BEST PRACTICES IN: Oral Contraception Counseling:
Recommendations for Best Practices

This supplement is the third of three articles on oral contraception. The content is based on the proceedings of an experts' roundtable held on November 4, 2010, in Miami, Florida, with panelists:

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Introduction

The safety and efficacy of traditional 28-day and contemporary extended-regimen oral contraceptives (OCs) (eg, 91-day regimens) are well established in the medical literature. However, ensuring that women consistently adhere to their OC regimens in a way that enhances efficacy and satisfaction requires counseling. Periodic in-office, didactic, evidence-based talks with women about efficacy, safety, and side effects are insufficient, according to Dr Johnson-Mallard. Regardless of the quality of information presented, approaching patients as passive recipients of clinical information does not ensure contraceptive success, she explained.

Successful contraceptive counseling—the prevention of pregnancy—is not enough. Encouraging safe sexual practices and adherence to therapy is vital, and requires ongoing patient education, counseling, and coaching. Contraceptive success means discussing strategies for missed pills, coping with unscheduled bleeding, emphasizing the continued need for condom use to prevent sexually transmitted infections (STIs), and discussing how different regimens may facilitate adherence while improving lifestyle. Contraceptive success means effectively communicating with women about the benefits, risks, and side effects of OCs and finding the regimen best suited to the individual woman, said Dr Johnson-Mallard.

Counseling Techniques

Contraceptive methods and choices should be discussed during every office visit. The first consideration when counseling women about OCs and other forms of contraception is *how* to communicate. Above all else, according to Dr Johnson-Mallard, women must always be active decision makers. "A woman should never be a passive person within a conversation about birth control methods," she said.

Active decision making, continued Dr Johnson-Mallard, begins with a discussion of the patient's role in the decision-making process, reviewing her current birth control methods, her level of satisfaction with those methods, and her interest in alternative methods. "Bear in mind," added Dr Johnson-Mallard, "many women come into the office in search of methods to decrease bleeding, not necessarily for family-planning methods." The conversation provides an opportunity to introduce OCs to women who are not using contraception and, among women already taking an OC, the opportunity to assess satisfaction and adherence.

Often, commented Dr Johnson-Mallard, adherence and satisfaction are intertwined. Patients will often reveal how important dates (eg, weddings), recreational and sporting activities, and vacations are planned around anticipated bleeding dates—either menstrual bleeding or withdrawal bleeding dates. In fact, in a survey of 270 women without menstrual-related diagnoses, 75.6% said that menstrual periods interfered with sexual activity, 28.8% preferred not having their menstrual period when at work, and 48.4% reported that menstrual periods interfered with exercise and sports.[1] More than half of the women (n=152) in the survey desired reducing menstrual frequency. Ascertaining such information helps inform and direct the type of counseling needed for individual women.

Table. Key Points for Oral Contraceptive (OC) Counseling[2]

Contraceptive Efficacy
• All OCs are highly efficacious when taken correctly
• Missed doses may lead to decreased efficacy of the OC, especially with 21/7 regimens
• Precautionary methods should be discussed in the event of a missed dose
Safety
• OCs are clearly safer than pregnancy
• Risk of venous thrombosis should be discussed, and signs and symptoms should be clearly described, as should other rare health risks
Side Effects
• Minor side effects may occur upon initial use, including nausea, breast tenderness, and unscheduled bleeding
• These side effects usually subside within the first few months of initiation
Fertility
• Fertility returns rapidly upon discontinuation of OC use
• Patients should be told to start using another method of contraception as soon as they stop using OCs; they should not wait until their next period
Noncontraceptive Benefits
• Bleeding is decreased with all OCs
• OCs provide greater cycle predictability if taken cyclically
• All OCs are associated with a decreased risk of benign breast disease, pelvic inflammatory disease, and ovarian and endometrial cancers
Other
• OCs do not protect against sexually transmitted infections

Source: Nelson[2]

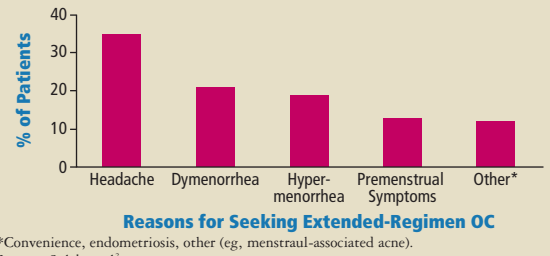
Key Counseling Messages

Key OC counseling messages are detailed in the **Table**[2] and should include efficacy, safety, and side effects, as well as return to fertility, noncontraceptive benefits (eg, predictability and less bleeding), and, importantly, continued use of condoms to protect against STIs.

Counseling should also include discussions of extended-regimen OCs, said Dr Johnson-Mallard. Although the US Food and Drug Administration approved an extended-regimen OC in 2003, women are often unaware of the safety associated with having only four withdrawal bleeds per year. They are also unaware that extended regimens reduce bleeding frequency and the menstrual-like withdrawal symptoms that occur with 21/7 regimens. These factors, combined with the more convenient dosing, which are appealing to many women, may improve adherence, commented Dr Johnson-Mallard.

In fact, after counseling, women frequently switch to extended regimens.[3] In a retrospective analysis of 318 women taking 21/7 regimens and experiencing hormonal withdrawal symptoms, 91% chose to switch to an extended regimen after counseling (**Figure 1**).[3] At 5-year follow-up, 46% of these women continued with an extended regimen.

Figure 1. Most Common Reasons Women Switch to an Extended-Regimen Oral Contraceptive (OC)[3]



*Convenience, endometriosis, other (eg, menstraul-associated acne).
Source: Sulak et al[3]

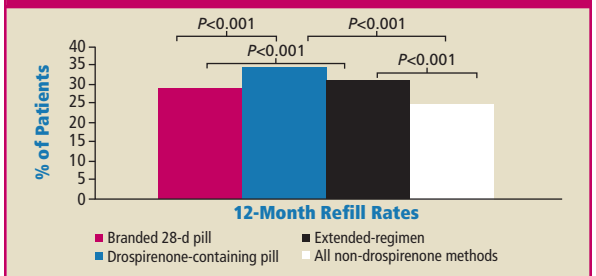
Key counseling messages for extended-regimen OCs do not differ greatly from those provided for 21/7 regimens. However, there are two additional key points. First, when introducing extended-regimen OCs, clinicians should reassure women that amenorrhea is safe when using an OC and is an indication of efficacy, and that the absence of bleeding does not portend "exploding," said Dr Johnson-Mallard. Women starting extended-regimen OCs also need to be reassured that breakthrough spotting/bleeding will diminish over time and that, in total, there is less bleeding with extended regimens than with no OC or 21/7 regimens.

Counseling and Adherence

Counseling women about OC options, efficacy, and bleeding can and does improve adherence and satisfaction, said Dr Johnson-Mallard. Counseling about extended regimens often leads to extended-regimen use, and extended regimens are associated with better adherence than are other methods.[3,4] For example, an analysis of OC prescription refill rates among 2.7 million women found that prescription refill rates after 12 months of use were substantially higher than with other methods, including 21/7 regimens. The 12- month refill rate for branded 28-day regimens was 29% versus 34.5% for drosperinone-containing pills and 31% for extended regimens ($p<0.001$, **Figure 2**).

Counseling also improves patient satisfaction and adherence by providing women with the knowledge to accept transient unscheduled bleeding, a common cause of dissatisfaction, poor adherence, and discontinuation.[5,6] Dr Johnson-Mallard explained, "There is a cycle. A woman misses a pill and has unscheduled bleeding. She stops the pill, but is now at risk for pregnancy, and so she restarts the pill. As she restarts the pill, there is again the possibility of unscheduled bleeding. This is the point: we need to talk about emergency contraception and consistent pill use. Education, education, education."

Figure 2. Timely Refill Rates Higher With Extended Regimens[4]



Source: Nelson et al[4]

Case Study

An 18-year-old woman, a patient for the last 4 years, presented in March seeking an OC. She was a high school senior and planning to attend college in the fall. She reported virginal status but was interested in starting an OC. The initial counseling session included the following messages:

- All OCs are highly efficacious when taken correctly.
- OC use is safer than pregnancy.
- Minor side effects may occur upon initial use.
- Consistent use is essential for efficacy.
- Condom use is essential if she becomes sexually active to prevent STIs.

She was prescribed a 21/7 OC.

In December, during the winter break, the young woman returned to the office seeking alternatives to her current OC. She was sexually active and reported that her current method of OC worked well for her and her partner. However, she was also a varsity basketball player and, because of her frequent game schedule, found the monthly withdrawal bleeds inconvenient and asked about other options.

Given the young woman's history, an extended-regimen OC was an obvious choice. She was again counseled on adherence, safety, and side effects, and the importance of consistent condom use to protect against STIs. In addition to safe-sex counseling, key messages to compliance included:

- Unscheduled bleeding may be a common side effect but should diminish over time.
- Unscheduled bleeding may be more common in the first 3 to 4 months of use.
- Adherence to a pill regimen is important.

Conclusion

Counseling, adherence, and contraceptive success are inseparable. Ongoing counseling during each office visit can help ensure that women are satisfied with their contraceptive choices, and satisfaction improves adherence. In addition to safety and efficacy data, counseling sessions should include information about options for withdrawal bleeding frequency, how different regimens may change lifestyle, and the continued need for prevention of STIs.

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