SUBSPECIALIST CONSULT

Contraception Counseling for Adolescent Girls

Adolescents value confidentiality with their health care clinicians very highly. To support the opportunity for confidentiality, you should speak with female adolescents without a parent in the room for at least part of each visit. This fosters an honest conversation about the sensitive issues around contraception, including any intimate relationships, current or planned sexual activity, and the safety and protection afforded by contraception.


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Girls are allowed to discuss sexually transmitted infections confidentially with their physicians, and hopefully can be offered a confidential discussion of their sexual activity as well. Ideally, a girl also feels comfortable talking with a parent about her concerns, but this scenario may not be an option for all your patients.

Begin with a discussion about relationships. Avoid preaching to them or asking blunt questions such as: "Hey, are you having sex?" Acknowledge that "sex" can refer to activities beyond sexual intercourse as well.

Ask your patients if they are in a relationship with a girl, a boy, or both. A teenager who is not heterosexual or is unsure will then know you are willing to discuss any specific concerns.

Make sure the teenager knows that abstinence is always the best protection against sexually transmitted infection and/or pregnancy.

Once you ascertain she is heterosexual or bisexual, is sexually active, and needs contraception, focus next on safety. Ask the patient: Are you doing anything to protect yourself against the consequences of sexual activity? Also ensure her participation in the intimate relationship is voluntary and free of any coercion, particularly among younger teenage girls.

There are multiple means of protection against sexually transmitted infections. Educate her that, aside from abstinence, the use of condoms is her best strategy. Make sure the girl understands that she is equally responsible for the proper use of condoms. If you take care of a lot of adolescents, it is reasonable to have a supply of condoms on hand so you can provide them.

Also consider providing a patient who is sexually active (or contemplating sexual activity) with a prescription for emergency, postcoital contraception. She could fill the prescription as needed, within 72 hours of sexual intercourse, to decrease the likelihood of pregnancy considerably. Even if she regularly uses a birth control method, this prescription provides a good backup plan.

Keep the child's developmental level in mind when discussing contraception and sexuality. In general, a 14-year-old girl who is sexually active or considering sex is vastly different from a 17-year-old patient. Also consider the patient and family's culture, ethnic, and/or religious background. For example, there are some religious groups where the kids cannot tell parents they have become sexually active – it could mortify the parents and be dangerous for the teenager.

Title X–funded projects are an option if a girl cannot tell her parent she wants to use contraception and/or if a third party (such as an insurance company) makes confidentiality impossible. Become familiar with the Title X–funded contraception projects in your area, which are frequently run through Planned Parenthood or a university obstetrics and gynecology program (www.hhs.gov/opa/familyplanning/index.html). By the rules of the Title X fund, girls can receive confidential care, including contraception.

You really should get to the point where you feel moderately comfortable talking about the basics of contraception and sexuality. There are not enough adolescent medicine specialists in the world to take care of all the teenagers out there, and most ob. gyns. do not see very many teenagers.

Some pediatricians may be comfortable prescribing the birth control pill, but they may not know much about the patch, the contraceptive ring, the implant, or the IUD. If a patient is interested in one of these options, you can refer her to a gynecologist or a family practitioner in your area who is particularly adept at young women's health issues. Planned Parenthood also is a good resource.

The birth control pill and the patch are the two most common birth control methods for first-time users. You do not need to know all the different types of birth control pills; it is sufficient to become comfortable prescribing one or two brands.

Check for any contraindications, such as a history of migraine headache with aura or a clotting abnormality (personal or in a first-degree relative) before prescribing oral contraception. If your patient is having regular, monthly periods, and she's had a period in the last month, some pediatricians still will feel comfortable prescribing only if they get a urine pregnancy test. On the other hand, if you give contraception without the test and the girl does miss her next period, you can always give the pregnancy test then.

If you prescribe contraception for sexual activity only, keep in mind that most teenagers have a passionate relationship that lasts a few months, followed by an interval without a relationship, followed by involvement with another person. These intermittent relationships mean that they are likely to start and stop contraception. Keep this in mind when discussing contraception options and monitor compliance with less-permanent options over time.

Children's Hospital of Boston produces www.youngwomenshealth.org, a useful Web site where the patient, parent, and general pediatrician can learn more about these issues. In addition, the American College of Obstetricians and Gynecologists offers online information about contraception for patients (www.acog.org/publications/patient_education/ab020.cfm). Also, the American Academy of Pediatrics Web site includes a policy statement on contraception and adolescents (aappolicy.aappublications.org/cgi/content/full/pediatrics;120/5/1135). ■

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Legius Syndrome Can Be Easily Misdiagnosed as NF1

BY BRUCE JANCIN

EXPERT ANALYSIS FROM THE ANNUAL CONGRESS OF THE EUROPEAN ACADEMY OF DERMATOLOGY AND VENEREOLOGY

GOTHENBURG, SWEDEN – Legius syndrome, first described only 3 years ago, can be easily misdiagnosed as neurofibromatosis type 1.

The diagnostic confusion has important consequences for the peace of mind of patients and their families. While Legius syndrome and neurofibromatosis type 1 (NF1) share several phenotypic features, Legius syndrome, unlike NF1, does not carry an increased cancer risk. Nor do patients with Legius syndrome develop clusters of benign cutaneous neurofibromas, Dr. Sirkku Peltonen said at the congress.

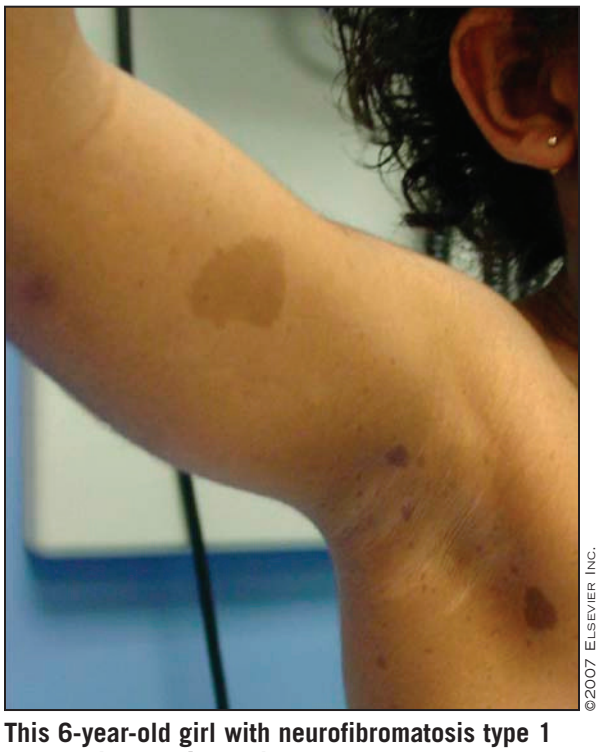
As first described by Dr. Eric Legius and coworkers (Nat. Genet. 2007;39:1120-6) at the Catholic University of Leuven (Belgium), the hallmarks of Legius syndrome include multiple café au lait macules, axillary freckling, and autosomal dominant transmission, all of which are also among the NF1 diagnostic criteria established by the National Institutes of Health (JAMA 1997;278:51-7).

But patients with Legius syndrome do not develop any other characteristic findings of NF1, such as bone lesions, plexiform or cutaneous neurofibromas, Lisch nodules in the iris, and nervous system tumors.

Legius syndrome is caused by mutations in the SPRED1 gene, while NF1 is caused by mutations in the gene encoding neurofibromin. Consider the possibility of Legius syndrome, which can be confirmed by molecular genetic analysis, in patients with six or more café au lait macules and axillary freckling but none of the other classic features of NF1, urged Dr. Peltonen of the University of Turku (Finland).

How often is Legius syndrome mistaken for NF1? A report by Dr. Legius and coworkers concluded half a cohort of 40 patients with Legius syndrome confirmed by genetic analysis fulfilled the NIH diagnostic criteria for NF1 based upon the presence of the requisite number of café au lait spots, axillary freckling, and/or a family history compatible with NF1. In the same report, the international group of investigators determined that 1.9% of a series of 1,318 patients with the clinical diagnosis of NF1 based upon the NIH criteria actually had Legius syndrome (JAMA 2009;302:2111-8).

Dr. Peltonen declared having no relevant financial interests. ■



This 6-year-old girl with neurofibromatosis type 1 has multiple café-au-lait macules.