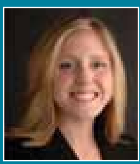
10 (+1) practical, evidence-based recommendations for you to improve contraceptive care *now*

Don't mandate a pelvic exam for every woman before you prescribe an OC. Use hormonal contraceptives for noncontraceptive indications. Nine other useful tips.

Colleen Krajewski, MD, and Mark D. Walters, MD

As other articles in this issue of OBG MANAGEMENT attest, medical science continues to focus attention on improving methods of family planning. That emphasis has meant a regular flow of new reports, studies, and guidelines for you to absorb and translate into better practice—no easy task.

Here is help: 10 (+ 1) practical, sensible recommendations for improving contraceptive care that have emerged from recent evidence and that are reasonably easy to incorporate into the care you provide. As with previous installments of this occasional "recommendations" series, we include a brief discussion and pertinent references for each tip.



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EDITOR'S NOTE: Brand names are given parenthetically in some places in the text solely to provide better recognition of methods discussed.

1 Pelvic exam? It isn't mandatory.

Do not require pelvic examination before you prescribe an oral contraceptive.

Henderson JT, Sawaya GF, Blum M, Stratton L, Harper CC. Pelvic examinations and access to oral hormonal contraception. Obstet Gynecol. 2010;116(6):1257–1264.

The World Health Organization and ACOG recommend that you consider pelvic examination optional before prescribing an oral contraceptive (OC). Recent evidence indicates, however, that many health-care providers don't follow that recommendation. Avoiding an unnecessary pelvic exam is a plus for a patient who may fear the procedure; following this guidance therefore removes a potential barrier to care and saves time in a busy practice.

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2 Provide more, not less

Prescribe (when possible, dispense) 6 to 12 months of an OC at office visits.

Potter JE, McKinnon S, Hopkins K, et al. Continuation of prescribed compared with over-the-counter oral contraceptives. Obstet Gynecol. 2011;117(3):551–557.

Foster DG, Hulett D, Bradsberry M, Darney P, Policar M. Number of oral contraceptive pill packages dispensed and subsequent unintended pregnancies. Obstet Gynecol. 2011;117(3):566–572.

Studies show that **1)** women who are given six or more pill packages at a clinic visit have a lower discontinuation rate than women given one to five packs and **2)** prescribing a 1-year supply of OC pill packages (as opposed to one to three packs) is associated with a 30% reduction in the odds of conceiving an unplanned pregnancy and a 46% reduction in the odds of having an abortion.

FAST TRACK

The LNG-IUS and OCs are highly effective, compared with placebo, for treating heavy menstrual bleeding in the absence of organic pathology

3 Make the case for long-acting reversibles

Use intrauterine devices and subdermal implants as first-line contraception more often.

American College of Obstetricians and Gynecologists Committee on Gynecologic Practice. ACOG Practice Bulletin No. 59: Intrauterine device. Clinical management guidelines for obstetrician-gynecologists. Obstet Gynecol. 2005;105(1):223–232.

Peipert JF, Zhao Q, Allsworth JE, et al. Continuation and satisfaction of reversible contraception. Obstet Gynecol. 2011;117(5):1105–1113.

Long-acting methods such as the copper intrauterine device (IUD) (Paragard) and the levonorgestrel intrauterine system (LNG-IUS) (Mirena) are the most effective reversible contraceptives because they eliminate the difference between perfect and typical use. A woman at low risk does not need to have a negative cervical culture before having an IUD or the LNG-IUS inserted, and a woman does not need to be on her menses at the time of insertion. In addition, antibiotic prophylaxis is not recommended before or at the time of insertion.

IUDs—and this applies to the subdermal contraceptive implant (Implanon), too—also have the highest rates of satisfaction and 12-month continuation.

4 Take advantage of broader benefits

Use hormonal contraceptives for noncontraceptive indications.

American College of Obstetricians and Gynecologists Committee on Gynecologic Practice. ACOG Practice Bulletin No. 110: Noncontraceptive uses of hormonal contraceptives. Obstet Gynecol. 2010;115(6):206–218.

Jensen JT, Parke S, Mellinger U, Machlitt A, Fraser IS. Effective treatment of heavy menstrual bleeding with estradiol valerate and dienogest: a randomized controlled trial. Obstet Gynecol. 2011;117(4):777–787.

Kaunitz AM, Bissonnette F, Monteiro I, Lukkari-Lax E, Muysers C, Jensen JT. Levonorgestrel-releasing intrauterine system or medroxyprogesterone for heavy menstrual bleeding: a randomized controlled trial. Obstet Gynecol. 2010;116:625-632.

Hormonal contraceptives have long been used for such indications as cycle control and treatment of acne. The LNG-IUS and OCs are highly effective, compared with placebo, for treating heavy menstrual bleeding in the absence of organic pathology.* As a potential alternative to surgical treatment of menorrhagia, OCs offer even broader benefit for many women.

*Mirena is approved by the Food and Drug Administration for treating heavy menstrual bleeding.

5 To encourage continuation, begin now

Get a "quick start" to improve adherence to oral contraceptives.

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Westhoff C, Kerns J, Morroni C, et al. Quick start: novel oral contraceptive initiation method. Contraception. 2002;66(3):141–145.

Starting OC pills immediately—instead of waiting for the Sunday after the next menses—can improve the short-term continuation rate for women patients who choose an OC.

6 Move away from every-day regimens

Consider a nondaily combined method, such as the transdermal patch or the vaginal ring, for current OC users.

Creinin MD, Meyn LA, Borgatta L, et al. Multicenter comparison of the contraceptive ring and patch: a randomized controlled trial. Obstet Gynecol. 2008;111(2 pt 1):267–277.

Many women who use an OC are satisfied with the positive effect the method has on menses and acne but find that they miss taking a pill some days; they might benefit from a method that involves nondaily administration. Studies show that switching from oral contraception to the transdermal patch (OrthoEvra) or vaginal ring (Nuvaring), for example, is acceptable to many women.

FAST TRACK

Starting OC pills immediately—instead of waiting for the Sunday after the next menses—can improve the short-term continuation rate

7 Preemptive prescribing

Prescribe emergency contraception before your patient needs it.

Jackson RA, Schwarz EB, Freedman L, Darney P. Advance supply of emergency contraception: effect on use and usual contraception—a randomized trial. Obstet Gynecol. 2003;102(1):8–16.

American College of Obstetricians and Gynecologists Committee on Gynecologic Practice. ACOG Practice Bulletin No. 112: Emergency contraception. Obstet Gynecol. 2010;115(5):1100–1109.

Consider giving every sexually active woman a prescription for emergency contraception before she leaves your office. She can fill the prescription and keep it at home in case of an emergency.

8 Get to know ella

Become familiar with ulipristal acetate (ella) for emergency contraception.

Glasier AF, Cameron ST, Fine PM, et al. Ulipristal acetate versus levonorgestrel for emergency contraception: a randomised non-inferiority trial and meta-analysis. Lancet. 2010;375(9714):555–562.

Barbieri RL. Levonorgestrel or ulipristal: is one a better emergency contraceptive than the other? OBG Manage. 2011;23(3):8–11.

This new FDA-approved agent for emergency contraception is effective for as long as 5 days after intercourse and results in fewer pregnancies than levonorgestrel does. It is available by prescription only, however, and is more expensive than levonorgestrel.

9 Pursue two urogenital pathogens

When you are not performing a speculum examination, screen for *N. gonorrhoeae* and *C. trachomatis* with a vaginal swab specimen or urine-based specimen.

Johnson RE, Newhall WJ, Papp JR, et al. Screening tests to detect Chlamydia trachomatis and Neisseria gonorrhoeae infections–2002. MMWR Recomm Rep. 2002;51(RR-15):1–38; quiz CE1–4.

Schachter J, Chernesky MA, Willis DE, et al. Vaginal swabs are the specimens of choice when screening for Chlamydia trachomatis and Neisseria gonorrhoeae: results from a multicenter evaluation of the APTIMA assays for both infections. Sex Transm Dis. 2005;32(12):725–728.

Under new screening guidelines for cervical cancer, Pap smears are not required for women who are younger than 21 years. Gonorrhea and chlamydial infection screening is still important in this population, however, and can be done without a speculum exam. The patient or provider collects a specimen for testing with a vaginal swab, or the patient submits a urine specimen.

10 Now not later: An IUD, post-evacuation

Consider immediate, rather than delayed, IUD insertion after uterine evacuation for spontaneous or elective abortion in women who desire this form of contraception.

Bednarek PH, Creinin MD, Reeves MF, et al. Immediate versus delayed IUD insertion after uterine aspiration. N Engl J Med. 2011;364:2208-2217.

A recent clinical trial enrolled 575 women who underwent uterine aspiration for induced or spontaneous abortion at 5 to 12 weeks' gestation and who desired an IUD. Subjects were randomized to IUD insertion immediately after the procedure or 2 to 6 weeks later. The 6-month expulsion rate was 5.0% after immediate insertion; 2.7%, after delayed insertion (P = NS). There were no differences in the rates of other adverse events. Only 71% of patients returned for their "delayed" IUD placement; five pregnancies occurred among these women. No pregnancies occurred in the immediate-insertion group.

BONUS Extend convenience, reduce risk

Offer office-based hysteroscopic sterilization.

Levie M, Weiss G, Kaiser B, Daif J, Chudnoff SG. Analysis of pain and satisfaction with office-based hysteroscopic sterilization. Fertil Steril. 2010;94(4):1189–1194.

Office hysteroscopy is well tolerated. Two hysteroscopic sterilization systems, Essure and Adiana, are available for use in the office. The systems are especially valuable in women who are poor surgical candidates or who want to avoid the inconvenience, or the risks, of a more major surgical procedure.

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Baha M. Sibai, MD (June 2011)

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Catherine A. Matthews, MD (April 2011)

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Mark D. Walters, MD (January 2011)

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Baha M. Sibai, MD

FAST TRACK

Consider immediate, rather than delayed, IUD insertion after uterine evacuation for spontaneous or elective abortion in women who desire this form of contraception