Interventions Overcome Obstacles to IUD Use

BY BRUCE K. DIXON
Chicago Bureau

La Jolla, Calif. — Specific interventions to increase the availability of intrauterine devices hold considerable potential for improving the use of these convenient and highly effective contraceptive tools, Dr. Suzan Goodman said at the annual meeting of the Association of Reproductive Health Professionals.

The interventions studied include immediate postabortal insertion, simplified screening criteria, allowed insertion on initial visit, staff training that includes clinician instruction on intrauterine device (IUD) counseling and insertion, and reevaluation and improvement of IUD educational materials.

While IUDs are a highly effective form of birth control equal to tubal sterilization, only 1% of reproductive age women in the United States use them, compared with over 20% in many other countries, said Dr. Goodman, director of medical education at Planned Parenthood Golden Gate in San Francisco.

"We hypothesized that barriers to insertion of IUDs are central to low utilization in the U.S. Postabortal IUD insertion can be a rapid, effective form of contraception, and studies show that complication rates do not increase when IUDs are inserted immediately post abortion," she explained.

The researchers obtained data on eight clinics' IUD utilization during three periods: an 18-month control group period, a 14-month period after initiation of postabortal insertion, and a 6-month period with all interventions, including the addition of same-day insertion with simplified screening criteria.

During the 3-year study a total of 2,184 IUDs were inserted, including 1,503 interval insertions and 681 postabortion insertions. About half the IUDs were nonhormonal ParaGuard devices and half were Mirena devices, which release a low dose of levonorgestrel. From period 1 to period 3, the average monthly ParaGuard insertions increased fourfold and Mirena insertions increased eightfold.

In the control period, 31 IUDs were inserted per month, on average, compared with 74 per month during the postabortal insertion period and 123 per month in the period with all interventions.

While the abortion rate in the clinics involved in the interventions increased 10%, IUD utilization increased 330%, showing that the observed IUD insertion trend was not just due to increasing abortions, Dr. Goodman said. A nearby Planned Parenthood affiliate that did not undertake these interventions had an increase in IUD utilization over the same period of 20%, she said.

A demographic analysis revealed that each progressive study period had more women using IUDs who were young, single, and of smaller mean family size. The number of white and black women using IUDs increased over the progressive study periods.

Over 90% of IUD users met Medicaid eligibility requirements.

Among the complications encountered were IUD expulsion, infection, pregnancy with the IUD in place, continuing viable pregnancy, and abortion. Dr. Goodman had no financial disclosures. ■

Gestational Diabetes Risk Cut By 72% With Physical Activity

Washington — Physical activity during the pregnancy of previously inactive women is associated with a lower risk for gestational diabetes, according to a review of women in the National Maternal and Infant Health Survey.

In the study of 3,770 women without diabetes who reported being physically inactive before their singleton pregnancy, Jihong Liu, Sc.D., and her associates at the University of South Carolina, Columbia, found that a significantly lower percentage of women who were physically active during pregnancy had gestational diabetes mellitus (GDM) than did those who remained inactive (1.5% vs. 4.2%).

About 14% of the women who were previously inactive began physical activity after they learned of their pregnancy.

The women who were classified as physically active during pregnancy were 72% less likely to develop GDM than were those who were inactive, Dr. Liu reported in a poster at the annual scientific sessions of the American Diabetes Association.

The comparison was statistically adjusted for age, race/ethnicity, education, parity, smoking status, bed rest, and prepregnancy body mass index. The study results were weighted to achieve a nationally representative sample.

—Jeff Evans

Clinical Guidelines for Family Physicians

Emergency Contraception

BY NEIL S. SKOLNIK, M.D., AND ANNE T. WIEDEMANN, M.D.

Approximately 50% of pregnancies in the United States are unplanned. Almost half of these pregnancies end in abortion. Emergency contraception ("the morning-after pill") is a backup method of contraception that can decrease rates of pregnancy after unprotected intercourse or initial contraception failure. It decreases the expected rate of pregnancy by 89% when used properly. On August 24, 2006, the Food and Drug Administration announced the approval of Plan B emergency contraception (EC) as an over-the-counter medication for women aged 18 years or older. Although this will lead to greater access to emergency contraception, it may decrease the opportunity for physicians to discuss birth control options with patients when they request prescriptions for EC. Physicians are therefore urged to address contraception and the availability of emergency contraception at office visits and physical exams, according to recommendations by the American College of Obstetricians and Gynecologists (ACOG Practice Bulletin 2005; no. 69).

Guidelines are most useful when they are available at the point of care. A concise yet complete handheld computer version of this guideline is available for download, compliments of Family Practice News, *at www.redi-reference.com.*

The Evidence

The ACOG guideline is based on a literature search of all relevant articles on the subject of emergency contraception from January 1985 to January 2005 using the college's private database as well as the Medline database and the Cochrane Library. Studies were evaluated for quality based on the method outlined by the U.S. Preventive Services Task Force, and recommendations were formulated by expert consensus.

The Recommendations

Emergency contraception is an oral hormone preparation that inhibits ovulation, interferes with tubal transport, and prevents implantation. It is not an abortifacient and has no effect on an already implanted pregnancy. There are a number of emergency contraceptives available. The Yuzpe regimen, or Preven, was the first emergency contraceptive approved by the FDA. It is a combination of four tablets of 0.25 mg levonorgestrel and 0.05 mg ethinyl estradiol. Two tablets are taken immediately and the final two are taken 12 hours later. Plan B is more commonly available and consists of two 0.75 mg pills of levonorgestrel taken 12-24 hours apart. The 1.5 mg of levonorgestrel may also be taken as a single dose. Oral contraceptive pill formulations may be used as EC, as well. An intrauterine device (IUD) may prevent pregnancies after unprotected intercourse if it is placed within 5 days.

Emergency contraception should be initiated as soon as possible after unprotected intercourse. The medication is FDA approved for up to 72 hours after intercourse but may still be effective up to 120 hours. Women can use EC multiple times, even within the same menstrual cycle, and do not require clinical examination or pregnancy testing prior to use. However, if a woman's menstrual cycle is delayed by more than 1 week, a pregnancy test should be done. Side effects of EC include nausea, vomiting, irregular bleeding, breast tenderness, abdominal pain, dizziness, and fatigue. Because nausea and vomiting are worse with estrogen-progesterone combinations, the progesterone-only preparation is preferred. If an estrogen-progesterone combination is used, an antiemetic should be given 1 hour before the EC dose is taken.

The only contraindications for use are known pregnancy or hypersensitivity to any component of the product. There are no clinical data on the risk of using EC in women with contraindications to conventional oral contraception, but it is believed that the medication can be used safely in these women. There are also no particular medical conditions that preclude the use of EC. There is an increased risk of ectopic pregnancy in patients using progestin-only contraceptives, but there are no studies on this risk with emergency contraception. Any woman complaining of severe lower abdominal pain after EC should be evaluated for ectopic pregnancy. In addition, patients with diabetics may require an increased dose of insulin after EC use because of decreased glucose tolerance. There is no known adverse effect from EC use in pregnancy or during breast-feeding.

Studies have shown that provisions for EC in advance of need can increase accessibility and use. Physicians are advised to provide information regarding effective contraceptive methods to every women requiring EC, and to use regular office visits as an opportunity to broach discussions on safe sex practices and the importance of contraception.

Plan B has just been approved for over-the-counter sales for women aged 18 years and older. Proper identification will be required for purchase. Women younger than 18 years will require a prescription to purchase Plan B. Duramed, the makers of Plan B, will provide education on STD prevention and routine birth control in the package insert, and will monitor sales for appropriate distribution and use.

The Bottom Line

Emergency contraception should be available to all sexually active women who do not desire pregnancy. With proper use up to 120 hours after unprotected intercourse, it can significantly decrease rates of unwanted pregnancy. Plan B is the preferred method because of its low side-effect profile.

Dr. Skolnik *is an associate director of the Family Medicine Residency program at Abington (Pa.) Memorial Hospital and a coauthor of "Redi-Reference Clinical Guidelines."* Dr. Wiedemann *is a third-year resident in the program.*