



CONTRACEPTIVE TECHNOLOGY UPDATE®

THE TRUSTED SOURCE FOR CONTRACEPTIVE AND STI NEWS AND RESEARCH SINCE 1980

DECEMBER 2019

Vol. 40, No. 12; p. 133-144

➔ INSIDE

Advocates push for access to OTC birth control 136

Abortion rates in the U.S. continue to decline 137

Women's health clinic closures affect cervical cancer markers . . 139

Chlamydia, gonorrhea, and syphilis rates on the rise 140

Discuss vulvovaginal health with patients during well woman exams 142

STI Quarterly:
Time for innovative research on STI vaccines; educate patients on link between HPV and anal, penile, oral cancers



RELIAS
MEDIA

Research Confirms Cost Savings of Same-Day LARC Placement in Teens

Delay in insertions can result in missed pregnancy protection

When it comes to use of long-acting reversible contraception (LARC)

in adolescents, the consensus among professional organizations is clear: Intrauterine devices (IUDs) and the contraceptive implant should be offered routinely as safe and effective birth control options.¹ The American Academy of Pediatrics and the American College of Obstetricians and Gynecologists both endorse the use of LARC, including IUDs, for teens, and the U.S. Medical Eligibility Criteria for Contraceptive Use ranks use of the IUD in adolescents as Category 2 (a

condition for which the advantages of using the method generally outweigh the theoretical or proven risks).²⁻⁴

RESEARCH INDICATES THAT WHEN LARC IS NOT OFFERED ON THE SAME DAY, MORE THAN HALF OF WOMEN FAIL TO RETURN FOR THE SECOND VISIT FOR LARC PLACEMENT.

Both the IUD and the implant can be inserted at any time in the menstrual cycle, as long as pregnancy can be reasonably excluded, according to the U.S. Selected Practice Recommendations for Contraceptive Use.⁵ However, many clinics frequently require two visits to receive LARC methods, for reasons such as staffing/training issues and the cost of stocking the devices.

For teens, the delay in receiving IUDs and implants can result in missed

ReliasMedia.com

Financial Disclosure: Consulting Editor **Robert A. Hatcher**, MD, MPH, Nurse Planner **Melanie Deal**, MS, WHNP-BC, FNP-BC, Author **Rebecca Bowers**, Editor **Jill Drachenberg**, Associate Editor **Journey Roberts**, and Editorial Group Manager **Leslie Coplin** report no consultant, stockholder, speaker's bureau, research, or other financial relationships with companies having ties to this field of study.

Contraceptive Technology Update® (ISSN 0274-726X), is published monthly by Relias LLC, 1010 Sync St., Ste. 100, Morrisville, NC 27560-5468. Periodicals Postage Paid at Morrisville, NC, and additional mailing offices.

POSTMASTER: Send address changes to: *Contraceptive Technology Update*, Relias LLC, 1010 Sync St., Ste. 100, Morrisville, NC 27560-5468.

SUBSCRIBER INFORMATION:
Customer Service: (800) 688-2421
customerservice@reliasmedia.com
ReliasMedia.com

MULTIPLE COPIES: Discounts are available for group subscriptions, multiple copies, site licenses, or electronic distribution. For pricing information, please contact our Group Account Managers at groups@reliasmedia.com or (866) 213-0844.

Back issues: \$75. Missing issues will be fulfilled by customer service free of charge when contacted within one month of the missing issue's date.

GST Registration Number: R128870672.

ACCREDITATION: Relias LLC is accredited as a provider of continuing nursing education by the American Nurses Credentialing Center's Commission on Accreditation. Contact hours [1.5] will be awarded to participants who meet the criteria for successful completion. California Board of Registered Nursing, Provider CEP#13791.

Relias LLC is accredited by the Accreditation Council for Continuing Medical Education (ACCME) to provide continuing medical education for physicians. Relias LLC designates this enduring material for a maximum of 1.5 AMA PRA Category 1 Credits™. Physicians should claim only credit commensurate with the extent of their participation in the activity.

This activity is intended for OB/GYNs, nurses, nurse practitioners, and other family planners. It is in effect for 36 months from the date of publication.

Opinions expressed are not necessarily those of this publication. Mention of products or services does not constitute endorsement. Clinical, legal, tax, and other comments are offered for general guidance only; professional counsel should be sought for specific situations.

AUTHOR: Rebecca Bowers
EDITOR: Jill Drachenberg
ASSOCIATE EDITOR: Journey Roberts
EDITORIAL GROUP MANAGER: Leslie Coplin
ACCREDITATIONS MANAGER: Amy M. Johnson, MSN, RN, CPN

© 2019 Relias LLC. *Contraceptive Technology Update*® and *STI Quarterly*™. All rights reserved. No part of this newsletter may be reproduced in any form or incorporated into any information-retrieval system without the written permission of the copyright owner.

protection against pregnancy. Research indicates that when LARC is not offered on the same day, more than half of women fail to return for the second visit for LARC placement.⁶

Data Back Same-Day Insertion

Data from a recent study indicate allowing teens the option to obtain a LARC on the same day as their clinic visit could lead to significant cost savings.⁷

Research has demonstrated that LARC is “highly effective” at preventing unintended pregnancy, says study co-author **Brownsyne Tucker Edmonds, MD, MPH, MS**, associate professor of obstetrics and gynecology and pediatrics at the Indiana University School of Medicine. Unintended pregnancy is associated with poor pregnancy outcomes, such as premature birth, which is a leading cause of infant mortality, Edmonds said in a statement.⁸ “Seeing as unintended pregnancy, premature birth, and infant mortality disproportionately impact women and infants of color and low-income populations, it stands to reason that by improving access to same-day LARC, Medicaid

could not only cut costs, but could potentially also improve health disparities related to prematurity and infant mortality,” Edmonds noted.

Researchers analyzed Indiana Medicaid's cost savings associated with providing teens same-day LARC insertion. Using data from August 2017 through August 2018, researchers developed a cost model to examine the anticipated outcome of providing LARC at the first visit compared with requiring a second visit for placement. Factors including costs and probabilities of clinic visits, devices, device insertions and removals, unintended pregnancy, and births, also were incorporated into the model.

“We thought about the typical young woman seeking contraception and drew a branching tree representing all of the things that might happen if she could or could not get it that day,” explained co-author **Stephen Downs, MD, MS**, Indiana University School of Medicine professor of pediatrics.⁸

Research has determined the potential outcomes, and medical claims demonstrate the potential cost, said Downs. By developing the model, the researchers could compare the average expected cost if one or two visits are required.

Analysis findings indicate

EXECUTIVE SUMMARY

Data from a recent study indicate allowing teens the option to obtain a long-acting reversible contraceptive (LARC) on the same day as their clinic visit could lead to significant cost savings.

- In comparison to the return-visit strategy, same-day LARC was associated with an unintended pregnancy rate of 14% vs. 48%.
- Abortion rates were 4% for same-day insertions, compared to 14% associated with subsequent visits.
- Analysis findings indicate that same-day LARC placement was associated with lower overall costs compared with placement at a subsequent visit.

that same-day LARC placement was associated with lower overall costs compared to placement at a subsequent visit (\$2,016 per patient vs. \$4,133 per patient over one year). Compared to the return-visit strategy, same-day LARC was associated with an unintended pregnancy rate of 14% vs. 48%. Abortion rates were 4% for same-day insertions, compared to 14% associated with subsequent visits.⁷

What Are the Next Steps?

Based on their analysis, the researchers offered four action steps for state Medicaid officials:

First, officials should offer bonus payments for clinicians to make same-day contraceptive access the most attractive payment option. These payments would dissipate the reimbursement-to-cost differential that leads to the two-visit strategy.

Second, by creating a single, uniform reimbursement structure, some of the procedural delays that occur when a device has to be ordered for an individual patient may be decreased.

Third, by moving toward purchasing LARC devices in bulk and distributing devices upfront to clinics, facilities could move toward same-day placement.

Finally, Medicaid officials should develop a policy whereby LARC devices that were ordered for a specific patient but were ultimately unused could be used for another patient.

“Access matters, and any barrier to access means that fewer people will actually get to that finish line,” said co-author **Tracey Wilkinson**, MD, MPH, Indiana University School of Medicine assistant professor of

pediatrics. “When you have people who desire contraception not being able to access it, the outcomes of all our communities are less than ideal.”⁸

Remove the Barriers

In working with a LARC program, it is important to acknowledge that the high cost is a primary barrier for many women. The Colorado Family Planning Initiative (CFPI), which has had

“WHEN YOU HAVE PEOPLE WHO DESIRE CONTRACEPTION NOT BEING ABLE TO ACCESS IT, THE OUTCOMES OF ALL OUR COMMUNITIES ARE LESS THAN IDEAL.”

success in expanding access to long-acting methods, suggested the following ways to address cost barriers:

- Put LARC devices on the same sliding fee scale as other contraceptive methods, and be sure that LARC removal is on the same sliding fee scale;
- Double-check that all LARC methods are included in state Medicaid benefits and receive adequate reimbursement;
- Ensure all LARC methods are included in private insurance benefits.

CFPI suggests that facilities partner with 340B health centers to ensure lower price devices. Look for federal funding sources, as well

as state and county dollars, to fund LARC costs, and seek gifts, grants, and donations to supplement programs. (*Visit the CFPI website, www.larc4co.com, to get further tips and information on building a successful LARC program.*) ■

REFERENCES

1. Committee on Practice Bulletins-Gynecology, Long-Acting Reversible Contraception Work Group. Practice bulletin 186: Long-acting reversible contraception: Implants and intrauterine devices. *Obstet Gynecol* 2017;130:e251-e269.
2. ACOG committee opinion no. 735 summary: Adolescents and long-acting reversible contraception: Implants and intrauterine devices. *Obstet Gynecol* 2018;131:947-948.
3. American Academy of Pediatrics. Contraception for adolescents. *Pediatrics* 2014;134:e1244-e1256.
4. Curtis KM, Tepper NK, Jatlaoui TC, et al. U.S. medical eligibility criteria for contraceptive use, 2016. *MMWR Recomm Rep* 2016;65:1-103.
5. Curtis KM, Jatlaoui TC, Tepper NK, et al. U.S. selected practice recommendations for contraceptive use, 2016. *MMWR Recomm Rep* 2016;65:1-66.
6. Bergin A, Tristan S, Terplan M, et al. A missed opportunity for care: Two-visit IUD insertion protocols inhibit placement. *Contraception* 2012;86:694-697.
7. Wilkinson TA, Downs SM, Tucker Edmonds B. Cost minimization analysis of same-day long-acting reversible contraception for adolescents. *JAMA Netw Open* 2019;doi:10.1001/jamanetworkopen.2019.11063.
8. Indiana University School of Medicine. Study shows cost savings from same-day long-acting reversible contraception. Sept. 11, 2019. Available at: <https://bit.ly/35B48h2>.

ACOG Expands Backing for OTC Contraception

The American College of Obstetricians and Gynecologists (ACOG) has updated its guidance regarding over-the-counter (OTC) access to hormonal contraception, expanding its support for access to vaginal rings, the contraceptive patch, and contraceptive injections with no age restrictions.¹

The new guidance updates and expands the organization's 2012 recommendation that oral contraceptives be available OTC.² Regulatory action is needed to achieve OTC access, according to the guidance. While some states are implementing direct access to hormonal contraception at pharmacies or through online ordering, OTC access should be the ultimate goal.

A prescription is an “unnecessary obstacle” for some women to get their preferred contraceptive method, observed **Rebecca Allen**, MD, MPH, an ACOG committee member who helped update the opinion. OTC hormonal birth control would be a step toward greater access to an essential component of women's healthcare and give adolescents and women more options to manage their

reproductive health, she noted in a statement.³

While OTC access to hormonal contraception will improve availability, it should not be at the expense of affordability, said Allen, assistant professor of obstetrics and gynecology in the Warren Alpert Medical School at Brown University. Insurance coverage and other financial support for contraception still should apply, she stated.

“Each woman should be able to select the contraception that works best for her, including over-the-counter hormonal contraceptives, a long-acting reversible contraceptive provided by her healthcare provider, or other methods,” Allen said.

The need to consistently obtain a prescription, get a refill approval, or schedule an appointment can lead to inconsistent use of a preferred birth control method, said **Michelle Isley**, MD, MPH, who co-authored the opinion.

“Making more methods available over the counter would lead to reliable, equitable access for more women,” said Isley, assistant professor of obstetrics and gynecology at Ohio State University Wexner Medical

Center in Columbus. “A move to over-the-counter status would complement, not replace, policies that ensure availability of the full range of contraceptive options and safeguard access to a robust network of qualified family planning providers.”³

Laying Groundwork for OTC Pill

Two companies are researching pills for OTC approval; however, such a pill likely is years away. Oakland, CA-based Cadence Health is working to bring an OTC pill to market, while HRA Pharma, a French firm, is working with Oakland, CA-based Ibis Reproductive Health on a progestin-only OTC pill. The hormone component in the Cadence Health pill is unknown.⁴ HRA Pharma is looking at norgestrel as the component for its progestin-only pill.

Lawmakers are laying groundwork to ensure that contraception is as accessible as possible. In June 2019, Sen. Patty Murray, D-WA, and Rep. Ayanna Pressley, D-MA, introduced the Affordability is Access Act in their respective chambers, which will require insurance companies to cover any OTC birth control pill without copay or prescription.

The new ACOG Committee Opinion says that any plan to make contraception available OTC should address the issue of cost, including for women whose insurance currently covers their preferred method. It also says there is no medical or scientific justification to limit access to OTC contraception based on age.

Until an OTC method is available, several states have passed laws designed to make it easier for women to

EXECUTIVE SUMMARY

The American College of Obstetricians and Gynecologists has updated its guidance regarding over-the-counter (OTC) access to hormonal contraception, expanding its support for access to vaginal rings, the contraceptive patch, and contraceptive injections with no age restrictions.

- The new guidance updates and expands the organization's 2012 recommendation that oral contraceptives be available OTC.
- Two companies are researching pills for OTC approval; however, such a pill is likely still years away.
- Until an OTC method is available, several states have passed laws designed to make it easier for women to obtain and use hormonal contraceptives through pharmacist provision.

obtain and use hormonal contraceptives. According to the Association of State and Territorial Health Officials, 11 states and the District of Columbia passed legislation to allow pharmacists to issue contraception without a prescription.

Almost all states with such legislation require pharmacists to assess patients before prescribing and dispensing contraceptives, most often by using a self-screening risk assessment. Most states also require pharmacists to provide patients with a standardized information sheet about contraceptives, a written summary of the consultation, advice about follow-up with a primary care provider, and a referral to a reproductive care provider or clinic if there is no established contact.

Age limits may restrict pharmacist

provision. In Utah and Washington, pharmacists cannot prescribe contraceptives to those under age 18, while Oregon allows provision if a minor has previously had a prescription from a physician. (Oregon's age limit is set to expire in 2020.) Pharmacists in Tennessee can prescribe to minors only if they are emancipated.

Some pharmacists may not participate in contraceptive provision due to lack of insurance reimbursement for counseling services. Medi-Cal, California's Medicaid system, implemented reimbursement in April 2019. The Medi-Cal program covers more than 2.4 million reproductive-age women; the effect of reimbursement on the percentage of pharmacists who prescribe contraceptives is not yet known.⁴ ■

REFERENCES

1. Over-the-counter access to hormonal contraception: ACOG committee opinion, number 788. *Obstet Gynecol* 2019;134:e96-e105.
2. Committee on Gynecologic Practice, American College of Obstetricians and Gynecologists. Committee Opinion No. 544: Over-the-counter access to oral contraceptives. *Obstet Gynecol* 2012;120:1527-1531.
3. American College of Obstetricians and Gynecologists. ACOG updates guidance on over-the-counter access to hormonal contraception. Sept. 24, 2019. Available at: <http://bit.ly/33AbXBL>.
4. Rubin R. High unintended pregnancy rate spurs efforts to ease contraceptive access. *JAMA* 2019;doi:10.1001/jama.2019.15237.

Abortion Rate in United States Continues to Decline

Results of a new analysis of 2017 data indicate that the abortion rate in the United States dropped to 13.5 abortions per 1,000 women of reproductive age, the lowest rate recorded since abortion was legalized in 1973 and an 8% decline from 2014.¹ Rates of abortion have continued to decline since 1981, when the rate reached a high point of 29.3 per 1,000 women of reproductive age.¹ Factors that may have contributed to the decline include improvements in contraceptive use and increases in the number of individuals relying on self-managed abortions outside of a clinical setting, analysts noted.

The Guttmacher Institute report identified 808 clinic facilities providing abortions in 2017, a 2% increase from 2014. However,

regional and state disparities in abortion access persist: While the number of clinics increased in the Northeast by 16% and in the West by 4%, clinic numbers dropped by 6% in the Midwest and by 9% in the South. In five states — California, Connecticut, Hawaii, Nevada, and New York — fewer than 10% of women lived in a county without a clinic facility. However, in Mississippi and Wyoming, more than 90% of women lived in a county without such a clinic, analysis authors reported.¹

“Abortion access, as measured by number of clinics, has become more polarized,” said **Rachel Jones**, PhD, principal research scientist at Guttmacher and lead author of the report, in a statement. “Individuals living in the Midwest and the South

already have to deal with numerous abortion restrictions, and having fewer clinics that provide this care can put abortion out of reach for some groups, particularly low-income individuals.”²

Data from the new analysis show growth in the prevalence of medication abortions. These accounted for 339,640 abortions in 2017, a 25% increase from 2014. Medication abortions accounted for 39% of all abortions in 2017, researchers indicated.¹ The proportion of clinics with medication abortion services only rose from 26% in 2014 to 30% of all clinic facilities in 2017.

In 2017, 25% of all nonhospital facilities (including physicians' offices) and 30% of clinics provided only early medication abortion. This is a small increase from 2014, when these

figures were 23% and 26%, respectively. According to the new figures, a higher proportion of nonspecialized clinics (41%) than specialized abortion clinics (4%) offered only early medication abortion.¹

Researchers also attempted to gauge whether an increasing share of abortions are occurring outside of medical facilities. According to the report, 18% of nonhospital facilities in 2017 reported that they had seen patients who had attempted to self-manage their abortion, representing an increase from 12% in 2014.

Drugs similar to those used in the U.S. medication abortion regimen now are available via the internet, as well as information on how to safely and effectively self-manage abortions. March 2018 saw the launch of Aid Access, which provides medication abortion via mail in the United States, with 2,500 prescriptions reportedly filled in that year.¹

“Abortion care is evolving to meet people’s needs and preferences,” said **Megan Donovan**, JD, Guttmacher policy expert and study co-author. “It is important that policies and funding support these advances, so that individuals can access abortion in the way that works best for them.”

Are long-acting reversible contraceptive (LARC) methods reducing the

need for abortion services? Between 2014 and 2016, the rate of women ages 15-44 using LARC methods grew by 23%, from 13% to 16%,

“STATES WITH LIBERAL ACCESS TO BOTH HIGHLY EFFECTIVE CONTRACEPTION AND ABORTION SERVICES ALSO EXPERIENCED DECREASED DEMAND FOR THE LATTER DUE TO THE FORMER.”

while levels of sterilization were 25% and 26%, respectively.³ The move to highly effective methods matches a decline in the use of hormonal methods such as the pill and the contraceptive injection, which dropped from 29% to 25% of all contraceptive use. Researchers pointed out that state-level efforts to increase access to LARC methods also may have had a measurable effect, particularly in states with higher-than-average abortion rates.

“This is an important study that clearly demonstrates that contraception, not restrictive laws, deserves the credit,” says **Anita Nelson**, MD, professor and chair of the obstetrics and gynecology department at Western University of Health Sciences in Pomona, CA. “States, like California, with liberal access to both highly effective contraception and abortion services also experienced decreased demand for the latter due to the former.”

The Guttmacher Institute analysts noted that restrictive policies do not appear to be the primary driver of declining abortion rates, since there is no consistent relationship between increases or decreases in clinic numbers and changes in state abortion rates. Abortion rates declined in all four regions and in most states, the analysts stated.

“Abortion laws affect those seeking services. Restrictions create barriers to access that can make it more difficult for already marginalized individuals, who may need to travel further or forgo other necessities to get the care they need,” said **Elizabeth Nash**, the Guttmacher Institute’s state policy analyst and co-author. “Protective laws can ensure people have access to abortion when they need it.”² ■

EXECUTIVE SUMMARY

Results of a new analysis of 2017 data indicate that the U.S. abortion rate dropped to 13.5 abortions per 1,000 women of reproductive age, the lowest rate recorded since abortion was legalized in 1973 and an 8% decline from 2014.

- Factors that may have contributed to the decline include improvements in contraceptive use and increases in the number of individuals relying on self-managed abortions outside of a clinical setting, analysts noted.
- In five states, fewer than 10% of women lived in a county without a clinic. However, in Mississippi and Wyoming, more than 90% of women lived in a county without such a clinic, the analysis reported.

REFERENCES

1. Jones RK, Witwer E, Jerman J. Abortion incidence and service availability the United States, 2017. New York: Guttmacher Institute, 2019. Available at: <https://bit.ly/2W0ACgi>.
2. Guttmacher Institute. U.S. abortion rate continues to decline, reaching historic low in 2017. Sept. 18, 2019. Available at: <https://bit.ly/35z9l3m>.
3. Guttmacher Institute. Contraceptive use in the United States. Fact sheet. Available at: <https://bit.ly/2dlcFaX>.

Women's Health Clinic Closures Affect Cervical Cancer Markers

Results of a recent analysis indicate that more women were diagnosed with advanced stages of cervical cancer, mortality rates increased, and fewer women were screened for the disease following the closure of nearly 100 women's health clinics across the United States from 2010 to 2013.¹

The findings are "troubling," said **Amar Srivastava**, MD, MPH, a resident physician in radiation oncology at Washington University School of Medicine in St. Louis, and lead author of the study. Reducing the availability of cervical cancer screening has very real, negative consequences for women, noted Srivastava, who presented the study at the 2019 annual meeting of the American Society for Radiation Oncology in Chicago.

"Cervical cancer is largely preventable because of the wide availability of the HPV vaccine and screening that can detect precancerous lesions," said Srivastava in a statement. "The pressing issue now is to ensure that all women have access to screening."²

Nearly 100 comprehensive women's clinics closed between 2010

and 2013, primarily due to changes in Title X funding regulations and new legislation regarding clinic standards. Srivastava and his team grouped states into two cohorts. One cohort (37 states) experienced a decline in women's health clinics per capita from 2010 to 2013, while the second (13 states) experienced either no decrease in clinic numbers or saw an increase.

Researchers used data for nearly 200,000 women enrolled the Behavioral Risk Factors Surveillance System to evaluate screening utilization, with data for more than 10,000 women enrolled in the Surveillance, Epidemiology, and End Results Program to evaluate cancer stage at diagnosis and mortality. For each cohort of states, scientists compared data for women in both data sets from 2008 to 2009 with outcomes from 2014 to 2015.

Study findings indicate that states that experienced clinic closures also saw a 2% drop in cervical cancer screenings, relative to states without clinic closures, with the greatest declines in screening for patients without insurance (-6.18%), Hispanic women (-5.32%), women ages 21 to

34 (-4.81%) and unmarried women (-4.37%).

Overall, cervical cancer survival rates improved in states without clinic closures but dropped in those with clinic closures, researchers report. Findings suggest an increase in mortality risk from cervical cancer (hazard ratio [HR] 1.36, 95% confidence interval [CI] 1.02-1.83, $P = 0.04$) in states where clinics were closing, especially among residents in urban areas (HR 1.40, 95% CI 1.04-1.90, $P = 0.03$).

Scientists also reported a rise in early-stage diagnoses among women ages 18-34 in states in which no clinics had closed, with a decrease in early-stage diagnoses for this same age group in states in which clinics had been shuttered. In those states, 13% fewer women were diagnosed in the early stages of cervical cancer than in states without closures. There also was a trend toward increased late-stage diagnoses in this age group, with 8% more women being diagnosed with late-stage disease in states with clinic closures.¹

"At first we thought it sounded good that there were fewer early-stage diagnoses," Srivastava said. "But then we saw the trend toward later-stage diagnoses, for which patients need more invasive treatments, all of which have side effects."²

Follow Screening Guidance

According to the latest U.S. Preventive Services Task Force (USPSTF) cervical cancer screening recommendations, all women ages 21 to 29 should be tested

EXECUTIVE SUMMARY

Results of a recent analysis indicate that more women were diagnosed with advanced stages of cervical cancer, mortality rates increased, and fewer women were screened for the disease following the closure of nearly 100 women's health clinics across the United States from 2010 to 2013.

- Nearly 100 comprehensive women's clinics closed from 2010 to 2013, primarily due to changes in Title X funding regulations and new legislation regarding clinic standards.
- There also was a trend toward increased late-stage diagnoses in women ages 18-34, with 8% more women being diagnosed with late-stage disease in states with clinic closures.

every three years with cervical cytology. For women ages 30 to 65, recommendations call for screening with the Pap test alone every three years, screening with the high-risk human papillomavirus (hrHPV) test alone every five years, or screening with both tests together every five years.³

Regular screening for women ages 21 to 65 greatly reduces the rate of cervical cancer and the number of deaths resulting from cervical cancer.⁴ The most effective screening test depends on a woman's age, according to USPSTF's evidence search. For women ages 21-29, many HPV infections will resolve on their own, so the Pap test is most effective.⁵ For women ages 30-65, HPV infections are more likely to lead to cancer, so either Pap tests or hrHPV tests are effective for screening, the evidence review noted.⁶

Results from a recent analysis suggested that when it comes to screening for cervical cancer, the percentage of women who receive care may be far lower than national data reflect.⁷ Less than 66% of women ages 30-65 were current with their cervical cancer screenings in

2016, with more than half of women ages 21 to 29 current during the same time period. Such numbers fall below the 81% screening compliance rate self-reported in the 2015 National Health Interview Survey.⁸

Findings from the current study may help justify more rapid adoption of home self-collected screening tests, says **Anita Nelson**, MD, professor and chair of the obstetrics and gynecology department at Western University of Health Sciences in Pomona, CA. Clinicians should continue to advocate for HPV vaccination, she notes. ■

REFERENCES

1. Srivastava A, Barnes JM, Markovina S, et al. The impact of the closure of women's health clinics on cervical cancer in the United States. *Intl J Rad Onc* 2019;105:S98.
2. Women's clinic closures associated with higher cervical cancer mortality, lower screening. Sept. 26, 2019. Available at: <https://bit.ly/2PahQBN>.
3. U.S. Preventive Services Task Force, Curry SJ, Krist AH, et al. Screening for cervical cancer: U.S. Preventive Services Task Force recommendation statement. *JAMA*

2018; 320:674-686.

4. Safaeian M, Solomon D. Cervical cancer prevention — cervical screening: Science in evolution. *Obstet Gynecol Clin North Am* 2007;34:739-760.
5. Kotaniemi-Talonen L, Anttila A, Malila N, et al. Screening with a primary human papillomavirus test does not increase detection of cervical cancer and intraepithelial neoplasia 3. *Eur J Cancer* 2008;44:565-571.
6. Melnikow J, Henderson JT, Burda BU, et al. Screening for cervical cancer with high-risk human papillomavirus testing: Updated evidence report and systematic review for the U.S. Preventive Services Task Force. *JAMA* 2018;320:687-705.
7. MacLaughlin KL, Jacobson RM, Radecki Breitkopf C, et al. Trends over time in Pap and Pap-HPV cotesting for cervical cancer screening. *J Womens Health (Larchmt)* 2019;28:244-249.
8. Watson M, Benard V, King J, et al. National assessment of HPV and Pap tests: Changes in cervical cancer screening, National Health Interview Survey. *Prev Med* 2017;100:243-247.

Turn Back the Rise in STIs

Public health officials are calling for a full-court press against the rising numbers of sexually transmitted infections (STIs). New data from the CDC indicate that combined cases of syphilis, gonorrhea, and chlamydia reached an all-time high in the United States in 2018.¹

The three most common STIs — syphilis, gonorrhea, and chlamydia — all recorded increases from the previous years, statistics show. Figures for primary and secondary syphilis cases rose 14% to more than

35,000 cases, the highest number reported since 1991. Cases of syphilis in newborns increased 40% to more than 1,300 cases. Figures for gonorrhea rose 5% to more than 580,000 cases, the highest number for the STI that has been reported since 1991. Numbers for chlamydia moved up 3% to more than 1.7 million cases, representing the most ever reported to the CDC.

“STDs can come at a high cost for babies and other vulnerable populations,” said **Jonathan Mermin**,

MD, MPH, director of CDC's National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention in a statement. “Curbing STDs will improve the overall health of the nation and prevent infertility, HIV, and infant deaths.”²

Concern for Congenital Syphilis

Public health officials voiced serious concern in the dramatic rise

in congenital syphilis cases. While most states recorded at least one incident of congenital syphilis, five states — Texas, California, Florida, Arizona, and Louisiana — accounted for 70% of cases in 2018.¹

“There are tools available to prevent every case of congenital syphilis,” said **Gail Bolan**, MD, director of CDC’s Division of STD Prevention.² “Testing is simple and can help women to protect their babies from syphilis — a preventable disease that can have irreversible consequences.”

Untreated syphilis infection during pregnancy directly affects the risk of adverse pregnancy outcomes. In a 2013 systematic review, data indicate that untreated maternal syphilis infection during pregnancy was associated with a difference of 21% for stillbirth or fetal loss, 9% for neonatal death, and 5% for prematurity or low birth weight in comparison with pregnancies that did not have infection.³ While infants born with congenital syphilis often are asymptomatic at birth, some babies may develop such signs as rash, hemorrhagic rhinitis, lymphadenopathy, and skeletal abnormalities within the first several weeks.⁴ Further symptoms include anemia, meningitis, and neurologic

impairment such as blindness or deafness.

What Is Driving the Increase?

What factors are contributing to the overall increase in STIs? Drug use, poverty, stigma, and unstable housing affect access to STI prevention and care, according to reports.⁵

Public health officials also point to a decline in condom use among vulnerable groups, including young people and gay and bisexual men. According to a recent report, while 54% of sexually active high school students in 2017 used a condom at their last sexual intercourse, such use has declined since 2013.⁶

Budget cuts to reproductive health clinics also have affected care. Health departments that participated in a 2017 survey reported stagnant or declining funds for HIV, STIs, and viral hepatitis services. While not nationally representative, local departments reporting funding cuts noted that the services they reduced were most likely to affect disease surveillance and STI partner services, as well as HIV testing and hepatitis B vaccination. Forty-three percent

reported reductions in HIV, STIs, and/or viral hepatitis program staffing levels. The greatest staffing loss was in public health nurses.⁶

The U.S. Department of Health and Human Services (HHS), which includes the CDC, is developing a STI Federal Action Plan with input from 20 federal agencies and offices, as well as healthcare providers, local and state health departments, community-based and faith-based organizations, national organizations, and tribes and tribal organizations. The plan will include input from six listening sessions hosted by HHS, which included more than 1,000 participants representing nearly every state. More than 300 comments also were gathered following a request for information published in the *Federal Register*.

“It is time to reverse the worrisome upward trend in sexually transmitted infections, and the STI Plan will help lead the way,” wrote **Brett Giroir**, MD, Assistant Secretary for Health, in a blog post.⁷ ■

REFERENCES

1. Centers for Disease Control and Prevention. Sexually transmitted disease surveillance 2018. Aug. 27, 2019. Available at: <https://bit.ly/2pUCtal>.
2. Centers for Disease Control and Prevention. New CDC report: STDs continue to rise in the U.S. Oct. 8, 2019. Available at: <https://bit.ly/316sNXj>.
3. Gomez GB, Kamb ML, Newman LM, et al. Untreated maternal syphilis and adverse outcomes of pregnancy: A systematic review and meta-analysis. *Bull World Health Organ* 2013;91:217-226.
4. Kingston M, French P, Higgins S, et al; Members of the Syphilis Guidelines Revision Group 2015.

EXECUTIVE SUMMARY

New data from the CDC indicate that combined cases of syphilis, gonorrhea, and chlamydia reached an all-time high in the United States in 2018.

- Primary and secondary syphilis cases rose 14% to more than 35,000 cases, the highest number reported since 1991. Cases of syphilis in newborns increased 40% to more than 1,300 cases.
- Gonorrhea rates rose 5% to more than 580,000 cases, the highest numbers that have been reported since 1991.
- Chlamydia numbers moved up 3% to more than 1.7 million cases, representing the most cases ever reported to the CDC.

- UK national guidelines on the management of syphilis 2015. *Int J STD AIDS* 2016;27:421-446.
5. National Academy of Public Administration. The impact of sexually transmitted diseases on the United States: Still hidden, getting worse, can be controlled. December 2018. Available at: <https://bit.ly/2GYvGV5>.
 6. Witwer E, Jones RK, Lindberg LD. Sexual behavior and contraceptive and condom use among U.S. high school students, 2013-2017. Guttmacher Institute; September 2018. Available at: <https://bit.ly/35YXMbe>.
 7. Giroir BP. HHS federal plan to tackle rising rates of sexually transmitted infections. Oct. 8, 2019. Available at: <https://bit.ly/2lyV42q>.

Discuss Vulvovaginal Health With Patients During Well Woman Visits

Results of a new study involving more than 1,500 postmenopausal women indicate that patients still are not comfortable in proactively discussing vaginal issues related to menopause with their healthcare providers.¹

Genitourinary syndrome of menopause (GSM) is defined as the signs and symptoms associated with a decrease in estrogen and other sex steroids involving changes to the labia majora/minora, clitoris, vestibule/introitus, vagina, urethra, and bladder. Women may report genital symptoms of dryness, burning, and irritation; sexual symptoms of lack of lubrication, discomfort or pain, and impaired sexual function; and urinary symptoms of urgency, dysuria, and recurrent urinary tract infections.² Low-dose vaginal estrogen and ospemifene provide effective therapy

for the such symptoms, and vaginal moisturizers and lubricants are available for those who do not choose hormonal therapy.³

In the new study, 45% of women reported some type of postmenopausal vulvovaginal symptom, such as vaginal dryness, itching, soreness, or odor. However, only 39% of symptomatic women discussed their symptoms at their well woman visits. When conversations about vulvovaginal health did occur, researchers report it often was the patient who initiated the discussion, rather than the clinician (59% vs. 22%).¹

“Nearly half of these postmenopausal women reported having a vulvovaginal problem, yet a minority discussed their symptoms at a well woman visit,” said **Amanda Clark**, MD, MCR, lead author of

the study and an affiliate investigator with the Kaiser Permanente Center for Health Research in Portland, in a statement. “Since the discussions that did occur led to helpful interventions, this suggests a role for greater clinician-initiated screening for genitourinary syndrome of menopause.”⁴

It is time to talk with women about symptoms. In a 2016 study, researchers recruited women ages 55 and older from primary care offices and senior centers for survey on common symptoms after menopause. Participants reported that the most common symptoms were itching, burning, stinging, pain, irritation, dryness, discharge, or odor. Fifty-one percent said they experience one or more of these symptoms, 40% of women said symptoms posed emotional problems, and 33% said they had an effect on their lifestyle.⁵

EXECUTIVE SUMMARY

Results of a new study involving more than 1,500 postmenopausal women indicate that patients still are not comfortable in proactively discussing vaginal issues related to menopause with their healthcare providers.

- In the new study, 45% of women reported some type of postmenopausal vulvovaginal symptom, such as vaginal dryness, itching, soreness, or odor. However, only 39% of symptomatic women discussed their symptoms at well woman visits.
- When conversations about vulvovaginal health did occur, researchers report it usually was the patient who initiated the discussion, rather than the clinician.

Ask About Symptoms

During menopause, estrogen deficiency can lead to thinning of the vaginal epithelium. As a result, women may encounter vaginal dryness, itching, dyspareunia, and urinary symptoms. In a study that analyzed data from more than 2,400 women over a 17-year-period who were enrolled in the Study of

Women's Health Across the Nation, at baseline, 19.4% of women, ages 42-53, reported vaginal dryness. In the same study, by the time women reached ages 57-69, 34% of them complained of symptoms.⁶

The effects of GSM can prevent postmenopausal women from having or enjoying sex. Lubricants and vaginal moisturizers are nonhormonal options. Other therapies include vaginal estrogen tablets, creams, vaginal ring, and intravaginal dehydroandrosterone. In 2016, the FDA approved Intrarosa to treat women experiencing moderate to severe pain during sexual intercourse due to menopause. Intrarosa contains the active ingredient prasterone, also known as dehydroepiandrosterone (DHEA).

Data indicate that low-dose tablets, the vaginal ring, and creams have comparable efficacy in treating vulvovaginal symptoms.⁷ Research suggests that vaginal estradiol may reduce the risk of recurrent urinary tract infections and overactive bladder symptoms in menopausal women.⁸ The low-dose vaginal ring is approved to treat urinary urgency and dysuria.³ A systematic review that evaluated current evidence for the efficacy and safety of vaginal estrogen products for GSM treatment concluded that commercially available vaginal estrogen therapies

are safe and effective first-line options for treating moderate to severe GSM.⁹

“With so many options now available, such as over-the-counter lubricants and moisturizers as well as low dose vaginal hormonal products containing estrogen or DHEA, there is no reason for women to continue to suffer in silence,” said **Stephanie Faubion**, MD, MBA, medical director of the North American Menopause Society, in a statement. “Hopefully, studies like this one will open the door to better patient-provider communication at well woman visits.”⁴ ■

REFERENCES

1. Clark AL, Bulkley JE, Bennett AT, et al. Discussion of vulvovaginal health at postmenopausal well woman visit — patient characteristics and visit experiences. Presented at the 2019 North American Menopause Society Annual Meeting, Chicago, September 2019.
2. Shifren JL, Gass ML; NAMS Recommendations for Clinical Care of Midlife Women Working Group. The North American Menopause Society recommendations for clinical care of midlife women. *Menopause* 2014;21:1038-1062.
3. Stuenkel CA, Davis SR, Gompel A, et al. Treatment of symptoms of the menopause: An Endocrine Society clinical practice guideline. *J Clin Endocrinol Metab* 2015;100:3975-4011.
4. North American Menopause Society. More discussion needed about vulvovaginal health at well woman visits. Sept. 24, 2019. Available at: <https://bit.ly/2mqlcnO>.
5. Erekson EA, Li FY, Martin DK, et al. Vulvovaginal symptoms prevalence in postmenopausal women and relationship to other menopausal symptoms and pelvic floor disorders. *Menopause* 2016;23:368-375.
6. Waetjen LE, Crawford SL, Chang PY, et al. Factors associated with developing vaginal dryness symptoms in women transitioning through menopause: A longitudinal study. *Menopause* 2018;25:1094-1104.
7. Rahn DD, Carberry C, Sanses TV, et al. Vaginal estrogen for genitourinary syndrome of menopause: A systematic review. *Obstet Gynecol* 2014;124:1147-1156.
8. Management of symptomatic vulvovaginal atrophy: 2013 position statement of The North American Menopause Society. *Menopause* 2013;20:888-902.
9. Biehl C, Plotsker O, Mirkin S. A systematic review of the efficacy and safety of vaginal estrogen products for the treatment of genitourinary syndrome of menopause. *Menopause* 2019;26:431-453.

Assess • Manage • Reduce
Healthcare RISK

Listen to our free podcast!

Episode 15: Physician Burnout, or 'Misery Not Otherwise Specified'

www.reliasmedia.com/podcasts



Editorial Advisory Board

Chairman Robert A. Hatcher, MD, MPH
Senior Author, Contraceptive Technology
Professor Emeritus of Gynecology and Ob-
stetrics, Emory University School of Medicine,
Atlanta

David F. Archer, MD, Professor of OB/GYN,
The Jones Institute for Reproductive Medi-
cine, The Eastern Virginia Medical School,
Norfolk

Kay Ball, RN, PhD, CNOR, FAAN, Professor
of Nursing, Otterbein University,
Westerville, OH

Melanie Deal, MS, WHNP-BC, FNP-BC,
Nurse Practitioner, University Health Ser-
vices, University of California, Berkeley

Linda Dominguez, RNC, WHNP, Clinical
Consultant, Southwest Women's Health,
Albuquerque, NM

Andrew M. Kaunitz, MD, FACOG,
NCMP, University of Florida, Term Profes-
sor; Associate Chairman, Department of
Obstetrics and Gynecology, University of
Florida College of Medicine-Jacksonville

Anita L. Nelson, MD, Professor and Chair,
Obstetrics & Gynecology Department,
Western University of Health Sciences,
Pomona, CA

David Turok, MD, MPH, Associate Profes-
sor, Department of Obstetrics and Gyne-
cology, University of Utah, Salt Lake City

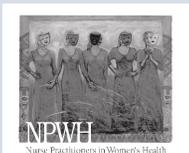
Susan Wysocki, WHNP-BC, FAANP,
President & CEO, iWomansHealth
Washington, DC

Interested in reprints or posting an article
to your company's site? There are numer-
ous opportunities for you to
leverage editorial recognition for the benefit
of your brand. Call: (800) 688-2421
Email: reprints@reliasmedia.com

Discounts are available for group subscrip-
tions, multiple copies, site licenses, or
electronic distribution. For pricing informa-
tion, please contact our Group Account
Managers. Call: (866) 213-0844
Email: groups@reliasmedia.com

To reproduce part of Relias Media newslet-
ters for educational purposes, contact The
Copyright Clearance Center for permission.
Phone: (978) 750-8400 | Web: Copyright.com |
Email: Info@Copyright.com

Contraceptive Technology Update is
endorsed by the **National Association of**
Nurse Practitioners in Women's Health
and the **Association of Reproductive**
Health Professionals as a vital informa-
tion source for healthcare professionals.



CME/CE INSTRUCTIONS

To earn credit for this activity, please follow these instructions:

1. Read and study the activity, using the provided references for further research.
2. Log on to ReliasMedia.com and click on My Account to view your available CE activities. Tests are taken after each issue. First-time users must register on the site using the subscriber number on their mailing label, invoice, or renewal notice.
3. Pass the online tests with a score of 100%; you will be allowed to answer the questions as many times as needed to achieve a score of 100%. Tests are taken with each issue.
4. After successfully completing the test, your browser will be automatically directed to the activity evaluation form, which you will submit online.
5. Once the completed evaluation is received, a credit letter will be emailed to you.

CME/CE QUESTIONS

1. **What classification does the U.S. Medical Eligibility Criteria for Contraceptive Use give for use of the IUD in adolescents?**
 - a. Category 1
 - b. Category 2
 - c. Category 3
 - d. Category 4
2. **In which two U.S. states are more than 90% of women living in a county without an abortion clinic?**
 - a. Mississippi and Wyoming
 - b. California and Connecticut
 - c. Hawaii and Nevada
 - d. New York and North Dakota
3. **The U.S. Preventive Services Task Force cervical cancer screening recommendations call for women ages 30-65 to be screened with the Pap test and high-risk human papillomavirus together in what period?**
 - a. Every five years
 - b. Every six years
 - c. Every seven years
 - d. Every eight years
4. **Which five states accounted for 70% of cases of congenital syphilis in 2018?**
 - a. North Dakota, Michigan, Texas, South Carolina, Florida
 - b. Nevada, Mississippi, Florida, Illinois, and Louisiana
 - c. Texas, California, Florida, Arizona, and Louisiana
 - d. New York, California, Florida, Arizona, and Washington, DC

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.

Time for Innovative Research on STI Vaccines

Funding aimed at vaccine candidates for syphilis, gonorrhea, and chlamydia

With more than 1 million new sexually transmitted infection (STI) cases diagnosed each day on a global basis, public health officials are calling for new approaches on the scientific front to combat the rising number of infections.¹

Leaders from the National Institute of Allergy and Infectious Diseases (NIAID) called for a “refocused, dedicated, and intensive biomedical research program” in a recent perspective piece. NIAID Director Anthony Fauci, MD, Robert Eisinger, PhD, special assistant for scientific projects in NIAID’s Immediate Office of the Director, and Emily Erbeling, MD, director of the agency’s Division of Microbiology and Infectious Diseases, co-authored the paper.

Response to Significant Need

The agency plans to commit \$41.6 million over five years to support four clinical research centers in an effort to stimulate collaborative, multidisciplinary research on the bacteria that cause syphilis, gonorrhea, and chlamydia. The hope is for each center to identify at least one candidate vaccine ready for testing in clinical trials by the end of the five years.

“At this time, no vaccines are available to prevent syphilis, gonorrhea, or chlamydia,” said Fauci in a statement. “However, research at these new centers should help fill the pipeline with several vaccine candidates that have feasible pathways to licensure in the U.S.”²

Researchers at the University of Connecticut School of Medicine will spearhead efforts to develop a syphilis vaccine candidate. Led by **Justin Radolf**, MD, professor at the University of Connecticut School of Medicine, and **Michael Anthony Moody**, MD, associate professor at Duke University, the center will receive up to \$11 million over five years to study potential candidates.

The need for a vaccine is significant. Syphilis is the second-leading cause of miscarriage and stillbirth worldwide.³ According to the CDC, there were 30,644 cases of early syphilis in the United States in 2017, representing an increase of 76% since 2013.⁴

“An effective syphilis vaccine would represent a triumph for biomedical research over an ailment that has defied conventional public health strategies for prevention and control,” said Radolf. “If successful, the scientific and public health impact of our approach will

extend well beyond syphilis and establish a model to tackle other pathogens.”⁵

Using structural biology approaches, scientists plan to investigate surface-exposed proteins within the outer membrane of *Treponema pallidum*, the bacterium that causes syphilis, in the search for vaccine targets.

Two of the NIAID-funded centers will aim their efforts at gonorrhea, which is caused by *Neisseria gonorrhoeae*. CDC statistics indicate that more than a half-million gonorrhea diagnoses were reported in 2017, representing a 67% jump from 2013.⁴ Impetus to develop an effective vaccine candidate stems from the fact that the

ACCORDING TO THE CDC, THERE WERE 30,644 CASES OF EARLY SYPHILIS IN THE UNITED STATES IN 2017, REPRESENTING AN INCREASE OF 76% SINCE 2013.

bacteria that cause gonorrhea have become resistant to most antibiotics.⁶

Nine Candidates Identified

Scientists recently completed proteomic profiling on all the proteins produced by 15 gonorrhea strains; among the isolates were World Health Organization-maintained reference strains that show all known profiles of gonococcal antimicrobial resistance.⁷ Nine new potential vaccine candidates were identified as a result of the research.

The NIAID-funded Gonorrhea Vaccine Cooperative Research Center will be led by Ann Jerse, PhD, of the Uniformed Services University of Health Sciences in Bethesda, MD. Researchers from Emory University, University of North Carolina, Duke University, University of New Mexico, Oregon State, and the University of Virginia will participate in the center's efforts, which will receive up to \$10.7 million over five years.

Cynthia Cornelissen, PhD, director of the Center for Translational Immunology in the Institute for Biomedical Sciences at

Georgia State University, will head efforts in the second of the NIAID-funded centers.⁷

What About Chlamydia?

Chlamydia is the most commonly reported STI in the United States. According to the CDC, more than

MORE THAN 1.7 MILLION CASES OF CHLAMYDIA WERE DIAGNOSED IN 2017, WITH 45% AMONG FEMALES AGES 15-24.

1.7 million cases were diagnosed in 2017, with 45% among females ages 15-24.⁴

Efforts to develop an effective chlamydia vaccine will be based at the University of North Carolina (UNC) at Chapel Hill. Leading the center efforts is Toni Darville, MD, chief of the UNC Division of Pediatric Infectious Diseases, vice chair of pediatric research and a

distinguished professor of pediatrics, microbiology, and immunology at the UNC School of Medicine. Up to \$10.7 million over five years will be issued by NIAID to advance science on chlamydia vaccine research.

Previous research funding was awarded to Darville and scientists at the University of Pittsburgh to study the T-cell response against chlamydia.⁸ Since chlamydia multiplies inside host cells in a protective vacuole, researchers are looking for a robust T-cell response for protection.

In the first of three projects funded through the UNC center, Darville and researchers at the University of Pittsburgh will further study candidate vaccine antigens identified in their previous project. With the University of Pittsburgh as the clinical core, scientists will enroll 150 women at high risk of chlamydia infection into a longitudinal study. All women will be tested for chlamydia, treated with an antibiotic to clear infection, and followed over the next year to check for reinfection. Samples will be sent to UNC for further T-cell antigen testing, while collaborators at the German Cancer Research Center in Heidelberg will examine the women's antibody responses. ■

EXECUTIVE SUMMARY

The National Institute of Allergy and Infectious Diseases plans to commit \$41.6 million over five years to support four clinical research centers to develop vaccine candidates for syphilis, gonorrhea, and chlamydia.

- Researchers at the University of Connecticut School of Medicine will spearhead efforts to develop a syphilis vaccine candidate. Syphilis is the second-leading cause of miscarriage and stillbirth worldwide.
- The Gonorrhea Vaccine Cooperative Research Center will be located at the Uniformed Services University of Health Sciences in Bethesda, MD. A second gonorrhea vaccine center will be established at Georgia State University.
- The University of North Carolina at Chapel Hill will serve as the center for chlamydia vaccine research.

REFERENCES

1. Eisinger RW, Erbeding E, Fauci AS. Refocusing research on sexually transmitted infections. *J Infect Dis* 2019;doi:10.1093/infdis/jjz442.
2. National Institute of Allergy and Infectious Diseases. NIH awards will advance development of vaccines for sexually transmitted infections. May 9, 2019. Available at: <https://bit.ly/2M8owhW>.
3. Korenromp EL, Rowley J, Alonso M, et al. Global burden of maternal and congenital syphilis and associated

- adverse birth outcomes — Estimates for 2016 and progress since 2012. *PLoS One* 2019;doi:10.1371/journal.pone.0211720.
4. Centers for Disease Control and Prevention. Sexually transmitted disease surveillance 2017. Oct. 15, 2018. Available at: <https://bit.ly/2pleV8y>.
 5. Connecticut Children's Medical Center. Connecticut Children's co-develops first syphilis vaccine. May 20, 2019. Available at: <https://bit.ly/35sVa5t>.
 6. Kirkcaldy RD, Ballard RC, Dowell D. Gonococcal resistance: Are cephalosporins next? *Curr Infect Dis Rep* 2011;13:196-204.
 7. Noinaj N, Buchanan SK, Cornelissen CN. The transferrin-iron import system from pathogenic *Neisseria* species. *Mol Microbiol* 2012; 86:246-257.
 8. Russell AN, Zheng X, O'Connell CM, et al. Analysis of factors driving incident and ascending infection and the role of serum antibody in *Chlamydia trachomatis* genital tract infection. *J Infect Dis* 2016; 213:523-531.

Educate Patients on Link Between HPV and Anal, Penile, Oral Cancers

When it comes to human papillomavirus (HPV), many patients are unaware of the link between HPV and anal, penile, and oral cancers. Results of a new analysis led by researchers at The University of Texas Health Science Center at Houston indicate that more than 70% of U.S. adults do not know that HPV causes such cancers.¹

HPV is the most common sexually transmitted infection in the United States.²⁻⁵ Research indicates that 79 million people in the U.S. are infected, with approximately half of new infections occurring before age 24.⁶ It is estimated that more than 9,000 cases of HPV-related cancers occur in men on an annual basis, with HPV responsible for 63% of

penile, 91% of anal, and 72% of oropharyngeal cancers.⁷

In an analysis of responses from 2,564 men and 3,697 women who participated in the Health Information National Trends Survey, researchers found that two-thirds of men and one-third of women ages 18-26 were unaware that HPV causes cervical cancer. More than 80% of men and 75% of women in the same age group did not know that HPV can cause oral, anal, and penile cancers.¹

Recommendations from the CDC call for boys and girls ages 9-14 to receive the two-dose HPV immunization. A three-dose schedule is recommended if the first dose was given on or after the 15th birthday.⁸

Recent recommendations also advise that adults ages 27-45 may receive the HPV vaccine, based on discussion with their clinician.⁹

Findings from a recent CDC study indicate that 51% of all teens ages 13-17 have received all recommended doses of the HPV vaccine.¹⁰ The lack of knowledge about the link between HPV infection and anal, penile, and oral cancers may have contributed to low vaccination rates, said **Ashish Deshmukh**, PhD, MPH, assistant professor at The University of Texas Health Science Center at Houston. "HPV vaccination campaigns have focused heavily on cervical cancer prevention in women," Deshmukh noted in a statement. "Our findings demonstrate a need to educate both sexes regarding HPV and HPV vaccination."¹¹

EXECUTIVE SUMMARY

Results of a new analysis led by researchers at The University of Texas Health Science Center at Houston indicate that more than 70% of U.S. adults do not know that human papillomavirus (HPV) causes anal, penile, and oral cancers.

- HPV infection is the most common sexually transmitted infection in the United States. Research indicates that 79 million people in the U.S. are infected, with approximately half of new infections occurring before age 24.
- It is estimated that more than 9,000 cases of HPV-related cancers occur in men on an annual basis, with HPV responsible for 63% of penile, 91% of anal, and 72% of oropharyngeal cancers.

Use Strong Recommendations

When discussing the HPV vaccine, are clinicians using their strongest, most persuasive recommendation? In a recent survey of national physician networks, researchers found that only 65%

of pediatricians and 42% of family practitioners used the presumptive style of discussion, leading off with “we have three vaccines for today.” About 24% of family practitioners and 16% of pediatricians used a more conversational style, which is less effective.¹²

HPV vaccination rates are higher in teens whose parents reported receiving a recommendation from their child’s healthcare professional.¹⁰ Research indicates that healthcare providers play a key role in educating parents and are the most trusted source of information for parents of preteens eligible for vaccination.^{13,14} Clinicians can avoid missed opportunities by strongly recommending the HPV vaccine to parents of children ages 11-12 on the same day and in the same way that Tdap and meningococcal vaccines are recommended. ■

REFERENCES

1. Suk R, Montealegre JR, Nemutlu GS, et al. Public knowledge of human papillomavirus and receipt of vaccination recommendations. *JAMA Pediatr* 2019;doi:10.1001/jamapediatrics.2019.3105.
2. Clifford GM, Smith JS, Plummer M, et al. Human papillomavirus types in invasive cervical cancer worldwide: A meta-analysis. *Br J Cancer* 2003;88:63-73.
3. Chaturvedi AK, Engels EA, Pfeiffer RM, et al. Human papillomavirus and rising oropharyngeal cancer incidence in the United States. *J Clin Oncol* 2011;29:4294-4301.
4. Jemal A, Simard EP, Dorell C, et al. Annual Report to the Nation on the Status of Cancer, 1975-2009, featuring the burden and trends in human papillomavirus (HPV)-associated cancers and HPV vaccination coverage levels. *J Natl Cancer Inst* 2013;105:175-201.
5. Khan MJ, Castle PE, Lorincz AT, et al. The elevated 10-year risk of cervical precancer and cancer in women with human papillomavirus (HPV) type 16 or 18 and the possible utility of type-specific HPV testing in clinical practice. *J Natl Cancer Inst* 2005;97:1072-1079.
6. Satterwhite CL, Torrone E, Meites E, et al. Sexually transmitted infections among U.S. women and men: Prevalence and incidence estimates, 2008. *Sex Transm Dis* 2013; 40:187-193.
7. Juckett G, Hartman-Adams H. Human papillomavirus: Clinical manifestations and prevention. *Am Fam Physician* 2010;82:1209-1213.
8. Meites E, Kempe A, Markowitz LE. Use of a 2-dose schedule for human papillomavirus vaccination — updated recommendations of the Advisory Committee on Immunization Practices. *MMWR Morb Mortal Wkly Rep* 2016; 65:1405-1408.
9. Meites E, Szilagyi PG, Chesson HW, et al. Human papillomavirus vaccination for adults: Updated recommendations of the Advisory Committee on Immunization Practices. *MMWR Morb Mortal Wkly Rep* 2019;68:698-702.
10. Walker TY, Elam-Evans LD, Yankey D, et al. National, regional, state, and selected local area vaccination coverage among adolescents aged 13-17 years — United States, 2018. *MMWR Morb Mortal Wkly Rep* 2019;68:718-723.
11. University of Texas Health Science Center at Houston. Most American adults do not know that HPV causes oral, anal, and penile cancers. Sept. 16, 2019. Available at: <https://bit.ly/2PiXma5>.
12. Kempe A, O’Leary ST, Markowitz LE, et al. HPV vaccine delivery practices by primary care physicians. *Pediatrics* 2019;doi:10.1542/peds.2019-1475.
13. Gilkey MB, Moss JL, McRee A-L, et al. Do correlates of HPV vaccine initiation differ between adolescent boys and girls? *Vaccine* 2012;30:5928-5934.
14. Stokley S, Jeyarajah J, Yankey D, et al. Human papillomavirus vaccination coverage among adolescents, 2007-2013, and postlicensure vaccine safety monitoring, 2006-2014 — United States. *MMWR Morb Mortal Wkly Rep* 2014;63:620-624.

Assess • Manage • Reduce Healthcare RISK

Listen to our free podcast!

Episode 4: Reflections of a Nurse: What Made Me Stay or Leave?

www.reliasmmedia.com/podcasts

