

# Ob.Gyn. News

www.obgynnews.com

VOL. 46, NO. 9

The Leading Independent Newspaper for the Obstetrician/Gynecologist—Since 1966

SEPTEMBER 2011

## WHAT'S NEWS

Pregnant women are more likely to get information about **the Tdap vaccine** from pediatricians than from obstetricians, one survey shows. **2**

**Early IUD expulsions** aren't increased with tampon use or menstrual cup use, a study found. **13**

Self-therapy or low-dose prophylaxis may help **recurring, uncomplicated urinary tract infections**. **14**



Experts call for a clinical trial of **salpingectomy for ovarian cancer prevention**. **15**

ATHENA trial finds **cobas HPV test outperforms cytology** for detecting CIN 3 or worse. **16**

Add **Trichomonas vaginalis to STD screen** to reduce risk of HIV acquisition and transmission. **17**



**Flu shot** that pregnant mom gets **may benefit baby too**. **22**

In the **Master Class** column, Dr. E. Albert Reece and Dr. Thomas R. Moore discuss the **optimal management of gestational diabetes mellitus**. **24**



In the **Drugs, Pregnancy, and Lactation** column, Dr. Lee Cohen discusses a recent study that looks at a possible link between use of **selective serotonin reuptake inhibitors during pregnancy and the risk of autism**. **26**



## Many Ob.Gyns. Cling To Annual Pap Testing

BY MITCHEL L. ZOLER

FROM THE AMERICAN JOURNAL OF OBSTETRICS & GYNECOLOGY

**I**ntroduction of the human papillomavirus cotest for cervical screening in 2003 failed to make a dent in the tendency of U.S. physicians to overuse Pap tests, according to data collected in a 2006 national survey.

In 2006, at least two-thirds of the office-based physicians surveyed said that they would use Pap tests annually even in women aged 30-60 years who had a current negative human papillomavirus (HPV) test result, a current normal Pap test, and two consecutive previous normal Pap results in the past 5 years, even though U.S. recommendations at the time (and currently) called for a retesting interval of at least 3 years, Katherine B. Roland and her associates reported (Amer. J. Obstet. Gynecol. 2011 [doi:10.1016/j.ajog.2011.06.001]).

"Annual screening [with Pap tests] is persistent regardless of a woman's screening history or HPV test results,"

See **Annual Pap Testing** page 4



COURTESY CDC

**Divergence from the recommendations for a longer screening interval in these women produces unnecessary testing costs and risks, said Katherine B. Roland of the Centers for Disease Control and Prevention in Atlanta.**

## HHS Mandates Copay-Free Contraception, With Exceptions

BY JANE ANDERSON

**S**tarting next August, all new health plans will be required to provide copayment-free coverage of a range of women's preventive services, including contraception, the Health and Human Services department announced.

Covered services include well-woman visits; screening for gestational diabetes; DNA testing for the human papillomavirus in women age 30 and older; counseling for sexually-transmitted infections; HIV screening and counseling; Food and Drug Administration-

approved contraceptive methods as well as sterilization procedures; breastfeeding support and supplies; and screening and counseling for domestic violence, according to the HHS.

New private health plans must offer these recommended services without copayments, coinsurance, or deductibles under the Affordable Care Act. The requirements take effect for plan years beginning on or after Aug. 1, 2012. HHS estimates that about 34 million women ages 18-64 years will be in new private health plans by 2013.

The new requirements do not apply to

**The decision was a controversial one, but also 'common sense.'**

so-called "grandfathered" plans – those in existence today.

The list of women's preventive services was developed for HHS by an expert panel of the Institute of Medicine. HHS accepted all of the IOM's recommendations, which were released earlier this summer. "These historic guidelines are based on science and existing literature and will help ensure women get the preventive health benefits they need," HHS Secretary Kathleen Sebelius said in a statement.

The decision to provide copayment-free coverage of these services is a landmark step. See **Mandates** page 8

Medical  
News Net

Want Daily Medical  
News and Commentary?

Follow us on **twitter**  
Twitter.com/MedicalNewsNet

# Religious Exemptions Allowed

Mandates from page 1

free contraceptives was a controversial one, but also “common sense,” Ms. Sebelius said during a news briefing.

“Since birth control is the most common drug prescribed to women ages 18-44, insurance plans should cover it,” she said. “Not doing it would be like not covering flu shots or any of the other basic preventive services that millions of Americans count on every day.”

HHS plans to allow religious institu-

tions that offer insurance to their employees to opt out of covering contraception. HHS issued an interim final rule that allows these groups to buy or sponsor group health insurance that does not cover contraception if it violates the group’s beliefs. The interim final rule is modeled after similar religious exemptions in place in the 28 states that already require insurance companies to cover contraception,

according to the HHS.

The list of preventive services was recommended by an expert panel of the Institute of Medicine.

In a report released July 19, the IOM said that each of the services identified by IOM committee members is critical to ensure “women’s optimal health and well-being.” Their recommendations are based on a review of existing guidelines and on an assessment of the evidence of the effectiveness of different preventive services.

Dr. E. Albert Reece commented, “The charge of the Preventive Services for

Women committee, of which I was a member, was to identify the ‘gaps’ in coverage that could potentially have a major impact on the health of women in this country. Our other charge was to make recommendations regarding only those preventive services where there was an extremely high level of scientific evidence supporting their health benefits.

“Thus, all of the recommendations we made were based on a very strong scientific evidence of a clear health benefit, as well as evidence from many sources that, if implemented, would fill a significant health care gap in providing optimal preventive care for women. Contraception was just one of a handful of preventive services that emerged from this very rigorous process out of the many services that we considered.”

He continued, “Unintended pregnancies are a major cause of preterm births in this country, and preterm birth is a

**‘Despite strong evidence to support the use of contraceptives to ameliorate preterm births, we found a significant gap in access to and availability of this highly effective preventive method.’**

major contributor to infant mortality and fetal health problems. Despite strong evidence to support the use of contraceptives to ameliorate preterm births, we found a significant gap in access to and availability of this highly effective preventive method.

“As physicians and public health professionals, we on the IOM committee would have been ethically and morally remiss if we had omitted a recommendation to provide a service – without any barriers to access – that can potentially prevent this incredibly costly public health problem,” Dr. Reece, vice president for medical affairs at the University of Maryland, Baltimore, as well as the John Z. and Akiko K. Bowers Distinguished Professor and dean of its school of medicine, said in an interview.

In a press briefing, IOM panel chair Linda Rosenstock, dean of the University of California, Los Angeles, noted that the final decision on whether a woman should receive a particular service will remain between that woman and her physician.

However, she said, “It is appropriate to decrease the barriers to what we have identified to be evidence-based, effective preventive measures.”

The report won praise from the American Congress of Obstetricians and Gynecologists. “I’m delighted with the terrific work the IOM committee did,” said Dr. James N. Martin Jr., ACOG president and director of the division of maternal-fetal medicine and obstetric services at Winfred L. Wiser Hospital for Women and Infants in Jackson, Miss.

ACOG has pushed for better coverage of preventive services, including many  
*Continued on following page*

**Makena**<sup>TM</sup>  
hydroxyprogesterone  
caproate injection

## BRIEF SUMMARY OF PRESCRIBING INFORMATION

Please consult full prescribing information.

### INDICATIONS AND USAGE

Makena is a progestin indicated to reduce the risk of preterm birth in women with a singleton pregnancy who have a history of singleton spontaneous preterm birth. The effectiveness of Makena is based on improvement in the proportion of women who delivered <37 weeks of gestation. There are no controlled trials demonstrating a direct clinical benefit, such as improvement in neonatal mortality and morbidity.

**Limitation of use:** While there are many risk factors for preterm birth, safety and efficacy of Makena has been demonstrated only in women with a prior spontaneous singleton preterm birth. It is not intended for use in women with multiple gestations or other risk factors for preterm birth.

### CONTRAINDICATIONS

Do not use Makena in women with any of the following conditions:

- Current or history of thrombosis or thromboembolic disorders
- Known or suspected breast cancer, other hormone-sensitive cancer, or history of these conditions
- Undiagnosed abnormal vaginal bleeding unrelated to pregnancy
- Cholestatic jaundice of pregnancy
- Liver tumors, benign or malignant, or active liver disease
- Uncontrolled hypertension

### WARNINGS AND PRECAUTIONS

#### Thromboembolic Disorders

Discontinue Makena if an arterial or deep venous thrombotic or thromboembolic event occurs.

#### Allergic Reactions

Allergic reactions, including urticaria, pruritus and angioedema, have been reported with use of Makena or with other products containing castor oil. Consider discontinuing the drug if such reactions occur.

#### Decrease in Glucose Tolerance

A decrease in glucose tolerance has been observed in some patients on progestin treatment. The mechanism of this decrease is not known. Carefully monitor prediabetic and diabetic women while they are receiving Makena.

#### Fluid Retention

Because progestational drugs may cause some degree of fluid retention, carefully monitor women with conditions that might be influenced by this effect (e.g., preeclampsia, epilepsy, migraine, asthma, cardiac or renal dysfunction).

#### Depression

Monitor women who have a history of clinical depression and discontinue Makena if clinical depression recurs.

#### Jaundice

Carefully monitor women who develop jaundice while receiving Makena and consider whether the benefit of use warrants continuation.

#### Hypertension

Carefully monitor women who develop hypertension while receiving Makena and consider whether the benefit of use warrants continuation.

### ADVERSE REACTIONS

For the most serious adverse reactions to the use of progestins, see *Warnings and Precautions*.

#### Clinical Trials Experience

Because clinical trials are conducted under widely varying conditions, adverse reaction rates observed in the clinical trials of a drug cannot be directly compared to the rates in the clinical trials of another drug and may not reflect the rates observed in practice.

In a vehicle (placebo)-controlled clinical trial of 463 pregnant women at risk for spontaneous preterm delivery based on obstetrical history, 310 received 250 mg of Makena and 153 received a vehicle formulation containing no drug by a weekly intramuscular injection beginning at 16 to 20 weeks of gestation and continuing until 37 weeks of gestation or delivery, whichever occurred first. [See *Clinical Studies*.]

Certain pregnancy-related fetal and maternal complications or events were numerically increased in the Makena-treated subjects as compared to control subjects, including miscarriage and stillbirth, admission for preterm labor, preeclampsia or gestational hypertension, gestational diabetes, and oligohydramnios (Tables 1 and 2).

**Table 1 Selected Fetal Complications**

Pregnancy Complication	Makena n/N	Control n/N
Miscarriage (<20 weeks) <sup>1</sup>	5/209	0/107
Stillbirth (≥20 weeks) <sup>2</sup>	6/305	2/153

<sup>1</sup>N = Total number of subjects enrolled prior to 20 weeks 0 days

<sup>2</sup>N = Total number of subjects at risk ≥20 weeks

**Table 2 Selected Maternal Complications**

Pregnancy Complication	Makena N=310 %	Control N=153 %
Admission for preterm labor <sup>1</sup>	16.0	13.8
Preeclampsia or gestational hypertension	8.8	4.6
Gestational diabetes	5.6	4.6
Oligohydramnios	3.6	1.3

<sup>1</sup>Other than delivery admission.

#### Common Adverse Reactions:

The most common adverse reaction was injection site pain, which was reported after at least one injection by 34.8% of the Makena group and 32.7% of the control group. Table 3 lists adverse reactions that occurred in ≥2% of subjects and at a higher rate in the Makena group than in the control group.

**Table 3 Adverse Reactions Occurring in ≥2% of Makena-Treated Subjects and at a Higher Rate than Control Subjects**

Preferred Term	Makena N=310 %	Control N=153 %
Injection site pain	34.8	32.7
Injection site swelling	17.1	7.8
Urticaria	12.3	11.1
Pruritus	7.7	5.9
Injection site pruritus	5.8	3.3
Nausea	5.8	4.6
Injection site nodule	4.5	2.0
Diarrhea	2.3	0.7

In the clinical trial, 2.2% of subjects receiving Makena were reported as discontinuing therapy due to adverse reactions compared to 2.6% of control subjects. The most common adverse reactions that led to discontinuation in both groups were urticaria and injection site pain/swelling (1% each).

Pulmonary embolus in one subject and injection site cellulitis in another subject were reported as serious adverse reactions in Makena-treated subjects.

#### DRUG INTERACTIONS

No drug-drug interaction studies were conducted with Makena.

#### Drugs Metabolized by CYP1A2, CYP2A6 and CYP2B6

The metabolism of drugs metabolized by CYP1A2 (such as theophylline, tizidine, clozapine), CYP2A6 (such as acetaminophen, halothane, nicotine) and CYP2B6 (such as efavirenz, bupropion, methadone) may be increased during treatment with Makena [See *Clinical Pharmacology*].

#### USE IN SPECIFIC POPULATIONS

##### Pregnancy

**Pregnancy Category B:** There are no adequate and well-controlled studies of Makena use in women during the first trimester of pregnancy. Data from a vehicle (placebo)-controlled clinical trial of 310 pregnant women who received Makena at weekly doses of 250 mg by intramuscular injection in their second and third trimesters, as well as long-term (2-5 years) follow-up safety data on 194 of their infants, did not demonstrate any teratogenic risks to infants from in utero exposure to Makena.

Reproduction studies have been performed in mice and rats at doses up to 95 and 5, respectively, times the human dose and have revealed no evidence of impaired fertility or harm to the fetus due to Makena.

Makena administration produced embryolethality in rhesus monkeys but not in cynomolgus monkeys exposed to 1 and 10 times the human dose equivalent every 7 days between days 20 and 146 of gestation. There were no teratogenic effects in either species.

##### Labor and Delivery

Makena is not intended for use to stop active preterm labor. The effect of Makena in active labor is unknown.

##### Nursing Mothers

Discontinue Makena at 37 weeks of gestation or upon delivery. Detectable amounts of progestins have been identified in the milk of mothers receiving progestin treatment. Many studies have found no adverse effects of progestins on breastfeeding performance, or on the health, growth, or development of the infant.

##### Pediatric Use

Makena is not indicated for use in children. Safety and effectiveness in pediatric patients less than 16 years of age have not been established. A small number of women under age 18 years were studied; safety and efficacy are expected to be the same in women aged 16 years and above as for users 18 years and older. [See *Clinical Studies*.]

Marketed by: Ther-Rx Corporation St. Louis, MO 63044

*Continued from previous page*

on the IOM's list, for many years, Dr. Martin said in an interview. "The recommendation for coverage of the annual well-woman visit is going to go very nicely with the other things suggested, especially the recommendation for [copayment-free] contraception," he said.

Dr. Martin noted that the recommendation for copayment-free contraception should help to reduce the number of unplanned pregnancies in the United States, especially for low- and middle-income women who may have had trouble affording birth control.

"It's amazing to me that a country as advanced as we are is as casual as we are about contraception."

He also called out the IOM recommendations for better breastfeeding support along with coverage of gestational diabetes and domestic violence screening, saying they will help improve overall women's health.

"All of these are good recommendations," Dr. Martin said. "I couldn't be happier with this report."

The recommendations also were hailed by Planned Parenthood on its website, which said the recommendations could remove barriers which keep many women from using birth control consistently.

However, Cardinal Daniel DiNardo of Galveston-Houston, Tex., chairman of

the Committee on Pro-Life Activities of the United States Conference of Catholic Bishops, said in a statement that "Pregnancy is not a disease, and fertility is not a pathological condition to be suppressed by any means technically possible."

Cardinal DiNardo urged HHS to block the recommendations on contraception, as did the conservative group Family Research Council, which focused specifically on the recommendations for coverage of emergency contraceptives in the statement on its website.

Dr. Rosenstock noted that many health care plans currently provide coverage for these services and added that "This is just a recommendation for first-dollar coverage."

The Affordable Care Act of 2010 requires health plans to provide first-dollar coverage for the preventive services listed in HHS' comprehensive list of preventive services beginning in 2014.

These include the services with Grade A and B recommendations made by the U.S. Preventive Services Task Force, the Bright Futures recommendations for adolescents from the American Academy of Pediatrics, and vaccinations

specified by the Centers for Disease Control and Prevention's Advisory Committee on Immunization Practices. Services on the list include blood pressure measurement, diabetes and cholesterol tests, and mammography and colonoscopy screenings.

However, HHS officials, concerned that some preventive services key to women's health were not included on those lists, asked the IOM to investigate and recommend additions to the coverage list that would be specific to women.

At the request of HHS officials, an IOM committee made up of women's health experts identified critical gaps in preventive services for women as well as measures that will further ensure women's health and well-being.

The committee identified diseases and conditions that are more common or more serious in women than in men, or for which women experience different outcomes or benefit from different interventions.

The panel considered only effectiveness, not any cost data or cost-effectiveness data, according to Dr. Rosenstock. The group's charge also required members to consider only services provided

in clinical settings, even though "preventive services can be effective when provided in settings outside the physician's office," she said.

The report backed up each of the committee's recommendations with the science behind it. For example, it noted that deaths from cervical cancer could be reduced by adding DNA testing for HPV to the Pap smears that are part of the current guidelines for women's preventive services because HPV testing increases the chances of identifying women at risk for cervical cancer.

To reduce the overall rate of unintended pregnancies, which can lead to babies being born prematurely or at a low birth weight, the IOM report urged HHS to consider adding the full range of Food and Drug Administration-approved contraceptive methods as well as patient education and counseling for all women with reproductive capability. This included emergency contraceptives such as levonorgestrel.

Lactation counseling already is part of the HHS guidelines that dictate what preventive services health plans must cover. However, the IOM report went further, recommending coverage of breast pump rental fees along with counseling by trained providers to help women initiate and continue breastfeeding. ■

Mary Ellen Schneider, New York Bureau, contributed to this story.

**The IOM identified diseases and conditions that are more common or serious in women than in men, or for which women experience different outcomes or benefit from different interventions.**

## COMMENTARY

# Ob.Gyns. Need to Support Copay-Free Contraceptives

Implementation of the list of preventive services developed by the Institute of Medicine for the U.S. Department of Health and Human Services will save many lives and avoid vast



BRUCE L. FLAMM, M.D.

amounts of suffering. The IOM and HSS deserve our accolades, as does ACOG for supporting the recommendations. Sadly, some misguided individuals are fighting against one key component of

these preventative services, namely, copayment-free contraceptives. Their objections are based on religion, not science. They believe that the use of condoms and oral contraceptives is immoral. Hence, they mandate the "abstinence only" and "rhythm" methods of family planning. Those of us who have practiced medicine for many years have personally witnessed the abject failure of these ancient methods. Scientific evidence-based medicine has proved that condoms decrease the spread of STDs, including deadly HIV, and that oral contraceptives prevent unintended pregnancies. Ironically, and

tragically, antiabortion organizations that also campaign against condoms and oral contraceptives inadvertently increase both the transmission of STDs and the number of abortions. As physicians and as advocates for women's health, we must fully support copayment-free contraceptives.

DR. FLAMM is an ob.gyn. practicing in Riverside, Calif. He is a member of the Editorial Advisory Board of OB.GYN. NEWS. He said he had no relevant financial disclosures.

The adoption by HHS of the recommendations made by the IOM's Committee on Preventive Services for Women will improve women's health. Specifically, the provision for copayment-free contraception will allow more options for women who cannot consider some contraceptives because of the cost. For example, women who cannot afford an IUD will no longer have a financial barrier to one of the most effective forms



CONSTANCE J. BOHON, M.D.

of contraception. Currently, 49% of all pregnancies in the United States are unintended. Approximately 48% of women terminating a pregnancy were using contraception during the month in which conception occurred. Without a financial barrier, there will not only be more contraceptive options, but also more reliable forms of contraception available for us to discuss with our patients. This provision should be supported by all of us who provide contraception to women.

DR. BOHON is an ob.gyn in private practice in Washington. She is a member of the Editorial Advisory Board of OB.GYN. NEWS. She said she had no relevant financial disclosures.

The list of preventive health services to be covered per the HHS mandate in response to the IOM recommendations is a welcome shift toward the provision of true prevention in health care. Health outcomes for reproductive-age women and their children are absolutely linked to the reproductive health care provided to women. Contraception, health screening, breastfeeding, sexually transmitted infection screening, and intimate partner violence screening address the most immediate health concerns of many women, and are essential in maintain-

ing health. It is important to recognize that although many of these services focus on supporting reproductive health for women, their effects go well



MELISSA KOTTKE, M.D., M.P.H.

beyond reproduction and sexuality. Indeed, these mandated services are linked to 8 of the 10 leading health indicators for "Healthy People 2010." Furthermore, the services go beyond the health

of woman by also including their children, families, and links to the greater community. Removing cost as a barrier to preventive health care for women has the power to save dollars and lives.

DR. KOTTKE is an assistant professor of ob.gyn. at Emory University and the director of the Jane Fonda Center for Adolescent Reproductive Health, both in Atlanta. She is a member of the Editorial Advisory Board of OB.GYN. NEWS. She disclosed that she is a trainer for the implantation of the subcutaneous contraceptive device Implanon.