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Interpreting News and Research on Contraceptives and STIs

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AHC Media

Most women should wait 3-5 years between Pap tests, says ACOG

National groups now in alignment on less frequent screenings

An annual Pap smear might soon become a thing of the past. Most women should be screened for cervical cancer no more often than once every three to five years, according to new cervical cancer screening guidance issued by the American College of Obstetricians and Gynecologists (ACOG).[1] The recommendations fall in line with information released in 2012 by the American Cancer Society, the American Society for Colposcopy and Cervical Pathology, and the American Society for Clinical Pathology.[2] *(To read more about the 2012 guidance, see the* Contraceptive Technology Update *article, "Guidance issued on cervical cancer screening: Update your practice now," June 2012, p. 61.)*

The biggest change in ACOG's cervical cancer screening guidelines is for women ages 30-65. For women in this age group who have negative test results, ACOG calls for a screening strategy of testing with the Pap test, using the conventional Pap or liquid-based method, combined with human papillomavirus (HPV) testing once every five years. A Pap test alone — without HPV co-testing — once every three years is acceptable for women in this age group if HPV testing is not available, the ACOG guidance states.

Science indicates that while HPV infections are common, most are transient and don't progress to cervical cancer, says **David Chelmow**,

Contraceptive Survey included in this month's issue of *CTU*

This month's issue of *Contraceptive Technology Update* includes the annual Contraceptive Survey that asks about your facility's prescribing practices. If you haven't filled out the survey already, here is another chance. Please complete the survey and return it in the attached envelope. Look for coverage in an upcoming issue of CTU!

MD, chair of the Department of Obstetrics and Gynecology in the Virginia Commonwealth University School of Medicine in Richmond. "The evidence clearly shows that less frequent cervical cancer screening is warranted," says Chelmow, who led development of the ACOG guidance. "With co-testing, screening every five years provides an excellent balance between achieving extremely low cancer rates while avoiding the potential harms of unnecessary interventions."

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Check the schedule

Women younger than 21 should not be screened for cervical cancer or HPV, regardless of whether they have had sexual intercourse, the guidance notes. While the prevalence of HPV is high among sexually active adolescents, invasive cervical cancer is rare in women younger than 21, the guidance notes.[1] Most cervical abnormalities that occur related to HPV infection in this age group typically spontaneously resolve and require no treatment, the guidance states.

Although women younger than age 21 will not receive screening, clinicians can emphasize prevention of cervical cancer by encouraging the HPV vaccine and providing counseling about safe sex practices, the guidance points out.[1] HPV-vaccinated women should follow the same cervical cancer screening guidelines as unvaccinated women.

For women ages 21-29, cervical cancer screening should be performed once every three years instead of once every two years. Clinicians may opt to use the conventional Pap or the liquid-based method. Women younger than 30 should not be screened with co-testing, according to the practice bulletin.

"The new guidelines emphasize that there is no role for tests that look for low-risk types of HPV," notes Chelmow. "When co-testing, we should be using only tests for high-risk, oncogenic types of HPV."

Screening should be discontinued in women older than 65 if they have no history of cervical intraepithelial neoplasia (CIN) 2, CIN 3, adenocarcinoma in situ, or cervical cancer, and who also have had three consecutive negative Pap test results

EXECUTIVE SUMMARY

Most women should be screened for cervical cancer no more often than once every 3-5 years, according to new cervical cancer screening guidance issued by the American College of Obstetricians and Gynecologists (ACOG).
- The recommendations fall in line with information released earlier in 2012 by the American Cancer Society, the American Society for Colposcopy and Cervical Pathology, and the American Society for Clinical Pathology
- The biggest change in guidance is for women ages 30-65. For women in this age group who have negative test results, ACOG calls for a screening strategy of testing with the Pap test, using the conventional Pap or liquid-based method, combined with human papillomavirus testing once every five years.

or two consecutive negative co-test results within the previous 10 years, with the most recent test performed within the past five years, the guidance states.

Regardless of age, women who have had a hysterectomy with removal of the cervix and have no history of CIN 2 or CIN 3 should discontinue routine cervical cancer screening, the practice bulletin advises.

Women with certain conditions will require more frequent screening, the practice bulletin advises. These populations include:

- women with HIV;
- women who have received organ transplants or are immunocompromised for other reasons;
- women who were exposed to diethylstilbestrol in utero;
- women previously treated for CIN 2, CIN 3, or cancer.

Emphasize well-woman care

Planned Parenthood Federation of America health centers already have changed their cervical cancer screening guidelines to align with those issued by the American Cancer Society, United States Preventive Services Task Force, and other professional medical organizations, noted **Vanessa Cullins**, MD, MPH, vice president for external medical affairs.

"We are pleased to see that the new ACOG guidelines call for nearly identical evidenced-based protocols, which will help patients and their healthcare providers balance the benefits and risks of being screened for cervical cancer," said Cullins in a statement issued with release of the ACOG guidance.

The new changes in recommendations are significant for physicians and patients alike, notes Chelmow. It will take time and effort to re-educate both audiences that the annual Pap is no longer the standard of care. It is critical, however, that women understand that their annual well-woman visit is still important for many other aspects of their healthcare, he says.

Be sure your practice captures the important aspects of the well-woman exam. According to guidance issued by ACOG in July 2012, an annual well-woman visit provides an excellent opportunity for counseling patients about maintaining a healthy lifestyle and minimizing health risks.[3] To assess overall health, a physical exam generally includes checks of blood pressure, weight, body mass index, palpation of the abdomen and lymph nodes, and an assessment of the patient's overall health.

ACOG advises annual pelvic exams begin at age 21. For younger women, an internal exam is not recommended unless a patient has signs of a menstrual disorder, vaginal discharge, pelvic pain, or other reproductive-related symptom. Screening for sexually transmitted infections is an important part of the annual exam; however, testing can be performed using urine samples or vaginal swabs without an internal pelvic exam, the guidance notes.

Clinical breast exams (CBEs) also are part of the well-woman visit, ACOG notes. The organization, along with the American Cancer Society and the National Comprehensive Cancer Network, continues to recommend CBEs every one to three years for women ages 20-39. The ACOG recommendations call for annual CBEs and annual mammograms for women age 40 and older.

Although most women no longer need annual Pap tests based on recent cervical cancer screening guidelines, they still need annual well-woman exams with their provider for other important screenings, evaluations, and immunizations based on their age and individual risk factors, ACOG states. Remember that decisions on whether to perform internal pelvic exams and/or breast exams always should be made with the patient's consent. *[Did you receive the* CTU *bulletin on this latest ACOG guidance? To receive breaking news as it occurs, provide your e-mail address to AHC Media customer service at (800) 688-2421 or customerservice@ahcmedia.com.]*

REFERENCES

1. Screening for cervical cancer. *Obstet Gynecol* 2012; 120:1,222-1,238.
2. Saslow D, Solomon D, Lawson HW, et al. American Cancer Society, American Society for Colposcopy and Cervical Pathology, and American Society for Clinical Pathology screening guidelines for the prevention and early detection of cervical cancer. *Am J Clin Pathol* 2012; 137(4):516-542.
3. The American College of Obstetricians and Gynecologists Committee on Gynecologic Practice. Committee opinion number 534: Well-woman visit. *Obstet Gynecol* 2012; 120:421. ■

Put contraceptive pearls to work in your practice

Unscheduled spotting and bleeding occurs in 30% to 50% of women in the first few months of combined oral contraceptive (OC) use.[1] How

EXECUTIVE SUMMARY

Use contraceptive "pearls" gleaned from the 20th revised edition of Contraceptive Technology to help women stay the course when using combined oral contraceptives.

- If spotting or bleeding occurs before a patient completes active pills, more endometrial support may be needed. Increase the progestin content of her pills, by changing to a different monophasic formulation or by switching to a triphasic formation that boosts the progestin levels in the last active pills.
- If a patient continues to have spotting or bleeding following the scheduled bleeding, more estrogen might be needed to proliferate the endometrium. Consider increasing the estrogen in the first pills in the pack or decrease the progestin content of those first pills.

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can you help patients "stay the course"?

Use contraceptive "pearls" gleaned from the 20th revised edition of Contraceptive Technology, advises **Deborah Kowal**, MA, PA, chief executive officer and president of Contraceptive Technology Communications in Atlanta.[2] Kowal presented highlights from the recently revised family planning handbook at the Contraceptive Technology: Quest for Excellence conference in Atlanta.

Page 313 in the new edition offers handy tips for dealing with spotting and bleeding, Kowal says. If spotting or bleeding occurs before a patient completes active pills, more endometrial support might be needed, according to the tips. Increase the progestin content of her pills, by changing to a different monophasic formulation or by switching to a triphasic formation that boosts the progestin levels in the last active pills.

If a patient continues to have spotting or bleeding following the scheduled bleeding, more estrogen might be need to proliferate the endometrium. Consider increasing the estrogen in the first pills in the pack or decrease the progestin content of those first pills, the book advises.

How about mid-cycle bleeding? One approach for this relatively uncommon bleeding pattern is to prescribe a triphasic formulation that increases the estrogen and progestin levels in the middle pills.

Be prepared to deal with unscheduled spotting and bleeding in women who use extended cycle pills, especially after week number 5 in the first cycle, the book advises. Be sure to inform women that as with all other pills, they will have more spotting when they begin taking extended OCs and that this unscheduled bleeding will decrease rapidly over time. However, if having completed 21 days of pills a patient still finds this bothersome, she can stop taking pills for two to three days to allow a withdrawal bleed to start. Then she should restart taking the active pills, taking at least three weeks of pills before she stops again. As she takes pills in this flexible pattern, the length of time between unscheduled spotting and bleeding episodes will increase. Instruct the patient that eventually she will be able to take pills for 3-12 months at a time with little or no unscheduled bleeding or spotting.[1]

How about missed pills?

Missed pills happen, notes **Michael Rosenberg**, MD, MPH, clinical professor of obstetrics and gynecology and adjunct professor of epidemiology at the University of North Carolina at Chapel Hill and chief executive officer of Health Decisions, a Durham, NC, private research firm with expertise in reproductive health. Rosenberg points to a prospective cohort study of 943 U.S. women who began or switched to a new OC brand at study enrollment. At follow up two months after enrollment, 47% of pill users reported missing one or more pills per cycle, and 22% missed two or more pills in each cycle.[3] Those who missed one or more pills were significantly more likely than those who did not to lack an established pill-taking routine, not to have read or understood the informational material accompanying the pill, and to have experienced spotting or heavy bleeding.[3]

The issues are the same today as when the study was conducted, says Rosenberg. They perhaps might be a bit more important, because the trends to prescribed lower estrogen pills means that consistent use and anticipating spotting and bleeding problems is more important, he notes.

Want a simple way to approach missed pills? Kowal directs readers to page 322 of Contraceptive Technology for simplified recommendations. First, ask the patient if she had intercourse without extra protection before she missed her pill. If she did, provide her with emergency contraception.

If the woman is less than 12 hours late taking her pill, advise her to take it now and take her next pills at the time she usually would.

If the patient is more than 12 hours late in taking her pill, advise her to take her missed pill now and any other pill she is supposed to take today. Instruct her to finish taking all the other pills in her pack on time.

Counsel that abstinence or condoms should be used with every act of sex until the woman has taken seven active pills.[1] All of these steps might

overtreat the situation, but they are easy to follow, the book advises.[1]

REFERENCES

1. Nelson AL, Cwiak C. Combined oral contraceptives (COCs). In: Hatcher RA, Trussell J, Nelson AL, et al. Contraceptive Technology: 20th revised edition. New York: Ardent Media; 2011.
2. Kowal D. Clinical pearls: diving into the new 20th edition of Contraceptive Technology. Presented at the Contraceptive Technology: Quest for Excellence conference. Atlanta; November 2012.
3. Rosenberg MJ, Waugh MS, Burnhill MS. Compliance, counseling and satisfaction with oral contraceptives: a prospective evaluation. *Fam Plann Perspect* 1998; 30(2):89-92,104. ■

The New Year will bring new recommendations

Get ready to add new information to your contraceptive clinical dataset. The Centers for Disease Control & Prevention (CDC) is working with national family planning experts in preparing the U.S. version of the World Health Organization's Selected Practice Recommendations (SPR) for release in spring 2013 to provide clinicians with practical applications for contraceptive management.

The recommendations are one of the four cornerstones of family planning guidance as developed by the World Health Organization, says **Tara Cleary**, MD, MPH, research assistant professor at the University of North Carolina — Chapel Hill and CDC guest researcher. U.S. clinicians already are familiar with the Medical Eligibility Criteria for Contraceptive Use[1], which was adapted for U.S. use in 2010. The recommendations act as a companion piece to the criteria, notes Cleary, who spoke at the recent Contraceptive Technology: Quest for Excellence conference in Atlanta.[2] The international organization also has developed a decision-making tool for family planning clients and providers, as well as a global family planning guidebook for providers. *(Information on all four publications is available at http://bit.ly/SFxVbA.)*

According to **Andrew Kaunitz**, MD, professor and associate chair in the Obstetrics and Gynecology Department at the University of Florida College of Medicine — Jacksonville, the US Selected Practice Recommendations for Contraceptive Use has been developed to help clinicians address such contraceptive management issues as:

- when to initiate methods;
- what assessments are appropriate before method initiation;
- what follow-up is appropriate after method initiation and during method use;
- how to manage common issues during contraceptive use;
- when to stop contraception in older reproductive age women.

"The SPR will provide a treasure trove of evidence-based management guidance for clinicians who provide contraceptive services," says Kaunitz, who served as one of many advisers in development of the recommendations.

EXECUTIVE SUMMARY

The Centers for Disease Control & Prevention is preparing the U.S. version of the World Health Organization's Selected Practice Recommendations for release in spring 2013 to provide clinicians with practical applications for contraceptive management.

- The new guidance is being developed to help clinicians address such questions as when to initiate methods, what assessments are appropriate before method initiation, what follow-up is appropriate after method initiation and during method use, and how to manage common issues during contraceptive use.
- Implementation activities, including development of clinical algorithms and other provider tools, electronic access to the guidance and tools, and development of training materials for residency programs, are being readied to launch the guidance.

Check possible topics

An initial meeting was held in October 2010 to determine if the recommendations should be considered for U.S. adaptation, says Cleary. The experts present at that meeting recommended that most of the existing material be reviewed for adaptation. Removed from review were any recommendations dealing with contraceptive methods not available in the United States.

New topics for consideration included such issues as:

- female sterilization;
- when to stop contracepting;
- what can be done if a woman has menstrual abnormalities while using continuous combined hormonal contraception;
- expansion of recommendations to include the

contraceptive patch and vaginal ring;

• addition of ulipristal acetate to emergency contraception pill recommendations;

• how to start regular contraception after use of emergency contraceptive pills.

A systematic review of evidence was conducted from 2010-2011, with a meeting of experts held October 2011 to discuss and draft recommendations. Those recommendations have been developed into the final version, which will be printed in the CDC's Morbidity and Mortality Weekly Report in early 2013, says Cleary.

The recommendations are not a comprehensive textbook, nor are they a substitute for the Medical Eligibility Criteria, says Cleary. Clinicians should not look at them for rigid guidelines, and they do not speak to well-woman care, she notes.

The U.S. guidance will highlight the essential points for each question, with algorithms and charts added to make it user-friendly, says Cleary. Each topic has recommendations, comments, evidence summary, and provider tools, as well as a listing of gaps in evidence research, she notes.

Get out the word

When the guidance is released, the CDC plans to work closely with its partners in reproductive health and primary care to disseminate and implement this guidance, says **Kathryn Curtis**, PhD, a health scientist in the CDC's Women's Health and Fertility Branch in the Division of Reproductive Health.

The CDC will work through professional and service organizations to disseminate the guidance to healthcare providers, states Curtis. It also is working on several implementation activities, including development of clinical algorithms and other provider tools, electronic access to the guidance and tools, development of training materials for residency programs, and continuing education activities, explains Curtis. Also in preparation are hands-on case studies and examples of how to use the guidance in practice to facilitate its use, says Curtis.

The CDC will completely review the US SPR every three to four years, with updates published at http://1.usa.gov/chY2AV. The agency also will be conducting a survey of family planning providers before and after release of the recommendations to assess attitudes and practices related to contraceptive use. Results from this survey will assist the CDC in evaluating the impact of the guidance on contraceptive provision in the United States.[3]

REFERENCES

1. World Health Organization. Medical Eligibility Criteria for Contraceptive Use. Fourth edition. Geneva; 2009.
2. Cleary TP. The new U.S. Selected Practice Recommendations: practical applications for contraceptive management. Presented at the Contraceptive Technology: Quest for Excellence conference. Atlanta; November 2012.
3. Curtis KM, Tepper NK, Jamieson DJ, et al. Adaptation of the World Health Organization's Selected Practice Recommendations for Contraceptive Use for the United States. *Contraception* 2012. Doi:10.1016/j.contraception.2012.08.024. ■

Expand knowledge base on combined pills

In discussing birth control options with a patient, she tells you she is interested in taking the Pill, but is concerned that it might be dangerous due to "all the risks." What's your next move?

Remind women that in general, contraceptives pose few serious health risks.[1]

When considering combined oral contraceptives (OCs), the use of the Pill is generally safer than unintended pregnancy, says **Anita Nelson**, MD, professor in the Obstetrics and Gynecology Department at the David Geffen School of Medicine at the University of California in Los Angeles.

Pregnancy-related mortality in the United States from 1998 to 2005 was higher than any other period in the prior 20 years[2], says Nelson, who provided an OC update at the recent

EXECUTIVE SUMMARY

When considering combined oral contraceptives, the use of the Pill is generally safer than unintended pregnancy, research indicates.

• To compare the risks of death, the risk of death from pregnancy and delivery is about 1 in 8,700. For healthy, nonsmoking woman ages 15-34, the chance of dying from oral contraceptive use is less than 1 in 1 million.

• In a recent survey conducted to assess women's knowledge of the health risks of pregnancy and how their assessment of pregnancy risks compared to their estimates of the risks of oral contraceptives, more than 75% of respondents rated pills as more hazardous to a woman's health than pregnancy.

Contraceptive Technology: Quest for Excellence conference.[3] To compare the risks of death, the risk of death from pregnancy and delivery is about 1 in 8,700, lower than the annual risk of death from an automobile accident. For healthy, nonsmoking women ages 15-34, the chance of dying from oral contraceptive use is less than 1 in 1 million.[4]

Women have an underestimation of fertility risk, an under-appreciation of the health risks of pregnancy, and an over-estimation of the risks of contraception, says Nelson.

In a recent survey conducted to assess women's knowledge of the health risks of pregnancy and how their assessment of pregnancy risks compared to their estimates of the risks of oral contraceptives, more than 75% of respondents rated birth control pills as more hazardous to a woman's health than pregnancy.[5] Less than half knew that risks of venous thromboembolism (VTE), diabetes, and hypertension increase in pregnancy.

Oral contraceptives are safe and well-tested, says Nelson. They are the best-studied medication in history, with more than 50 years of clinical experience logged in the United States, she notes. *(Remind women of the Pill's noncontraceptive benefits; see the list, right.)*

There are often stories in the news challenging the safety of birth control pills, Nelson notes. She offers the following messages to present to patients if the evening news carries such a story:

- Do not stop your pill until we talk.
- Whatever pill you are taking is safer than pregnancy.
- When you stop taking your pill for only four weeks and then restart it, you experience the risks that happen at the time of pill initiation.
- Keep on letting your pill work for you until the dust settles.

Check extended cycle

How many women in your practice use pills in an extended regimen? While research indicates that extended cycle OCs have demonstrated safety, with less blood loss than standard 21/7 pills, their use has not been popular, says Nelson.[6]

However, recent surveys show that many women would prefer to bleed less frequently than once a month.[3] To help patients considering extended cycle pills, Nelson offers the following counseling points:

- Validate the patient's beliefs in need for monthly menses without hormonal contraception.

Non-contraceptive Health Benefits of OCs

Proven reduction in risk:
- Ovarian cancer
- Endometrial cancer
- Pelvic inflammatory disease
- Ectopic pregnancy
- Benign breast disease
- Menorrhagia
- Dysmenorrhea
- Iron deficiency anemia
- Low bone density

Possible reduction in risk:
- Cardiovascular disease
- Uterine fibroids
- Endometriosis
- Rheumatoid arthritis

Source: Nelson AL. Combined oral contraceptives: update 2012. Presented at the Contraceptive Technology: Quest for Excellence conference. Atlanta; November 2012.

- Menses represents reproductive failure. It's a cleanup operation to prepare for better luck next cycle.
- Dispel patients' concerns proactively. Explain that in extended cycle, a woman's blood is not building up, and her ovaries are not swelling. When she chooses to discontinue the method, her fertility will return, if she is not menopausal.
- Use of extended regimen pills does not increase a woman's cancer risk.

Up OC access, success

How can your clinic streamline prescribing practices to improve access and success with combined OCs? Nelson reviews the following key points:

- No pelvic exam is needed prior to prescription.[7] The American College of Obstetricians and Gynecologists (ACOG) and the World Health Organization (WHO) require only a check of weight, blood pressure, and health history.
- If there is a need to screen for sexually transmitted infections (STIs), use urine tests.
- Be sure to use Same Day/Quick Start protocols. Advise the patient to take her first pill at

the time of the office visit or within the next 12 hours. Unless she has started the pills within five days of starting her period, counsel her to use a backup method, such as condoms, for at least seven days.

• A pregnancy test is indicated only if the patient has had unprotected intercourse since her last menstrual period. Provide her with emergency contraception (EC) immediately if she has had unprotected intercourse in last five days.

• If possible, provide several months' supply of pills. Dispensing a year's supply of pill cycles is associated with higher method continuation and lower costs than dispensing fewer cycles per visit.[8]

• Provide a supply of condoms for use if the patient decides to stop using pills. Provide a demonstration of proper condom use.

"Give EC by advance prescription," advises Nelson. "Accidents will happen."

Remember that noncompliance is cited in 86% of unintended pregnancies with combined oral contraceptives, says **Robert Hatcher**, MD, MPH, professor of gynecology and obstetrics at Emory University School of Medicine in Atlanta. "This can be avoided by prescribing pills continuously instead of 21/7, 21/7, 21/7, the dual use of OCs with condoms, or by quickly switching women from OCs to long-acting reversible contraception if they are missing pills each month," says Hatcher.

REFERENCES

1. Trussell J. Choosing a contraceptive: efficacy, safety, and personal considerations. In: Hatcher RA, Trussell J, Nelson AL, et al. Contraceptive Technology: 20th revised edition. New York: Ardent Media; 2011.
2. Berg CJ, Callaghan WM, Syverson C, et al. Pregnancy-related mortality in the United States, 1998 to 2005. *Obstet Gynecol* 2010; 116(6):1,302-1,309.
3. Nelson AL. Combined oral contraceptives: update 2012. Presented at the Contraceptive Technology: Quest for Excellence conference. Atlanta; November 2012.
4. Trussell J, Jordan B. Reproductive health risks in perspective. *Contraception* 2006; 73(5):437-439.
5. Nelson AL, Rezvan A. A pilot study of women's knowledge of pregnancy health risks: implications for contraception. *Contraception* 2012; 85(1):78-82.
6. Edelman AB, Gallo MF, Jensen JT, et al. Continuous or extended cycle vs. cyclic use of combined oral contraceptives for contraception. *Cochrane Database Syst Rev* 2005; (3):CD004695.
7. Stewart FH, Harper CC, Ellertson CE, et al. Clinical breast and pelvic examination requirements for hormonal contraception: Current practice vs evidence. *JAMA* 2001; 285(17):2,232-2,239.
8. Foster DG, Parvataneni R, de Bocanegra HT, et al. Number of oral contraceptive pill packages dispensed, method continuation, and costs. *Obstet Gynecol* 2006; 108(5):1,107-1,114. ■

Hope vs. reality – Access to EC pills doesn't work

Emergency contraception (EC) should be widely available and easily accessible to all women, according to a just-released committee opinion issued by the American College of Obstetricians and Gynecologists (ACOG).[1]

Age restrictions, cost, insurance coverage, and misconceptions about EC are all unnecessary barriers that continue keeping women from using emergency contraception to prevent unwanted pregnancies in the first few days after unprotected sex, sexual assault, or contraceptive failure, the opinion states.

Although the Food and Drug Administration (FDA) approved the first dedicated product for emergency contraception in 1998, numerous barriers to access to emergency contraception remain. ACOG continues advocating for the FDA to remove the over-the-counter age restriction for the levonorgestrel emergency contraceptive pill (Plan B One Step, Teva Women's Health, Woodcliff Lake, NJ; Next Choice and Next Choice One Step, Watson Pharmaceuticals, Parsippany, NJ; levonorgestrel 0.75 mg tablets, Perrigo, Allegan, MI) because there is no scientific or medical reason for it. Clinicians are advised to write advance prescriptions for EC for adolescents under age 17 to prevent delayed access, the ACOG opinion asserts.

EXECUTIVE SUMMARY

Fifteen studies have examined the impact of increased access to emergency contraceptive pills on pregnancy and abortion rates. Only one has shown any benefit.

• In comparison, more than 12,000 post-coital insertions of copper-bearing intrauterine devices have been performed. With only 12 failures, this approach has a pregnancy rate of 0.1%.

• Because they are safe for most women, highly effective and cost-effective when left in place as ongoing contraception, whenever clinically feasible, IUDs should be included in the range of EC options offered to patients presenting after unprotected intercourse, according to a new systematic review.

In addition, private and public insurers are encouraged to cover all forms of EC and to publicize this coverage to their members, the opinion states. Any physician or pharmacist who objects to prescribing or dispensing EC should offer referrals to women who request the contraceptive, it notes.[1]

The IUD is best

While the ACOG opinion notes that oral EC is more common, the copper intrauterine device (IUD) is the most effective form of emergency contraception. This point is driven home by the research presented at the recent Contraceptive Technology: Quest for Excellence conference by **James Trussell**, PhD, professor of economics and public affairs and faculty associate at the Office of Population Research at Princeton (NJ) University.[2]

Fifteen studies have examined the impact of increased access to emergency contraceptive pills on pregnancy and abortion rates,[3] and only one has shown any benefit[4], says Trussell.

While there might be flaws in the studies, Trussell notes their consistency is compelling. The evidence does suggest that provision of EC pills does not increase risk taking. Also, insufficient use of EC pills is definitely a problem, he says.

"Stress efficacy for individuals," says Trussell. "Everyone deserves a second chance to prevent an unintended pregnancy."

More than 12,000 post-coital insertions of copper-bearing intrauterine devices have been performed since the practice was introduced in 1976; with only 12 failures, this approach has a pregnancy rate of 0.1%.[5]

Because they are safe for most women, highly effective and cost-effective when left in place as ongoing contraception, whenever clinically feasible, IUDs should be included in the range of emergency contraception options offered to patients presenting after unprotected intercourse, states Trussell and co-authors of a just-published systematic review of 35 years' experience with the device.[6]

Check ulipristal acetate

Uptake of the emergency contraceptive drug ulipristal acetate, (Watson Pharmaceuticals) has been slow since it has been introduced in the United States in 2010, says Trussell. *(*Contraceptive Technology Update *reported on the introduction; see "Add ella to options for emergency contraception," October 2010, p. 112.)*

Use of the prescription-only drug might swing upward, predicts Trussell. A meta-analysis of two randomized studies indicates ulipristal acetate is superior to levonorgestrel when used as an emergency contraceptive.[7] In another study, research indicates that ulipristal acetate can significantly delay follicular rupture when given immediately before ovulation.[8] The evidence suggests the drug could possibly prevent pregnancy when administered in the advanced follicular phase, even if luteal hormone levels already have begun to rise. This distinction is important, for it is a time when levonorgestrel EC is no longer effective in inhibiting ovulation, researchers note.[8]

Clinicians might wish to keep body mass index (BMI) in mind when discussing any emergency contraceptive pill, says Trussell. Recent data indicates that levonorgestrel pills showed a rapid decrease of efficacy with increasing BMI, reaching the point where it appeared no different from pregnancy rates expected among women not using EC at a BMI of 26 kg/m2 compared with 35 kg/m2 for women using ulipristal acetate.[7]

REFERENCES

1. Access to emergency contraception. *Obstet Gynecol* 2012; 120(5):1,250-1,253.
2. Trussell J. High hopes, harsh reality: an update on emergency contraception. Presented at the Contraceptive Technology: Quest for Excellence conference. Atlanta; November 2012.
3. Polis CB, Schaffer K, Blanchard K, et al. Advance provision of emergency contraception for pregnancy prevention: a meta-analysis. *Obstet Gynecol* 2007; 110(6):1,379-1,388.
4. Shaaban OM, Hassen SG, Nour SA, et al. Emergency contraceptive pills as a backup for lactational amenorrhea method (LAM) of contraception: a randomized controlled trial. *Contraception* 2012; Doi:10.1016/j.contraception.2012.07.013.
5. Trussell J, Schwarz EB. Emergency contraception. In: Hatcher RA, Trussell J, Nelson AL, et al. Contraceptive Technology: 20th revised edition. New York: Ardent Media; 2011.
6. Cleland K, Zhu H, Goldstuck N, et al. The efficacy of intrauterine devices for emergency contraception: a systematic review of 35 years of experience. *Hum Reprod* 2012; 27(7):1,994-2,000.
7. Glasier AF, Cameron ST, Fine PM, et al. Ulipristal acetate versus levonorgestrel for emergency contraception: a randomised non-inferiority trial and meta-analysis. *Lancet* 2010; 375(9714):555-562.
8. Brache V, Cochon L, Jesam C, et al. Immediate pre-ovulatory administration of 30 mg ulipristal acetate significantly delays follicular rupture. *Hum Reprod* 2010; 25(9):2,256-2,263. ■

Health reform rolls on post election

By **Adam Sonfield**
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One of the clearest outcomes of the 2012 election is that the Affordable Care Act (ACA), better known as Obamacare, has survived the last major threat to its existence. By November 2014's mid-term elections, all of the major components of the ACA should be in place, and tens of millions of Americans should be benefiting from new insurance options and protections, all of which would make the law far more difficult for policymakers to dismantle.

Yet, in part because so many decisions were put on hold preceding this election, the timetable for implementing the ACA is increasingly short. Numerous federal regulations are expected over the next year. Indeed, several are under review by the Office of Management and Budget at press time. States face multiple deadlines as well.

For example, the federal and state governments have considerable work ahead of them to establish the health insurance exchanges that must be in place by January 2014 and to set crucial standards for benefits, provider networks, and many other details for the health plans that will be sold through those marketplaces to individuals, families, and small businesses. States have been struggling with even the most basic decision — whether to establish an exchange itself, partner with other states or the federal government, or default to a federally run exchange — and the Department of Health and Human Services (HHS) extended several deadlines for that decision just days after the election.[1]

Similarly, deadlines are imminent for the ACA's requirement that most private health plans cover the full range of contraceptive methods and services for women, along with numerous other key preventive care services, without out-of-pocket costs for patients. Because most private plans renew at the beginning of each calendar year, the contraceptive coverage mandate will start affecting tens of millions of women's plans in January 2013. Insurers have been provided with little guidance about how far they can go in using formularies and other cost-control mechanisms. The Obama administration also has promised new regulations by August 2013 to detail the "accommodation" announced in February 2012 that will allow some religiously affiliated employers to avoid paying for or talking about contraceptive coverage, while still ensuring seamless coverage for their employees.[2]

Big decisions ahead

Perhaps the most critical questions for family planning and other reproductive health services are tied to Medicaid. The authors of the ACA envisioned an expanded role for Medicaid as a health insurance program available to almost all Americans with an income below 138% of the federal poverty level, which is roughly $26,350 in 2012.[3] That expansion would account for more than half of the 30 million Americans who would gain insurance under the law[4], including coverage for family planning services and supplies, maternity care, sexually transmitted infection testing and treatment, and cervical cancer screening and vaccination.

The Supreme Court's June 2012 decision, however, effectively converted this Medicaid expansion into a state option. Quirks in the ACA mean that unless the statute is amended, most of the residents in a state that opts out who would have been eligible for Medicaid also would be excluded from the subsidies the ACA provides to help defray the cost of private coverage in the exchanges. The Urban Institute projects that 11.5 million uninsured adults, all of them with incomes below the poverty line, would end up in this "donut hole" without any access to affordable insurance coverage.[5]

There are numerous incentives for states to opt into the expansion, from improving the health of millions of their most vulnerable citizens to supporting cash-strapped hospitals to drawing billions of federal dollars into the state. Indeed, the federal government will pay all of the cost of the expansion for the first three years, then phasing down to 90% by 2020, which is still a far higher rate than for Medicaid traditionally. Yet, conservative politics and perceived fiscal constraints

have led policymakers in several states to declare they will not expand Medicaid or that they intend to use their leverage to negotiate new flexibility for shaping their state's Medicaid program.

The political calculus at the state level might have changed post-election, but it might take years for the situation to be fully resolved. DHHS has not yet provided clarity about states' options, and 2014 is not a hard deadline for states to opt in. Under past optional expansions to Medicaid, every state ended up participating, but many delayed that decision for a few years. These decisions could be complicated further if Medicaid is dragged into negotiations, which are just beginning as of this writing, to make a grand bargain on the budget and avoid the so-called fiscal cliff. Medicaid is one of the few key programs that was excluded from the automatic cuts ("sequestration") established in the 2011 budget deal. However, the program's size makes it a perennial target, and there are no guarantees it will be protected going forward.

REFERENCES

1. Galewitz P. Obama administration extends deadline for state exchanges. Kaiser Health News 2012. Accessed at http://bit.ly/WMCk3r.
2. Department of the Treasury, Department of Labor, and Department of Health and Human Services. Certain preventive services under the Affordable Care Act. Fed Reg 2012; 77(55):16,501-16,508.
3. Department of Health and Human Services. Annual update of the HHS poverty guidelines. Fed Reg 2012; 77(17):4,034-4,035.
4. Congressional Budget Office. Updated Estimates for the Insurance Coverage Provisions of the Affordable Care Act. Washington, DC: Congressional Budget Office, 2012. Accessed at http://1.usa.gov/ApJZDu.
5. Kenney GM, Dubay L, Zuckerman S, et al. Opting Out of the Medicaid Expansion under the ACA: How Many Uninsured Adults Would not Be Eligible for Medicaid? Washington, DC: Urban Institute, 2012. Accessed at: http://bit.ly/MZNoR2. ■

COMING IN FUTURE MONTHS

- ■ Check drug interactions with contraceptives
- ■ Obesity & birth control — What do we know?
- ■ How to boost male STD testing
- ■ How to manage IUD complications

CNE/CME OBJECTIVES & INSTRUCTIONS

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

1. Read and study the activity, using the provided references for further research.
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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.

CNE/CME QUESTIONS

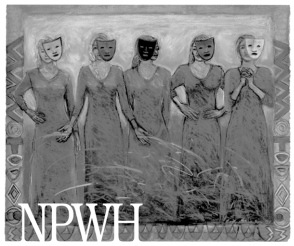
1. According to 2012 screening guidance issued by the American College of Obstetricians and Gynecologists, how often should most women be screened for cervical cancer?
   A. Annually
   B. Once every 2-3 years
   C. Once every 2-4 years
   D. Once every 3-5 years

2. What new guidance is the Centers for Disease Control releasing in 2013 to aid in contraceptive management?
   A. Selected Practice Recommendations
   B. Medical Eligibility Criteria for Contraceptive use
   C. A family planning guidebook for providers
   D. A decision-making tool for family planning clients and providers

3. According to the American College of Obstetricians and Gynecologists and the World Health Organization, what are the only requirements prior to prescribing combined oral contraceptives?
   A. Pelvic exam, check of weight and blood pressure
   B. Check of weight, blood pressure, and health history
   C. Health history and check for sexually transmitted infections
   D. Pregnancy test, pelvic exam, check of blood pressure

4. What is the unintended pregnancy rate of the emergency contraceptive use of copper-bearing intrauterine devices?
   A. 0.5%
   B. 0.1%
   C. 1%
   D. 2.2%

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 healthcare professionals.



Association of Reproductive Health Professionals

2012 SALARY SURVEY RESULTS

CONTRACEPTIVE TECHNOLOGY UPDATE®

A Monthly Update on Contraception and Sexually Transmitted Diseases

Family planning clinicians see steadiness in salaries and in clinic staffing levels

Keep eye out on federal budget battles that may lead to local cuts

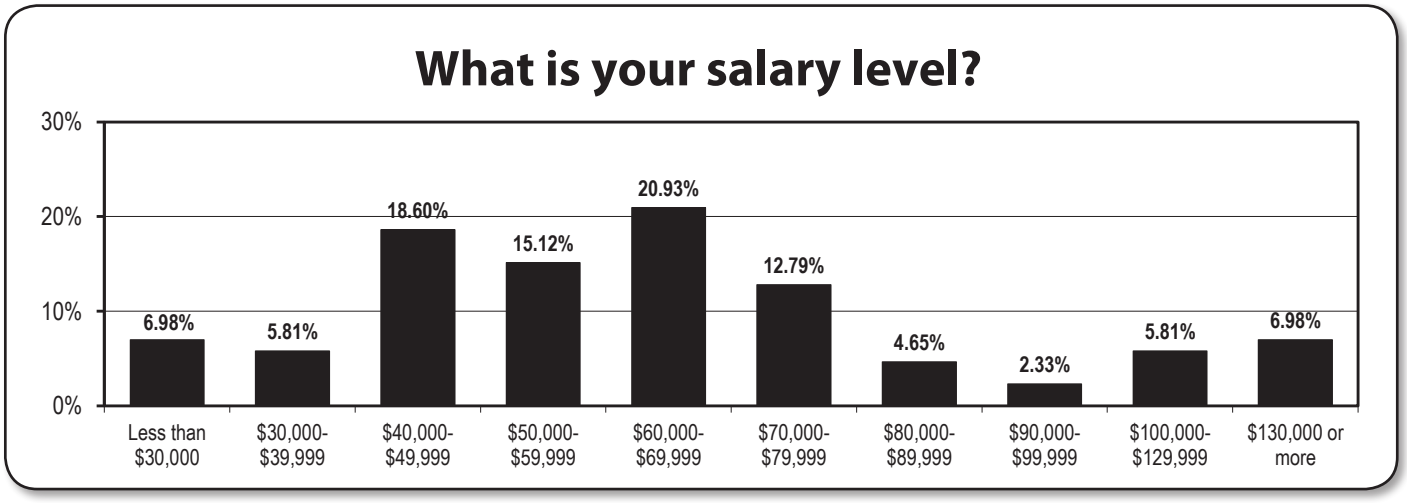
Public health is a familiar setting for many readers of *Contraceptive Technology Update*. About 51% of respondents to the *2012 Salary Survey* say they work in a health department, and most noted no changes in 2012 staffing numbers.

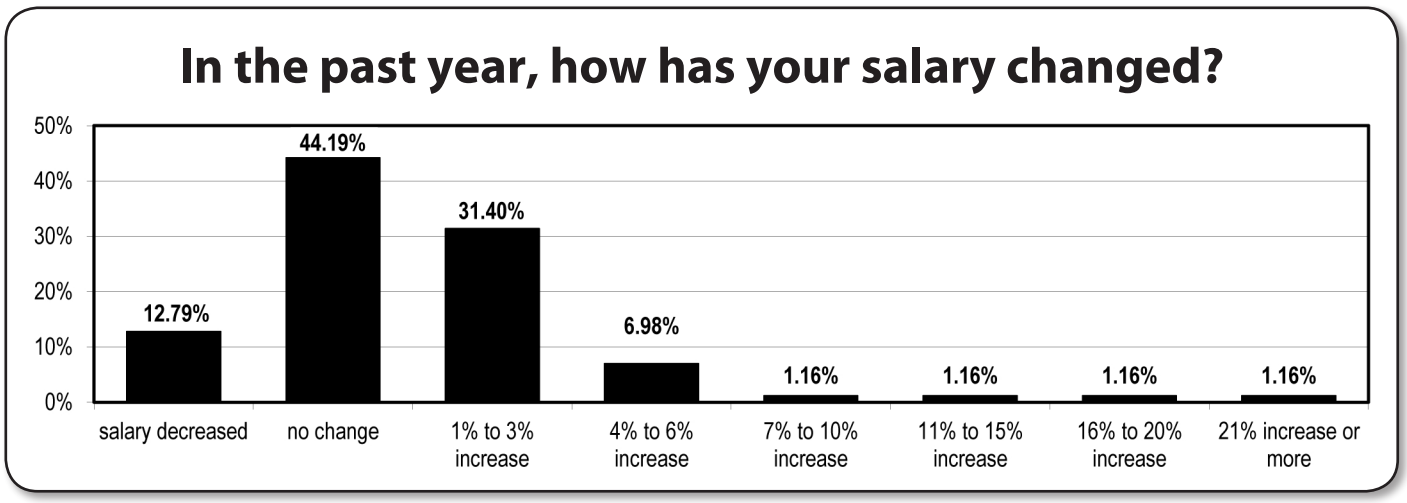
Don't get too comfortable with your staffing numbers, though, if you are a public health employee. According to a recent report issued by the Arlington, VA-based Association of State and Territorial Health Officials (ASTHO), a federal sequester scheduled for Jan. 2, 2013, will adversely affect local public health employment figures. Sequestration is the term for automatic budget cuts to federal government programs. Such action was included as a budget reduction enforcement mechanism in the Budget Control Act of 2011. The sequester is scheduled to take place in 2013 unless Congress passes legislation to postpone it or finds other ways to reduce the federal deficit.

According to the ASTHO report, the sequester will cut about $2.4 billion in funding at the major federal agencies concerned with public health in FY 2013.[1]

Due to widespread budget cuts to state public health over the past several years, many state health agencies have had to eliminate staff, ASTHO reports. Since 2008, 48 states have reported budget cuts to health departments, and more than 45,700 state and local health department jobs have been lost.

Federal public health spending already has been





reduced by 8% ($2.5 billion) from FY 2010 through FY 2012. Sequestration will reduce that level by an additional 8.4% in a single fiscal year, for a total reduction since 2010 of $4.9 billion (16%).

"Sequestration is intended to force the government to save money, but it's important to remember how much we'll lose if it takes place," said **Paul Jarris**, MD, MBA, ASTHO executive director in a statement accompanying the new report. "Billions in cuts could put American lives at risk."

In the second presidential debate in October 2012, President **Barack Obama** said that the sequester "will not happen." However, at press time, no consensus has been reached by Congressional delegates.[2]

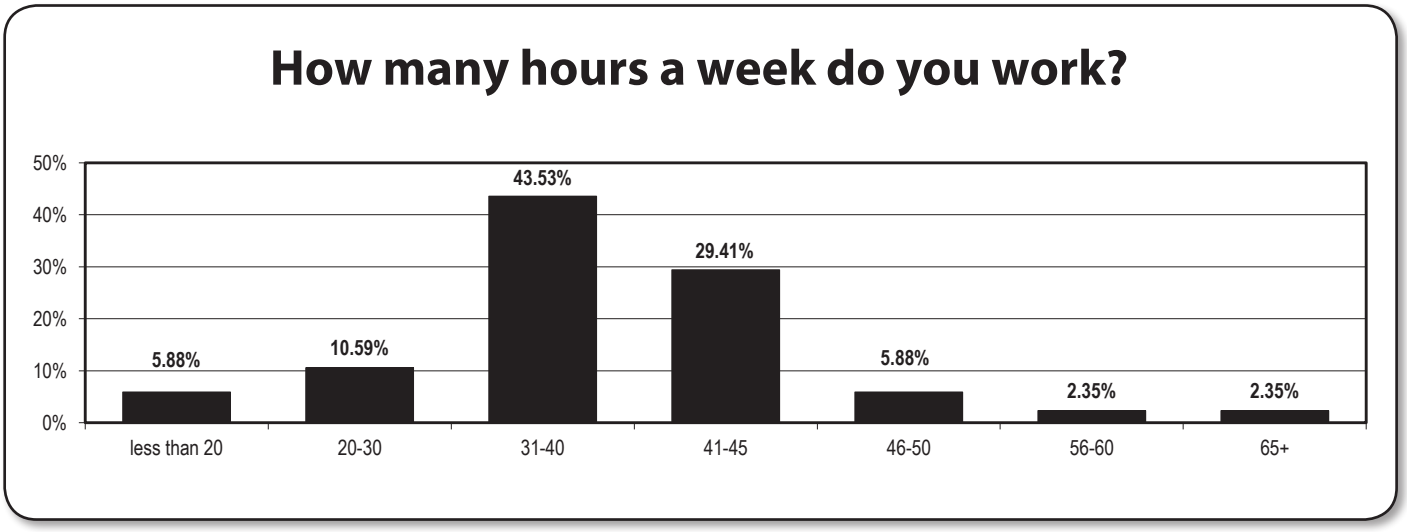
Bright spots seen

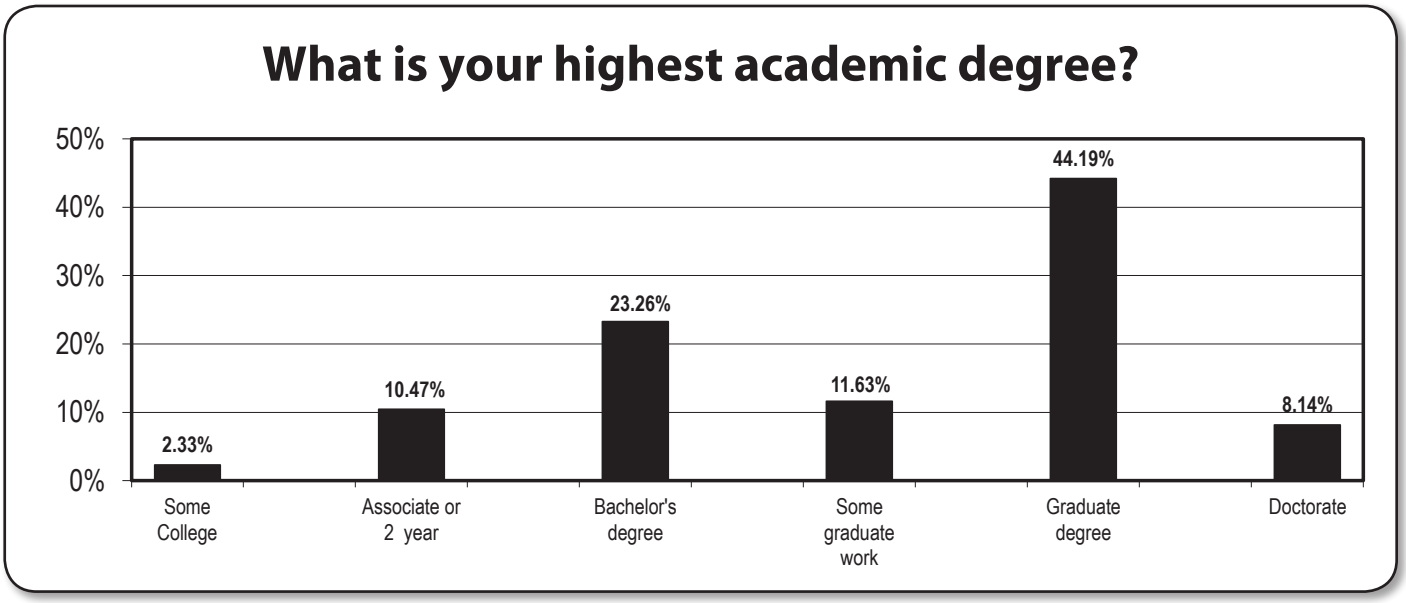
While staffing cuts were noted by *2012 CTU Salary Survey* respondents, the reductions were not as severe as in 2011. About 36% reported lower staffing numbers, compared to 56% in 2011. About half (45%) reported no changes in employment levels, compared to 31% in the previous year. More good news: 19% saw increases in staffing, a jump above 2011's 13% level.

A holding pattern is seen when it comes to salaries for survey respondents About 31% of survey reported a 1-3% increase in salary, with 44% seeing no change in pay levels. This finding is a near mirror image from the previous year, when 36% said they got a 1-3% bump, and 42% noting no change. While about 13% saw a drop in salary; about 7% saw a 4-6% raise. These amounts compare with 2011's 14% and 6% respective figures. *(See "In the past year, how has your salary changed?" graphic above.)*

Extra hours don't enter into the picture for most survey respondents. About 61% report working 40 hours or less a week. *(See "How many hours a week do you work?" graphic below.)* About 31% say they supervise between 4-10 people. *(See "How many people do you supervise, directly or indirectly?" graphic on p. 4.)*

Does location make a difference? Almost half (48%) reported working in a rural area, with 22% in





a medium-sized city. About 16% said they worked in an urban setting, with 15% in a suburban location. While the majority of respondents said they worked in a public health agency, some 19% reported clinic employment. About 14% said they worked in a college health service environment, with 7% at an agency. *(Check the snapshot on p. 4 for an overview of 2012 respondents.)*

Make your resume work

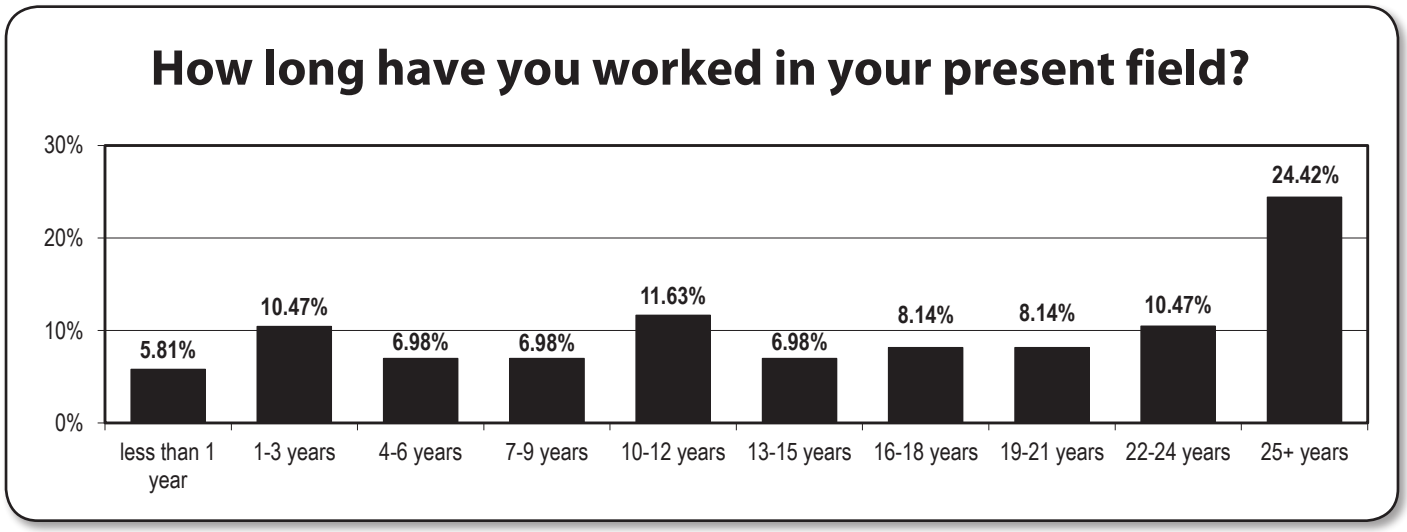
If you are considering searching for a new job, make sure your resume is up to the task. Include updated contact information, says **Renee Dahring**, MSN, NP, family nurse practitioner and career coach. Dahring operates a career coaching web site, www.nursepractitionerjobsearch.com and pens a "Career Coach" blog at www.advanceweb.com/NPPA. Under "Blogs," click on "Career Coach."

E-mail has become the preferred mode of communication for employers, so be sure you include your physical and e-mail address, as well as a telephone number, she says.

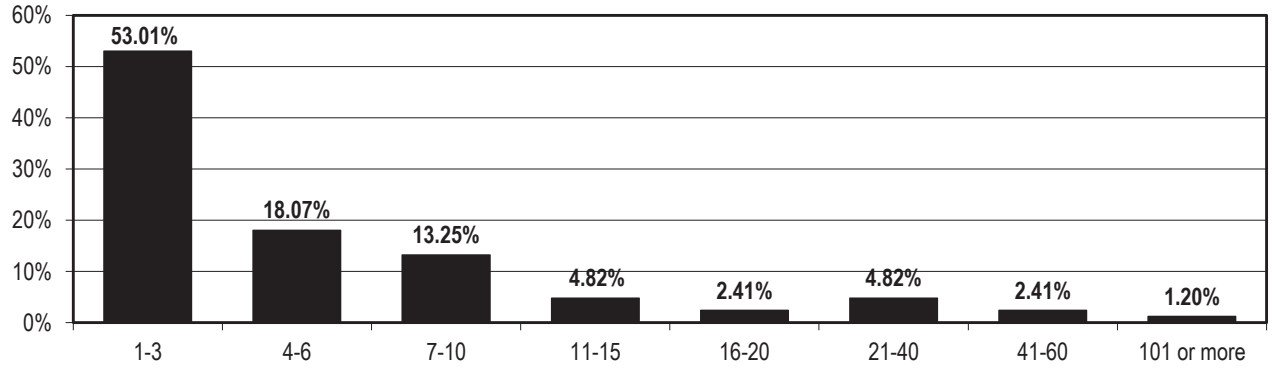
Be specific about your skill set, says Dahring. Play up abilities that fall in line with the prospective job. Stating that you "provided quality care" is one thing. Be sure to spell out how you achieved it, Dahring says. Also, study the requirements listed in a job posting and make sure your resume reflects the same language. Many employers are using electronic resume tracking. For example, if you don't include your nursing license number when the position listing calls for it, your resume might automatically be kicked out, states Dahring.

"These systems can't read between the lines," she notes.

A cover letter can help a prospective employer know if you are open to options, such as travel, relocation, or other positions, says Dahring. Use the cover letter to state such interests. If you are not a good fit



How many people do you supervise, directly or indirectly?



for the position now open, an employer might file your resume for a future, different position if you declare such flexibility, she states.

Flex networking power

Is it time to add to your academic credentials? About 44% of 2012 survey respondents have a graduate degree. About 48% have worked in their present field for 15 years or less. *(See "What is your highest academic degree?" and "How long have you worked in your present field?" graphics on p. 3.)*

When looking to add to your knowledge base, be sure to widen your circle of professional networking options as well, states Dahring. Networking continues to be number one method in landing a new job, says Dahring. Networking can be combined with enhancing your clinical practice, she explains. By checking the community and state health departments on public health issues, you'll gain current information, as well as contacts that might be able to help you in potential job searches. Don't limit yourself to your profession. Physicians, occupational therapists, speech language pathologists, and other health professionals might have valuable job information that can help you when you are ready to make an employment move, Dahring says.

Know that many job positions might not even be advertised, Dahring advises. Employers are looking for recommendations from employees; if you keep your networking circle current, you might be included in one of those recommendations, she notes.

"Employers are finding that the best way to find to get a trusted employee is to ask a trusted employee," states Dahring.

REFERENCES

1. Association of State and Territorial Health Officials. Potential Impact of Sequestration on Public Health. Accessed at http://bit.ly/VkPPnp.
2. Arnold M. Full steam ahead for Obamacare, but gridlock isn't going anywhere. Medical Marketing & Media 2012. Accessed at http://bit.ly/TATD1K. ■

Survey Snapshot

About 49% of the *2012 Contraceptive Technology Update Salary Survey* respondents identified themselves as nurse practitioners (NPs), with about 21% as registered nurses, and 5% as nurse-midwives. Administrators comprised about 18% of the current year's responses. About 5% identified themselves as physicians, and 2% were health educators. The survey was mailed in September 2012 to 800 subscribers with 85 responses, for a response rate of 10.6%.

About 47% of all respondents indicated they made $59,000 or less; about 40% reported salaries between $59,000 and $99,999. About 13% said they earned a six-figure salary. *(See "What is your salary level" graphic on p. 1.)*

Source: 2011 *Contraceptive Technology Update* Salary Survey results.