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Research examines interventions for reducing pain during IUD insertion

More studies needed to identify ideal solution for pain reduction

More women are taking a second look at the intrauterine device (IUD) for contraception. IUD insertions went up 23% between January 2008 and January 2009, according to SDI Health, a health care analytics firm in Plymouth Meeting, PA.[1] While better access to information and a decreasing stigma against the device has led more women to consider the IUD, many women might choose another method due to fear of pain during insertion.

While most women experience mild-to-moderate discomfort during IUD insertion, rarely is the pain is severe. A 2006 study identified nulliparity, age greater than 30 years, lengthier time since last pregnancy or last menses, and not currently breastfeeding as predictors of pain during IUD insertion.[2]

Researchers have looked at different ways to reduce pain during IUD insertion. These options include drugs that reduce cramping of the uterus, such as nonsteroidal anti-inflammatory drugs (NSAIDs), drugs that soften and open the cervix, and drugs that numb the cervix. A 2009 Cochrane Review examined all randomized controlled trials that looked at methods to reduce pain during IUD insertion.[3] Reviewers identified four trials from four countries, with 2,204 women studied, that met criteria for review.

Until more studies are completed on regimens for pain during IUD insertion, the ideal intervention is unknown, says the review's lead author, **Rebecca Allen**, MD, MPH, assistant professor in the

Next month: *CTU* **Salary Survey Results**

Where do you stand when it comes to your professional income? Review the results of the 2010 *Contraceptive Technology Update* annual salary, along with a comprehensive look at what is happening family planning careers, included in the upcoming January 2011 issue of the newsletter.

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Department of Obstetrics and Gynecology at the Warren Alpert Medical School of Brown University in Providence, RI.

In the Cochrane Review, results of two studies that looked at use of the NSAID ibuprofen at doses of 400 mg and 600 mg indicate the drug did not help to reduce pain during IUD insertion.[2,4]

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Whether higher doses would have been effective is unknown, the Cochrane reviewers note.

While naproxen, another NSAID, might help with pain in the first two hours after IUD insertion, the trial which examined its effectiveness used the Dalkon Shield, a larger IUD that is no longer available.[5]

Allen says it is reasonable to offer women NSAIDs prior to insertion, especially higher doses, such as 600-800 mg of ibuprofen. Although the treatment might not reduce pain during the insertion itself, it might reduce cramping pain post-insertion, she notes.

Findings from one study that did not meet inclusion criteria for the Cochrane Review suggest that lidocaine gel might offer pain relief during IUD insertion. The trial examined application of 2% lidocaine gel; application of the gel to the cervix one minute prior to insertion was more effective than no treatment in reducing pain with IUD insertion. Of 44 women in the 2% lidocaine gel arm, 29 reported moderate to severe pain, compared with 36 women of 38 in the no-treatment arm (odds ratio 0.11; 95% confidence interval 0.02 to 0.51).[6] Topical lidocaine gel merits further study with proper methods, the Cochrane Review team concludes.

Misoprostol under review

Intrauterine contraceptive use is expanding in the United States and is now routinely recommended for nulliparous women. The US Medical Eligibility Criteria for Contraceptive Use ranks use of the Copper-T IUD (ParaGard Copper T380A IUD, Teva Women's Health, Woodcliff Lake, NJ) and the levonorgestrel intrauterine system (Mirena IUS, Bayer HealthCare Pharmaceuticals, Wayne, NJ) as a "2" — a condition for which the advantages of using the method generally outweigh the theoretical or proven risks.[7]

However, the cervix of a nulliparous woman has a smaller diameter, which can lead to more difficult and uncomfortable IUD insertions. Because of misoprostol's known ability to cause cervical dilation, research is eyeing its use in IUD insertion, particularly among nulliparous women.

A 2007 Swedish study included in the Cochrane Review looked at the use of misoprostol in IUD insertions among nulliparous women.[8] The trial included 80 nulliparous women who requested an IUD; patients were allocated randomly to receive sublingually 400 mcg misopros-

tol and 100 mg diclofenac, or 100 mg diclofenac alone, one hour prior to IUD insertion. Study results indicate that misoprostol did not help to reduce pain during IUD insertion in the nulliparous women; however, the study was not focused on women's pain but rather the ease of placing the IUD from the provider's perspective.[8] At this point, the routine use of misoprostol for cervical ripening prior to IUD insertion in nulliparous women to reduce pain is not supported by the literature, says Allen.

Six study sites in the United States are now aiming to determine whether misoprostol relative to placebo prior to IUD insertion in nulliparous women eases insertion and decreases pain. The results of the trial will be contributed to a prospective meta-analysis on the subject, **David Turok**, MD, assistant clinical professor in the Department of Obstetrics and Gynecology at the University of Utah in Salt Lake City.

Turok is heading the trial site at the University of Utah. Other investigators include Alison Edelman, MD, MPH, associate professor in the Department of Obstetrics/Gynecology at Oregon Health and Science University in Portland; Eve Espey, MD, MPH, associate professor of obstetrics and gynecology at the University of New Mexico in Albuquerque; Eva Lathrop, MD, MPH, assistant professor in Emory University School of Medicine's Department of Gynecology and Obstetrics in Atlanta; Pamela Lotke, MD, MPH, assistant professor of clinical obstetrics and gynecology at the University of Arizona in Tucson, and Stephanie Teal, MD, MPH, associate professor of obstetrics and gynecology and pediatrics at the University of Colorado, Denver School of Medicine.

The study intervention is 400 mcg of misoprostol inserted vaginally or buccally, whatever method is most acceptable to the patient, says Turok. The drug is administered up to 24 hours before IUD insertion, and both types of IUDs will be included in the analysis. The study's primary outcome is the availability to insert the IUD without adjunctive measures, which includes dilation of the cervix, ultrasound guidance, or administration of additional pain medication. Four of the sites are enrolling patients, says Turok. Results of one site's study were presented at the Reproductive Health 2010 conference in September. A total of 36 women completed the study, with the misoprostol group demonstrating a trend toward a more painful insertion. Provider-reported ease of placement was no different between groups. The misoprostol group had more pre-insertion symptoms, such as nausea and cramping than the placebo group (50% versus 16%).[9]

Researchers don't yet have the definitive answer yet on use of misoprostol in IUD insertions in nulliparous women, says Turok. "We are making progress on getting the answer, though, which is good," he states.

EXECUTIVE SUMMARY

While most women experience mild-to-moderate discomfort during intrauterine device (IUD) insertion, rarely is the pain is severe. Research has looked at options for pain relief during insertion. Until more studies are completed on these regimens, however, the ideal intervention is unknown.

- Science has eyed different ways to reduce pain during IUD insertion, including drugs that reduce cramping of the uterus, such as nonsteroidal anti-inflammatory drugs (NSAIDs), drugs that soften and open the cervix, and drugs that numb the cervix.
- It is reasonable to offer women nonsteroidal anti-inflammatory drugs prior to insertion. Although the treatment might not reduce pain during the insertion itself, it might reduce cramping pain post-insertion.

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Women hit by recession — Clinics feel the blow, too

A Guttmacher Institute analysis of new U.S. Census Bureau data reveals the number of U.S. women ages 15-44 covered by private insurance dropped between 2008 and 2009, as widespread job losses resulted in many Americans losing their employer-based insurance.[1] What has been the impact on family planning clinics?

Maternal and Family Health Services in Wilkes-Barre, PA, coordinates services to more than 38,000 family planning clients annually through a network of 46 contract and direct service sites in 15 Pennsylvania counties. Patient numbers have increased in the past year, growing by 7-7.5% from 2007 to 2009. In the same time period, the agency has seen an 28% increase in its lower-end sliding fee scale categories, says **Bette Cox Saxton**, president and chief executive officer.

"We have observed in many of our sites women coming back to us because they cannot afford birth control and anecdotally talk about the need to delay pregnancy because they just cannot afford to become pregnant or have another child," Saxton states.

EXECUTIVE SUMMARY

The number of U.S. women ages 15-44 covered by private insurance dropped between 2008 and 2009, as widespread job losses resulted in many Americans losing their employer-based insurance, according to a new analysis by the Guttmacher Institute.

- The number of women who were uninsured grew by more than 1.3 million, and the number of women on Medicaid increased by more than one million from 2008 to 2009.
- According to the analysis, 22.3% of all women of reproductive age in 2009 were uninsured and 14.8% were on Medicaid, compared with 20.1% and 13.2% in 2008.

The Indiana Family Health Council in Indianapolis is a private, non-profit corporation that administers federal Title X funds through contracts with non-profit and public agencies to provide family planning services for low-income working poor and teens. The number of those under 100% of poverty has risen in the past three years. It climbed from 71% in 2007 to 76.1% in 2010, states **Gayla Winston**, president & chief executive officer.

Family planning clinics across the country reported service delivery challenges in a 2009 Guttmacher Institute report. Almost half (48%) said they had to freeze or cut staffing levels, reduce the number of contraceptive options made available to patients (32%), or lengthen wait time for patients (25%).[2]

Maternal and Family Health Services has had one or more service delivery challenges that are focused more on staffing shortages and operations, rather than funding reductions, says Saxton. "Our challenges are not unique and only underscores how vital publicly funded family planning centers are as safety-net providers," she states.

Take a look at numbers

According to the Guttmacher Institute analysis, the decrease in the number of women of reproductive age who had private insurance was paired with significant increases in the number of women who were uninsured or on Medicaid. The Census Bureau also reported an upsurge in the overall number of Americans living in poverty.

The new calculations indicate the number of women ages 15-44 covered by private insurance fell by 2.3 million, from about 39 million in 2008 to 36.7 million in 2009. This shift resulted in a decrease (from 63.3% to 59.5%) in the share of women who had private insurance coverage.

Consequently, the number of women who were uninsured grew by more than 1.3 million, and the number of women on Medicaid increased by more than one million. According to the analysis, 22.3% of all women of reproductive age in 2009 were uninsured and 14.8% were on Medicaid, compared with 20.1% and 13.2% in 2008. This gain in the number of reproductive age women who are uninsured was at a higher and faster rate than for the U.S. population overall, the analysis shows.[1]

Options narrow for women

A 2009 Guttmacher Institute national survey of some 1,000 low- and middle-class sexually active women shows that nearly half of all women sur-

veyed, and more than half of those with an annual family income below $25,000, said that due to the economy, they wanted to get pregnant later, wanted fewer children, or now did not want any more children. *(To read more about the survey results, see the* Contraceptive Technology Update *article "Recession impacts women's choices — How is your facility responding?" December 2009, p. 133.)*

With less income, women opt for risky contraceptive strategies, survey results show. For those women using oral contraceptives, 18% reported inconsistent use as a means of saving money. Pill users said they skipped pills (4%), delayed getting a prescription filled (12%), went off the Pill for at least a month (11%), and obtained fewer pill packs at one time (8%). Again, women in less fortunate straits were more apt to have inconsistent use (25% versus 6%).[3]

Start polling your patients on what they pay at local pharmacies for their contraceptive prescriptions, advises **Robert Hatcher**, MD, MPH, professor of gynecology and obstetrics at Emory University School of Medicine in Atlanta. Look at affordable options for them; many "big box" retailers such as Wal-Mart, Target, and Kroger sell Sprintec, a 0.035 mg ethinyl estradiol/0.250 mg norgestimate pill from Teva Pharmaceuticals USA, North Wales, PA, for $9 a cycle, he notes.

If you prescribe a pill that is too expensive for a patient to fill, then don't be surprised to see that patient without contraceptive coverage when she returns for the next visit, says Hatcher. Results of a 2010 study show that one-quarter of all prescriptions go unfilled.[4]

One issue in unfilled prescriptions is cost, says Hatcher. Help women review options that they can use, and afford, for successful pregnancy prevention, he notes.

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To get flu shots: Pregnant and postpartum women

Get ready to recommend flu vaccine to your pregnant and postpartum patients. According to the Centers for Disease Control and Prevention (CDC), less than one-fourth of pregnant women in the United States were vaccinated against seasonal influenza during the 2007-08 flu season.[1]

The Advisory Committee on Immunization Practices (ACIP) is recommending that pregnant and postpartum women receive the seasonal influenza vaccine this year, even if they received 2009 H1N1 or seasonal influenza vaccine last year. Manufacturers have informed the CDC that they expect to produce approximately 160 million doses of vaccine this year, so there should be a substantial supply to cover those who wish to receive it, including pregnant women, says **Tom Skinner,** a CDC spokesperson.

What flu viruses are included in the seasonal vaccine for the years 2010 and 2011? The World Health Organization (WHO) in Geneva, Switzerland, has recommended that the Northern Hemisphere's 2010 and 2011 seasonal influenza vaccine contain the following three vaccine viruses: an A/California/7/2009 (H1N1)–like virus, an A/Perth/16/2009 (H3N2)–like virus, and a B/Brisbane/60/2008–like virus. The Food and Drug Administration, which determines which viruses will be used in U.S.-manufactured vaccines, has selected the same vaccine viruses. The H1N1 virus that is recommended for inclusion in the current seasonal influenza vaccine is a pandemic 2009 H1N1 virus; it is the same vaccine virus as was used in the 2009 H1N1 monovalent vaccine.

EXECUTIVE SUMMARY

The Advisory Committee on Immunization Practices is recommending that pregnant and postpartum women receive the seasonal influenza vaccine this year, even if they received 2009 H1N1 or seasonal influenza vaccine last year.

- The 2010-2011 seasonal influenza vaccine contains three vaccine viruses. The H1N1 virus that is recommended for inclusion in the current vaccine is a pandemic 2009 H1N1 virus. It is the same vaccine virus as was used in the 2009 H1N1 monovalent vaccine.
- Counsel on the safety and efficacy of the flu vaccine for mother and baby. Clinicians should receive vaccination to serve as role models for patients.

Several medical groups, including the American College of Obstetricians and Gynecologists; the Association of Women's Health, Obstetric and Neonatal Nurses; and the American College of Nurse-Midwives have joined the CDC and the March of Dimes in emphasizing the need for immunization for pregnant and postpartum women.

Why should pregnant and postpartum women receive the seasonal influenza vaccine? Consider the following four reasons:

- Influenza is more likely to cause severe illness in pregnant women than in women who are not pregnant. Changes in the immune system, heart, and lungs during pregnancy make pregnant women more prone to severe illness from the flu.
- Risk of premature labor and delivery is heightened in pregnant women with influenza.
- Vaccination during pregnancy has been shown to protect the mother and baby (up to six months old) from lab-confirmed influenza. Influenza hospitalization rates in infants less than six months of age are more than 10 times that of older children.
- Pregnant women accounted for 5% of 2009 U.S. H1N1 influenza deaths, while only about 1% of the population was pregnant. Severe illness in postpartum women also was documented.[2]

Vaccine is safe

Educate pregnant and postpartum women about the importance of getting the seasonal flu shot, as well as the safety of the vaccine. Results of a cross-sectional study of 813 postpartum women during the 2009-10 flu season at the Aurora, CO-based University of Colorado Hospital indicate that many women might not be getting the message. Women in the study who chose not to receive the seasonal or H1N1 vaccine cited the following reasons: not knowledgeable about the importance of vaccination (25%), concern for effects on fetal health (18%), concern for effects on maternal health (9%), and not knowing where to obtain vaccination (9%).[3]

How can clinicians get the message across to patients? Number one: Be sure to get immunized, so you can serve as a good role for patients, says **Barbra Fisher**, MD, PhD, a maternal fetal medicine fellow/instructor at the University of Colorado, Denver, and lead author of the study. Educate patients about the safety of the vaccination for mother and baby, she advocates.

Emphasize the following points about safety:

- Influenza vaccines have been given to millions of pregnant women over the last decade and have not been shown to cause harm to women or their infants.
- The flu shot can be administered to pregnant women in any trimester.
- Pregnant women should receive inactivated vaccine, which is used in the flu shot, but should not receive the live attenuated vaccine, which is used in the nasal spray.
- Postpartum women, even if breastfeeding, can receive either type of vaccine.

Also, talk about potential complications for pregnant women who contract influenza, says Fisher. Explain that the best way to avoid those complications is become vaccinated, she states.

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How to integrate male services

Where do male services fit in the picture when it comes to your facility? While most family planning centers report a percentage of male patients who receive sexually transmitted infection care (74%) and contraceptive care (68%), males make up only 5% nationally of their overall caseload.[1]

Take a tip on how to increase male services in your facility from presenters at the 2010 National Male Family Planning and Reproductive Health

Services Conference in Philadelphia. The conference was sponsored by the Male Training Center for Family Planning and Reproductive Health (MTC), a program of the Family Planning Council in Philadelphia in collaboration with the Center for Sexually Transmitted Disease and Reproductive Health Research, Prevention, and Training; School of Medicine; Johns Hopkins Medical Institutions in Baltimore. The conference was designed to increase the capacity of family planning agencies and other providers to address service needs of males in family planning and reproductive health care settings, with presentations aimed at strategies for building and maintaining an effective family planning program for males, including successful approaches to staff training, policy development and implementation, environmental assessment, and program evaluation. *(To obtain an overview of the conference, visit the MTC web site at www.fpcmtc.org. Select "Conference Materials.")*

Get the word out

The Family Planning Association of Northeast Ohio (FPANEO), based in Painesville, has been providing clinical services to males since 2001, says its executive director, **Mary Wynne-Peaspanen**, MEd, CHES. The target population for its male program are reproductive age men in Lake, Ashtabula, and Geauga counties in northeast Ohio.

How has the facility spread the word about the availability of such services? When it first started offering services, FPANEO got out the word in several ways: through its female clients, through an outreach worker, and through referral partners in the community, says Wynne-Peaspanen. Other than normal outreach and educational activities, the agency doesn't typically do any special outreach to males, except in cases of special grant funding that may enable it to engage in specific outreach targeted to males, she notes.

"In surveys, most men tell us they heard about us from a friend, family member, partner, or other client," notes Wynne-Peaspanen. "The age-old word of mouth system still seems to be the most effective."

Male services have been received very well, and the number and percentage of males served annually have increased steadily, reports Wynne-Peaspanen. About 8% of FPANEO's nearly 6,000 clients are male, she states.

Staff, being mostly female, were uncomfortable at first; not because they didn't want to provide services to men, but because they weren't sure they knew enough to do it well, says Wynne-Peaspanen. The agency originally hired a male nurse practitioner who did interviews and exams, while female staff checked clients in and out at the front desk, she notes. The male clinic began as a designated service; however, as the clinic got busier, female staff joined in to do interviews and exit interviews. When funding was lost for the male clinician and the dedicated clinic for males, men were integrated into the general clinics. Female clinicians now are trained to do male exams, she states.

Results of a 2010 male patient exit survey show men are accepting of care through general clinics. Just 14% of men said they would prefer a clinic time dedicated to males only; 76% said it did not matter.

EXECUTIVE SUMMARY

While most family planning centers report a percentage of male patients who receive sexually transmitted infection care (74%) and contraceptive care (68%), males make up a small proportion (5% nationally) of their overall caseload.

- About 8% of patients at the Family Planning Association of Northeast Ohio are male. Female clinicians have received education to perform male exams.
- Nine of the University Health System, San Antonio clinics, which are spread out throughout San Antonio and Bexar County, offer Health for Men services, making staying healthy easier for male patients.

Men want services

Understand that men might need affordable services through your clinic. In Bexar County, TX, 23% of its residents are uninsured, says William Sandburg, Family Planning Program male health educator at University Health System, San Antonio, TX. Some 174,000 men in the county do not have access to healthcare; the county's population in 2006 was estimated at 1.6 million, with 57% of its residents listed as Hispanic, 33% non-Hispanic Caucasian, 7% African-American, and 3% other.

The University Health System had been providing limited male services through its Title X Family Planning grant for several years, but upon being awarded a Department of Health and Human Services cooperative research grant in September 2008, the Male Family Planning and Reproductive Health Project was born, Sandburg explains. The first year of the project was programmed to initi-

ate a comprehensive service model that focuses on three areas: restructuring the clinic environment; training of staff; and targeting out/in reach promoting clinical services.

Although the Health for Men Program began taking shape in September 2008, the University Health System developed historical expertise in this area by participating with Texas Department of State Health Services (TDSHS) in a Title X Male Involvement grant and the TDSHS Title X Family Planning grant.

How has the program gotten the word out about the availability of such services? University Health System has been very active in promoting the Health for Men program, says Sandburg. The program uses several collateral pieces to give patients an idea of what services they can receive at its ambulatory clinics, including bilingual service cards, bilingual brochures, bilingual posters, retractable banners, and other incentive items.

The Health for Men program also is represented at various health fairs and other community outreach programs throughout the city on an annual basis. Nine of the agency's clinics, conveniently spread out throughout San Antonio and Bexar County, offer Health for Men services, which makes staying healthy easier for men. The Health for Men Program has established numerous collaborations with community based organizations throughout the San Antonio community provide additional avenues to get the message out about its services, says Sandburg.

How has the addition of male services been received by patients, as well as staff? Since the preventive health clinics had traditionally provided well child and women's health services, there was some initial resistance, Sandburg notes. As part of the comprehensive service model, several staff trainings were conducted on the male exam, communication, and sexual health. As a result, the staff was able to demonstrate more comfort and sensitivity to providing services to men.

And as for patients? As Sandburg observes, the most common response from patients on the addition of male services can be summarized in the statement "It's about time!"

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Sexual health: Time for a national strategy?

As a reproductive health clinician, you might be looking to upcoming health care reform to make a difference in improving the status of sexual health care in the United States. Don't be so sure, though. No mention is made once regarding "sexual health" in the more than 1,000 pages of the new health care reform legislation, say co-authors of a current commentary in the *Journal of the American Medical Association*.[1]

The time is now to raise the issue among policyholders for a national strategy to promote sexual health, say **Jonathan Zenilman**, MD, professor of medicine at Johns Hopkins University School of Medicine and chief of the Infectious Diseases Division at Johns Hopkins Bayview Medical, both in Baltimore, and **Andrea Swartzendruber**, MPH, a PhD student in the Johns Hopkins Bloomberg School of Public Health in Baltimore. Such a strategy can serve as a unifying goal and provide a framework for building on proven evidence, they state.

One problem in developing a national sexual health initiative lies in the way current health care is delivered, says Zenilman. As in all facets of healthcare, the health system does not get paid if people are healthy, he notes; it gets paid if people are sick. Given the intensive nature of care needed in educating and counseling people about sexual health, many providers might not provide such care because they cannot get reimbursed for it, says Zenilman.

EXECUTIVE SUMMARY

The time is now to raise the issue among policyholders for a national strategy to promote sexual health, say co-authors of a current commentary in the Journal of the American Medical Association.

- Prevention reduces incidence of sexually transmitted diseases (STDs), and interventions have been highly cost-effective. However, when inflation is factored in, federal STD prevention investment per capita has decreased more than 25% since 1973.
- Reproductive and sexual health are key primary health issues for adolescents and young adults; however, up until 2010, federal dollars were aimed at abstinence-only sex education. Comprehensive sex education is needed to protect adolescent health, say the co-authors.

Prevention reduces STD incidence, and STD interventions have been shown to be highly cost-effective, state Zenilman and Swartzendruber. However, the 30-year experience correlating prevention funding with subsequent STD rates has been ignored, they state; when inflation is factored in, federal STD prevention investment per capita has decreased more than 25% since 1973, they state.[2]

Many providers are not properly educated to address sexual health issues, says Zenilman. A 2008 report issued by the National Campaign to Prevent Teen and Unplanned Pregnancy and the Association of Reproductive Health Professionals looked at providers' perspectives of unintended pregnancy and barriers to more effective contraceptive use. The report notes there is no clear picture of the amount of didactic and hands-on experience health care providers receive in contraception and family planning during their training.[3]

The consequence? Lack of training is the primary reason cited by health care providers for not taking a sexual health history from patients on a routine basis, followed by provider embarrassment and a belief that sexual health is not relevant to the patient's visit.[4]

Boost care, information

Reproductive and sexual health are key primary health issues for adolescents and young adults; however, up until 2010, federal dollars were aimed at abstinence-only sex education. A body of evidence now indicates that such education is ineffective; findings from a 2007 analysis of four abstinence-only education programs indicate that abstinence-until-marriage programs do not keep teens from having sex.[5] *(To review the analysis of the four programs, see the* Contraceptive Technology Update *article "New data casts doubts on abstinence-only programs," July 2007, p. 75.)* In that same year, the National Campaign to Prevent Teen and Unplanned Pregnancy released a comprehensive review of sex education evaluation research that concluded that "there does not exist any strong evidence that any abstinence program delays the initiation of sex, hastens the return to abstinence, or reduces the number of sexual partners."[6] Two reviews by the Government Accountability Office (GAO) found that many of the curricula used by grant recipients for abstinence-only programs included false claims about condoms, other contraceptive methods, abortion, and sexually transmitted infections.[7,8]

"Abstinence-only sex education is not effective," state Zenilman and Swartzendruber in their commentary. "No one advocates lifelong abstinence; providing accurate and comprehensive information to protect adolescents' health and prepare them for responsible decision making are public health, family, and community responsibilities."

Funding must be included for ensuring sexually active adolescents have access to contraception and other sexual health services, say the two authors. Teens should have easy access to contraceptives and condoms at low or no cost via schools, health plans, Title X, Medicaid, and other federally funded programs. Health plans and federally funded services should cover the cost of contraceptives for all women without restriction, they advocate.

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TEEN TOPIC

Consider IUC method for teen contraception

By **Anita Brakman**, MS, Assistant Director of Education & Research
Physicians for Reproductive Choice and Health
New York City
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Clinical Professor of Pediatrics
University of Pittsburgh School of Medicine
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While increased use of contraception has contributed to declines in teen pregnancy over the past two decades,[1] the methods most teens choose — oral contraceptive pills or condoms — require ongoing maintenance and carry a high possibility of user errors. Fifty-four percent of females ages 15-19 who use contraception rely on oral contraceptive pills. Twenty-three percent rely on condoms.[2]

There are two forms of intrauterine contraception (IUC) approved by the Food and Drug Administration (FDA) that can provide teens with effective, long-term protection from pregnancy with few challenges in adherence. They are the Copper T380A (ParaGard CuT380A IUD, Teva Women's Health, Woodcliff Lake, NJ) and the levonorgestrel intrauterine system (Mirena IUS, Bayer HealthCare Pharmaceuticals, Wayne, NJ). Intrauterine contraception is easily kept private, does not require periodic visits to a health care provider for refills, and has perfect and typical use failure rates lower than 1%.[3] Still, less than 6% of American women, and less than 4% of women ages 15-19, choose to use IUC.[2] Lack of knowledge about IUC among adolescents creates one barrier to greater utilization. In one recent study, only 20% of participants under age 18 had ever heard of IUC methods.[4]

Concerns about pelvic inflammatory disease (PID), infertility, expulsion, and pain during insertion prevent many clinicians from providing IUC to adolescents. However, these concerns are mostly unfounded. Use of IUC does not increase the risk of PID, and some evidence suggests the LNG-IUS is protective against pelvic infection.[5-7] There also is strong evidence against linking IUC use with future infertility.[8] Available evidence suggests expulsion rates, estimated at 2-10%, are comparable between nulliparous and parous women using the LNG-IUS but might be slightly increased for users of the CuT380A.[9]

Young women might experience higher levels of anxiety and perceived pain during IUC insertion compared to older women. Pre-insertion treatment with misoprostol for cervical softening, analgesics, anti-inflammatory medications, or paracervical blocks have the potential to decrease pain, but evidence to date has not uniformly supported their use for this purpose.[10,11]

The American Congress of Obstetricians and Gynecologists (ACOG) and World Health Organization (WHO) support IUC use in female adolescents. In 2007, ACOG recommended IUC as a first-line choice for contraception in nulliparous and parous female adolescents.[12] The WHO classifies IUC as Category 2 for this age group, meaning the method generally can be used.[13] The CuT380A is FDA approved for use in women as young as age 16 and for nulliparous women.

Young women need specific counseling to choose a contraceptive method that meets their needs. Irregular bleeding, a common side effect of the LNG-IUS, might be poorly tolerated by female adolescents if they have not been carefully counseled. It is critical to counsel that irregular bleeding generally decreases with duration of use.[14] Likewise, counsel CuT380A users that they may experience heavier menses and cramping, but dysmenorrhea can be lessened with non-steroidal anti-inflammatory medications.

Considering the prevalence of sexually transmitted infections (STIs) in this population, adolescents should be screened routinely for chlamydia and gonorrhea prior to IUC insertion. When an STI is diagnosed, IUC insertion should be delayed until one week after the completion of antibiotic treat-

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ment. If an IUC is already in place when the infection is detected, antibiotic treatment should commence without removal. Condom use should be encouraged, as IUC use does not protect against STIs.[12]

More research is needed to understand which form of IUC is most appropriate for adolescents. However, female adolescents who have dysmenorrhea, menorrhagia, or anemia are better candidates for LNG-IUS compared to the CuT380A.[15]

By educating teens about IUC use and offering the method as an option, clinicians aid women in preventing pregnancy during critical years when they might finish school and begin careers.

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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 December issue, you must complete the evaluation form provided and return it in the reply envelope provided in that issue to receive a letter of credit. When your evaluation is received, a letter will be mailed to you. ■

CNE 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.

21. Which approach has **NOT** been studied to reduce pain during intrauterine device insertion?
A. Drugs to block progesterone receptors
B. Drugs to reduce cramping of the uterus
C. Drugs that soften and open the cervix
D. Drugs that numb the cervix

22. Which counseling message about the seasonal flu vaccine is ***incorrect***?
A. Influenza vaccines have been given to millions of pregnant women over the last decade and have not been shown to cause harm to women or their infants.
B. The flu shot can be administered to pregnant women in only the first two trimesters.
C. Pregnant women should receive inactivated vaccine, which is used in the flu shot, but should not receive the live attenuated vaccine, which is used in the nasal spray.
D. Postpartum women, even if breastfeeding, can receive either type of vaccine.

23. According to the CDC study [*MMWR* 2010;59:1201-1207], what percentage of gay and bisexual men in 21 U.S. cities were found to be infected with HIV?
A. 5%
B. 10%
C. 19%
D. 25%

24. Research indicates that herpes simplex virus-2 infection increases the risk for HIV infection by:
A. 5%.
B. 10%.
C. 25%.
D. 50%.

Answers: 21. A; 22. B; 23. C; 24. D

years' comparative experience of levonorgestrel- and copper-releasing intrauterine devices. *Obstet Gynecol* 1991;77:261-264.
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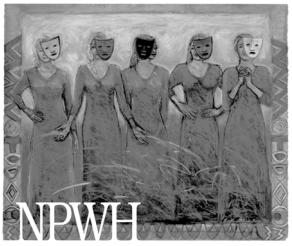
Contraceptive Technology Update is endorsed by the National Association of Nurse Practitioners in Women's Health and the Association of Reproductive Health Professionals as a vital information source for health care professionals.



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Study highlights HIV impact in U.S.: It's time to step up prevention efforts

1 in 5 men who have sex with men in 21 cities has HIV — 44% unaware

If you think your facility's efforts to stem the spread of HIV is working, you might need to redouble your efforts. Results of a new analysis of 21 major U.S. cities from the Centers for Disease Control and Prevention (CDC) indicate approximately one in five (19%) men who have sex with men (MSM) in a study is infected with HIV, and nearly half (44%) of those men are unaware of their infection.[1]

This research serves as a reminder that HIV remains a serious health threat among gay and bisexual men in America's major cities, says **Amanda Smith**, MPH, an epidemiologist in the CDC's Division of HIV/AIDS Prevention and lead author of the paper. The analysis, a review of data from the 2008 National HIV Behavioral Surveillance System, found a high prevalence of HIV among MSM of all races. However, black men who have sex with men were the most affected; 28% of black MSM were infected, versus 18% of Latinos and 16% of whites, Smith states.

A troubling fact: the CDC research also suggests that a high proportion of MSM who were infected were unaware of their illness. In fact, nearly half (44%) of MSM who were infected in the study were unaware of their infections, says Smith.

HIV exacts a devastating toll on men who have sex with men in America's major cities, and yet far too many of those who are infected don't know it, said **Kevin Fenton**, MD, director of CDC's National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention, in a statement accompanying the new research. "We need to increase access to HIV testing so that more MSM know their status, and we all must bring new energy, new approaches, and new champions to the fight against HIV among men who have sex with men," Fenton said.

The new statistics underscore two important points for clinicians who work with MSM, says **Robert Hatcher**, MD, MPH, professor of gynecology and obstetrics at Emory University in Atlanta. They are: Talk with patients about the importance of learning their HIV status, and counsel on the need

EXECUTIVE SUMMARY

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- The analysis found a high prevalence of HIV among MSM of all races. However, black men who have sex with men were the most affected; 28% of black MSM were infected, versus 18% of Latinos and 16% of whites.
- While those gay and bisexual men under age 30 had lower HIV prevalence than older men, they were far more likely to be unaware of their HIV infection.

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Consulting Editor **Robert A. Hatcher,** MD, MPH, Author **Rebecca Bowers**, Executive Editor **Coles McKagen**, and Senior Managing Editor **Joy Dickinson** 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.

for consistent condom use for disease protection.

The study provides additional insight into the populations of MSM most in need of HIV testing and prevention, says Smith. Among racial/ethnic groups, black MSM with HIV were least likely to be aware of their infection (59% unaware, compared to 46% for Hispanic MSM and 26% for white MSM).[1]

While those gay and bisexual men under age 30 had lower HIV prevalence than older men, they were far more likely to be unaware of their HIV infection, states Smith. Among MSM ages 18-29 who had HIV, nearly two-thirds (63%) were unaware of their status, versus 37% for men age 30 and older. *(See graphic below.)* Among young gay and bisexual men, young MSM of color were less likely than whites to know they were HIV-infected. Among HIV-infected black MSM under age 30, 71% were unaware of their infection; among HIV-infected Hispanic MSM under age 30, 63% were unaware. This compares to 40% of HIV-infected white gay and bisexual in the same age group, says Smith.

The study's finding of low awareness of HIV status among young MSM is not surprising. CDC officials note several factors might lead to low awareness among young men, who might:

- have been infected more recently;
- underestimate their personal risk;
- have had fewer opportunities to get tested; or
- believe that advances in HIV treatment minimize the threat of HIV.

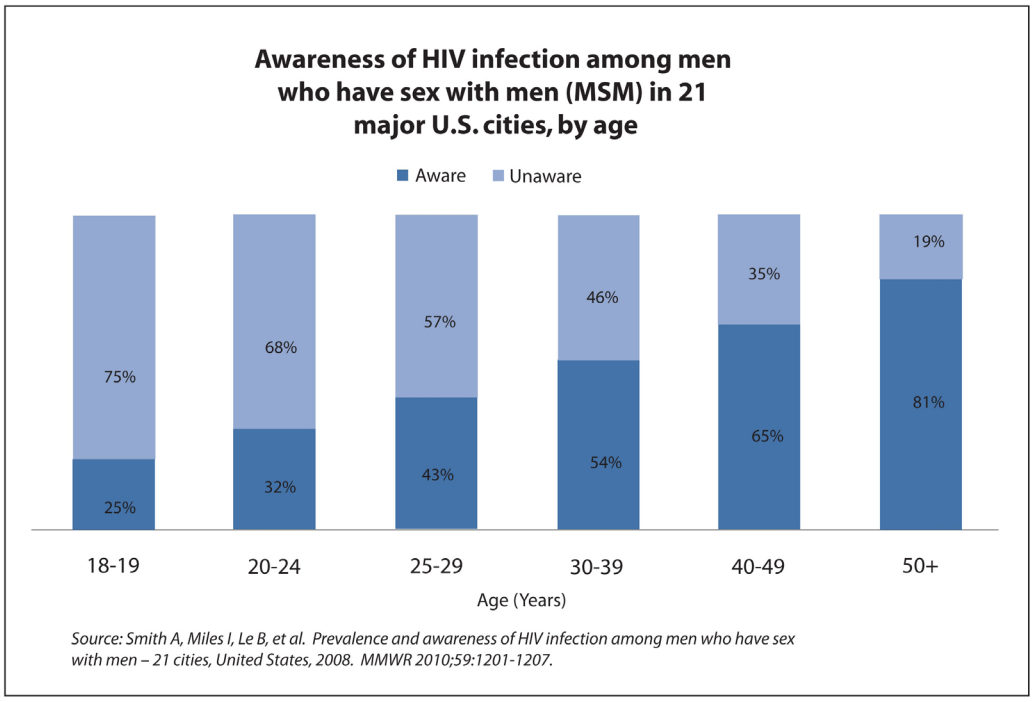
For young gay and bisexual men of color, discrimination and socioeconomic factors such as poverty, homophobia, stigma, and limited health-care access might present obstacles to testing and care, CDC officials say. **Jonathan Mermin**, MD, director of CDC's Division of HIV/AIDS Prevention, in a statement accompanying the new research, said, "For young men who have sex with men — including young men of color who are least likely to know they may be infected — the future is truly on the line. It is critical that we reach these young men early in their lives with HIV prevention and testing services and continue to make these vital services available as they become older."

Testing is the key

The CDC estimates that the majority of new sexually transmitted infections are transmitted by individuals who are unaware of their infection, and studies show that once people learn they are HIV-infected, most take steps to protect their partners. Because undiagnosed infection likely plays a major role in HIV transmission, reaching younger MSM with regular HIV testing is critical, CDC officials state.

The CDC recommends that gay and bisexual men of all ages get tested for HIV at least annually, or more often (every three to six months) if they are at increased risk, such as those with multiple or anonymous sex partners, or who use drugs during sex.[2] Such stepped-up testing is imperative. In the current CDC study, 45% of HIV-infected MSM who were unaware of their infection had been tested in the past year, says Smith.

In April 2010, the agency announced a new three-year, $31.5 million expansion of its testing initiative. Funding for the new phase of the initiative is expected



Source: Smith A, Miles I, Le B, et al. Prevalence and awareness of HIV infection among men who have sex with men – 21 cities, United States, 2008. MMWR 2010;59:1201-1207.

to total approximately $142.5 million over the next three years and will be provided to state and local health departments across the country to increase access to testing and early diagnosis of HIV. The initiative, originally designed to increase testing and knowledge of HIV status primarily among African-American men and women, will now reach more U.S. jurisdictions and populations at risk. These include gay and bisexual men, as well as male and female Latinos and injection drug users. *(*Contraceptive Technology Update *reported on the expansion. See "Report outlines impact of syphilis, HIV in U.S. gay and bisexual men,"* STD Quarterly *supplement, July 2010, p. 1.)*

Smith says, "Here at CDC, HIV prevention for MSM of all races remains a top priority. Supporting HIV testing has long been a critical part of our testing efforts, and the recent three-year, multi-million dollar expansion of our successful HIV testing initiative will enable us to target our testing efforts to increase access to HIV testing and diagnosis of HIV to even more individuals at highest risk, including gay and bisexual men." *(Editor's note: Help get the word out about the importance of HIV testing; use the CDC patient handout, "HIV and AIDS among Gay and Bisexual Men," included with the online issue of* Contraceptive Technology Update. *For assistance, contact customer service at (800) 688-2421 or customerservice@ahcmedia.com.)*

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New research eyes herpes screening practices

Results of a recent analysis of a survey of HIV care providers shows that clinicians often don't screen for genital herpes (herpes simplex virus-2 or HSV-2) in HIV-positive patients. Fewer than half knew that most patients with HIV also are infected by herpes.[1]

Several studies have shown that HSV-2 infection increases the risk for HIV infection by at least twofold.[2] In a study designed to monitor trends in HIV seroprevalence in the United States, HIV testing was included in the National Health and Nutrition Examination Survey conducted from 1999 to 2006. Male-to-male sex and the presence of HSV-2 antibody were the strongest predictors of HIV infection.[3]

Knowledge of possible HSV-2 infection can inform HIV treatment. Studies suggest that patients with co-infection have more frequent genital lesions that might last longer and be more debilitating. Research also indicates that in some patients who have both HSV-2 and HIV infection, HSV-2 reactivation seems to increase plasma HIV ribonucleic acid levels.[4]

The Centers for Disease Control and Prevention (CDC) does not recommend HSV-2 screening for the general population; however, CDC guidance states such testing might be useful for individuals who are unsure of their status and at high risk for the disease, such as those with multiple sex partners or HIV infection, and men who have sex with men (MSM).[5]

One advantage of HSV-2 screening in these high-risk groups is there is some indirect data that suggests those diagnosed with HSV might use additional safety precautions to reduce transmission, says **Scott Bryan**, a CDC spokesperson. However, Bryan notes there are two disadvantages: The tests are costly, and there is a lack of data about whether learning one's HSV-2 infection status leads to changes in sexual behavior and reduction in HSV-2 transmission.

"Additional research is needed to determine the overall benefit, feasibility, and cost effectiveness of serologic testing to prevent HSV-2 transmission," he states.

Look at HSV-2 and HIV

The currently published analysis of HIV care providers' practice was launched in anticipation of results from a large Phase III clinical study designed to examine herpes suppression with acyclovir as a possible means of reducing the risk of HIV transmission, says **Hayley Mark**, PhD, MPH, RN, assistant professor at the Johns Hopkins University School of Nursing in Baltimore. The acyclovir study, conducted by the HIV Prevention Trials Network, a worldwide collaborative, ultimately found that acyclovir did not reduce the risk of acquiring HIV when given to men and women infected with HSV-2.[6]

EXECUTIVE SUMMARY

Results of a recent analysis of a survey of HIV care providers shows that clinicians often don't screen for genital herpes (herpes simplex virus-2 or HSV-2) in HIV-positive patients. Fewer than half knew that most patients with HIV also are infected by herpes.
- Knowledge of possible HSV-2 infection can inform HIV treatment. Studies suggest that patients with co-infection have more frequent genital lesions that might last longer and be more debilitating.
- Additional research is needed to determine the overall benefit, feasibility, and cost effectiveness of serologic testing to prevent HSV-2 transmission.

Science continues to look at acyclovir; research has uncovered details of an immune-cell environment conducive to HIV infection that persists at the location of HSV-2 genital skin lesions long after they have been treated with oral doses of acyclovir. This research might explain why HSV-2 infection increases the risk for HIV infection even after successful treatment heals the genital skin sores and breaks that often result from HSV-2.[7]

The analysis of HIV care providers indicates clinicians are reluctant to test HIV patients for herpes. Twelve percent reported always testing HIV-infected patients for genital herpes, 65% sometimes or usually tested, and 23% rarely or never tested for such infection. Providers were more likely to recommend a herpes test if the patient had symptoms (94%) or had a partner with herpes (83%). They were less likely to recommend testing if patients had no partners (60%) or would rather not know their HSV-2 status(49%).[1]

Fewer than half of the providers surveyed knew that most people with HIV also are infected by HSV, or that most often, symptoms of HSV-2 are silent. Such findings indicate that efforts need to be made to better educate healthcare providers who, in turn, can educate their patients, says Mark.

"Patients with HIV need to know that if they have HSV-2, too, it can be transmitted to their partners," says Mark. "And if they don't now have HSV-2, they are heightened at risk for acquiring it, unless they practice safe sex."

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CDC slide set focuses on women with HIV

Do you need updated slide information for presentations regarding women with HIV? Check the Centers for Disease Control and Prevention (CDC) web site for the latest slides on HIV/AIDS surveillance in women.

The 15 slides cover such topics as diagnoses of HIV infection among adult and adolescent females by race/ethnicity, 2005-2008, and diagnoses of HIV infection among adult and adolescent females by transmission category and age at diagnoses. The slides are available in Adobe Acrobat, Microsoft PowerPoint, and Macromedia Flash formats.

To download the slides free of charge, go to the CDC web site, www.cdc.gov/hiv, and select the "eHap FYI: October 26, 2010" link. At the bottom of the page, under "Resources," select "Updated Slide Set: HIV Surveillance in Women." ■

More than 1 in 4 teens binge drink, CDC says

Be sure to include questions on alcohol consumption during adolescent screenings. Why? Results of a new analysis of national data from the Centers for Disease Control and Prevention (CDC) show that more than one in four U.S. teens and young adults admit they are binge drinkers.[1]

Binge drinking is defined as having four or more drinks for women and five or more drinks for men. The numbers vary because men and women metabolize alcohol differently.

"Binge drinking is a very large health and social problem" and one that has gone largely unnoticed, said CDC director **Thomas Frieden**, MD, in a press statement. "Most people who binge drink are not alcoholics. It may be because binge drinking has not been recognized as a problem [that] it has not decreased in the past 15 years."

Binge drinkers put themselves and others at risk for HIV transmission and sexually transmitted diseases, unplanned pregnancy, alcohol-related car accidents, and violence, according to the CDC.

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2010 Index

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