Fellow, AANP
- Owned a private practice for 12 years in Massachusetts (1984-1996)

Mimi Secor, DNP, FNP-BC, FAANP
Disclosure

Speaker: GenPath, Shionogi
Hologic
Objectives (75% Pharm)  
Contraception Update

- Describe trends and contraceptive challenges facing clinicians and patients. 15 minutes

- Explain the new CDC medical eligibility criteria for prescribing various contraceptive methods and medical conditions. 30 minutes

- Discuss new contraceptive research regarding efficacy, risks, benefits as this pertains to prescribing. 15 minutes
6.3 Million U.S. pregnancies: Intended vs. Unintended

- Intended Pregnancies
  - Birth 43%
  - Miscarriage 9%

- Unintended Pregnancies
  - Birth 19%
  - Miscarriage 6%

Henshaw, Family Planning Perspectives, 1996; 30:1

Family Planning Challenges

- High unplanned pregnancy rate continues
- Few easy, effective methods
- Low pt compliance & lack of knowledge
- Societal conflict about family planning
- Clinical challenge: little time, tight budgets
- Risk taking behaviors!
If you've been swept off your feet
You've got 3 days to get them back on the ground

Emergency Contraception

Lack of Public Awareness Still…

- Progestin only - 0.75 mg (Plan B)
  - 2 pills po STAT; or 1 pill 12 hrs apart
  - Taken within 72 hours of unprotected sex
  - 95% effective if taken within 24 hours
  - 89% effective if taken within 72 hours
  - SAFE, few side effects
  - Over-The-Counter in most states > 17 yrs
  - Less effective if BMI >26 !!!! (165 lbs)


Emergency Contraception: Ulipristal

- Ulipristal (ella) 30 mg orally, 1 dose
- Up to 5 days after unprotected intercourse, UPI
- Delays ovulation, NOT an abortifacient
- Preferred for Overweight/Obese
- Prescription required:
  - www.ella-kwikmed.com/
  - Avoid if already pregnant
  - Side effects = placebo
  - Headache 18%, Nausea 12%, Abd pain 15%
  - If BMI > 35, less effective (Glasier et al, 2011)

Contraceptive Options

- **Combination Hormonal Contraceptives (CHC)**
  - Orals
  - Transdermal Ethinyl Estradiol (EE) Patch, *(Ortho Evra)*
  - Vaginal EE Ring, *(NuvaRing)*

- **Progestin Only Contraceptives (POC)**
  - Etonogestrel Implant, *(Nexplanon)* 3 year rod (upper arm)
  - Depo Medroxyprogesterone, DMPA “Depo Provera”
    - IM 150 mg, SC 104 mg
  - LNG-IUD, Levonorgestrel *(Mirena, Skyla)*
  - Progestin only “Mini-pill”: Norgestrel *(Ovrette)*,
    Norlethisterone *(Micronor, Nor-QD, Errin, Camilla)*

- **Other:**
  - Sterilization, male/female *(Essure)*
  - CU-IUD *(Paragard)*; Other: Condoms, Caps, Natural (NFP)

**Typical Effectiveness of Contraception**

- Long acting reversible contraceptives (LARCs)

- **Tier 1**
  - Implants
  - IUD
  - Vaginal ring

- **Tier 2**
  - Intrauterine progestin
  - Injectable progestin
  - Condoms
  - Female sterilization

- **Tier 3**
  - Male condom
  - Male sterilization
  - Spironolactone

- **Tier 4**
  - Withdrawal
  - Natural (NFP)
  - Spermicides

**US Medical Eligibility Criteria for Contraceptive Use**

[MMWR logo]

U.S. Medical Eligibility Criteria for Contraceptive Use, 2016
Adopted from the World Health Organization
Medical Eligibility Criteria for Contraceptive Use, 4th edition
2010 CDC US Medical Eligibility Criteria: Categories

1. No restriction for the use of the contraceptive method for a woman with that medical 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 – or that there are no other methods that are available or acceptable to the women with that medical condition
4. Unacceptable health risk if the contraceptive method is used by a woman with that medical condition


Handheld App: CDC Contraception
U.S. Medical Eligibility Criteria for Contraceptive Use, 2010 (MEC)
**NEW CDC MEC Update: 2012**

**HIV and Contraceptives**

2010: Revised Recommendations for the Use of Hormonal Contraception Among Women at High Risk for HIV Infection or HIV+

- Combination Hormonal Contraceptives (CHC): OK, Cat 1, 2
- Progestin Only Injectables:
  - Unclear risk re: acquisition of HIV ???
- IUC: OK, no increase in shedding

Tepper, Nami K. | Curtis, Kathryn M. | Jamieson, Denise J. | Marchbanks, Polly A.

Intrauterine Systems: IUC
Effectiveness = Sterilization

- Copper T380 IUS (Paragard)
  - Approved for 10 years
  - Off-label for 12 years
  - Easier to insert if nulliparous

- Levonorgestrel IUC (Mirena)
  (Skyla- smaller device)
  - Approved for 5, 3 years
  - Reduced menstrual bleeding
  - May reduce fibroids

Xu. Contraception Sep 2010; 82; 301-309, n -20

IUC: New, Smaller (Skyla)
LNG containing, Similar to (Mirena)

- Levonorgestrel-releasing
- Total of 13.5 mg of LNG
- Approved: January 2013
- For 3 years
- Good for Nulliparous

www.skyla-us.com
Tel 1-888-842-2937
Bayer HealthCare
Manufactured in Finland

NEW IUC Approved: Liletta 2015

- Levonorgestrel- releasing IUC
- By Actavis/Medicines 360
- Will be offered at reduced cost to public health clinics
- Enrolled in the 340B drug pricing program
Dispelling Common Myths About IUCs

In fact, IUCs:

- Can be used by nulliparous women
- Can be used by women who have had an ectopic pregnancy
- Do NOT need to be removed for PID treatment
- Do NOT have to be removed if actinomyces-like organisms (ALO) are noted on a Pap test


Screening: Poor Candidates for Intrauterine Contraception

- Known or suspected pregnancy
- Puerperal sepsis
- Immediate post septic abortion
- Unexplained vaginal bleeding
- Cervical or endometrial cancer

WHO. 2009.
Screening: Poor Candidates for Intrauterine Contraception

- Uterine fibroids that interfere with placement
- Uterine distortion (congenital or acquired)

- Current PID
- Current purulent cervicitis
- Current chlamydia or gonorrhea

- Known pelvic tuberculosis

**IUC: MEC Conditions**

**Age**
- Menarche to <20: 2
- ≥ 20: 1
- Nulliparous women: 2
- Postpartum: 2
- <10 minutes PP, CU: 1
- **Puerperal sepsis**: 4

**Postabortion**
- First trimester: 1
- Second trimester: 2

**IUC: Cardiovascular Disease**

**Hypertension**: 1  
*except*
- S ≥160/D≥100 & vascular disease: 
  LNG = 2

**DVT/PE**: 1  
- Cu: 1
- LNG: 2
- Acute DVT/PE: 2
- Known thrombosis: 2
Safety: IUC May Be Used by HIV+ Women

- No increased risk of complications compared w HIV-negative women
- No increased cervical viral shedding
- WHO, CDC Category 2

IUC Issues: Infection

- PID and IUC use: confined to early weeks
  - Low risk even then
- Large meta-analysis 22,908 insertions
  - Grimes et al. Cochrane Review 2004;
  - Infection in first 20 days 9.7/1,000 woman years
    - From vaginal contamination despite aseptic technique
    - Infection rate after 20 days 1.4/1,000 woman yrs of use

PID with IUC: Not so NEW 2010 Guidelines

- May leave IUC in place
- Treat infection
- Close follow-up, 1-3 days
- If not improved, consider removing IUC
- Counseling & Condoms
- If history of PID, increased risk for STIs

CDC, WHO, ACOG 2009-2010
Combined Hormonal Contraceptives: CHC

Pills: medium        Patch- high       Ring- low

Serum EE Levels of Ring, OC & Patch
Ethynyl Estradiol (EE)

- Vaginal Ring: Lowest EE serum levels
- Orals (COC): Mid-range serum levels
- Transdermal Patch: Highest EE serum levels

NEW 2013: Risk of Thromboembolism/CV Events in CHC Users- DSP OC YES, Patch & Ring NO

- N 835,826, ages 10-50, population based cohort
- Conclusions:
  - In NEW users, DSP* was associated with higher risk of VTE/ATE relative to low dose CHC comparator
  - NO increased risk with Patch OR Vaginal Ring
- VTE in younger group (77% increase) 10-34 years
- ATE in older group (2 fold increase) 35-55 years

*Drospirenone
Sidney et al. Contraception 2013 Jan; 87 (1) :95-100

Hormonal Contraceptives and Coexisting Medical Conditions

CHC- Category 4 Contraindications

- Smokers ≥35
- Breast cancer
- Postpartum < 21 days
- Acute hepatitis/flare
- Severe cirrhosis
- Liver tumors
- Migraine with aura !!!
- Diabetes > 20 years
- Major surgery
- CVD
  - Ischemic, stroke,
  - Multiple risk factors
  - HTN ≥160/≥100
- DVT/VTE
  - On therapy
  - Acute
  - History of
**CHC- Category 3**
**Relative Contraindications**

- Drug interactions
- Rifampicin
- Certain anti-seizure meds ie Lamictil incr. seizures
- ARV meds (t)
  - Ritonavir-boosted PI
- BP 140-159/90-9
- CVD: multiple risk factors
- Diabetes <20 years: NO vascular complications
- Migraine without aura
- Hepatitis acute
- Bariatric surgery (bypass)
- Postpartum 21-42 days

**CHC: Age**

Menarche to <40 years = C 1

- 40 years old 2

Smoking

- <35 smoker: 2
- ≥35 smoker <15/day: 3
- >35 and smoke > 15/day: 4

**Post-partum: 2013 CDC MEC Update**

NEW

- < 21 days postpartum: No CHCs- Cat 4!
- 21-42 days Postpartum PLUS risk for VTE, Cat 3
- 21-42 days, NO risk factors, Cat 2
- > 42 days, No restrictions, Cat 1
- > 1 month postpartum, breast feeding, Cat 2
- < 1 month postpartum, breast feeding, Cat 3
- Post abortion, Cat 1
CHC, Smokers, Obesity and VTE Risk:

- Smokers risk of CVD Death & using COCs
  - 3.3 per 100,000 women if < 35 yr
  - 29.4 per 100,000 women if > 35 yr !!!!

- If BMI ≥ 30 and CHC user
  - risk < death faced by smokers younger than 35 yrs old
    - 2.4 >BMI vs 3.3 smokers per 100,000)

- NO data on BMI > 40


CHC: Obesity

BMI > 30
- Category 2
- Possible increased risk of VTE, MI, stroke
- NOT more likely to gain

Obesity & CHC Failure: 2013

Good News!

- Efficacy of pill, patch, or vaginal ring
  NOT impaired by high BMI
- N 1523
- 128 Pregnancies
  Higher parity
  History of unintended pregnancies

McNicholas C et al. Contraceptive failures in overweight and obese combined hormonal contraceptive users. Obstet Gynecol 2013 Mar; 121:585. (http://dx.doi.org/10.1097/AOG.0b013e318283177c)
Combined Oral Contraceptives

- Contain estrogen & progestin
- Most newer formulations contain 20 – 35 mcg of ethinyl estradiol + 1 of 8 available progestins


Contraceptive Approaches (COCs)

- Quick start: In-office or same day
- First day start: 1st day of menses
- Extended regimens
- Continuous
  - Shorter “placebo” interval
  - Low-dose placebo interval

COC: Initial Pill Selection

**Estrogen:** (cycle control primarily)
- Heavy periods: Higher estrogen 30-35 mcg
- “Normal” menses: Lower estrogen 20-25 mcg

**Progestin:** (contraceptive effects primarily)
- Levonorgestrel: Very safe, less BTB*
- Norethindrone: Safe, more BTB
- Drospirenone: Avoid if unknown family hx
  - Or family hx of clots, or coagulopathies

MPR= Prescribers Reference, *BTB= breakthrough bleeding
COC: EE/LNG, (Quartette) by Teva: NEW 2013

Goal: to Minimize BTB

- 91-day oral regimen
- Triphasic: with Ethinyl Estradiol/EE
- Estrogen, EE increases at 3 distinct points over the first 84 days
- Progestin, “Levonorgestrel” remains consistent
- 7 days of ethinyl estradiol 10mcg

Estradiol Valerate, Dienogest (Natazia) 2012 FDA Approved for Menorrhagia

- 2 dark yellow = 3 mg Estradiol Valerate
- 5 red = 2 mg EV and 2 mg Dienogest
- 17 light yellow = 2 mg EV, 3 mg Dienogest
- 2 dark red = 1 mg EV
- 2 white = inert pills

OCs and Breakthrough Bleeding (BTB)

Early vs Later Use BTB

- BTB declines over 1st year, TTT
- Rule out infection: Esp. chlamydia!!!
- Take same time each day: < 4 hours
- NSAIDS for 5 days !!!
- Change progestin: levonorgestrel, norgestimate
- Increase estrogen
- Generic to Brand
- Later use BTB: 4 to 7 placebo pills

Am J Ob Gyn, 2006;195:935
Venous Thrombosis: Risk and COCs*
2 - 3 X incr. risk: 8-10/10,000 women/years

RISKS !!!
- First 3 months of CHC use, RED FLAGS!
- Age, especially smokers
- BMI higher: no data > 40
- ESTROGEN, higher dose
- 20 mcg = 20% lower VT risk versus 30 mcg
- 50 mcg = 50% higher VT risk vs. 30 mcg
- PROGESTIN type, risk may differ

*Combination hormonal contraceptives = CHC

FDA Warning 2011:
Drospirenone & Risk of Non-fatal VTE

- 2 fold increased risk, compared to Levonorgestrel
- 30.8/100,000 woman years for Drospirenone
- 12.8/100,000 woman years for Levonorgestrel


Research: Drospirenone & Risk of Non-fatal VTE
2 Fold Increased Risk, Compared to Levonorgestrel

- Parkin L, Sharples K, Hernandez RK, Jick SS. Risk of venous thromboembolism in users of oral contraceptives containing drospirenone or levonorgestrel: nested case-control study based on UK General Practice Research Database. BMJ 2011; 342:d2139.
Combination Hormone Contraceptives, CHC
NEW Medical Criteria: OK=2, NO=3

- Hepatitis acute viral = 3, 4
- Chronic…………………………1
- Liver adenoma, or hepatoma 4
- Sickle cell 2
- Anticonvulsants & Rifampin 3
  - Reduced efficacy of OC/CHC

Combination Hormonal Contraceptives/ CHC
NEW 2010 Medical Criteria

- Hypertension:
  - Controlled 3
  - BP 140-159/90-99 3
  - BP > 160/100 4
  - HTN in Pregnancy 2
  - Vascular disease 4

CHC and NEW Medical Criteria

- History of DVT/PE 4
- Acute DVT/PE 4

- Family History of DVT/PE
  - 1st degree relative 2
- Thrombogenic mutation 4 !!!
  - Factor V Leiden, prothrombin, protein S
  - 2-20 x Fold increased risk !!!
**CHC: History of DVT, PE**

NOT on anticoagulant

**Higher risk of recurrence: 4**
- Estrogen associated
- Pregnancy associated
- Idiopathic
- Thrombophilia
- Cancer
- History of recurrence

**Lower risk for recurrence: 3**

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**CVD: DVT & PE**

- **Family History: 1st degree**  2
- **Major surgery:**
  - Prolonged immobilization:  4
  (Not defined!)
  - No prolonged immobilization:  2
- **Minor surgery: no immobilization**  1

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**NEW: Headaches and CHC/ Combination Hormonal Contraceptives**

- Non-migraine  1, 2
- Migraines
  - Without Aura
    - Age < 35  2, 3
    - Age > 35  3, 4
  - With Aura, ANY age  4, 4

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CHCs: Drug Interactions

Antiretroviral therapy
- NRTIs: 1
- NNRTIs: 2
- Ritonavir-boosted protease inhibitors: 3

Anticonvulsant therapy
- COC: reduced efficacy
- So minimum 30μg EE dose
- Lamotrigine (Lamictal)
  - Possible incr. seizures!!

Antimicrobial therapy
- Broad-spectrum antibiotics 1
- Antifungals 1
- Antiparasitics 1
- Rifampicin 3
  - Reduces OC efficacy

Breast Cancer Family History and OC
NO Increased Risk

Systematic review 1966 – 2008 (USPSTF)
- 10 studies, 1 pooled analysis of 54 studies
- 4 studies suggest some women may be at increased risk esp. if took OCs prior to 1975

Conclusion:
- OCs did NOT significantly influence risk

Ovarian Cancer and OCs
Protection with 15 years of Use!
Massive reanalysis study; 45 studies, n= 23,257 women

- 50% lower risk if used for 15 years: even non-continuous!!!
- Longer duration associated w/ lower risk
- Protection up to 30 yrs after stopping OC !!!!
- Protects low AND high risk women
- 100,000 deaths prevented worldwide!
- Could prevent 30,000 cases annually in US


2012: Update- Package Insert
Transdermal Patch: Package Information (PI)

- "You will be exposed to about 60% more estrogen than an OCP with 35 mcg of estrogen," = 56 mcg
- NEW per FDA (May 2012) "the benefits outweigh the risks”, but consumers must be educated about the risks

2010: NO Incr. Risk of Nonfatal VTE in Users of Contraceptive Transdermal Patch: n 297,262

- Compared to users of OCs containing NGM/EE 35 mcg
  Observational case-control study
- 56 cases of VTE, 212 matched controls: New users only!
- PharMetrics US-based, longitudinal database on 55 million lives back to 1995
  Medical claims & diagnoses from managed care
- OR 1.1 (95% CI 0.6-2.1)
- NO increased risk compared to NGM /EE containing Ocs

Dore et al. Contraception 2010 May; 81(5):408-413
VTE OR 2.0 extension study, n 18, c 148 (297,262 women)
When new data pooled w previous data no increased risk
Jick, Kaye, Li and Jick. Contraception 2007;76: 47-48 (OM.Boston)
Same authors. Contraception 2006;73:223-228. 17 month study
2012: Incr. Risk of Nonfatal VTE in Users of Contraceptive Patch and Ring: n 1.5 million

- Danish national registries used

Risk of thrombosis:
- Non-users 2/10,000
- 6.2/10,000 exposure years w COC (2-3 x incr. risk)
- 9.7/10,000 exposure years w Patch (7.5 x incr. risk)
- 7.8/10,000 exposure years w Ring (6.5 x incr. risk)

- Implant or LNG IUS users: NO increased risk

BMJ 2012;344 doi: 10.1136/bmj.e2990 (Published 10 May 2012)

Who Says Women Pro Golfers are at a Disadvantage to Men?

Michelle Wie, pro golfer:
- Matching lavender outfit: $2,000
- New pair of French sunglasses: $500
- NIKE products Endorsements: $10,000,000

Having that special place to hold your putter .... Priceless !!!

Contraceptive Vaginal Ring:

- Very low steady dose
  - 120 μg/day etonogestrel
  - 15 μg/day ethinyl estradiol
- Flexible (54 mm)
- Easy to insert
- One ring per cycle:
  - 3 weeks in, 1 week ring-free
  - Or change monthly
- Less BTB than with OC
- With “Quick Start”

Weinroth et al. Obstet Gynecol 2005 Jul;106:89-96
Progestin-Only Contraceptives:

Pills (POP), Injections, Implants

Progestin Only:

Age
- POP .................1
- DMPA <18, >45 2

Breastfeeding
- < 1 month ..........2
- ≥ 1 month 1

Postpartum ..........1
Postabortion ........1
Past ectopic
- POP .................2

Progestin Only: Misc Conditions

Smoking: .................1

Obesity: ................. 1
<18 ..................... 2

Bariatric:
Malabsorptive procedures
POP (Mini Pills) only 3
Sz meds, Rifampin, ARV 3
Progestin Only: Hypertension

Adequately controlled
- POP, Implant ……1
- DMPA……………2

S ≥ 160/D ≥ 100
- POP/ I……………… 2
- DMPA 3

Elevated BP
- HTN in pregnancy…… 1

S 140-159/D 90-99
- POP, Implant …… 1
- DMPA…………… 2

S > 160/D > 100
- POP/ I……………… 2
- DMPA 3
- HTN in pregnancy…… 1

Progestin Only: SAFE

NO Evidence of Incr. DVT/ PE Risk

DVT/ PE
- History or acute………………2
- On or off anticoagulant 2
- Major surgery, immobilized…2
- Thrombotic mutations………2
- Family History……………... 1
- Superficial thrombosis………1

Progestin Only: Headache w Aura!

Rheumatic
- SLE
  - Positive or unknown APL antibodies 3
  - Severe thrombocytopenia: 3
  - Immunosuppressed …………2
  - RA
    - POP, 1 1
    - DMPA 2
  - Liver tumors/Severe cirrhosis 3
  - Breast cancer current 4

Neurologic
- Headaches, non-migraine: 1
  - Migraines
    - No aura 2
    - Start OC 1
    - Aura: Start 2
    - Aura: Continue 3
  - Epilepsy 1
  - Depressive disorders: 1
Contraceptive Implant:
“Nexplanon” with NEW Inserter
- Single rod, “Radiopaque”
- Progestin only
  Etonogestrel
- 3 year contraceptive
- High efficacy > 99%
- No weight restriction
  BUT
- Unpredictable bleeding
- Special training required

Adapted from
www.contraceptiononline.org
Mansour et al. Contraception 2010 sep;82(3):49

Advantages
DMPA: Medroxyprogesterone Acetate
- Effective, easy, convenient
- Shorter menses, no menses
- No backup needed 1st month
- No BMI weight restriction
- May be used in smokers esp. >35 yrs
- OK if ESTROGEN contraindicated
- Injection schedule: 4 week grace period


DMPA, HIV or at High Risk for HIV and MEC:
NEW: CDC Update June 2012
- Safe: Category 1,2 (encourage condoms too)
  - Combined oral contraceptives
  - Progestin-only pills
  - Depot DMPA
  - Implants
- Women at high risk for HIV !!!!
  - Caution re: use of Progestin-only injectables
  - Inconclusive evidence re: HIV acquisition risk

MMWR, June 22, 2012 / 61(24):449-452
2015 New Study: DMPA and HIV Risk

- This new meta-analysis adds to evidence suggesting that *depot medroxyprogesterone acetate* (DMPA, marketed as Depo-Provera) is associated with increased risk for HIV acquisition.

- 12 observational studies that evaluated the association between hormonal contraception and HIV acquisition in women in sub-Saharan Africa.


http://www.thelancet.com/journals/laninf/article/PIIS1473-3099(14)71052-7/abstract

DMPA – Category 3, 4

**Cat 3**
- CVD
  - Hypertension ≥160/≥100
  - Stroke
  - Ischemic CVD
  - Multiple risk factors
  - Liver tumors, cirrhosis

**Cat 4**
- Breast cancer-current
- Unexplained vaginal bleeding

NEW DMPA Research- 2012: Breast Cancer Risk Increased?

- Possible 2 fold increased risk
- Only during use
- But absolute risk very low
- Risk reverses when DMPA stopped

Effects of Long Term DMPA on BMD

- DMPA > 2 yrs had a significant adverse effect on BMD
  - 2.8% loss after 1 yr, 5.8% loss after 2 years

**BUT GOOD NEWS!**
- Large, cross sectional study of 3500 ethnically diverse pts
  - Used DMPA >10 years
  - Reversibility of loss complete in 2 to 3 years


NEW 2013: DMPA and Bone Health
No Increased Fracture Risk

- Large retrospective cohort study shows DMPA did NOT raise fracture risk.
  - N 312,395
- Fracture risk did NOT increase after initiation of DMPA
- “Black Box warning should be removed by the FDA”


BMD, Identifying “at Risk Patients”

- **Vaginal pH check routinely**
  - Normal pH of 4.0 is yellow = normal estrogen levels!
- **Atrophic Vaginitis**
  - High pH, pallor, scant discharge, WBCs, small cells
- **Add back Estrogen** - may be considered
  - Ethinyl Estradiol 20 mcg oral daily
  - **Vaginal Ring**: may reduce BTB and bone loss!

[Dempsey et al, Contraception 82 (Sept 2010) 25–255]
### Progestin Only: No Evidence of Incr. DVT/PE Risk

**DVT/PE**

- History or acute: 2
- On or off anticoagulant: 2
- Major surgery, immobilized: 2
- Thrombotic mutations: 2
- Family History: 1
- Superficial thrombosis: 1

### Progestin Only: Cardiovascular Disease

**Ischemic heart disease/Stroke**

- **Initiation:**
  - POP: 2
  - DMPA: 3

- **Continuation:**
  - POP: 3

**Valvular heart disease:** 1

**Peripartum cardiomyopathy**

- Mild: 1
- Moderate/severe: 2

**Hyperlipidemia:** 3
Progestin Only (PO):

Rheumatic
- SLE:
  - Positive or unknown APL antibodies: 3
  - Severe thrombocytopenia: 3
  - Immunosuppressed: 2

Neurologic
- Headaches, non-migraine: 1
- Migraines
  - No aura: 2
  - Start OC: 1
- Aura:
  - Start: 2
  - Continue: 3 !!!
- Epilepsy: 1
- Depressive disorders: 1

PO: Reproductive Tract Conditions

Category 1:
- Endometriosis
- Benign ovarian tumors
- Severe dysmenorrhea
- Gestational trophoblastic disease
- Benign breast disease
- FHx breast cancer
- Endometrial hyperplasia or cancer
- Ovarian cancer
- Uterine fibroids
- STIs, PID
- HIV/AIDS

Category 2:
- Irregular, heavy, or prolonged vaginal bleeding
- CIN/Cervical cancer (DMPA)
- Undiagnosed breast mass

Category 3:
- Past breast cancer (>5 years)
- Unexplained vaginal bleeding

Category 4:
- Current breast cancer

Resources

  www.mimisecor.com

- ARHP.org
  “Contraception” Journal with membership
  Many other resources
  Contraceptive choices, online tool kit for patients
## Resources

- U.S. Selected Practice Recommendations (US SPR) for Contraceptive Use, 2013
- **Journal Watch Women’s Health**
  - [www.jwatch.org](http://www.jwatch.org)
  - [www.Amazon.com](http://www.Amazon.com)

## Summary of Objectives

**Contraception Update**

- Describe trends and contraceptive challenges facing clinicians and patients. 15 minutes
- Explain the new CDC medical eligibility criteria for prescribing various contraceptive methods and medical conditions. 30 minutes
- Discuss new contraceptive research regarding efficacy, risks, benefits as this pertains to prescribing. 15 minutes
Questions

Thank you and good luck!

Mimi Secor, DNP, FNP-BC, NCMP, FAANP

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