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INSIDE

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Updates Issued for *US MEC, SPR* — What Do the Changes Mean?

Most women can safely use most contraceptive methods

Time to update your practice. The *U.S. Medical Eligibility Criteria for Contraceptive Use, 2016 (US MEC 2016)* and the *U.S. Selected Practice Recommendations for Contraceptive Use, 2016 (US SPR 2016)* have new information.[1,2]

The CDC published the first guidance to provide recommendations on the safe use of contraceptive methods for women with various medical conditions and other characteristics in 2010.[3] It was adapted from global guidance developed by the World Health Organization. The new *US MEC 2016* contains more than 1,800 recommendations for more than 60 conditions, says **Kathryn Curtis**, PhD, a health scientist in the CDC's Women's Health and Fertility Branch in the Division of Reproductive Health. Curtis recently presented on the updates at the 2016 National Reproductive Health Conference in Chicago.[3]

"THE *US MEC* CAN HELP PROVIDERS DECREASE BARRIERS TO CHOOSING CONTRACEPTIVE METHODS."
— KATHRYN CURTIS, CDC

In formatting the 2016 *US MEC*, the decision was made to list methods in order of contraceptive effectiveness. Other notable updates to the guidance include the following:

- the addition of recommendations for women with cystic fibrosis, women with multiple sclerosis, and women using certain psychotropic drugs or St. John's wort;
- revisions to the recommendations for emergency contraception, including the addition of ulipristal acetate;
- revisions to the recommendations for postpartum women, women who are breastfeeding, and women with known dyslipidemias, migraine headaches,

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superficial venous disease, gestational trophoblastic disease, STIs, HIV, or who are using antiretroviral therapy.

"The *US MEC* can help providers decrease barriers to choosing contraceptive methods," notes Curtis. "Most women can safely use most contraceptive methods."

Certain conditions are associated with increased risk for adverse health events as a result of unintended pregnancy, says Curtis. Women, men, and couples should be informed of the full range of methods to decide what will be best for them, she advises.

The 2016 updated guidance from the CDC regarding contraception will be an important resource for clinicians who provide care to reproductive-age women, says **Andrew Kaunitz**, MD, University of Florida Research Foundation professor and associate chairman of the department of obstetrics and gynecology at the University of Florida College of Medicine–Jacksonville. The 2016 recommendations include new guidance for women with cystic fibrosis, multiple sclerosis, and those taking certain psychotropic drugs, as well as St. John's wort, he notes.

Clinicians who previously have not used CDC contraceptive guidance may find the color-coordinated Summary Chart available at the CDC website easiest to use, observes Kaunitz. For providers who don't have the free US MEC/SPR app or guidance links bookmarks, the guidance is easy to find online by typing "CDC contraception" into a search engine, Kaunitz notes.

Changes to *US SPR*

The 2016 *US SPR* includes new recommendations for medications to ease the insertion of IUDs, notes Curtis.Misoprostol is not recommended for routine use before IUD insertion; however, it might be helpful in select circumstances, such as with women who have a recently failed insertion. A paracervical block with lidocaine might reduce patient pain during IUD insertion, the guidance notes.[2]

Recommendations also have been updated regarding when to start regular contraception after ulipristal acetate (UPA) emergency contraceptive pills:

EXECUTIVE SUMMARY

Updates to the *U.S. Medical Eligibility Criteria for Contraceptive Use 2016 (US MEC 2016)* and the *U.S. Selected Practice Recommendations for Contraceptive Use 2016 (US SPR 2016)* have just been released.

- The 2016 *US MEC* contains more than 1,800 recommendations for more than 60 conditions. New additions include recommendations for women with cystic fibrosis, women with multiple sclerosis, and women using certain psychotropic drugs or St. John's wort, as well as revisions to the recommendations for emergency contraception, including the addition of ulipristal acetate.
- The 2016 *US SPR* includes new recommendations for medications to ease IUD insertion. Recommendations also have been updated regarding when to start regular contraception after emergency contraceptive use of ulipristal acetate.

• Advise the woman to start or resume hormonal contraception no sooner than five days after UPA use, and provide or prescribe the regular contraceptive method as needed. For methods requiring a visit to a healthcare provider, such as depo-medroxyprogesterone acetate, implants, and IUDs, starting the method at the time of UPA use may be considered. The risk that the regular contraceptive method might decrease the effectiveness of UPA must be weighed against the risk of not starting a regular hormonal contraceptive method, the guidance notes.

• Counsel the woman to abstain from sexual intercourse or use barrier contraception for the next seven days after starting or resuming regular contraception or until her next menses, whichever comes first.

• Any nonhormonal contraceptive method can be started immediately after the use of UPA.

• Advise the woman to have a pregnancy test if she does not have a withdrawal bleed within three weeks.[2]

6 Points to Remember

What are the take-home messages from the 2016 *US SPR*? Curtis lists the following:

• The guidance can help providers decrease medical barriers to initiating and using contraception.

• Most women can start most methods anytime.

• Few, if any, exams or tests are needed.

• Recommendations for anticipatory counseling for potential bleeding problems and proper management are provided.

• Routine follow-up generally is not required.

• Regular contraception should be started after emergency contraception.[3]

The CDC offers a wide array of resources that include the updated guidance documents on its website, http://bit.ly/29BzoSa. This page guides clinicians to the *US MEC* (http://bit.ly/2a5JdWN) and the *US SPR* (http://bit.ly/29KwzPB), as well as the *2016 US MEC* and *US SPR 2016* app, an easy-to-use reference that combines information from both CDC family planning guidances. The app features a streamlined interface so providers can access guidance information quickly and easily.

Another handy online resource is a one-page provider tool that contains quick information from the *US SPR* on how to be reasonably certain that a woman is not pregnant, when to start using a specific contraceptive method, and how to provide routine follow-up after contraceptive initiation.

An additional one-page tool contains recommended actions after a late or missed combined oral contraceptive, recommended actions after delayed application or detachment with a combined hormonal patch, and recommended actions after delayed insertion or reinsertion with a combined hormonal ring.

Two diagrams from the *US SPR 2016* are included in a one-page tool to guide management of women with bleeding irregularities while using contraception, as well as the management of an IUD when a copper IUD or a levonorgestrel IUD user is found to have pelvic inflammatory disease (PID). All the materials are free. Information on ordering free materials is included on the web pages.

Research Gaps Remain

While the *US MEC 2016* and *US SPR 2016* are based on the latest clinical evidence, there are still knowledge gaps when it comes to certain subjects, according to scientists who participated in the documents' publication.[4]

The current evidence leaves many important questions unanswered concerning the timing of IUD placement after treatment for STIs or PID, the researchers note. At the 2015 expert meeting to update the *US MEC* and *US SPR*, the group of family planning experts, along with CDC scientists, determined that the evidence was insufficient to make any recommendations. The current practice to wait three months after treatment for IUD insertion is based on the prescribing information; however, further research may help increase access to IUDs if studies determine that IUDs can be inserted safely sooner.[4]

Evidence also is lacking when it comes to safety issues of possible interactive effects of hormonal contraceptives and commonly used medications for behavioral or psychological disorders, according to the *US MEC*. After reviewing the evidence, the CDC added new recommendations for selective serotonin reuptake inhibitors to the drug interactions section of the 2016 *US MEC*. Due to the dearth of published research evaluating the safety of co-administration of most individual psychotropic drugs with hormonal contraceptives, the 2016 guidance does not include recommendations for any other category of psychotropic drugs.

The classifications for progestin-only contraceptive (POC) use in the 2010 *US MEC* were drawn from the understanding that such use generally is safe with respect to concerns about thromboembolism. However, emerging evidence raises potential concerns, and additional work on this issue is needed, the researchers note.

"Based on the evidence from the

systematic review and additional background information on thrombosis risk among women of reproductive age, CDC determined that there was not sufficient evidence to change recommendations for use of POCs related to thrombosis risk at this time," the scientists write. "Additional evidence of high quality is needed to inform recommendations for POC use among women who have risk factors for thrombosis." ■

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Get the Latest Guidance on Zika Virus In the Family Planning Setting

Clinicians can get up to speed on the latest strategies for Zika virus prevention, as well as implement the latest guidance surrounding Zika in the family planning setting, with new webinars hosted by the American College of Obstetricians and Gynecologists (ACOG) and the CDC.

On Aug. 24, 2016, the CDC updated its clinical guidance for healthcare providers caring for pregnant women, which is available at http://bit.ly/2bRQag6. The CDC also has issued two new handouts, "When to test for Zika virus," available at http://bit.ly/2biMrpE, and "Zika virus testing for any pregnant woman not living in an area with Zika, which can be accessed at http://bit.ly/2bllhxM.

Public health officials are moving on all fronts after the Florida Department of Health identified two areas in Miami where Zika is being spread by mosquitoes. The incidents from these areas are the first known cases of local mosquito-borne Zika virus transmission in the continental United States. The two areas are identified as Wynwood, which is an area of less than one square mile in Miami-Dade County just north of downtown, and a 1.5-square-mile area in Miami Beach, within the boundaries of Eighth and 28th streets. Readers can access the guidance at http://bit.ly/2aDzLM6.

The CDC is working closely with Florida officials to gather and analyze new information every day, says **Tom Frieden**, MD, MPH, CDC director. "With the new information that there are active mosquitoes still in the area and additional Zika infections, we conclude that pregnant women should avoid this area — and make every effort to prevent mosquito bites if they live or work there," said Frieden in a press statement. "We apply the same criteria within and outside of the United States, and are working closely with the State of Florida and Miami health departments to provide preventive services, including mosquito control."

To estimate the prevalence of contraceptive use among nonpregnant and postpartum women at risk for unintended pregnancy and sexually active female high school students living in the 41 states where mosquito-borne transmission might be possible, the CDC has looked at

EXECUTIVE SUMMARY

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- The Florida Department of Health has identified two areas in Miami where Zika is being spread by mosquitoes. The incidents from these areas are the first known cases of local mosquito-borne Zika virus transmission in the continental United States.
- State and local strategies are needed to increase access to contraceptive methods and related services, reduce the risk for unintended pregnancy, and minimize the number of pregnancies affected by Zika infection.

2011-2013 and 2015 survey data from four state-based surveillance systems: the Behavioral Risk Factor Surveillance System (BRFSS, 2011-2013), which surveys adult women; the Pregnancy Risk Assessment Monitoring System (PRAMS, 2013); the Maternal and Infant Health Assessment (MIHA, 2013), which surveys women with a recent live birth; and the Youth Risk Behavior Survey (YRBS, 2015), which surveys students in grades 9-12.[1]

The percentage of women at risk of unintended pregnancy who used long-acting reversible contraception (LARC) ranged from 5.5% to 18.9% for BRFSS-surveyed women and 6.9% to 30.5% for PRAMS/MIHA-surveyed women. The percentage of women not using any contraception ranged from 12.3% to 34.3% in one survey (BRFSS) and from 3.5% to 15.3% in others (PRAMS/MIHA). YRBS data indicate that among sexually active female high school students, use of LARC at last intercourse ranged from 1.7% to 8.4%, and use of no contraception ranged from 7.3% to 22.8%.[1]

State and local strategies are needed to increase access to contraceptive methods and related services, reduce the risk for unintended pregnancy, and minimize the number of pregnancies affected by Zika infection, CDC researchers report. Potentially effective strategies include addressing policies on high device costs and provider reimbursement, comprehensive provider training on insertion and removal of LARC, provision of youth-friendly services, support to resource-challenged jurisdictions, client-centered counseling, assessment of patient satisfaction, and increased consumer awareness of the full range of contraceptive methods to delay or avoid pregnancy.[1]

Use Zika Toolkit

In her ACOG presentation, **Melissa Kottke**, MD, MPH, MBA, associate professor in the Department of Gynecology and Obstetrics at the Emory University School of Medicine in Atlanta, pointed to the job aids in the free "Providing Family Planning Care for Non-Pregnant Women and Men of Reproductive Age in the Context of Zika — A Toolkit for Healthcare Providers," developed by the federal Department of Health and Human Services' Office of Population Affairs.[2]

The toolkit was developed for those in family planning services, including those in Title X clinics and in primary care sites such as federally qualified health centers, to help women and men make informed decisions about pregnancy and childbirth in the context of Zika. Readers can download the toolkit at http://bit.ly/2an4mMm.

> " ... ESTABLISH A PLAN, PROVIDE INFORMATION THAT CAN BE UNDERSTOOD AND RETAINED BY THE WOMAN ... "

What should family planning providers do in light of the Zika virus? Kottke outlined five important steps:

- Screen for exposure to Zika virus.
- Educate about the risks of infection during pregnancy.
- Provide basic information about strategies that can be used to prevent Zika.
- Provide contraceptive services to those who wish to prevent or delay pregnancy.
- Provide condoms to men and women who are at risk for sexual transmission of Zika.

Use strategies for contraceptive counseling in talking with women, said Kottke. Establish and maintain rapport, she said. Assess the woman's needs, and personalize discussions accordingly, Kottke added.

"Work with her interactively to establish a plan, provide information that can be understood and retained by the woman, and confirm her understanding," she stated.

Access the ACOG webinar at http://bit.ly/1J3LVKQ. Click on "Biting Back: Contraception and Zika Prevention."

To access the CDC Aug. 9, 2016, webinar slides for "Updated Interim Zika Clinical Guidance for Pregnant Women and Data on Contraceptive Use to Decrease Zika-affected Pregnancies," readers can go online to http://bit.ly/2aG3iBL. Under "Read Now," select "Slides." ■

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Combined Hormonal Contraception and Migraine — Add Clinical Information to Your Practice

What do you know when it comes to prescribing combined hormonal methods for women with migraines? A new two-part Association of Reproductive Health Professionals webinar series, "Migraines & the Female Patient," offers information on the epidemiology of migraines and how to counsel affected women on their contraceptive options.

The two-part event is presented by **Pelin Batur**, MD, FACP, NCMP, CCD, an internist at the Cleveland (OH) Clinic, and **Anne Calhoun**, MD, FAHS, the co-founder of the Carolina Headache Institute in Durham, NC, and a professor in the departments of anesthesiology and psychiatry at the University of North Carolina at Chapel Hill. To access the webinar series, readers can go to http://bit.ly/2aMa5NK. Select "Migraines in the Female Life-Cycle" to access links to the presentations.

Using criteria established in *The International Classification of Headache Disorders*, the diagnosis of a migraine requires the presence of two of four criteria: unilateral location, pulsating/throbbing nature of pain, at least moderate intensity, and aggravation by or preference to avoid activity.[1] It also requires nausea or a combination of both photophobia and phonophobia with the episode. The last criterion can be established by the individual's simple preference to avoid bright lights and loud noises during an attack.

Patients with a stable pattern of episodic, disabling headache and a normal physical exam should be considered to have a migraine in the absence of contradictory evidence.[2,3] In a study of patients seeking care for their headaches from a primary care provider, more than 90% were diagnosed to have migraines or probable migraines as defined by standardized diagnostic criteria.[4] In a large epidemiologic study, 30,758 adults were asked if they had headaches and, if so, how they would label them. Headaches were reported by 23,564 of the participants and subsequently were diagnosed by formal International Headache Society criteria. Among the 3,074 individuals who met the criteria for a migraine, about 50% correctly recognized their headaches as migraines; the most common erroneous labels were "sinus headache" and "stress headache."[5]

To diagnose a migraine with aura, at least two attacks must be recognized, accompanied by fully reversible visual, sensory, and/or speech/language symptoms.[1] At least one of these symptoms must be unilateral and spread gradually over five minutes; alternatively, two or more aura symptoms may occur in succession. Each individual aura symptom must last between five and 60 minutes, with the aura followed by the onset of a headache within 60 minutes.[1] Blurring, floaters, or split-second flashes before or during a migraine headache do *not* meet criteria for aura.

Steady or rising concentrations of estrogen do not precipitate a migraine, but the steep decline in estrogen levels that occurs prior to menstruation can precipitate unusually severe attacks that are known as menstrual-related migraines, notes Calhoun. These attacks are often refractory to therapy.

Have a good strategy for addressing contraceptive choices in women with migraines, because most of them experience menstrual migraines, says Calhoun. "The best way to prevent menstrual migraine is simply by eliminating the hormonal trigger, which can be accomplished with the right choice of combined hormonal contraceptive," notes Calhoun. "If the woman has migraine

EXECUTIVE SUMMARY

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- The diagnosis of a migraine requires the presence of two of four criteria: unilateral location, pulsating/throbbing nature of pain, at least moderate intensity, and aggravation by or preference to avoid activity. It also requires nausea or a combination of both photophobia and phonophobia with the episode. The last criterion can be established by the individual's simple preference to avoid bright lights and loud noises during an attack.
- Steady or rising concentrations of estrogen do not precipitate a migraine, but the steep decline in estrogen levels that occurs prior to menstruation can precipitate unusually severe attacks that are known as menstrual-related migraines.

with aura, we now have a couple of contraceptives that can potentially decrease their aura frequency and, thereby, hopefully, decrease any stroke risk."

Use of a combined hormonal contraceptive for migraines with aura remains controversial, due to data suggesting that aura increases stroke risk and that high-dose oral contraceptives increase stroke risk.[6-8]

While studies have shown that continuous use of combined oral contraceptives and use of combined pills that minimize drops in estrogen can help improve general headaches and menstrual-related migraines, such research has excluded patients who have migraines with aura.[9,10] A small pilot study of women with migraines with aura and menstrual-related migraines was conducted, in which women were offered a vaginal ring that releases 15 µg ethinyl estradiol per 24 hours, with instructions to use the continuous ultra-low dose hormonal contraception without placebo days. After a mean follow-up of eight months, data indicate this regimen reduced aura frequency from a baseline average of 3.2 per month to 0.2 per month. No woman had an increase in aura frequency, and menstrual-related migraine was eliminated in 91.3% of the patients.[11]

Continuous or extended cycle regimens can be prescribed using any generic 20 µg combined hormonal contraceptive which the patient tolerates, along with specific instructions on the prescription to take the pills in a continuous fashion to decrease the frequency of menstrual-related migraines, advises Batur.

The just-released *U.S. Medical Eligibility Criteria for Contraceptive Use, 2016 (US MEC 2016)* lists the copper T and the levonorgestrel IUDs, the contraceptive shot, the contraceptive implant, and progestin-only pills as Category 1 (no restrictions on use) for women with migraines without aura and women with migraines with aura. Use of combined hormonal contraceptives in women with migraines without aura is classified as Category 2 (benefits generally outweigh risks), while use in women with migraines with aura is classified as Category 4 (condition represents unacceptable health risk if method is used.)[12]

"THE MOST COMMON ERRONEOUS LABELS WERE "SINUS HEADACHE" AND "STRESS HEADACHE."

This represents no change from the 2010 guidance, which also classified use of combined hormonal contraception for women of all ages with aura as a Category 4.[13] ■

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Counsel on Convenience and Effectiveness Of Immediate Postpartum LARC

Unplanned pregnancies can happen in the postpartum period. Data indicate 40-57% of women report having unprotected intercourse before the routine six-week postpartum visit.[1,2] The American College of Obstetricians and Gynecologists (ACOG) has just issued a new committee opinion on the use of long-acting reversible contraception (LARC) in the postpartum period to help stem such pregnancies.[3]

With effectiveness greater than 99%, the IUD and the contraceptive implant represent the most effective forms of reversible contraception and have the highest continuation rates among reversible methods.[4] The Contraceptive CHOICE offers definitive proof. This study offered more than 9,000 women counseling on all contraceptive methods and provided contraceptives free of charge; 75% chose LARC methods. At the 12-month follow-up, 86% of LARC users still were using the method, compared with 55% of those who initiated short-acting methods, such as oral contraceptives or depot medroxyprogesterone acetate. In this study, women who used LARC had the highest satisfaction rates and lowest rates of unintended pregnancy.[5]

Use of LARC in the postpartum period is safe. The *US Medical Eligibility Criteria for Contraceptive Use 2016* classifies immediate postpartum initiation of IUDs and implants as Category 1 (no restriction for use) or Category 2 (advantages generally outweigh theoretical or proven risks).[6]

Many Miss Appointment

While many women may plan to resume or implement a contraceptive method at their postpartum follow-up visit, data indicate up to 40% of women do not attend a follow-up appointment and, as a result, never obtain a birth control method.[7] Women who do come in for care may face barriers to receiving a LARC method at that appointment. Some clinics or clinicians may not offer the IUD or implant, or protocols may call for a repeat visit for placement.

ACOG's committee on obstetric practice, which developed the opinion, encourages providers to begin discussions about postpartum contraception before delivery to ensure women have the time and information they need to select the best method for them, says **Ann Borders**, MD, MSc, MPH, adjunct assistant professor in the Department of Medical Social Sciences at the Northwestern University Feinberg School of Medicine in Chicago. Borders was co-author of the opinion.

In a statement accompanying the opinion publication, Borders noted, "The period following delivery is a busy, exhausting and often stressful time and immediate postpartum insertion of LARC may eliminate some of the stressors during that time, like scheduling multiple appointments for LARC insertion."

While expulsion rates for immediate postpartum placement of IUDs are higher, many women find that the advantages of insertion before leaving the hospital outweigh the disadvantages, said Borders. The contraceptive implant does not have contraindications or risks specific to insertion in the immediate postpartum period.

"As obstetricians, we should be prepared to counsel all of our pregnant patients about the option of immediate postpartum LARC," stated Borders. "We should also support our institutions in developing the infrastructure and processes needed to operationalize this practice."

Plan for "4th Trimester"

ACOG also has issued an additional committee opinion on optimizing postpartum care.[8] The publication is designed to help develop patient-centered, maternal postpartum care in an effort to improve outcomes for women, infants, and families.

EXECUTIVE SUMMARY

The American College of Obstetricians and Gynecologists has issued a new committee opinion on the use of long-acting reversible contraception (LARC) in the postpartum period to help stem pregnancies.

- Unplanned pregnancies can happen in the postpartum period. Data indicate 40-57% of women report having unprotected intercourse before the routine six-week postpartum visit.
- Providers are encouraged to begin discussions about postpartum contraception prior to delivery to ensure women have the time and information they need to select the best method for them. Use of LARC methods in the postpartum period is safe and effective.

In the weeks after birth, women are adapting to multiple physical, social, and psychological changes, such as recovering from childbirth, adjusting to changing hormones, and learning to feed and care for newborns. This "fourth trimester" can present major challenges such as lack of sleep, pain, depression, lack of sexual desire, and urinary incontinence.

"We encourage providers to partner with women during pregnancy to begin planning for the 'fourth trimester'," says **Alison Stuebe**, MD, lead author of the committee opinion and assistant professor in the division of maternal-fetal medicine in the department of obstetrics and gynecology at the University of North Carolina at Chapel Hill School of Medicine. "Each woman has different postpartum needs, and we recommend that she and her provider identify members of her postpartum care team and develop an individualized postpartum care plan."

For all women, the committee opinion calls for a comprehensive postpartum visit that should take place within the first six weeks after birth. This visit should include a full assessment of physical, social, and psychological well-being. It provides an opportunity for the woman to ask questions about her birth experience and the implications of any complications for her future health. It also allows providers to discuss reproductive life plans to ensure each woman can receive her desired form of contraception, if placement of LARC was not done earlier. ■

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The Trajectories of Vasomotor Symptoms Eyed Across the Menopausal Transition

Most women will get hot flashes or night sweats at some point during menopause. Research indicates 42% to 79% of women experience vasomotor symptoms (VMSs) during the menopausal transition.[1-4] Just-published findings show that women fit into four distinct groups when it comes to having hot flashes and night sweats, which offers potential ramifications for therapy and prevention of future health conditions, according to research led by the Graduate School of Public Health at the University of Pittsburgh.[5]

"Most women get vasomotor symptoms, and we used to think these symptoms lasted from three to five years, right around the time of the final menstrual period," said senior author **Rebecca Thurston**,

EXECUTIVE SUMMARY

Just-published findings show that women fit into four distinct groups when it comes to having hot flashes and night sweats, which offers potential ramifications for therapy and prevention of future health conditions.

- Most women will get hot flashes or night sweats at some point during menopause. Research indicates 42% to 79% of women experience vasomotor symptoms during the menopausal transition.
- Depending on which category a woman falls into as determined by the research, there may be important implications regarding her health, scientists note. More investigation is needed to examine causal relationships.

PhD, a professor in the department of psychiatry at the University of Pittsburgh and an epidemiologist at the University of Pittsburgh Graduate School of Public Health. "We now know that these symptoms persist for far longer, typically 7-10 years, and occur at different times for different women."

Researchers looked at 1,455 women enrolled in the Study of Women's Health Across the Nation (SWAN), a longitudinal, multicenter study of about 3,000 women in midlife from five racial/ethnic groups. The women, who had not yet gone through menopause when they enrolled, were not on hormone therapy, and they did not have a hysterectomy. The women reported their VMSs on an annual basis, along with receiving a clinical examination and, sometimes, a blood test.

In their analysis, the researchers found that women could be relatively equally divided into four distinct trajectories for VMSs as they went through menopause transition:

- onset early (11 years before the final menstrual period), with a decline after menopause (early onset group);
- onset near the final menstrual period, with later decline (late onset group);
- onset early, with persistently high frequency (high group);
- persistently low frequency (low group).

Certain characteristics were more common in different categories, researchers note. Their analysis findings include the following:

- A consistently low chance of having symptoms throughout the menopause transition was more common in Chinese women than other women.
- A consistently high chance of having symptoms throughout the transition was more common in black women, those with less education, those who reported drinking alcohol moderately or heavily, and those who reported symptoms of depression or anxiety.
- An early onset of symptoms in the decade before the final period, with cessation thereafter, was more common among women who were obese, had symptoms of depression or anxiety, were in poorer health than their peers, and were older at menopause.
- A late onset of symptoms after the final period that gradually declined in the following decade was more common in women with a lower body mass index, those who smoked, and black women than other women.[5]

Co-author **Maria Brooks**, PhD, professor of epidemiology and associate professor of biostatistics at Pitt Public Health, says, "It's fascinating that we can distinguish these unique patterns and, then, pinpoint specific characteristics associated with each of these trajectories. When we see patterns like this, it indicates that there's something going on beyond hot flashes and night sweats being a passing nuisance."

Depending on which category a woman falls into, as determined by the researchers, there may be important implications regarding her health, says Brooks, who served as principal investigator of the SWAN coordinating center.

JoAnn Pinkerton, MD, NCMP, executive director of the Cleveland-based North American Menopause Society, notes, "This information provides insight into the different patterns of highly prevalent and often bothersome menopause symptoms. Interventions to treat vasomotor symptoms may be tailored to address specific factors, including ethnicity and patterns of hot flashes that contribute to VMS, allowing us to target women who are most affected and helping clinicians to counsel women and women's ability to make informed decisions about treatment options."

Research currently published by Thurston indicates that some of these trajectories are associated with risk factors for cardiovascular disease.[6]

"At this point, we can't completely untangle any causal relationship between vasomotor symptoms and health outcomes or suggest preventative measures for vasomotor symptoms without further study," states Thurston. "But women and their doctors can use these findings now to help them get a better idea what they're likely to experience as they go through menopause and to plan the best ways to manage their symptoms." ■

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U.S. Preventive Services Task Force Recommends Against Genital Herpes Screening

The CDC estimates that about one in six U.S. residents ages 14-49 has genital herpes.[1] In new draft guidance, the U.S. Preventive Services Task Force (USPSTF) recommends against using current blood tests to screen for genital herpes in people with no signs or symptoms of infection, including adolescents and adults, as well as pregnant women.[2]

"While genital herpes is relatively common, testing is not generally helpful for people who have not experienced symptoms, in part because the tests are often inaccurate," says Task Force member **Maureen Phipps**, MD, MPH, department chair and Chace-Joukowsky professor of obstetrics and gynecology and assistant dean for teaching and research on women's health at the Warren Alpert Medical School of Brown University in Providence, RI. "Further, because there's no cure, there isn't much doctors and nurses can do for people who don't have symptoms."

Most U.S. cases of genital herpes are caused by infection with herpes simplex virus-2 (HSV-2). According to the USPSTF evidence review, there is adequate evidence that the most widely used HSV-2 serologic screening test approved by the FDA is not suitable for population-based screening, due to its low specificity, lack of widely available confirmatory testing, and high false-positive rate.[2]

Task Force member **Ann Kurth**, PhD, RN, MSN, MPH, says, "People should be aware of the signs and symptoms of genital herpes and should talk to their doctor or nurse if they are concerned. This is especially true for women who are pregnant because there are things clinicians can do to help women who have genital herpes protect their babies during delivery." Kurth is dean of the Yale School of Nursing and an adjunct professor at the New York University College of Nursing and the College of Global Public Health, as well as an affiliate faculty member at the University of Washington's department of global health and School of Nursing.

The Task Force found that the benefits of screening are low, because screening, early identification, and treatment are unlikely to alter the course of the disease. However, the potential harms of screening for herpes are substantial, due in part to the high rate of false-positive results associated with blood tests.[2]

The draft recommendation is consistent with the Task Force's 2005 final recommendation. There are no major public health organizations that recommend universal screening for genital herpes in patients who have no signs or symptoms, including pregnant women.

According to the *2015 STD Treatment Guidelines,* all pregnant women should be asked whether they have a history of genital herpes. The guidance advises that at the onset of labor, women should be questioned carefully about genital herpes symptoms, including prodromal symptoms, and all women should be examined carefully for herpetic lesions. Women without symptoms or signs of genital herpes or its prodrome can deliver vaginally. While cesarean delivery does not completely eliminate the risk of HSV transmission to the neonate, women with recurrent genital herpetic lesions at the onset of labor should deliver by cesarean delivery to reduce the risk of neonatal HSV infection, the guidance advises.[3] ■

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CME/CE QUESTIONS

1. **According to the newly released *U.S. Selected Practice Recommendations for Contraceptive Use, 2016,* which of the following treatments might decrease pain during IUD insertion?**

   a. naproxen
   b. ibuprofen
   c. aspirin
   d. paracervical block

2. **To diagnose a migraine with aura, how many attacks must be recognized, according to The International Classification of Headache Disorders?**

   a. at least two attacks
   b. at least three attacks
   c. at least four attacks
   d. at least five attacks

3. **What percentage of women are estimated to have unprotected intercourse before the routine visit scheduled at six weeks postpartum?**

   a. less than 10%
   b. 17% to 25%
   c. 31% to 45%
   d. 40% to 57%

4. **What percentage of women experience vasomotor symptoms during the menopausal transition, according to four studies published between 2000 and 2002?**

   a. 15% to 24%
   b. 20% to 33%
   c. 42% to 79%
   d. 48% to 84%

CME/CE OBJECTIVES

After reading *Contraceptive Technology Update*, the participant will be able to:

1. identify clinical, legal, or scientific issues related to development and provisions of contraceptive technology or other reproductive services;
2. describe how those issues affect services and patient care;
3. integrate practical solutions to problems and information into daily practices, according to advice from nationally recognized family planning experts;
4. provide practical information that is evidence-based to help clinicians deliver contraceptives sensitively and effectively.