30th Anniversary

CONTRACEPTIVE TECHNOLOGY UPDATE®

A Monthly Newsletter for Health Professionals

AHC Media LLC

IN THIS ISSUE

■ **Cancer screening:** New guidance out for breast, cervical screening . . . . . cover

■ **Contraceptive vaginal ring:** Science eyes extended use 3

■ **Guest Column:** How to increase vaginal ring use . . . 5

■ **Postpartum birth control:** Check the options 6

■ **Lubricants:** Counsel on effective use 8

■ **Washington Watch:** Massachusetts sets example 9

■ **Enclosed in this issue:** — Results of the 2009 *CTU* Salary Survey

Statement of Financial Disclosure:
Consulting Editor **Robert A. Hatcher**, MD, MPH, Author **Rebecca Bowers**, Associate Publisher **Coles McKagen**, Senior Managing Editor **Joy Dickinson**, and **Adam Sonfield** (Washington Watch Columnist) report no consultant, stockholder, speaker's bureau, research, or other financial relationships with companies having ties to this field of study. **Sharon Schnare** (Nurse Reviewer) discloses that she is a retained consultant and a speaker for Barr Laboratories, Berlex, and Organon; she is a consultant for 3M Pharmaceuticals; and she is a speaker for FEI Women's Health, Ortho-McNeil Pharmaceuticals, and Wyeth-Ayerst Pharmaceuticals.

JANUARY 2010
VOL. 31, NO. 1 • (pages 1-12)

Check the new screening guidance for cervical cancer and breast cancer

Guidelines may change schedules for mammography, Pap smears

Women's health clinicians will take a hard look at cancer screening regimens now that new guidance has been issued by the U.S. Preventive Services Task Force (USPSTF) and the American College of Obstetricians and Gynecologists (ACOG).[1,2]

The USPSTF guidelines on breast cancer screening were issued in early November 2009. ACOG released its practice bulletin on cervical cancer screening in mid-November 2009. The two guidance documents stand as separate entities; the timing of publication is coincidental.[3]

The national task force recommendations on breast cancer screening update guidance issued in 2002. According to the new guidelines, the USPSTF:

• recommends against routine screening mammography in women ages 40-49. The decision to start regular, biennial screening mammography before age 50 should be an individual one and take patient context into account, including the patient's values regarding specific benefits and harms, the USPSTF notes;

Newsletter is marking a milestone: *CTU* celebrates 30th anniversary

This issue marks the 30th anniversary of *Contraceptive Technology Update.* Look to the upcoming February issue for a forecast of what lies ahead in the family planning field, and hear from national experts on what to expect in contraceptive development.

What will be the next method of birth control to emerge, and what can clinicians expect to see when it comes to prevention and treatment of sexually transmitted infections? Stay tuned for a special focus article in the February 2010 issue. ■

• recommends biennial screening mammography for women ages 50-74. The USPSTF concludes that current evidence is insufficient to assess the additional benefits and harms of screening mammography in women age 75 or older;

• recommends against teaching breast self-examination (BSE);

• concludes that current evidence is insufficient to assess the additional benefits and harms of clinical breast examination beyond screening mammography in women age 40 or older.[4]

ACOG's new practice bulletin on cervical cancer screening states that most women younger than age 30 should undergo testing once every two years instead of annually, using standard Pap or liquid-based cytology. Women ages 30 and older who have had three consecutive negative cervical cytology test results may be screened once every three years with the Pap or liquid-based cytology.

Women with certain risk factors might need more frequent screening, including those who have HIV, are immunosuppressed, were exposed to diethylstilbestrol *in utero*, and have been treated for cervical intraepithelial neoplasia (CIN) 2, CIN 3, or cervical cancer.[2] ACOG advises that routine cervical cytology testing should be discontinued in women, regardless of age, who have had a total hysterectomy for noncancerous reasons, as long as they have no history of high-grade CIN.

There are no changes in recommendations on the upper age limit for discontinuing cervical screening. ACOG advises that it is reasonable to stop cervical cancer screening at age 65 or 70 among women who have three or more negative cytology results in a row and record no abnormal test results in the past 10 years. The guidance also recommends that women who have been vaccinated against human papillomavirus (HPV) should follow the same screening guidelines as unvaccinated women.

National professional organizations have questioned the new USPSTF guidance on breast cancer screening. ACOG continues to maintain its current advice that women in their 40s receive mammography screening every one to two years and women age 50 or older go for annual screening.[5] Clinicians also should continue to counsel women that BSE has the potential to detect palpable breast cancer and can be recommended for use, states ACOG.[5]

The American Cancer Society also continues to recommend annual screening using mammography and clinical breast examination for all women beginning at age 40. "Our experts make this recommendation having reviewed virtually all the same data reviewed by the USPSTF, but also additional data that the USPSTF did not consider," said **Otis Brawley**, MD, American Cancer Society's chief medical officer in a press statement.[6] "When recommendations are based on judgments about the balance of risks and benefits, reasonable experts can look at the same data and reach

Contraceptive Technology Update® (ISSN 0274-726X), including **STD Quarterly**™, is published monthly by AHC Media LLC, 3525 Piedmont Road, Building Six, Suite 400, Atlanta, GA 30305. Telephone: (404) 262-7436. Periodicals Postage Paid at Atlanta, GA 30304 and at additional mailing offices.

POSTMASTER: Send address changes to ***Contraceptive Technology Update***®, P.O. Box 740059, Atlanta, GA 30374.

Subscriber Information

Customer Service: (800) 688-2421 or fax (800) 284-3291. E-mail: (customerservice@ahcmedia.com). Hours of operation: 8:30 a.m.-6 p.m. Monday-Thursday; 8:30 a.m.-4:30 p.m. Friday, EST.

Subscription rates: U.S.A., one year (12 issues), $449. Add $17.95 for shipping & handling. Outside U.S., add $30 per year, total prepaid in U.S. funds. Discounts are available for group subscriptions, multiple copies, site-licenses or electronic distribution. For pricing information, call Tria Kreutzer at 404-262-5482. **Back issues**, when available, are $75 each.(GST registration number R128870672.)

AHC Media LLC is accredited as a provider of continuing nursing education by the American Nurses Credentialing Center's Commission on Accreditation.

This activity has been approved for 15 nursing contact hours using a 60-minute contact hour.

Provider approved by the California Board of Registered Nursing, Provider #14749, for 15 Contact Hours.

AHC Media LLC is accredited by the Accreditation Council for Continuing Medical Education to provide continuing medical education for physicians.

AHC Media LLC designates this educational activity for a maximum of 18 *AMA PRA Category 1 Credits™*. Physicians should only claim 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 24 months from the date of publication.

Editor: **Rebecca Bowers**.
Associate Publisher: **Coles McKagen** (404) 262-5420 (coles.mckagen@ ahcmedia.com).
Senior Managing Editor: **Joy Daughtery Dickinson** (229) 551-9195 (joy.dickinson@ahcmedia.com).
Director of Marketing: **Schandale Kornegay**.
Senior Production Editor: **Nancy McCreary**.

Editorial Questions

Questions or comments?
Call **Joy Daughtery Dickinson** (229) 551-9195.

different conclusions."

The USPSTF recommendations ignore valid scientific data and place many women at risk, according to a press statement issued by the American College of Radiology and the American Roentgen Ray Society.[7] Mammography is not a perfect test, but it has unquestionably been shown to save lives, including those in women ages 40-49, the statement says.

"These new recommendations seem to reflect a conscious decision to ration care," said **Carol Lee**, MD, chair of the College's Breast Imaging Commission in the statement. "If Medicare and private insurers adopt these incredibly flawed USPSTF recommendations as a rationale for refusing women coverage of these life-saving exams, it could have deadly effects for American women."

ACOG previously recommended that cervical cancer screening begin three years after first sexual intercourse or by age 21, whichever occurred first. By moving the baseline cervical screening to age 21 in its new guidance, ACOG maintains the change represents a conservative approach to avoid unnecessary treatment of adolescents.

While the rate of HPV infection is high among sexually active adolescents, invasive cervical cancer is very rare in women under age 21, because the immune system clears HPV infection within one to two years among most teen women.[8] Because the adolescent cervix is immature, there is a higher incidence of HPV-related precancerous lesions; however, the large majority of these dysplasias in teens resolve on their own without treatment.[9] Recent research indicates a significant increase in premature births among women who have been treated with excisional procedures for dysplasia.[10]

In a statement regarding the new publication, **Alan Waxman**, MD, who headed the ACOG cervical cancer guidance development, said, "Adolescents have most of their childbearing years ahead of them, so it's important to avoid unnecessary procedures that negatively affect the cervix. Screening for cervical cancer in adolescents only serves to increase their anxiety and has led to overuse of follow-up procedures for something that usually resolves on its own."[11]

References

1. U.S. Preventive Services Task Force. Screening for breast cancer: U.S. Preventive Services Task Force recommendation statement. *Ann Intern Med* 2009; 151:716-726.

2. American College of Obstetricians and Gynecologists. Cervical cytology screening. Practice Bulletin No. 109. Accessed at journals.lww.com/greenjournal/documents/PB109_Cervical_Cytology_Screening.pdf.

3. Grady D. Guidelines push back age for cervical cancer tests. *New York Times;* Nov. 20, 2009. Accessed at www.nytimes.com/2009/11/20/health/20pap.html?_r=1&pagewanted=print.

4. American College of Obstetricians and Gynecologists. Interpreting the U.S. Preventive Services Task Force breast cancer screening recommendations for the general population. Accessed at www.acog.org/from_home/Misc/uspstfInterpretation.cfm.

5. American College of Obstetricians and Gynecologists. ACOG statement on revised U.S. Preventive Services Task Force recommendations on breast cancer screening. Nov. 16, 2009. Accessed at www.acog.org/from_home/publications/press_releases/nr11-16-09.cfm.

6. American Cancer Society. American Cancer Society responds to changes to USPSTF mammography guidelines. Accessed at www.cancer.org/docroot/MED/content/MED_2_1x_American_Cancer_Society_Responds_to_Changes_to_USPSTF_Mammography_Guidelines.asp.

7. American College of Radiology and American Roentgen Ray Society. USPSTF mammography recommendations will result in countless unnecessary breast cancer deaths each year. Accessed at www.eurekalert.org/pub_releases/2009-11/acor-umr111609.php.

8. Brown DR, Shew ML, Qadadri B, et al. A longitudinal study of genital human papillomavirus infection in a cohort of closely followed adolescent women. *J Infect Dis* 2005; 191:182-192.

9. Fuchs K, Weitzen S, Wu L, et al. Management of cervical intraepithelial neoplasia 2 in adolescent and young women. *J Pediatr Adolesc Gynecol* 2007; 20:269-274.

10. Kyrgiou M, Koliopoulos G, Martin-Hirsch P, et al. Obstetric outcomes after conservative treatment for intraepithelial or early invasive cervical lesions: Systematic review and meta-analysis. *Lancet* 2006; 367:489-498.

11. American College of Obstetricians and Gynecologists. First cervical cancer screening delayed until age 21. Accessed at www.acog.org/from_home/publications/press_releases/nr11-20-09.cfm. ■

Extending the use of vaginal ring eyed

[Editor's note: This story discussed off-label use of the vaginal ring (NuvaRing, Schering-Plough Corp.; Kenilworth, NJ).]

Many clinicians are familiar with continuous use of oral contraceptives, but how about extended regimen use of the vaginal ring? The advantages of extended cycling of the ring parallel those of extended-cycle use of the Pill, says **Anne Burke**, MD, MPH, assistant professor in the Department of Gynecology and Obstetrics at the Johns Hopkins University School of Medicine. Burke presented information on the vaginal ring

EXECUTIVE SUMMARY

Science is examining extended regimen use of the contraceptive vaginal ring. By extending use of the ring's prescribed regimen, women can gain control over the timing of their own periods and experience reduced blood loss due to fewer and lighter periods.

- Extended-cycle use also offers control of pre- and peri-menstrual symptoms that might be hormonally related, such as premenstrual syndrome and menstrual headaches.
- The main disadvantage of extended use of the ring lies in the potential side effect of irregular or breakthrough bleeding. Such bleeding is not heavy, and it appears to improve with time.

and other established methods of birth control at the recent *Contraceptive Technology* Quest for Excellence Conference.[1]

By extending use of the ring, women gain control over the timing of their own periods and experience reduced blood loss due to fewer and lighter periods, observes Burke. Extended cycle use also offers control of pre- and peri-menstrual symptoms that might be hormonally related, such as premenstrual syndrome and menstrual headaches, she notes.

While the ring has been found to be effective and tolerable when used without a hormone-free interval, breakthrough bleeding or spotting is a frequent side effect of extended-cycle hormonal contraception. In a 2005 study, 43% of women on a 49-day ring cycle experienced breakthrough bleeding, compared with 16% of those on a 28-day cycle.[2] ***(Contraceptive Technology Update* looked at extended-use research of the ring; see the article "Extended use of ring, patch now under review," August 2005, p. 95.)**

The main disadvantage of extended use of the ring lies in the potential for irregular or breakthrough bleeding as a side effect, notes Burke. "This can be troublesome or annoying to some women," she notes. "It is usually not heavy and seems to improve with time."

Extended-regimen use of the vaginal ring is currently considered "off label," but scientific evidence is emerging on its effectiveness. A 2009 study looked at the bleeding patterns of women using extended regimens of the vaginal ring compared to oral contraceptives.[3] Both groups used their respective contraceptive method over continuous periods of 84 days, followed by a seven-day pause, over one year. The total number of scheduled bleeding and spotting days decreased significantly during the one-year period of the study for both methods ($p = 0.001$; the decrease was significantly higher for Pill users. Scientists note there was a significant reduction in the total number of unscheduled bleeding and spotting days for both methods ($p = 0.01$), but the decrease was significantly higher among vaginal ring users ($p = 0.003$).[3]

A 2008 study did an assessment of bleeding patterns with continuous use of the ring.[4] Scientists designed a prospective analysis of daily menstrual flow during a 21/7 cycle, followed by six months of continuous use and institution of a randomized protocol to manage breakthrough bleeding/spotting. Women who completed the baseline 21/7 phase were randomized equally into two groups during the continuous phase. One group was instructed to replace the ring monthly on the same calendar day with no ring-free days. The second group was instructed to use the same process, but if breakthrough bleeding/spotting occurred for five days or more, they were to remove the ring for four days, store it, and then reinsert that ring. Most patients had no or minimal bleeding during continuous use, with the second group experiencing a statistically greater percentage of days without breakthrough bleeding or spotting (95%) compared with Group 1 (89%) ($P = 0.016$).[4]

This four-day "taking a break" described in the 2008 study might help women who choose to use the ring on a extended basis deal with breakthrough bleeding and continue with the method, says Burke. "For some women, the breakthrough bleeding may make them not want to do extended ring cycling, while for others, some spotting here and there is a small price to pay for the benefits they may get," she says. "There is no 'buildup' of hormones with extended ring use, as the contraceptive hormone levels decrease pretty quickly upon ring removal."

How can women use the vaginal ring in an extended regimen? For some women, the memory-triggering mechanism of the calendar day switch (changing the ring on the same date each month) might work, says Burke. For others, replacing the ring every 28 days might be acceptable, depending on patient preference.[5]

References

1. Burke A. What's new with the older methods? Rings, patches, Depo and more. Presented at the 2009 *Contraceptive Technology* Quest for Excellence conference. Atlanta; October 2009.

2. Miller L, Verhoeven C, Hout J. Extended regimens of

the contraceptive vaginal ring: A randomized trial. *Obstet Gynecol* 2005; 106:473-482.

3. Guazzelli CA, Barreiros FA, Barbosa R, et al. Extended regimens of the vaginal contraceptive ring: Cycle control. *Contraception* 2009; 80:430-435.

4. Sulak PJ, Smith V, Coffee A, et al. Frequency and management of breakthrough bleeding with continuous use of the transvaginal contraceptive ring: A randomized controlled trial. *Obstet Gynecol* 2008; 112:563-571.

5. Rowland K, Schumann SA. When to suggest this OC alternative. *J Fam Pract* 2009; 58:207-210. ■

GUEST COLUMN

How to make NuvaRing an option for patients

By **Robert Hatcher**, MD, MPH
Professor of Gynecology and Obstetrics
Emory University School of Medicine
Atlanta

While some clinicians think women will not be willing to place a foreign body into the vagina and then remove it, other providers have been successful in introducing women to the vaginal contraceptive ring (NuvaRing, Schering-Plough Corp.; Kenilworth, NJ). Exactly how is the method presented to women by those clinicians?

Outliers can be extraordinarily instructive to people trying to gain acceptance for their product. We can learn from ordinary people who achieve extraordinary results. Look at this example: a producer of soft ice cream machines received an order to send two machines to one address. It had never happened before . . . two of these huge machines being sent to a single site. The producer flew from Chicago to Los Angeles where he found a very effective purveyor of fast foods. In this way, Ray Kroc met the owner of the first McDonald's. They decided to work together. And, as they say, the rest is history.

I heard that some clinicians were finding women very receptive to the NuvaRing, while others had never prescribed them and said that their patients really didn't like the idea of placing something into their vagina. I wanted to know what was going on in the offices extensively prescribing the contraceptive. Three years after NuvaRing was approved for U.S. use, I contacted five nurse practitioners and five physicians by telephone. All were happy to talk about this vaginal contraceptive. I asked each clinician four questions:

- Of 100 of your patients using a combined hormonal contraceptive, what percentage will use pills, NuvaRing, and Ortho Evra patches?
- What are you doing to introduce NuvaRing to women?
- To what extent are your patients using NuvaRing for extended periods of time or continuously?
- What seems to be the feature women like best about this method?

Look at frequency

The below table outlines the extent of use of NuvaRing in 10 practices. Findings indicate that 30%-95% of all women using a combined hormonal contraceptive were using the vaginal contraceptive ring.

All of the surveyed clinicians were positive in

Of 100 Recent Patients Using a Combined Hormonal Method (Pill, Patch, Ring), Which Method Do Women Choose?

Title	Location	Ring	Pill	Patch
Physician	Jupiter, FL	95	5	0
Physician	Webster, OH	90	9	1
Nurse Practitioner	Palm Beach Gardens, FL	75	25	0
Physician	Cranford, NJ	65	30	5
Physician	Miami	50*	45	5
Nurse Practitioner	San Antonio	50	25	25
Nurse Practitioner	Washington, DC	45	45	10
Nurse Practitioner	Philadelphia	40	50	10
Physician	Pittsburgh	33**	33	33
Nurse Practitioner	New Brunswick, NJ	30	50	20

* 70% of new starts choose to use vaginal contraceptive rings.
** 40% of new starts choose to use vaginal contraceptive rings.

Source: Robert Hatcher, MD, MPH, Professor of Gynecology and Obstetrics, Emory University School of Medicine, Atlanta.

their comments about the method's convenience, acceptability, and low incidence of side effects. All of them report routinely offering to place a NuvaRing for their patient to demonstrate that it is easy to insert and does not cause discomfort. Two clinicians indicated that if acceptable to the patient, they will insert the ring after doing the Pap smear. They virtually make placement of a ring a routine part of the exam in order to demonstrate its ease of insertion.

Women were asked by eight of the 10 clinicians if they would like to remove and then reinsert the ring themselves. The clinician left the room, the patient removed and reinserted the vaginal ring, and then told the clinician if she wanted to try this contraceptive.

One clinician describes the process: "If a woman is interested in the ring, I insist on them putting it in and taking it out. I leave the room, have them remove the ring I have just inserted, and then they put it back in themselves. If they don't like the ring, I have them throw it away. Usually they are smiling when I return to the room, and they leave with the ring in place."

One clinician said Food and Drug Administration approval of extended-regimen oral contraceptives has increased the acceptability of extended and continuous use of all three combined hormonal methods (pills, patches, and rings). The percentage of women choosing to use NuvaRing in a continuous regimen in this set of 10 clinicians ranged from 25% to 97%. One clinician who provides most of the contraceptives for residents at her institution finds that almost all of them use the ring on a continuous basis.

What do women like most about the contraceptive vaginal ring? All of the surveyed clinicians say it is the convenience of inserting the ring and having nothing to do for a month. Other positive features include the low incidence of hormonal side effects and the decreased incidence of previously troublesome cyclic symptoms if the ring is used for an extended time, clinicians note. Removal of the NuvaRing at the time of intercourse is uncommon among the women, the clinicians report.

What does it take?

The Wal-Mart pharmacy near one of the surveyed clinicians might become the first in the country to have to purchase a second refrigerator to store all the NuvaRings prescribed for more than 1,500 patients! This exercise inspires me to look for outliers providing the levonorgestrel intrauterine system, another superb contraceptive, to high percentages of women.

The NuvaRing is a safe, effective, easy-to-use, and convenient contraceptive.[1,2] It remains effective for up to 35 days. This permits clinicians to teach women choosing this method to remove their ring and insert a new ring the first day of each month, or any other date of the month they can easily remember. Discuss this ease of use, and demonstrate insertion and removal, to help women achieve success with the vaginal contraceptive ring.

References

1. Alexander NJ, Baker E, Kaptein M, et al. Why consider vaginal drug administration? *Fertil Steril* 2004; 82:1-12.

2. Roumen F, Apter D, Mulders TM, et al. Efficacy, tolerability, and acceptability of a novel contraceptive vaginal ring releasing etonogestrel and ethinyl estradiol. *Hum Reprod* 2001; 16:468-475. ■

Check contraception options for postpartum

Your next patient in the clinic examination room is a 22-year-old who has just delivered her first child three weeks ago. She tells you that she wants a reversible contraceptive to delay future births for the next four to five years. She is breast-feeding her new baby, and she has no current medical complications. What options can be safely provided to her?

Women in the postpartum especially need effective contraception, notes **Mary Dolan**, MD, MPH, associate professor of gynecology and obstetrics

EXECUTIVE SUMMARY

Women in the postpartum especially need effective contraception. A new review of the types of contraception being used by women two to nine months postpartum shows that 88% of postpartum women report current use of at least one birth control method. Furthermore, 61.7% report using a method defined as highly effective, 20% use a method defined as moderately effective, and 6.4% use less effective methods.

- Postpartum insertion of an intrauterine contraceptive offers an effective form of contraception to breast-feeding and nonbreast-feeding new mothers.
- Progestin-only pills and the contraceptive injection also may be considered for new mothers.

and division director of gynecology and obstetrics at Emory University in Atlanta. Results from the most recent cycle of the National Survey of Family Growth indicate that 49% of all pregnancies were unintended, and 21% of women gave birth within 24 months of a previous birth.[1]

A new review of the types of contraception being used by women two to nine months postpartum shows that 88% of postpartum women report current use of at least one birth control method.[2] Furthermore, 61.7% report using a method defined as highly effective, 20% use a method defined as moderately effective, and 6.4% use less effective methods. Contraceptive effectiveness was categorized as:

- highly effective — less than 10% of women experience an unintended pregnancy. This category includes sterilization, intrauterine device, shot, pill, patch, and ring;
- moderately effective — 10%-15% failure rate. This category includes condoms;
- and less effective — greater than 15% failure rate. This category includes diaphragm, cervical cap, sponge, rhythm, and withdrawal.

Rates of using highly effective contraceptive methods postpartum were lowest among women who had no prenatal care (54.5%).[2]

What about an IUD?

What options are available to our hypothetical patient? Consider a Copper-T 380 intrauterine device (ParaGard IUD, Duramed Pharmaceuticals; Pomona, NY) or the levonorgestrel intrauterine contraceptive (Mirena IUC, Bayer HealthCare Pharmaceuticals; Wayne, NJ). Both birth control devices represent two effective options, says Dolan, who presented information on postpartum contraception at the recent *Contraceptive Technology* Quest for Excellence conference.[3]

Both forms of intrauterine contraception do not cause a negative impact on the quality of breast milk.[4] Both offer long-term effectiveness and do not require behavior changes related to the method. Disadvantages include risk of perforation, expulsion, and infection; however, a just-published review of evidence indicates that there is no increase in risk of complications among women who had an IUD inserted during the postpartum period.[5] The review notes some increase in expulsion rates occur with delayed postpartum insertion when compared to immediate insertion, and with immediate insertion when compared to interval insertion.[5]

There are several advantages to postpartum placement of an IUD, notes **Nathalie Kapp**, MD, MPH, medical officer in the Department of Reproductive Health and Research at the World Health Organization (WHO) in Geneva. These advantages include the ease of insertion, the ready availability of skilled staff and appropriate facilities, and the convenience and possible decrease in insertional pain for the woman who has just given birth, states Kapp, lead author of the review.

When is the best timing for insertion of an intrauterine contraception in a postpartum woman who plans to breast-feed her infant? The WHO Medical Eligibility Criteria rates placement of a Copper-T IUD before six weeks postpartum as a "2" in breast-feeding women, which means the advantages outweigh the theoretical or proven risks.[6] However, the criteria rates placement of a Mirena LNG IUS before six weeks as a "3," which means the theoretical or proven risks outweigh the advantages. However, after the six-week postpartum time period, both devices are rated as a "1" — no restrictions on contraceptive use — in lactating women.[6]

These numbers for postpartum women are being carefully scrutinized for the U.S. version of the Medical Eligibility Criteria, which will be published in early 2010, says **Robert Hatcher**, MD, MPH, professor of gynecology and obstetrics at Emory University.

Think POP for pills

What if the hypothetical patient prefers to take pills for contraception? Look at progestin-only pills (POPs), says Dolan. Advantages include:

- familiarity with taking a daily pill, with ability to discontinue easily;
- high efficacy;
- possible improvement of menstrual symptoms, such as dysmenorrhea and premenstrual syndrome;
- no effect on infant growth, and possible increase in milk volume;
- very little of the progestin entering the breast milk.

What are the disadvantages of POPs? These include hormonal issues; a recommended delay of six weeks postpartum in lactating women; the need for daily pill taking and timing; and irregular bleeding.[2]

Clinically, the most important disadvantage patients are faced with is taking a POP every day around the same time, says Dolan. Patients need

to be counseled on the importance of taking the POP within two hours of the same time each day.

"That's hard with a new baby and new schedules," Dolan observes. "The most important advantage is its effectiveness if taken appropriately."

Although some authorities and organizations, including the WHO, have been guarded about use of the contraceptive injection depot medroxyprogesterone acetate (DMPA, Depo Provera), immediately postpartum prior to hospital discharge, the evidence is reassuring that immediate postpartum initiation of DMPA is safe from a maternal and infant health perspective, says **Andrew Kaunitz**, MD, professor and associate chair in the Obstetrics and Gynecology Department at the University of Florida College of Medicine — Jacksonville.

Existing data are not sufficient to limit DMPA use postpartum in women at high risk for unintended pregnancy, according to a recently published review of scientific literature.[7] To minimize the maternal and neonatal risks of unintended pregnancy, DMPA should be administered prior to hospital discharge and no later than the third postpartum week in well-counseled women choosing to use DMPA as their contraceptive, regardless of lactation status, the review states.[7] **(*Contraceptive Technology Update* reported on the review in the article "Start postpartum contraception early," September 2009, p. 101.)**

References

1. Chandra A, Martinez GM, Mosher WD, et al. Fertility, family planning, and reproductive health of U.S. women: Data from the 2002 National Survey of Family Growth. *Vital Health Stat 23* 2005; (25):1-160.

2. Centers for Disease Control and Prevention (CDC). Contraceptive use among postpartum women — 12 states and New York City, 2004-2006. *MMWR* 2009; 58:821-826.

3. Dolan M. Births, babies, and beyond: Contraceptive management for postpartum and lactation. Presented at the 2009 *Contraceptive Technology* Quest for Excellence conference. Atlanta; October 2009.

4. Shaamash AH, Sayed GH, Hussien MM, et al. A comparative study of the levonorgestrel-releasing intrauterine system Mirena vs. the Copper T380A intrauterine device during lactation: Breast-feeding performance, infant growth, and infant development. *Contraception* 2005; 72:346-351.

5. Kapp N, Curtis KM. Intrauterine device insertion during the postpartum period: A systematic review. *Contraception* 2009; 80:327-336.

6. World Health Organization. Medical eligibility criteria for contraceptive use. Geneva; 2009.

7. Rodriguez MI, Kaunitz AM. An evidence-based approach to postpartum use of depot medroxyprogesterone acetate in breast-feeding women. *Contraception* 2009; 80:4-6. ■

Include lubricants in sexual health dialogue

When discussing sexual health with patients, does lubricant use come up in the conversation? Such discussion might be helpful. An Indiana University study involving 2,453 women ages 18-68 indicates that lubricant use during sexual activity alone or with a partner contributed to higher ratings of pleasurable and satisfying sex.[1] Lubricant use also reduces the likelihood of vaginal tearing, which can increase risk for HIV and other sexually transmitted diseases (STDs).

Why is it important that reproductive health clinicians discuss lubricant use?

Researchers from Indiana University's Center of Sexual Health Promotion have conducted a wide range of studies focusing on lubricant use. Researchers have found that men and women, but particularly women, are confused about lubrication, says **Michael Reece**, PhD, MPH, center director and associate professor in the Indiana University School of Health, Physical Education, & Recreation.

"Clinicians have a particularly important role to play by asking women about their lubrication, particularly when individuals complain of pain or other discomforts during or after sexual intercourse," states Reece. "By discussing with women and their male partners that perhaps an additional lubricant may be helpful will help to normalize their use."

While personal lubricants have been recommended to women to improve the comfort of sexual intercourse and to reduce the risk of vaginal tearing,

EXECUTIVE SUMMARY

Lubricant use during sexual activity alone or with a partner can contribute to higher ratings of pleasurable and satisfying sex, according to new research. Lubricant use also reduces the likelihood of vaginal tearing, which can increase risk for HIV and other sexually transmitted diseases.

- Clinicians need to counsel on use of water-based lubricants. Unlike water-based lubricants, oil-based lubricants such as petroleum jelly, baby oil, and hand lotions can reduce latex condom integrity and might facilitate condom breakage.
- Counsel patients to make sure that condoms are adequately lubricated before use and that lubrication is added periodically once sex has begun.

little data are available on women's use of lubricants or associated vaginal symptoms. In the new research, scientists looked at women who used one of six different water- or silicone-based lubricants.[1]

Data indicate that side effects were rarely associated with lubricant use. Vaginal tearing occurred during less than 1% of vaginal intercourse events, and genital pain was reported in less than 5% of intercourse acts when lubricant was used.

The take-away message for clinicians is that lubricants add to women's sexual pleasure and satisfaction, for masturbation and sexual intercourse, and are rarely associated with genital side effects, says **Debby Herbenick**, PhD, MPH, the center's associate director and lead author of the study. Center scientists plan to look at preferences for lubricants and genital symptoms in response to lubricants among women with vulvodynia and women who are prone to chronic yeast infections.

What about use of lubricants with condoms? Indiana University researchers performed a separate study involving 1,834 men to look at the use of lubricants during vaginal intercourse. The study involved 8,876 coital events, 46.8% of which involved the use of a latex condom and 24.7% of which involved the use of a lubricant.[2]

Researchers found that lubricant was added to the external tip of the condom after penile application (22.5%), directly in or around the partner's vagina (16.2%), and to both the condom and vagina (16.2%). The addition of lubricant to condoms was more likely during intercourse with a spouse than with a noncommitted partner; during intercourse events of longer duration; when a female partner applied the condom to the partner's penis; and when a female partner used a contraceptive vaginal ring, intrauterine device, or spermicidal jelly/foam as a method of contraception.[2]

What are some common myths that patients may have when it comes to lubricant use? Reece lists two:

• **Women are supposed to lubricate naturally.**

This might be the case for many women, but some women find it necessary to add additional lubrication for solo or partnered sexual behaviors, says Reece. The use of a lubricant during sexual interaction can have important outcomes in terms of supporting comfort during intercourse, helping to prevent tissue damage, and also adding to the comfort of using condoms, he observes.

• **All lubricants are the same.**

"There has been an explosion of lubricants in the retail marketplace, and it can be confusing," says Reece. "Sexually active individuals need to explore different lubricants and find the one that is most comfortable for them, and always be sure that the lubricant is compatible with condoms."

Unlike water-based lubricants such as K-Y Jelly, oil-based lubricants such as petroleum jelly, baby oil, and hand lotions can reduce latex condom integrity and might facilitate condom breakage.[3] Patients using oil-based lubricants might mistake them for water-based lubricants because they readily wash off with water. Talk about the need for water-based lubricants with latex condoms, and counsel patients to make sure that condoms are lubricated adequately before use and that lubrication is added periodically once sex has begun.[4]

References

1. Herbenick D, Hensel DJ, Jozkowski K, et al. Clinical and sexual outcomes following women's use of lubricants during sexual activity. Presented at the 137th annual meeting of the American Public Health Association. Philadelphia; November 2009.

2. Reece M, Hensel DJ, Herbenick D, et al. Adding lubricant to condoms during vaginal intercourse: An event level analysis. Presented at the 137th annual meeting of the American Public Health Association. Philadelphia; November 2009.

3. Warner L, Steiner MJ. Male condoms. In: Hatcher RA, Trussell J, Nelson AL, et al. *Contraceptive Technology*: 19th revised edition. New York City: Ardent Media; 2007.

4. Rural Center for AIDS/STD Prevention. *Condom Breakage: Possible Causes and Avoidance*. Fact sheet. Accessed at www.indiana.edu/~aids/factsheets/factsheet19v2.pdf. ■

Massachusetts holds health reform lessons

By **Adam Sonfield**
Senior Public Policy Associate
Guttmacher Institute
Washington, DC

With Congress edging closer to enacting broad health care reform legislation, questions abound about its potential impact on patients and providers.

Family planning centers can look for at least some guidance to the experience in Massachusetts, according to **Rachel Benson Gold**, Guttmacher Institute's director of policy analysis. Gold, who has looked into this matter extensively, observes that Massachusetts enacted its own reform legislation in 2006 that has served in part as a model for the federal effort.[1] As would the bills under consideration in Congress, the Massachusetts law imposed mandates on individuals and businesses, established a new marketplace for insurance, and provided subsidies for low-income residents, all in an effort to make coverage more affordable and prevalent.

By 2008, only 2.6% of Massachusetts residents were uninsured, compared with 6.4% in 2006, and more residents reported having a usual source of medical care and making use of care in the last year.[2,3] Yet, several problematic signs have emerged, including still-escalating costs; disproportionate levels of uninsurance among groups such as immigrants, young adults, and the poor; and — notably for safety-net providers — difficulties accessing care. Large numbers of low- and middle-income residents reported that they did not get care they thought they needed in 2008 and that physicians were either not accepting any new patients or not accepting patients with their type of insurance.[3]

For the most part, the federal health care reform legislation looks to community health centers (CHCs) as the solution to ensuring that millions of newly insured low-income Americans will have a place to go to make use of that insurance. Between the economic stimulus law passed early in 2009 and the health reform bills themselves, CHCs are being showered with billions of dollars in new funds each year to expand their reach and capacity.

Yet, although federal law requires CHCs to provide family planning (and nearly all report doing so), they serve relatively few family planning clients per center than do specialized family planning centers.[4] Anecdotal evidence from Massachusetts indicates that women themselves still see a need for specialized centers, with several major family planning providers reporting that they are serving large numbers of clients covered by the state's new, subsidized plans.[1] Furthermore, at least some CHCs appear reluctant to promote themselves specifically as a family planning provider, lest they taint their broad political appeal, or to invest in advanced training and expertise in reproductive health issues.

Role of the provider?

Health care reform appears likely to drive in new clients for CHCs and specialized family planning centers and should also offer centers an opportunity to formalize and be reimbursed for their role as a primary entry point to further health care, particularly for young women. Part of this role, as always, will be evaluating their clients' needs and referring them to other community providers when necessary. However, now they will refer them with more assurances that their clients will have insurance to pay for this care.

Family planning centers, moreover, might be able to help their clients enroll in an insurance plan that best fits their needs and navigate insurers' bureaucracy. Many already do so in several states that have expanded Medicaid eligibility specifically for family planning services.[5] Tapestry Health in western Massachusetts is being funded to serve that role for the state's new private insurance marketplace. Tapestry Health is helping clients with a range of key tasks such as comparing and choosing from among competing plans, completing an online application, locating in-network providers and labs, and understanding insurers' jargon.[1]

A prerequisite for family planning centers to adequately serve and be compensated as an entry point to insurance and to broader care is for them to be part of plans' provider networks. Only 28% of family planning agencies nationwide in 2003 had even a single contract with a private insurance plan.[6] To address this problem, the federal health reform proposals include provisions requiring plans in the new marketplaces to

COMING IN FUTURE MONTHS

- What's behind the increases in STDs?
- Research eyes ways to test youth for HIV
- How to stem the spread of HIV in women
- Video may aid in slowing spread of PID
- Review teen options for effective contraception

contract with "essential community providers," a group of safety-net providers that includes family planning centers.

Just as much a prerequisite is for policy-makers, insurers, and providers to address the shortcomings currently built into the private insurance system. These barriers include accessing specialists, inadequate information to enrollees on their benefits and rights, and insurance procedures that inadvertently violate a clients' confidentiality. These procedures include explanation of benefits forms routinely sent to the primary policyholder, who might not be the client herself.[7]

If all parties can find ways to adapt to a changing world, health reform can provide real opportunities for family planning centers to serve their clients better and improve their access to the full range of services they need.

References

1. Gold RB, Family planning centers meet health care reform: Lessons from Massachusetts. *Guttmacher Policy Review* 2009, 12:2-5.

2. Long SK, Phadera L. Estimates of health insurance coverage in Massachusetts from the 2009 Massachusetts Health Insurance Survey, Massachusetts Division of Health Care Finance and Policy. October 2009. Accessed at www.mass.gov/Eeohhs2/docs/dhcfp/r/pubs/09/his_policy_brief_estimates_oct-2009.pdf.

3. Long SK, Masi PB. Access and affordability: An update on health reform in Massachusetts, Fall 2008. *Health Affairs* 2009; 28:w578-w587.

4. Guttmacher Institute. *Contraceptive Needs and Services,*

(Continued on page 12)

CNE/CME Instructions

Physicians and nurses participate in this continuing nursing medical education/continuing education program by reading the articles, using the provided references for further research, and studying the questions at the end of the issue. Participants should select what they believe to be the correct answers and refer to the list of correct answers to test their knowledge. To clarify confusion surrounding any questions answered incorrectly, please consult the source material. After completing this activity with the **June** issue, you must complete the evaluation form provided and return it in the reply envelope provided in that issue to receive a certificate of completion. When your evaluation is received, a certificate will be mailed to you. ■

CNE/CME Questions

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

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

1. The U.S. Preventive Services Task Force's *Screening for Breast Cancer* (2009) recommends:

A. against routine screening mammography in women ages 40-49.
B. for routine screening mammography in women ages 40-49.
C. against routine screening mammography in women ages 50-74.
D. for every other year mammography in women ages 40-49.

2. A recent study (Sulak PJ, et al. *Obstet Gynecol* 2008) looked at extended use of the vaginal contraceptive ring. What technique was found effective to manage breakthrough bleeding in women using the method in this regimen?

A. Women were instructed to use exogenous estrogen during spotting days.
B. If breakthrough bleeding/spotting occurred for five days or more, women were instructed to remove the ring for four days, store it, and then reinsert that ring.
C. Women were instructed to call their clinicians for counseling and support.
D. If breakthrough bleeding/spotting occurred for five days or more, women were instructed to remove the ring for four days, then reinsert a new ring.

3. WHO *Medical Eligibility Criteria for Contraceptive Use* categorizes insertion of a Copper-T IUD before six weeks postpartum in breast-feeding women as:

A. 1 — No restriction for the use of the contraceptive method.
B. 2 — The advantages outweigh the theoretical or proven risks.
C. 3 — The theoretical or proven risks usually outweigh the advantages of using the method.
D. 4 — An unacceptable health risk if the contraceptive method is used.

4. Which of the following is not an oil-based lubricant?

A. Petroleum jelly
B. Baby oil
C. Hand lotion
D. K-Y Jelly

Answers: 1. A; 2. B; 3. B; 4. D.

2006. Accessed at www.guttmacher.org/pubs/win/index.html.

5. Sonfield A, Alrich C, Gold RB. *State Government Innovation in the Design and Implementation of Medicaid Family Planning Expansions.* New York City: Guttmacher Institute, 2008. Accessed at www.guttmacher.org/pubs/2008/03/28/StateMFPEpractices.pdf.

6. Lindberg LD, Frost J, Sten C, et al. The provision and funding of contraceptive services at publicly funded family planning agencies: 1995-2003. *Perspect Sex Reprod Health* 2006, 38:37-45.

7. Gold RB. Unintended consequences: How insurance processes inadvertently abrogate patient confidentiality. *Guttmacher Policy Review* 2009; 12:12-16. ■

BINDERS AVAILABLE

CONTRACEPTIVE TECHNOLOGY UPDATE has sturdy plastic binders available if you would like to store back issues of the newsletters. To request a binder, please e-mail **binders@ahcmedia.com**. Please be sure to include the name of the newsletter, the subscriber number, and your full address.

If you need copies of past issues or prefer online, searchable access to past issues, go to **www.ahcmedia.com/online.html**.

If you have questions or a problem, please call a customer service representative at **(800) 688-2421**.

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 information source for health care professionals.*

NATIONAL ASSOCIATION NPWH
National Association of Nurse Practitioners in Women's Health

Association of Reproductive Health Professionals

2009 SALARY SURVEY RESULTS

CONTRACEPTIVE TECHNOLOGY UPDATE®

A Monthly Update on Contraception and Sexually Transmitted Diseases

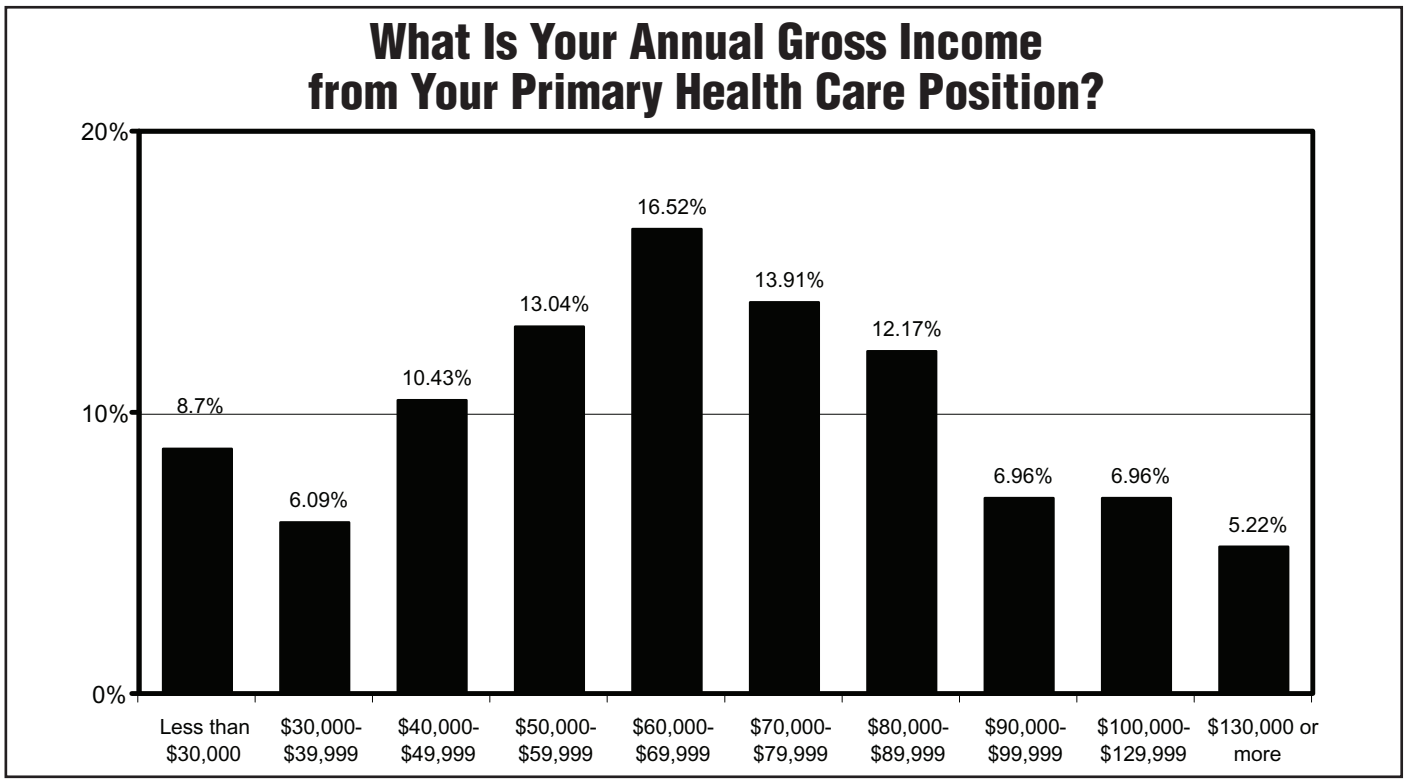
New year, but the same story: Salaries of clinicians show little pay rate increase

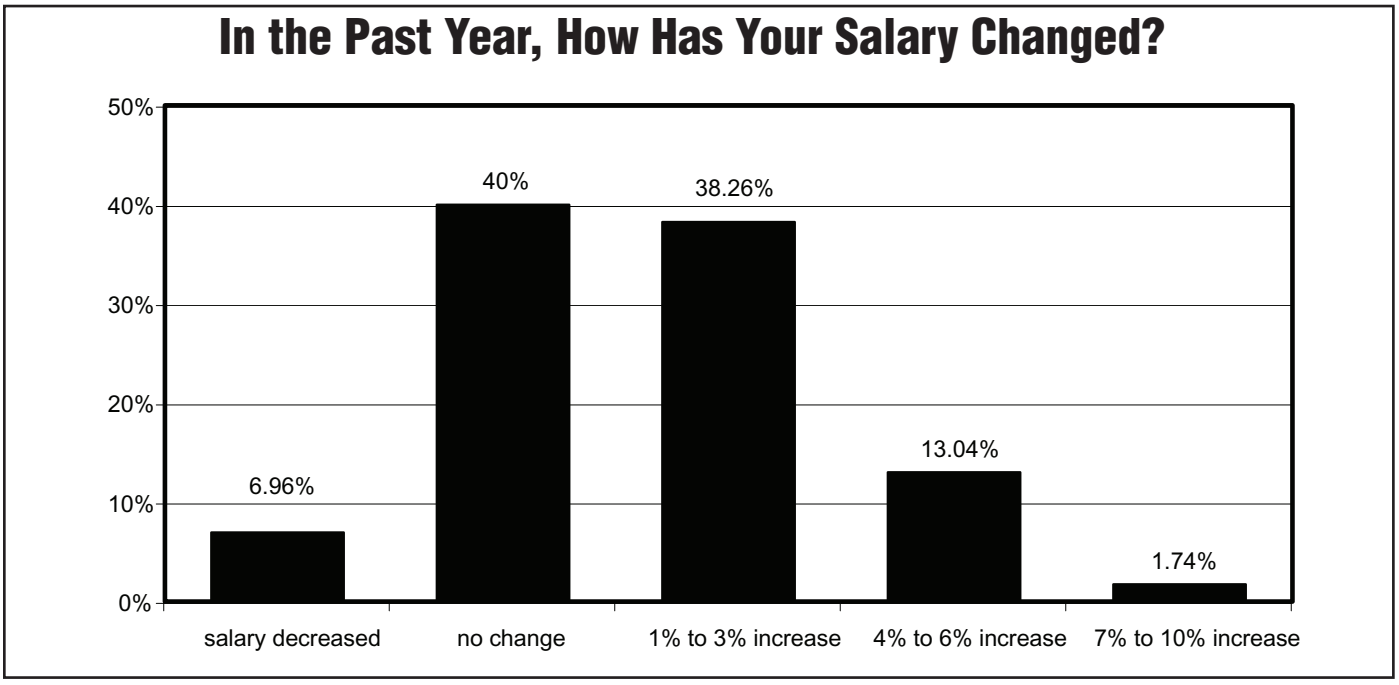
Networking on local, national level key to finding new jobs

Does your paycheck seem to go a little less far these days? No surprise. Results of the *Contraceptive Technology Update* Salary Survey indicate that 38% saw a 1%-3% increase in salary in the past year, with 40% seeing no change. **(See "In the past year, how has your salary changed?" graphic on p. 2.)**

The survey was mailed in August 2009 to 582 subscribers with 114 responses, for a response rate of 19.6%.

If you are contemplating a possible job change, perform a self-assessment of your professional status, says **Lynn Schiff**, FNP, president and CEO of Advanced Practice Solutions, Lake Elmo, MN, a recruitment agency (www.advancedpracticesolutions.com). For example, about 32% of survey





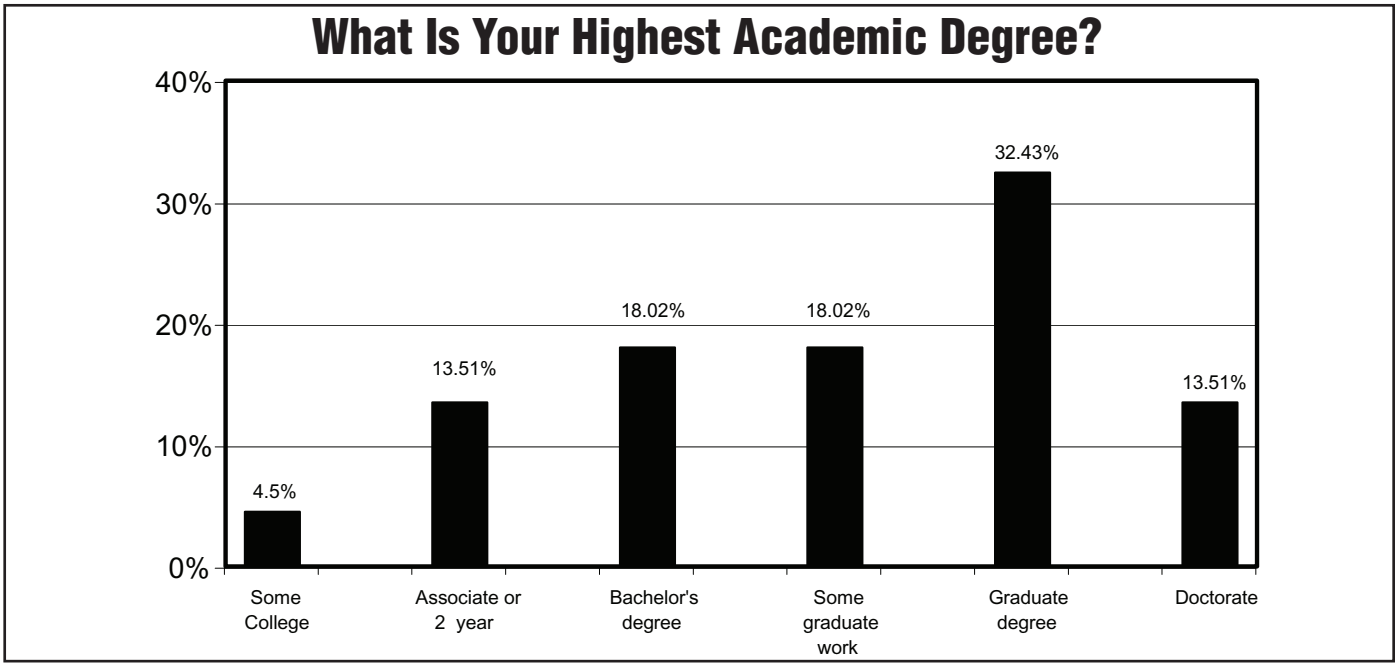
respondents hold graduate degrees, and almost 27% have worked in their present field for 25-plus years. **(See "What is your highest academic degree?" below, and "How long have you worked in your present field?" graphic on p. 3.)** About 35% say they supervise between four and 10 people. **(See "How many people do you supervise, directly or indirectly?" graphic on p. 4.)**

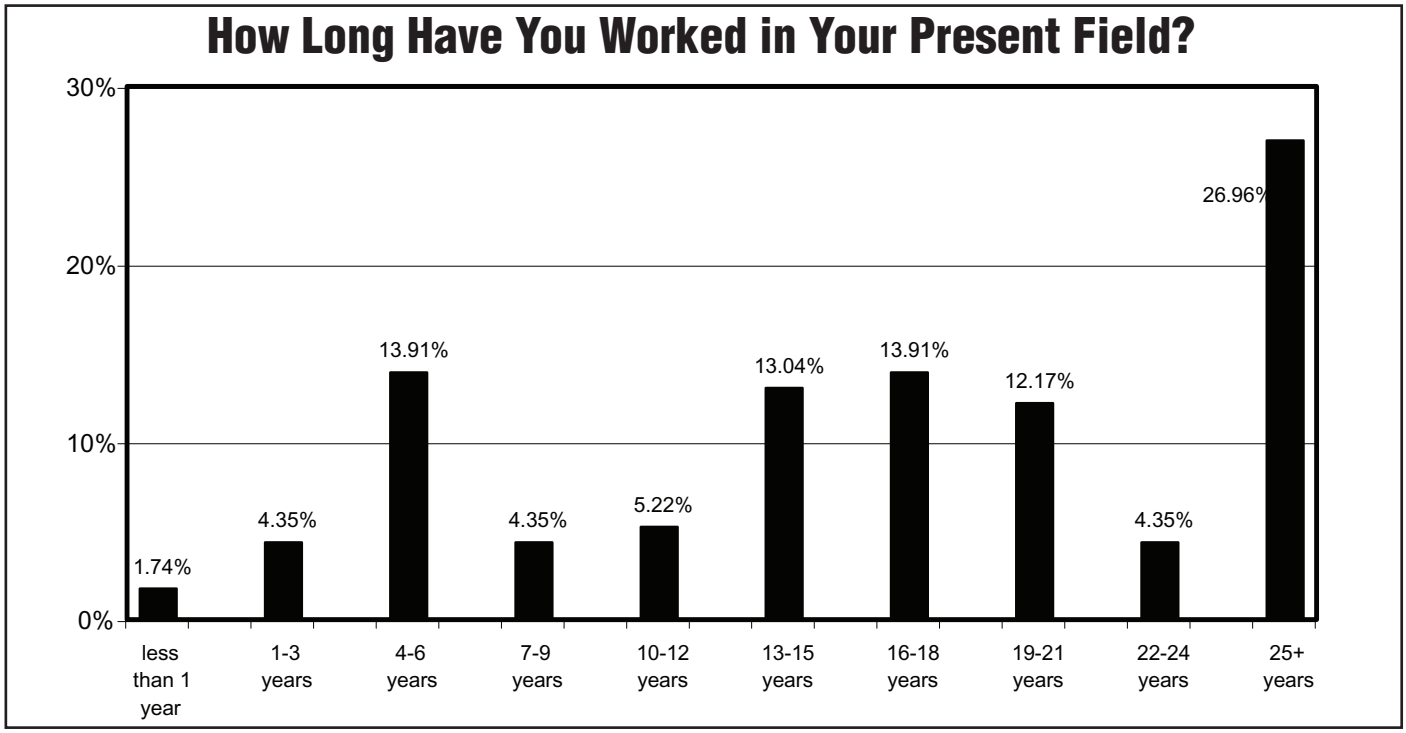
Once you have performed the assessment, determine what you are seeking in a new position. Figure out what is of most importance to you, such as flexibility, autonomy, salary, and benefits.

Next, begin to network, says Schiff. Networking is proving to be an effective tool, particularly in the current economy, she notes. Call your colleagues to let them know you are contemplating a possible relocation, she advises. Lunch provides an informal setting so job information can be shared, Schiff says.

How to promote yourself

Raise your visibility in the community, she advises. Some ambitious nurse practitioners and physician assistants have volunteered for community services to get their names circulating, Schiff observes. Such self-promotion is particularly important for new graduates who are just break-



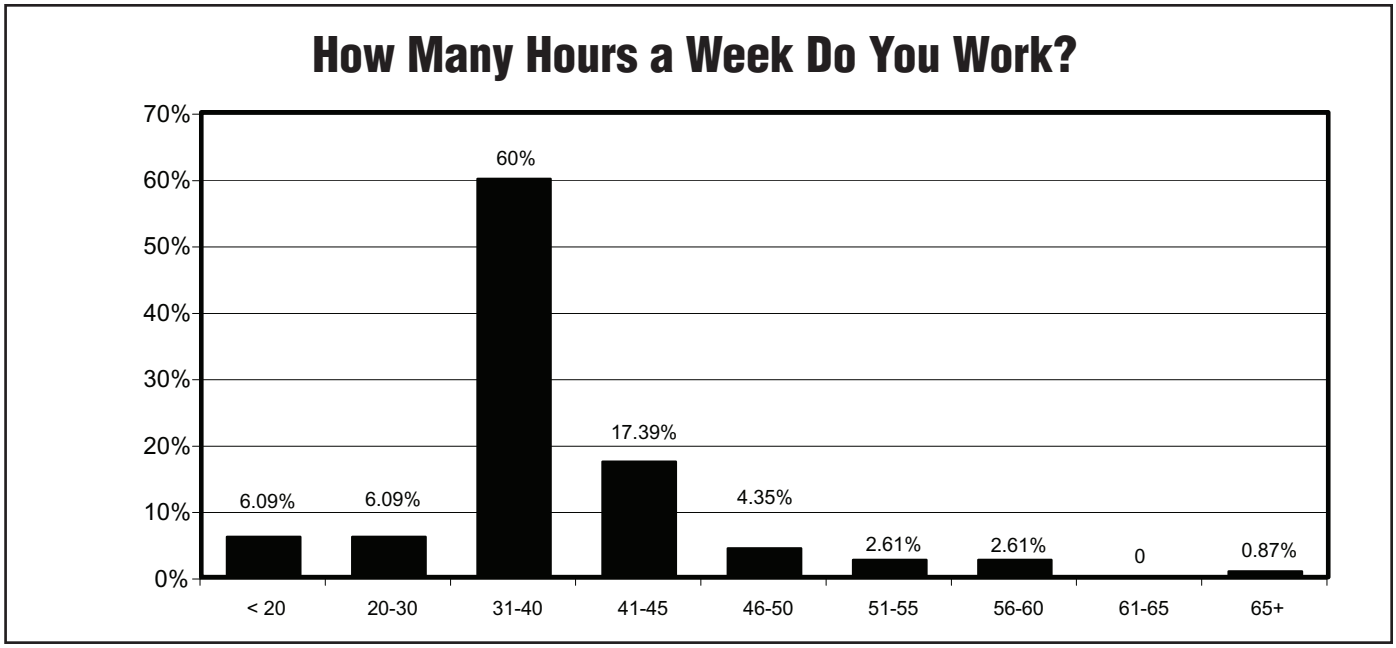


ing into the job market, she says.

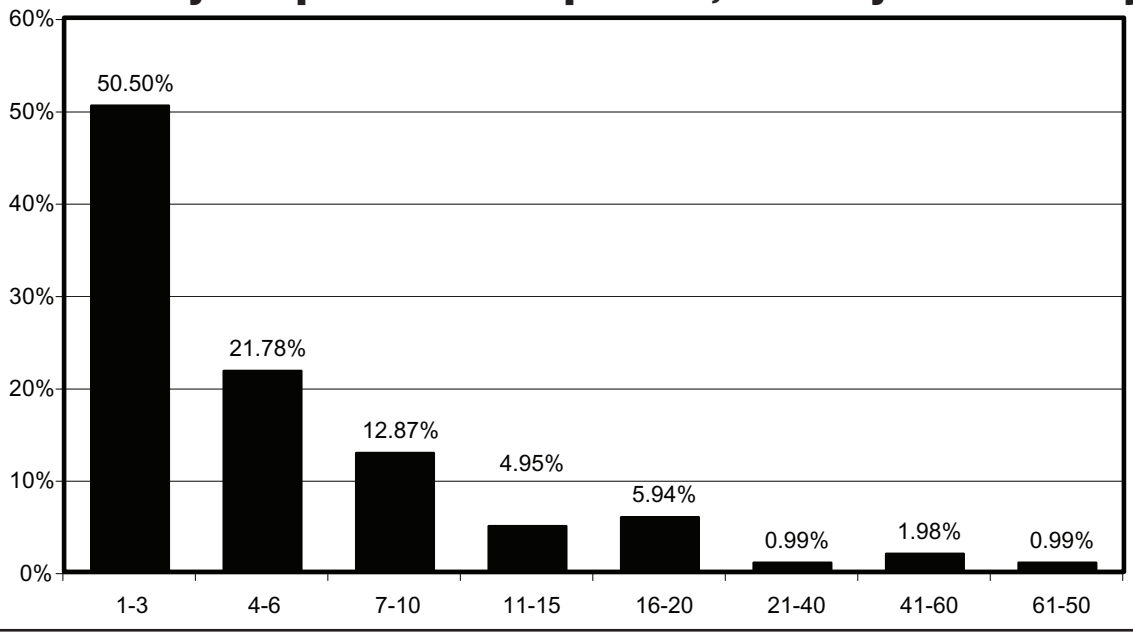
Look to national professional groups, such as the National Association of Nurse Practitioners in Women's Health (NPWH), for employment help. Such membership might not only help in securing a new job, but aid in bolstering your net worth to "recession-proof" your current position, says **Susan Wysocki**, RNC, NP, NPWH president and CEO. NPWH keeps its members current on changing rules with regard to certification, licensure issues, and federal reimbursement.

"I have received many calls from NPs who are no longer employable because they never were certified or they let their certification lapse and were unaware of the importance of national certification," says Wysocki. "Now a new employer requires national certification."

NPWH also monitors and comments on federal legislation to ensure that women's health nurse practitioners are included as primary care providers in federal legislation, says Wysocki. The organization also continues to fight for NPs to be paid the same as physicians, regardless of specialty, for the same services in Medicare reimbursement. Most important, NPWH looks to protect and promote health care to women by



How Many People Do You Supervise, Directly or Indirectly?



advocating that women receive the services they need and that those services are adequately compensated, says Wysocki.

Professional organizations such as NPWH (www.npwh.org), the American College of Nurse Midwives (www.midwife.org), and the American Academy of Physician Assistants (www.aapa.org) offer job banks for their memberships. If you are looking for a new job, professional membership might pay off by allowing you to search such databases.

Look for a recruitment firm that knows the positions well enough to determine whether you will be a good match for its employers, says Schiff. All firms are not created equal, she says. Make sure the firm you choose does not charge a candidate fee, Schiff says.

Longevity in the field is an important aspect when assessing a potential recruitment firm. Look for a firm that has been around for at least three years and one that understands the specialized skills you bring to the table.

"Nurse practitioners should look for firms that have been around for a long time and especially give that personalized attention," says Schiff. "Look for firms that will really take the time to get to know you as a candidate and know what your needs are." ■

Salary Survey at a Glance

- Half of the 2009 survey respondents identified themselves as nurse practitioners. 20% identified themselves as registered nurses, and 4% identified themselves as nurse-midwives. Administrators made up about 17% of the current year's responses. About 7% identified themselves as physicians, with about 2% identified as health educators.
- About 38% of all respondents indicated they made $59,000 or less. About half reported salaries between $59,000 and $99,999. About 12% said they earned a six-figure salary. **(See "What is your annual gross income from your primary care position?" graphic on p. 1.)**
- About half of 2009 survey respondents said no changes had been made in job staffing levels. About 36% reported a decrease in employees, with 14% seeing more employees on site.
- Working overtime is not an issue for the majority of survey respondents. About 72% report working 40 hours or less a week. **(See "How many hours a week do you work?" graphic on p. 3.)**
- 56% of survey respondents said they work in a health department setting, while 25% say they are employed by a clinic.
- 42% described their practice location as rural, with 26% in an urban location, and 20% in a medium-sized city.

Source: 2009 *Contraceptive Technology Update* Salary Survey results.

AHC Media LLC

AHC Media's Message to Subscribers about Copyright Law

Your newsletter is a copyrighted publication. It is protected under federal copyright law.

It is against the law to reproduce your newsletter in any form without the written consent of AHC Media's publisher. Prohibited under copyright law is:

- making "extra" copies of our publication for distribution in your office;
- posting newsletter articles on your facility or practice web site;
- downloading material to an electronic network;
- photocopying, e-mailing, or faxing newsletter articles.

Site licenses, which allow you to e-mail, fax, photocopy, or post electronic versions of your newsletter and allow additional users to access the newsletter online, are available for facilities or companies seeking wider distribution of your newsletter.

High-quality reprints of articles also are available at reasonable prices.

To get information about site license or multiple copy arrangements, contact Tria Kreutzer at (800) 688-2421, ext. 5482 (tria.kreutzer@ahcmedia.com); or for reprints, contact Steve Vance at (800) 688-2421, ext. 5511 (stephen.vance@ahcmedia.com).

Thank you for your cooperation,

Donald R. Johnston
Senior Vice President/Group Publisher
AHC Media LLC

N #4005

3525 Piedmont Road NE
Building Six, Suite 400
Atlanta, Georgia 30305-1515
Tel (404) 262-7436
Fax (404) 262-7837
www.ahcmedia.com