Teens With SLE Need Info About Contraception

Estrogen-free methods may be the best choice given the increased risk for thrombotic events in lupus.

BY ELIZABETH MECHCATIE

Counseling teenage girls with systemic lupus erythematosus about contraception "is a critical part" of caring for this group of patients.

Ensuring that they have access to effective contraception is "crucial" for those who are sexually active, according to a review article on contraceptive choices for this patient population that was published in Pediatric Rheumatology.

Many adolescent girls with systemic lupus erythematosus (SLE) see their pediatric rheumatologist more often than they see their primary care physician.

If they are sexually active, then they—like other teenage girls in the United States—are at a high risk of unplanned pregnancy.

In general, all women with lupus are at a greater risk of worsening disease during pregnancy and have a greater risk of developing obstetric and fetal complications, compared with healthy women. Moreover, many of the medications used in lupus treatment are teratogens or abortifacients, so "practitioners must expend extra effort to help these patients avoid unplanned pregnancy," the authors wrote (Pediatr. Rheumatol. Online 2010;8:10).

To provide the best possible care for this population, pediatric rheumatologists need to be comfortable discussing contraception and be knowledgeable about contraceptives, noted Dr. Melissa S. Tesher of the department of pediatrics at the University of Chicago and her colleagues.

The investigators didn't recommend any one option over another for this group of patients. "No contraceptive method is ideal," they wrote, adding, "the risk of a given contraceptive must be balanced against the known significant risks of pregnancy in an adolescent with lupus."

In an interview, Dr. Tesher said that pediatric rheumatologists should discuss these issues with their teenage patients, and encourage sexually active teens to use a highly effective form of contraception.

Although some of the newer, longer-acting contraceptives are good choices for this group, the contraceptive method should be chosen on a patient-by-patient basis, with the patient's participation, said Dr. Tesher, who decided to research and write the article with her colleagues after two teenaged lupus patients at the university clinic unexpectedly became pregnant.

If the pediatric rheumatologist doesn't bring up the issue of contraception, "it may not be addressed at all," she said, adding that the comfort level in this area varies, partly because there are not many studies indicating what contraceptives are best for teenagers with lupus.

"It's not comparing the risk of taking the contraceptive vs. the risk of not taking the contraceptive; it's the risk to the patient from pregnancy and the risk of flare, and the risk of complications during pregnancy [that] tend to be very high in this group of patients."

Although the investigators recommend condoms for protection against sexually transmitted infections, condoms and other barrier methods are not used consistently among adolescents and have high failure rates, so a second method should also be recommended.

The safety of estrogen-based oral contraceptives (OCs) in women with lupus is unclear. These agents have some benefits, but "OCs are not usually the best choice for a teen with lupus," because it is not entirely clear whether exogenous estrogen increases the risk of lupus flares, Dr. Tesher commented in the interview.

"But there definitely is a risk of thrombosis in patients with antiphospholipid antibodies, and there are issues with OCs and adherence in teens," she added.

Considering the documented thrombotic risks of estrogen-containing contraceptives, estrogen-free methods of birth control "are likely a more prudent choice in patients with other prothrombotic risk factors," according to the article. These options include the progestin-only OC, which "is unlikely to worsen lupus activity or promote thrombosis," but which has a high discontinuation rate among teens, the investigators noted.

The authors describe depot medroxyprogesterone acetate (DMPA), a widely available and cheap progestin-only method that is injected once every 3 months, as "a reasonable choice for many adolescents." But the irregular periods and weight gain associated with DMPA are drawbacks, and long-term use is associated with reductions in bone mineral density, a concern for women with SLE who are already at an increased risk of osteopenia because of their disease and corticosteroid use, they wrote.

A relatively new option, Implanon, a single implantable rod that releases etonogestrel, "could be an excellent choice for some young women with SLE," they said. There are no studies of the agent in women with lupus. The continuation rates among adolescent users are unknown, and Implanon use is often associated with irregular menstrual periods. However, the agent is highly effective for 3 years, is easily removed and rapidly reversible, and "does not appear to have a detrimental effect on bone density," they wrote.

Intrauterine devices (IUDs) are also highly effective, easily reversible, long-term contraceptives, and "offer many potential advantages to women with SLE," the authors said. There are limited data available on IUD safety in women with lupus. Data on the associated risk of pelvic inflammatory disease in another immunosuppressed population (HIV-infected women) are "encouraging." The investigators concluded that "existing evidence does not support the opinion that a diagnosis of lupus or immunocompromise are contraindications to the use of an IUD."

The levonorgestrel-releasing IUD, marketed as Mirena, "may be a better choice," than the copper IUD, which is often associated with menorrhagia, as anemia is common among adolescents with SLE, they added.

Finally, the authors said that educating adolescents about and providing a prescription for emergency contraception (oral levonorgestrel), which is available without a prescription for people aged 17 and older, "are also appropriate in many circumstances." ■

Disclosures: *The authors had no financial conflicts to disclose.*

Not All Children Outgrow 'Growing Pains,' Study Finds

BY AMY ROTHMAN SCHONFELD

NEW YORK — Almost half of children with "growing pains" have not outgrown them 5 years later.

Those children who continued to have growing pains had significantly lower pain thresholds than did controls or patients whose pains had resolved, said Dr. Lisa F. Imundo, referring to recently published data by other investigators (J. Pediatr. 2010 [doi:10.1016/j.jpeds.2009.11.078]). "These results suggest we should treat chronic pain problems as central pain-processing problems," said Dr. Imundo at a meeting sponsored by New York University.

Chronic and idiopathic pain complaints are responsible for 7% of referrals to pediatric rheumatology centers, said Dr. Imundo, director of pediatric rheumatology at the Morgan Stanley Children's Hospital of New York–Presbyterian. Idiopathic pain syndromes in children include growing pains, benign hypermobility, reflex sympathetic dystrophy, fibromyalgia syndrome, chronic fatigue, chronic Lyme disease, and Munchausen and conversion disorders.

Growing pains are generally considered to be a temporary, benign condition that affects children aged 2-6 years. Affected children may wake up crying from a deep sleep, rubbing one or both legs. Episodes tend to occur only at night, when children may be awakened for several nights in a row, followed by days or weeks of uninterrupted sleep, explained Dr. Imundo.

To see what actually happens to children with growing pains as they age, investigators examined 35 of the 44 patients in the original cohort. At the time of the reevaluation, the mean age of the children was 13.4 years, and 51% (18 of 35) said they no longer had pain.

In all, 17 patients (49%) reported persistent growing pains. Of these, 14 patients currently had fewer pain episodes, compared with the time of their first diagnosis, whereas 3 patients said the pains were more frequent. Most (94%) of the persistent-pain patients had pain in the lower extremities, and about one-quarter had pain in the upper extremities. Pain was symmetric for 88% of this group. Nine children used analgesics regularly to relieve pain. None reported missing school because of pain.

One of the study's objectives was to determine whether children with growing pains develop other pain syndromes in adolescence. Of the 35 in the original growing-pain cohort, 5 children (14%) reported symptoms of other pain syndromes, such as migrainelike headaches (9%) or recurrent abdominal pain (6%). No patients developed arthritis or fibromyalgia.

The fact that children with recalcitrant growing pains had lower pain thresholds suggests that 'we should treat chronic pain problems as central pain-processing problems.'

Pain thresholds were assessed in predefined body areas using a Fischer-type dolorimeter. Pressure was gradually increased in increments of 1 kg/sec until the patient reported feeling pain. The threshold was measured in 18 predefined pressure points of fibromyalgia, 3 control points, and in the mid–anterior tibia where these patients commonly report pain.

Children with persistent pains had lower pain thresholds than did 38 age- and sex-matched controls (P less than .05) or patients with resolved growing pains (P less than .02). Such heightened pain sensitivity of children with continued growing pains was seen for the fibromyalgia points, the control points, and the tibia point (P less than .01 for each).

Dr. Imundo does not recommend opioids or NSAIDs for conditions that are associated with central pain-processing syndromes. Instead, she suggests that antidepressants or anticonvulsants may be more effective. ■

Disclosures: *Dr. Imundo had nothing to disclose. This report contains information on the use of medications that are not approved for the use of growing pains.*