

Patient-centered contraceptive care for medically complex patients

Appropriate counseling for an obese patient with seizure disorder and migraines

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CASE Patient-centered counseling for contraception

A 19-year-old woman (G0) with moderately well-controlled seizure disorder while taking levetiracetam, who reports migraines, and has a BMI of 32 kg/m² presents to your office seeking contraception. She is currently sexually active with her second lifetime partner and uses condoms inconsistently. She is otherwise healthy and has no problems to report. Her last menstrual period (LMP) was 1 week ago, and a pregnancy test today is negative. How do you approach counseling for this patient?

The modern contraceptive patient

Our patients are becoming increasingly medically and socially complicated. Meeting the contraceptive needs of patients with multiple comorbidities can be a daunting task. Doing so in a patient-centered way that

also recognizes the social contexts and intimacy inherent to contraceptive care can feel overwhelming. However, by employing a systematic approach to each patient, we can provide safe, effective, individualized care to our medically complex patients. Having a few “go-to tools” can streamline the process.

Medically complex patients are often told that they need to avoid pregnancy or optimize their health conditions prior to becoming pregnant, but they may not receive medically-appropriate contraception.¹⁻³ Additionally, obesity rates in women of reproductive age in the United States are increasing, along with related medical complexities.⁴ Disparities in contraceptive access and use of particular methods exist by socioeconomic status, body mass index (BMI), age, and geography.^{5,6} Evidence-based, shared decision making can improve contraceptive satisfaction.⁷

Clinicians need to stay attuned to all options. Staying current on available contraceptive methods can broaden clinicians' thinking and allow patients more choices that are compatible with their medical needs. In the last 2 years alone, a 1-year combined estrogen-progestin vaginal ring, a drospirinone-only pill, and a nonhormonal spermicide have become available for prescription.⁸⁻¹⁰ Both 52 mg levonorgestrel-containing intrauterine devices (IUDs) are now US Food and Drug Administration (FDA)-approved for 6 years, and there is excellent data for off-label use to 7 years.¹¹



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Tools are available for use. To ensure patient safety, we must evaluate the relative risks of each method given their specific medical history. The Centers for Disease Control and Prevention (CDC) Medical Eligibility Criteria (MEC) provides a comprehensive reference for using each contraceptive method category with preexisting medical conditions on a scale from 1 (no restrictions) to 4 (unacceptable health risk) (TABLE 1).¹² It is important to remember that pregnancy often poses a larger risk even than category 4 methods. With proper counseling and documentation, a category 3 method may be appropriate in some circumstances. The CDC MEC can serve as an excellent counseling tool and is available as a free smartphone app. The app can be downloaded via <https://www.cdc.gov/reproductivehealth/contraception/mmwr/mec/summary.html> (TABLE 2).

In a shared decision-making model, we contribute our medical knowledge, and the patient provides expertise on her own values and social context.¹³ By starting the contraceptive conversation with open-ended questions, we invite the patient to lead the discussion. We partner with them in finding a safe, effective method that is compatible with both the medical history and stated preferences. Bedsider.org has an interactive tool that allows patients to explore different contraceptive methods and compare their various characteristics. While tiered efficacy models may help us to organize our thinking as clinicians, it is important to recognize that patients may consider side effect profiles, nonreliance on clinicians for discontinuation, or other priorities above effectiveness.

How to craft your approach

Developing a systematic approach to the medically complex patient seeking contraception can help to change an initially daunting task into a fulfilling experience (FIGURE 1, page 28). Begin by eliciting patient priorities. Then frame the discussion around them, rather than around efficacy. Although anecdotal reasoning can initially be frustrating (“My best friend’s IUD was really painful and

TABLE 1 CDC MEC risk categories¹²

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

Abbreviations: CDC, Centers for Disease Control and Prevention; MEC, Medical Eligibility Criteria.

TABLE 2 Resources

Resource	Website
CDC Medical Eligibility Criteria	https://www.cdc.gov/reproductivehealth/contraception/mmwr/mec/summary.html
Bedsider patient information	https://www.bedsider.org/
Provider updates	https://providers.bedsider.org/
ACOG LARC Program	https://www.acog.org/programs/long-acting-reversible-contraception-larc

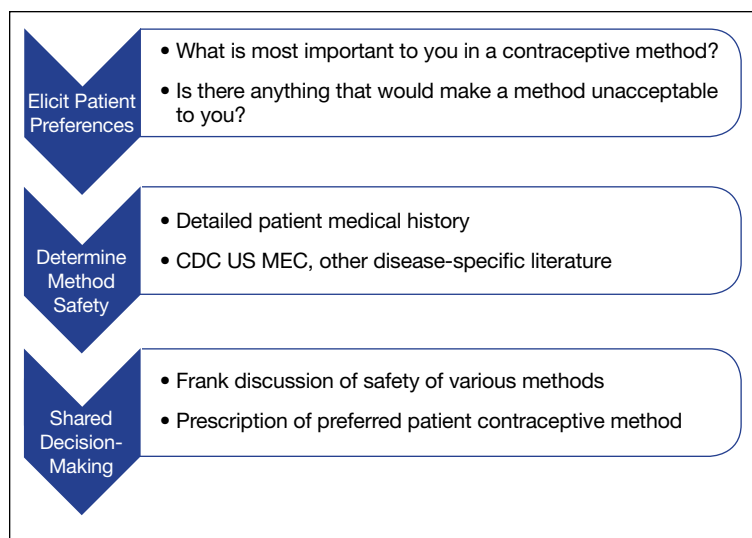
Abbreviations: ACOG, American College of Obstetricians and Gynecologists; CDC, Centers for Disease Control and Prevention; LARC, long-acting reversible contraception.

I don’t want anything like that inside me!”), learning about these experiences prior to counseling can be incredibly informative. Ask detailed questions about medical comorbidities, as these subtleties may change the relative safety of each method. Finally, engage the patient in a frank discussion of the relative merits, safety, and use of all medically appropriate contraceptive methods. The right method is the method that the patient will use.

CASE Continued: Applying our counseling method

Upon open-ended questioning, the patient tells you that she absolutely cannot be on a contraceptive method that will make her gain weight. She has several friends who told her that they gained weight on “the shot” and “the implant.” She wants to avoid these at all costs and thinks she might want to take “the pill.” She also tells you that she is in college and that her daily routine varies significantly between weekdays and weekends. She definitely does not want to get

FIGURE 1 Systematic contraceptive decision-making map



pregnant until she has completed her education, which will be at least 3 years from now.

To best counsel this patient and arrive at the most appropriate contraceptive option for her, clarify her medical history and employ shared decision-making for her chosen method.

FAST TRACK

Use open-ended questioning to assess the patient’s contraceptive preferences, and ensure that medical comorbidities don’t change the safety of available or preferred methods

Probe her seizure history

She tells you that she has had seizures since she was a child, and the last one occurred 4 months ago when she ran out of her anticonvulsant medication. Her seizures have never been associated with her menses. This is an important piece of information. The frequency of catamenial seizures can be decreased with use of any method that suppresses ovulation, such as depot-medroxyprogesterone (DMPA) injections, continuous combined hormonal contraceptive (CHC) pills or ring, or the implant. Noncatamenial seizures also can be suppressed by DMPA, which increases the seizure threshold.¹⁴ Many anticonvulsants are metabolized through cytochrome P450 in the liver and, therefore, interact with all oral contraceptive formulations. However, levetiracetam is not among them and may be safely taken with progestin-only pills. At this point, all contraceptive methods remain CDC MEC category 1 (FIGURE 2).¹²

Ask migraine specifics

It is important to clarify whether or not the patient experiences aura with her migraines. She says that she always knows when a migraine is coming on because she sees floaters in her vision for about 30 minutes prior to the onset of excruciating headache. One tool that may aid in the diagnosis of aura is the Visual Aura Rating Scale (VARs).¹⁵ The presence of aura renders all CHCs category 4 by the CDC MEC.¹² (See FIGURE 2.)

Discuss contraceptive pros and cons

Have a frank discussion about the relative risks and benefits of each method. For instance, although DMPA may improve the patient’s seizures, she has expressed a desire to avoid weight gain, and DMPA is the only method consistently shown in studies to do so.¹⁶ Her seizures are not associated with menses, so menstrual suppression is neither beneficial nor deleterious. Although her current medication levetiracetam does not influence the metabolism of contraceptive methods, many anticonvulsants do. Offer anticipatory guidance around seeking gynecologic consultation with any future seizure medication changes.

Allow for shared decision-making on a final choice

The patient indicated that she had been considering “the pill” when she made this appointment, but you have explained that CHCs are contraindicated for her. She is concerned that she will not be able to stick to the strict dosing schedule of a progestin-only pill. Although you inform her that the drospirone-only pill has a more forgiving window, the patient decides that she wants a “set it and forget it” method and opts for an IUD.

CASE Resolved

Following recommendations from the American College of Obstetricians and Gynecologists (ACOG), you provide for same-day insertion of a 52-mg levonorgestrel IUD.¹⁷ You use a paracervical block in addition to ibuprofen for pain control.¹⁸ The patient undergoes same-day testing for gonorrhea and chlamydia, and she understands

FIGURE 2 CDC MEC for case patient conditions¹²

Condition	Sub-Condition	Cu-IUD		LNG-IUD		Implant		DMPA		POP		CHC	
		I	C	I	C	I	C	I	C	I	C	I	C
Epilepsy	(see also Drug Interactions)	1		1		1		1		1		1	
Anticonvulsant therapy	a) Certain anticonvulsants (phenytoin, carbamazepine, barbituates, primidone, topiramate, oxcarbazepine)	1		1		2		1		3		3	
	b) Lamotrigine	1		1		1		1		1		3	
Headaches	a) Nonmigraine (mild or severe)	1		1		1		1		1		1	
	b) Migraine												
	i) Without aura (includes menstrual migraine)	1		1		1		1		1		2	
	ii) With aura	1		1		1		1		1		4	
Obesity	a) Body mass index (BMI) ≥30 kg/m ²	1		1		1		1		1		2	
	b) Menarche to <18 years and BMI ≥ 30 kg/m ²	1		1		1		2		1		2	

Abbreviations: CDC, Centers for Disease Control and Prevention; CHC, combined hormonal contraception; Cu-IUD, Copper intrauterine device; DMPA, depot medroxyprogesterone acetate; LNG-IUD, levonorgestrel intrauterine device; MEC, Medical Eligibility Criteria; POP, progestogen-only contraceptive pill.

that if a test is found to be positive, she can be treated without removing the IUD. You provide instruction on the importance of dual contraceptive use with barrier methods for the prevention of STIs. The patient is instructed on self-string checks, and she acknowledges that she will call if she has any concerns; no routine follow-up is required. She leaves her visit satisfied with her preferred, safe, effective contraceptive method in situ. ●

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