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Interpreting News and Research on Contraceptives and STIs

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IN THIS ISSUE

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More women moving to LARC methods — Will your facility follow the trend?

Over 95% of 2012 Contraception Survey responses see rise in LARC usage

When it comes to family planning, more women are choosing long-acting reversible contraception (LARC) methods such as intrauterine devices (IUDs) and the contraceptive implant, say respondents to the 2012 *Contraceptive Technology Update Contraception Survey*. More than 95% of survey participants say women are choosing such methods, which is a jump over 2011's 85% response. In 2011, 47.17% of respondents indicated they had performed 11 or more IUD insertions. In 2012, that number jumped to 62.5%. For implants, 59.3% in 2011 said their facility offered or planned to offer the implant. In 2012, that number rose to 63.4%.

Contraception Survey

What has led to the increase? There are several factors at play at Planned Parenthood of Southwest and Central Florida in Tampa, says **Sharon Carlisle**, CNM, lead clinician. More clinicians now are trained to insert intrauterine contraception, and there is a greater acceptance by clinicians of LARC methods as first-line contraception, she notes. More IUD insertions are being conducted immediately post surgical abortion or at the post medical abortion follow-up visit, says Carlisle. Also, screening for sexually transmitted infections are now primarily performed at the time of insertion, if indicated, says Carlisle.

Donna Gray, CNM, WHNP, clinician at the Wyoming County Men's and

EXECUTIVE SUMMARY

More women choose long-acting reversible contraception (LARC) methods such as intrauterine devices (IUDs) and the contraceptive implant, say respondents to the 2012 *Contraceptive Technology Update Contraception Survey*. More than 95% of participants say more women choose such methods.

- In discussing methods, refer to results of a recent study that indicated women who used the Pill, the patch, or vaginal ring were 20 times more likely to have an unintended pregnancy than those who used longer-acting forms such as an IUD or implant.
- Structured counseling on the potential side effects can improve continuation and satisfaction.

Women's Reproductive Health Services in Silver Springs, NY, says, "We are spending more time discussing LARC [methods]. Clients are willing to try them because they can't remember oral contraceptives [OCs]." Gray described the cost of OCs as "ridiculous" in terms of the insurance plans' high deductibles. Pill copay costs run between $50 and $75 per month, she says, "and clients can't afford this."

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Editorial Questions

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Copays of $50 to $75 per month mean that clients are paying $650 to $985 per year, says **Robert Hatcher**, MD, MPH, professor of gynecology and obstetrics at Emory University School of Medicine in Atlanta. This amount makes the cost of long-acting reversible methods that can be used for 3-10 years quite attractive compared to the cost of pills, he notes.

More women request the contraceptive implant (Nexplanon, Merck & Co. of Whitehouse Station, NJ), or IUDs than the contraceptive vaginal ring or transdermal patch, says **Dolores Conroy**, ARNP, senior advanced nurse practitioner specialist and nurse practitioner supervisor at Gulf County Health Department in Port Saint Joe, FL.

Jocelyn Stowell, CNM, ARNP, nurse practitioner at Liberty and Calhoun County Health Departments in Bristol and Blountstown, FL, says, "We promote the use of LARCs because of ease of use and low failure rates. Also, we have both Mirena and ParaGard available and a provider trained to put them in. We should have Nexplanon available soon also."

Clinician familiarity with LARC methods can make a difference in their use, says **Debbie Wright**, MSN, OGNP, nurse practitioner at the University of Wisconsin — Eau Claire Student Health Center. The student health center offers all three LARC methods, she notes. Wright, who estimates she performed 11-25 IUD insertions in 2012, says her familiarity with such methods, coupled with product advertising and the advocacy of a university human sexuality instructor, all have influenced the growing acceptance of long-acting methods among student women. *(See the box on p. 39 to get tips on helping women choose the right IUD for their needs.)*

Counseling is key

How important is provider counseling when it comes to successful LARC use? It is "critical," says **Jeffrey Peipert**, MD, MPH, MHA, Robert J. Perry professor of obstetrics and gynecology and vice chair for clinical research at Washington University School of Medicine in St. Louis. Definitive research from the Contraceptive CHOICE project in St. Louis, which was designed to evaluate reversible birth control methods, found that LARC methods are more effective than pills, patches, or rings in preventing unplanned pregnancy.[1] Women who used birth control pills, the patch or vaginal ring were 20 times more likely to have an unintended pregnancy than those who used longer-acting forms such as an intrauterine device or implant.[1] *(To read more about the research, see the* CTU *article "The 'Get It and Forget It' methods are here: Remove obstacles to use," April 2012, p. 37.)*

Which IUD is Right for your Patient?		
Key Features	Copper IUD (ParaGard)	Hormonal IUD (Mirena)
Highly effective?	Yes	Yes
Very Safe?	Yes	Yes
Effect on monthly period during first few months?	Bleeding may become more heavy and painful; problems often lessen over time. Spotting between periods might occur.	During the first month of Mirena use, there are more days of bleeding than there are days of no bleeding at all. Thereafter, Mirena markedly decreases number of days of bleeding, total blood loss, and cramping. Bleeding stops for some women. Spotting between periods might occur at any time during the duration of Mirena use.
Last how long?	12 years	At least up to 5 to 7 years
Hormone contents?	No hormones. Good option for women who can't or won't take hormones.	Includes a hormone (progestin). Side effects with this hormone can include bloating and tender breasts.

Source: Adapted from Association of Reproductive Health Professionals. A Woman's Guide to Understanding IUDs. Accessed at: http://bit.ly/9gEh3k.

First, when choosing a contraceptive method, patients should be aware that LARC methods are the top-tier reversible options when it comes to effectiveness, notes Peipert, who served as lead investigator of the CHOICE research. Second, patients must be counseled regarding the potential side effects of each LARC method. They should be reassured that irregular and unpredictable bleeding are side effects of all three LARC methods, he notes.

In Mirena users, bleeding typically gets lighter over time and amenorrhea is common, Peipert observes. With the copper IUD, menses typically become regular, but flow might be slighter heavier. With the implant, the bleeding pattern is unpredictable, and patients must accept the fact that the implant can cause irregular bleeding, he states.

Studies have shown that structured counseling on the potential side effects of the contraceptive method has the potential to improve continuation and satisfaction rates, says Peipert.[2] Patients should be counseled regarding side effects and potential noncontraceptive benefits of each method, he explains. "Mirena, for example, can control heaving bleeding and decrease dysmenorrhea, [while] Nexplanon also may reduce dysmenorrhea and may improve acne in women who have acne at baseline," Peipert states. "Both IUDs reduce the risk of endometrial cancer."

One of the reasons Norplant, the first contraceptive implant, was withdrawn from the market was the class action lawsuits against the pharmaceutical company that produced the method, observes Peipert. Women contended that they had not been adequately warned about Norplant's possible side effects, such as irregular menstrual bleeding, headaches, nausea, and depression, he states. "Thus, for all contraceptive methods including LARC, patients should be carefully counseled about the risks, benefits, and alternatives for each method," he states.

Knock down barriers

What are the barriers to increasing LARC access? **David Turok**, MD, MPH, associate professor of obstetrics and gynecology and codirector of the family planning fellowship at the Salt Lake City-based University of Utah, points to four misperceptions:

- Providers don't have time for counseling.
- IUDs hurt, they're hard to get in, and expensive.
- Too much irregular bleeding with the implant.
- Women discontinue the methods too quickly.[3]

Turok, who spoke at the meeting of the Association of Reproductive Health Professionals on the Contraceptive CHOICE Project, advises that clinics identify a staff member who is familiar with LARC methods to perform regular follow-up on IUD and implant users to ensure patient satisfaction with the methods. Women using LARC methods had the highest satisfaction at their one-year follow-up in the CHOICE project, which employed phone interviews to check method use at three, six, 12, 18, 24, 30, and 36 months post enrollment.[4]

Having a staff member connect with people and

express some interest in their continued satisfaction with whatever method they have chosen seems to be important in people continuing with a method, Turok states. This person might not be the most highly credentialed staff member, but someone who is familiar with the benefits and disadvantages of LARC methods and can communicate those, he notes.

Acknowledge the imperfections that come with LARC methods. Expect failed insertions and higher rates of expulsion/removal, Turok notes.

"Keep your eye on the prize," says Turok of LARC methods. "Increasing their use has the potential to dramatically decrease unintended pregnancies." *(Use English and Spanish versions of the "Get It & Forget It" patient information insert to talk with women about LARC. The inserts are available with the online version of this newsletter.)*

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Check methods with combined hormones

The contraceptive vaginal ring (NuvaRing, Merck & Co., Whitehouse Station, NJ) and patch (Ortho Evra, Ortho Women's Health & Urology, Raritan, NJ). are two effective options for women who choose combined hormonal methods.

Contraception Survey

Use of the ring continues to climb, as more than 95% of respondents to the 2012 *Contraceptive Technology Update Contraception Survey* report availability now or soon at their clinics, a slight rise over 2011's 91% figure.

NuvaRing is "pretty popular" at the University of Wisconsin — Eau Claire Student Health Center, notes **Debbie Wright**, MSN, OGNP, nurse practitioner at the facility. National sales figures for 2011 compiled by IMS Health, a Danbury, CT-based healthcare technology and information company, point to such popularity. In the category of hormonal contraceptives excluding the Pill, NuvaRing captured a little more than 63% of U.S. market share in 2011, with Evra sales at about 17%. Sales for the contraception injection depot medroxyprogesterone acetate (DMPA, Depo-Provera, Pfizer, New York City; Medroxyprogesterone Acetate Injectable Suspension USP, Teva Pharmaceuticals USA, North Wales, PA) registered about 19%.[1]

Conventional use of the ring follows a 28-day cycle. A woman inserts a new ring and keeps it in for three weeks, with one week in which the ring is removed, which allows for a withdrawal bleed. A new ring is inserted after the ring-free week.[2]

As with any birth control method, good counseling regarding potential problems can help women achieve success with the contraceptive vaginal ring. If a woman accidentally removes or expels her ring while removing a tampon, engaging in intercourse, or having a bowel movement, counsel that if less than three hours have passed, the ring should be rinsed with lukewarm water and re-inserted as soon as possible. If more than three hours have passed or there is uncertainty about the time period that it has been out, women should rinse and re-insert the ring, resuming the cycle. However, advise the patient to use back-up contraception for seven days and take emergency contraception as needed.[3]

How about the patch?

Each Ortho Evra patch contains 6 mg of norelgestromin, and 0.75 mg of ethinyl estradiol. It releases 150 mcg of norelgestromin and 20 mcg of ethinyl estradiol on a daily basis. It is designed to mimic the 28-day dosing regimen of oral contraceptives; women use three seven-day patches for one week each, then have a seven-day patch-free interval.[2]

EXECUTIVE SUMMARY

The contraceptive vaginal ring (NuvaRing, Merck & Co.) and patch (Ortho Evra, Ortho Women's Health & Urology) are two effective options for women who choose combined hormonal methods.

- Use of the ring continues to climb, as more than 95% of respondents to the 2012 *Contraceptive Technology Update Contraception Survey* report availability now or soon at their clinics.
- Use of the contraceptive patch declined in 2012, according to responses. 70% said their facility provided the method.

The patch offers convenience, with the weekly patch regimen easier for some women to remember than the daily dosing of a combined oral contraceptive.[2] The patch can be worn on the buttocks, upper arm, lower abdomen, or upper torso, excluding the breasts.[2] Be sure patients will be comfortable wearing the patch, says Wright. "We have found that this younger generation does not like wearing the patch on the body," observes Wright. "While they may shave their head, have tattoos, and do body modification, wearing the patch is not desirable."

New patch in wings?

Use of the contraceptive patch declined in 2012, according to survey responses. A total of 70% of respondents said their facility provided the method, compared to 78% in 2011. While patch use continues to decline, the potential advent of a new transdermal contraceptive option might change usage.

Developed by Agile Therapeutics of Princeton, NJ, AG200-15 is an investigational combination hormonal contraceptive patch designed to deliver a low dose of ethinyl estradiol and levonorgestrel comparable to low-dose combination oral contraceptives. Agile has filed a New Drug Application with the Food and Drug Administration for AG200-15 and has registered the trademarked name Twirla.

In a phase III pivotal trial of AG200-15, results suggest the study drug had significantly greater compliance (defined as no missed days of contraception in the cycle) than an oral contraceptive.[4] The data were presented at Association of Reproductive Health Professionals' 2012 Annual Meeting.

Of 1,328 women (mean age, 26.4 years; 60% new hormonal contraceptives users; 46% non-Caucasian; 33% obese), 998 received the patch and 330 received an oral contraceptive for the first six study cycles. Women in the study were treated for one year (13 cycles) with the patch or for six cycles with the Pill, followed by seven cycles of patch use. Subjects recorded patch application and pill-taking on diary cards. Cycles with perfect compliance were defined as cycles with 21 days of patch wear without missed days or any patch worn for more than seven days or cycles with 21 days of pill-taking without days of missed pills.

Over the first six cycles, the percentage of cycles with perfect compliance was significantly higher in the patch versus the pill group (90.5% vs. 78.8%, P less than .001). Compliance with the patch improved over the six treatment cycles, while compliance with the Pill worsened over the six cycles.[4]

Research presented at the 2012 American College of Obstetricians and Gynecologists Annual Meeting indicates the investigational low-estrogen patch is as effective as conventional oral contraceptives. An additional finding of the trial is that the efficacy of the investigational patch did not decline in obese women.[5] *(*CTU *reported on the trial. See "Data out on potential contraceptive patch," August 2012, p. 88.)*

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Ways to use the Pill: What's your strategy?

Contraception Survey

While several protocols are available to start women on a combined oral contraceptive (OC), respondents to the 2012 *Contraceptive Technology Update Contraception Survey* are firmly behind the Quick Start method of pill initiation. One hundred percent of survey participants say they use Quick Start, an increase from 2011's 93% response.

Also known as the Same-Day Start, the practice entails having the woman take the first pill in her pill pack on the day of her visit as long as it is reasonably certain that she is not pregnant and not in need of emergency contraception.[1]

Quick Start is so much simpler; most women choose to use it, says **Debbie Wright**, MSN, OGNP, nurse practitioner at the University of Wisconsin — Eau Claire Student Health Center. However, it requires

more counseling on breakthrough bleeding, she notes.

Quick Start is preferred because other combined oral contraceptive initial protocols generally have a time gap between the time of prescription and the time the patient begins taking it. Research indicates as many as 25% of women who use other protocols fail to take the pills as instructed because they conceive in the interim, fail to fill the prescription, or worry about taking the Pill.[2,3]

In using the Quick Start protocol, 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, 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. Nelson provided an OC update at the 2012 Contraceptive Technology: Quest for Excellence conference.[4]

Tara Cleary, MD, MPH, research assistant professor at the University of North Carolina — Chapel Hill and guest researcher at the Centers for Disease Control and Prevention in Atlanta, says a provider can be reasonably certain that a woman is not pregnant if she has no symptoms or signs of pregnancy and meets any of the following criteria:

- has not had intercourse since last normal menses; OR
- has been correctly and consistently using a reliable method of contraception; OR
- is within seven days after normal menses; OR
- is within four weeks postpartum (non-lactating); OR
- is within the first seven days postabortion or miscarriage; OR
- is fully or nearly fully breastfeeding, amenorrheic, and less than six months postpartum. This information comes from the Geneva, Switzerland-based World Health Organization's Selected Practice Recommendations, which is being adapted to provide U.S. clinicians with practical applications for contraceptive management.[5]

EXECUTIVE SUMMARY

While several protocols are available to start women on a combined oral contraceptive (OC), respondents to the 2012 *Contraceptive Technology Update Contraception Survey* are firmly behind the Quick Start method. 100% of survey participants say they use Quick Start, an increase from 2011's 93% response.

- Clinicians report that more women are choosing extended or continuous regimen pills. About 55% reported such use.
- Teva Women's Health has completed Phase III studies and filed a New Drug Application for an investigational ascending-dose, extended-regimen oral contraceptive, Quartette.

New extended regimen OC?

Clinicians report that more women are choosing extended or continuous regimen pills. About 55% reported such use, compared to 2011's 42% figure. *(Need tips on how to talk with patients about extended or continuous regimen pills? See box on p. 43.)*

Women like not having monthly cycles, says **Donna Gray**, CNM, WHNP, clinician at the Wyoming County Men's and Women's Reproductive Health Services in Silver Springs NY.

Women have requested continuous OC regimens for convenience purposes, including but not limited to not wanting menses while traveling or during their honeymoon, observes **Dolores Conroy**, ARNP, senior advanced nurse practitioner specialist and nurse practitioner supervisor at Gulf County Health Department in Port Saint Joe, FL.

Many women have medical indications for menstrual suppression or a personal preference to reduce or eliminate monthly bleeding, which can be achieved with extended and continuous regimens of combined estrogen and progestin contraceptives.[6] For extended regimen pills, there are four 30 mcg ethinyl estradiol/150 mcg levonorgestrel pills, packaged as 84 active pills and seven placebo pills: Seasonale and Jolessa (Teva Pharmaceuticals, North Wales, PA), Quasense (Watson Pharmaceuticals, Morristown, NJ) and Introvale (Sandoz, Princeton, NJ). There are three 30 mcg ethinyl estradiol/150 mcg levonorgestrel and 10 mcg ethinyl estradiol pills, packaged as 84 active pills and seven low-dose estrogen pills: Seasonique and Camrese (Teva Pharmaceuticals), and Amethia (Watson Pharmaceuticals). There are three 20 mcg ethinyl estradiol/100 mcg levonorgestrel pills and 10 mcg pills, packaged as 84 active pills and seven low-dose estrogen pills: LoSeasonique and CamreseLo (Teva Pharmaceuticals) and Amethia Lo (Watson Pharmaceuticals). Two continuous regimen pills, containing 20 mcg ethinyl estradiol/90 mcg levonorgestrel, packed as 28-day packs with no hormone-free interval: Lybrel (Wyeth Pharmaceuticals, Philadelphia) and Amethyst (Watson Pharmaceuticals).[6]

There might be an addition to the extended regimen pill roster. Teva Women's Health has completed Phase III studies and filed a New Drug Application with the Food and Drug Administration for regulatory approval of an investigational ascending-dose, extended-regimen oral contraceptive, Quartette, confirms **Louise Strong**, a Teva spokesperson.

Data on the Phase III, multicenter, open-label,

single arm efficacy and safety study were presented at the 68th Annual Meeting of the American Society of Reproductive Medicine. A total of 3,701 women were enrolled; 2,144 completed the study. The Pearl Index (PI) was 2.92 (95% confidence interval [CI],2.26-3.72), based on 65 pregnancies that occurred after the onset of treatment and within seven days after the last combination tablet in women ages 18-35, and excluding cycles in which another method of birth control was used. Life-table pregnancy rate was 2.68% (95% CI, 2.11%-3.42%) for all users ages 18-35. The most common treatment-related adverse effects were metrorrhagia (5.9%) and headache (4.5%).[7]

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Menstrual Suppression Counseling Checklist

Introducing the Concept

• Standard oral contraceptives (OCs) include placebo pills to mimic a woman's natural menses, but when a woman is on OCs, she does not have a natural bleeding episode.

• There is no medical or health reason to bleed while on hormonal contraceptives.

• Menstrual blood does not build up when women are using hormonal birth control.

Safety

• Safety appears comparable to that of conventional combined OC regimens.

• Return to fertility after discontinuation is expected to be the same as for conventional combined OC use.

Advantages

• Menstrual suppression can help alleviate menstruation-related conditions.

• Such regimens are more convenient in general and during particular occasions, such as vacations and athletic activities.

• Menstrual suppression eliminates the need to purchase and carry as many hygiene products.

Disadvantages

• Unpredictable breakthrough bleeding is initially more common than with conventional combined OCs. Bleeding will lessen as the body adjusts to the new hormone balance.

• It often takes a few months before the desired effect of reduced bleeding is achieved. If the method is being used to eliminate menstruation for a specific event, it should be initiated well in advance of the event.

• It may be more difficult to detect pregnancy with a suppressive regimen. Patients should be advised to look for other signs of pregnancy besides a skipped menstrual period, such as breast tenderness, nausea, fatigue, and other signs, and to obtain a pregnancy test if unsure.

• In some cases, the regimen may be more costly.

How to Follow an Extended-Use Regimen

• Discuss when to have hormone-free days, if any.

• Discuss the schedule of the method, such as taking combined OCs at the same time every day.

What to Expect

• Spotting

• Blood may be dark brown (oxidized due to remaining in vagina longer) rather than red (blood noted with active bleeding). Blood may have a different texture.

Source: Association of Reproductive Health Professionals. Menstrual Suppression. Accessed at http://bit.ly/14O4zyX. ■

Power of the Pill: Readers speak out

EXECUTIVE SUMMARY

The upswing of use of long-acting reversible contraception is making an impact on the use of combined oral contraceptives (OCs), according to responses to the 2012 *Contraceptive Technology Update Contraception Survey*.

• While about 40% of respondents to the 2012 survey said more than half of their patients use OCs, reports from clinicians underscore the increasing acceptance of other methods.

• Ortho Tri-Cyclen Lo once again is named as the leading choice as the top non-formulary pill for young women. Alesse (Wyeth) continues as the top pill of choice for older women.

The upswing of use of long-acting reversible contraception (LARC) is making an impact on the use of combined oral contraceptives (OCs), according to responses to the 2012 *Contraceptive Technology Update Contraception Survey*. While about 40% of respondents to the 2012 survey said more than half of their patients use OCs (a slight rise from 2011's 38% mark), reports from clinicians in the field underscore the increasing acceptance of other methods.

Contraception Survey

Fewer women are using the Pill, observes **Jocelyn Stowell**, CNM, ARNP, nurse practitioner at Liberty and Calhoun County Health Departments in Bristol and Blountstown, FL. She says fellow clinicians are promoting the use of LARC methods because of ease of use and low failure rates.

"More women seem to be opting for the contraceptive vaginal ring (NuvaRing, Merck & Co., Whitehouse Station, NJ) than ever before," notes **Sharon Carlisle**, CNM, lead clinician at Planned Parenthood of Southwest and Central Florida in Tampa. "Typically these women were former combined OC users."

Pill use is a "little down" at the University of Wisconsin — Eau Claire Student Health Center, confirms **Debbie Wright**, MSN, OGNP, nurse practitioner at the facility. So many patients go on and off oral contraceptives, she notes. "We need to change the name for 'birth control pills.' because so many young women are now using pills for non-contraceptive reasons, such as acne and premenstrual dysphoric disorder," Wright states. "Many virgins are looking at contraception for 'just in case.'"

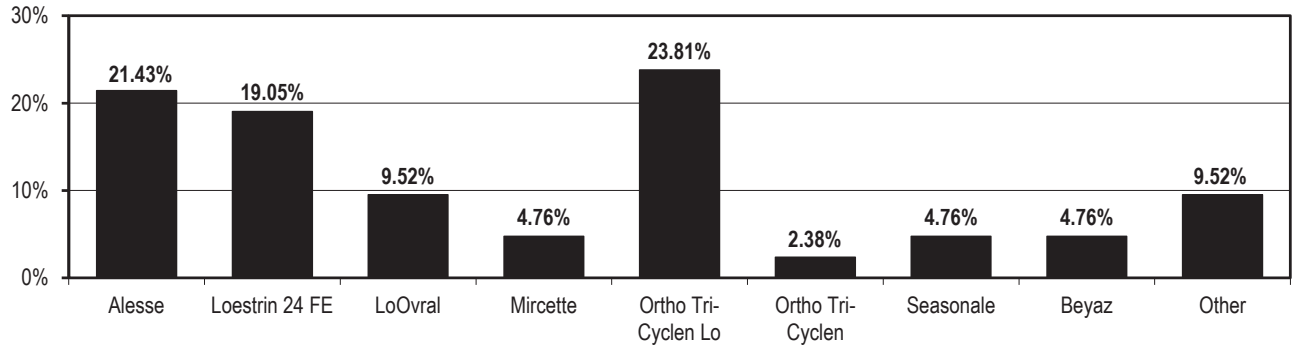
When talking about the Pill, take time to educate women about its noncontraceptive benefits. Use the following talking points:

- Dysmenorrhea can be treated successfully with combined oral contraceptives.
- Combined oral contraceptives have been shown to reduce and regulate menstrual bleeding.
- Combined oral contraceptives can treat acne in women also desiring contraception.
- Severe premenstrual syndrome might respond to drospirenone-containing combined oral contraceptives.
- Use of combined oral contraceptives decreases the risk of endometrial and ovarian cancer.[1]

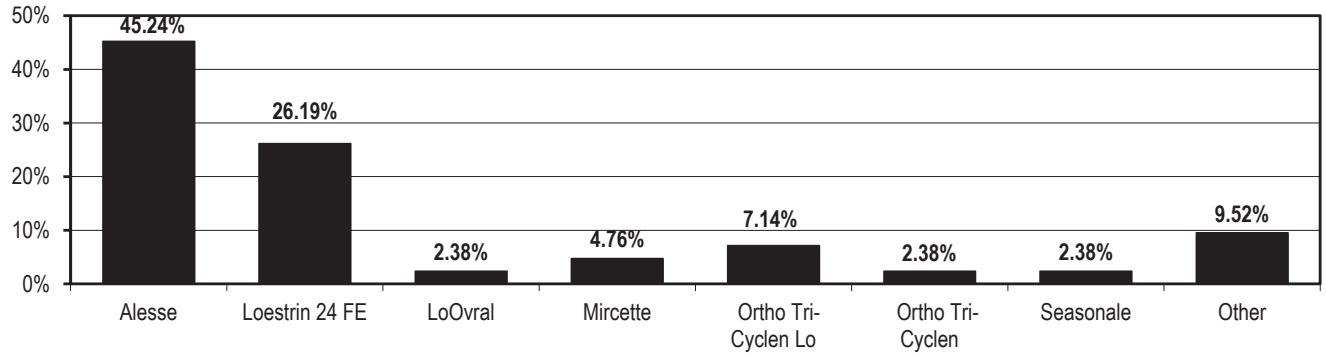
Ortho Tri-Cyclen Lo (Ortho-McNeil Pharmaceutical; Raritan, NJ) once again is named as the leading choice as the top non-formulary pill for young women, a spot it has maintained since 2008. *(See graphic below.)* It also takes the first spot when formulary rules dictate which pill to use for this age category. Respondents to the 2011 survey named Loestrin from Teva Pharmaceuticals as the leading formulary choice for 21 year olds.

Alesse (45%) remains in its top spot as the pill of choice for older women, followed by Loestrin 24 FE

Assume you could prescribe any pill for a woman initiating combined pills and there were no formulary issues dictating which pills you could prescribe. Which pill would you (or a clinician in your program) prescribe for a 21-year-old nonsmoking woman?



Assume you could prescribe any pill for a woman initiating combined pills and there were no formulary issues dictating which pills you could prescribe. Which pill would you (or a clinician in your program) prescribe for a 42-year-old nonsmoking woman who wants to use combined pills?



(Warner Chilcott, LLC, Rockaway, NJ). About 40% of 2011 respondents named Alesse, a 20-mcg pill from Wyeth, as top pill in this category. *(See graphic above.)*

Alesse also dominates as the leading option for women who have experienced nausea when using previous pills. More than half (55%) selected it in the current survey, with 49% naming it as top pill in the 2011 poll. The pill has consistently held the no. 1 position in this category since 1999.

When it comes to oral contraceptives, budget constraints are leading many clinics to stock more generic pills instead of branded OCs. About 62% say their facilities are using more generic drugs, compared to 2011's 75% reading.

Clinicians continue to hold the line when it comes to prescribing combined pills to older women (40 and above) who smoke 10 cigarettes a day. About 95% said they would withhold OCs from such patients, declining from 2011's 98% statistic. Readers are less emphatic when it comes to women smokers ages 35-39. About 77% said they would not prescribe combined pills to those who smoke 10 cigarettes a day, a sharp decline from 2011's 90% figure.

Clinicians likely are now adhering to the U.S. Medical Eligibility Guidelines for Contraceptive Use, which ranks use of combined hormonal contraceptives for smokers under age 35 as a "2," which is a condition for which the advantages of using the method generally outweigh the theoretical or proven risks. When it comes to combined OC use for women age 35 or older who smoke less than 15 cigarettes per day, the guidelines list it as a "3," which is a condition for which the theoretical or proven risks usually outweigh the advantages of using the method. For women in the same age range who smoke 15 cigarettes or more per day, the guidelines give a "4" ranking, because the condition represents an unacceptable health risk if the method is used.[2]

Survey Profile

Results of the 2012 *Contraceptive Technology Update (CTU) Contraception Survey* were tallied and analyzed by AHC Media, publisher of *CTU*. The survey was mailed in December 2012 to 800 subscribers with 43 responses, for a response rate of 5.4%.

Ninety-three percent of responses came from nurse practitioners or registered nurses. Physicians represented about 5%. About 88% of respondents identified themselves as care providers, with some 9% involved in administration, and about 2% identifying themselves as faculty/teachers/students.

About 77% said they worked in public health facilities, with about 12% listing student health centers or academic institutions as their employer. About 2% reported working in hospitals, with some 9% employed in other settings.

More than half (51%) said they worked in a rural areas. About 29% said they were employed in an urban area, while about 17% listed a suburban setting. ■

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Raise awareness on contraceptive sabotage

Birth control sabotage — in which a partner deliberately pokes holes in condoms, destroys birth control pills, or tampers with the efficacy of a method — is not uncommon. In one study of family planning clinic patients, 15% of women experiencing physical violence also reported birth control sabotage.[1] In another study among adolescent mothers on public assistance who experienced recent intimate partner violence, 66% experienced birth control sabotage by a dating partner.[2]

The American College of Obstetricians and Gynecologists (ACOG) has just issued a committee opinion calling for clinicians to routinely screen teens and women for sexual and reproductive coercion at annual exams, new patient visits, prenatal visits, and postpartum checks.[3]

The publication was prompted by work with Futures without Violence, an organization that works to end violence against women and children, says **Eve Espey**, MD, MPH. Espey, associate dean of students and professor in the Department of Obstetrics and Gynecology at the University of New Mexico in Albuquerque and chairperson of ACOG's Committee on Health Care for Underserved Women, which issued the opinion.

Sabotaging a woman's contraceptive method, pressuring her to become pregnant unwillingly, or forcing her to end or continue a pregnancy against her will are examples of reproductive coercion.[1] Repeated pressure to have sex, forcing sex without a condom, and intentionally exposing a partner to sexually transmitted infections are examples of sexual coercion.[1]

Data indicates that unintended pregnancy occurs more commonly in abusive relationships, which suggests that victimized women face compromised decision-making regarding contraceptive use and family planning, including condom use.[4-7]

The first quantitative examination of the relationship between intimate partner violence, reproductive coercion, and unintended pregnancy was designed by researchers from University of California, Davis, Harvard School of Public Health in Boston, Futures Without Violence and Planned Parenthood Shasta Pacific in Concord, CA.[1]

Conducted between August 2008 and March 2009 at five reproductive health clinics in California, the study involved about 1,300 women ages 16-29 who responded to a survey about experiences with relationships and pregnancy.

About one in five women said they experienced pregnancy coercion, and 15% said they experienced birth control sabotage. More than half of the respondents (53%) said they had experienced physical or sexual violence from an intimate partner. About 33% of the women who reported partner violence also noted pregnancy coercion or birth control sabotage.[1]

One of the outcomes of the 2010 study was the development of a small, easy-to-conceal, wallet-sized safety cards in English and Spanish, says **Rebecca Levenson**, MA, study co-author and senior policy analyst at Futures Without Violence. The cards, cobranded by ACOG, provide information to help women make the connection between unhealthy relationships and reproductive health concerns such as unintended pregnancies. The safety cards also include self-administered questions for intimate partner violence and reproductive and sexual coercion, harm-reduction and safety planning strategies, and information about how to get help and resources. *(See the resource at the end of this article for ordering information.)* The card also can be used by providers to help have a dialogue with patients regarding potential violence issues, says Levenson.

Question women about sexual and reproductive coercion and informing them of community resources to maintain their safety, as well as develop personal strategies to preserve reproductive autonomy, says Espey. These strategies include using birth control methods that are less apparent to partners,

EXECUTIVE SUMMARY

Birth control sabotageis not uncommon, according to a new committee opinion released by the American College of Obstetricians and Gynecologists (ACOG).

- The ACOG opinion says clinicians should routinely screen for sexual and reproductive coercion at annual exams, new patient visits, prenatal visits, and postpartum checks.
- Sabotaging a woman's contraceptive method, pressuring her to become pregnant unwillingly, or forcing her to end or continue a pregnancy against her will are examples of coercion. Repeated pressure to have sex, forcing sex without a condom, and intentionally exposing a partner to a n STI are examples of sexual coercion.

such as the copper-T intrauterine device (ParaGard IUD, Teva North America, North Wales, PA), says Espey. The copper IUD is particularly well-suited for this scenario, Espey says. Some partners count menstrual bleeding days, so the levonorgestrel IUD (Mirena, Bayer HealthCare Pharmaceuticals, Wayne, NJ) could alert a partner to a change in menstruation, she notes. For extra protection, an IUD string may be cut short into the endocervical canal so that it is not palpable by the partner and can't be pulled out, says Espey. Provide emergency contraceptive pills and advise women to put them into a plain envelope.

Create a safe and supportive environment for assessing and responding to reproductive and sexual coercion, the committee opinion advises. Practices should have a written policy and provide training to clinicians and employees on intimate partner violence and reproductive and sexual coercion, how to offer referrals, and how to establish relationships with women's shelters and state health department violence prevention programs. Be sure there are private spaces to interview women without interruption and where their conversations cannot be overheard. Place a clearly stated policy in the reception area to help the staff maintain the normal experience of seeing the patient alone without a friend or family member.

"We [ACOG] have presented together with Futures without Violence at the ACOG annual meeting for the last couple of years and plan another joint session this year to raise consciousness and help develop approaches to patients," states Espey.

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RESOURCES

• The Reproductive Health Safety Card is available at the Futures Without Violence web site, www.futureswithoutviolence.org. Select "Order Materials Online," "Health Care and Domestic Violence Materials," "Patient Education Safety Cards," then "Reproductive Health Safety Cards". Providers can download the free file or place an order for 50-250 preprinted cards. The preprinted cards are free, but a mailing charge is assessed.

• Download a free PDF of Futures Without Violence's guidebook, A Guide to Addressing Intimate Partner Violence, Reproductive and Sexual Coercion. Follow the prompts as listed above to "Health Care and Domestic Violence Materials," then select "Reproductive Health," then the guideline's title. ■

COMING IN FUTURE MONTHS

■ Seniors: Missing piece in HIV prevention puzzle

■ How to use social media in HIV prevention

■ New sterilization device in research

■ Contraceptive coverage: How will it come down?

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.
2. Log on to www.cmecity.com to take a post-test; tests can be taken after each issue or collectively at the end of the semester. First-time users will have to register on the site using the 8-digit subscriber number printed on their mailing label, invoice or renewal notice.
3. Pass the online tests with a score of 100%; you will be allowed to answer the questions as many times as needed to achieve a score of 100%.
4. After successfully completing the last test of the semester, your browser will be automatically directed to the activity evaluation form, which you will submit online.
5. Once the completed evaluation is received, a credit letter will be e-mailed to you instantly.

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

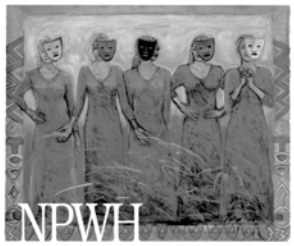
1. What is the progestin used in Evra, the contraceptive patch?
   A. Norelgestromin
   B. Levonorgestrel
   C. Norethindrone acetate
   D. Drospirenone

2. Which of the following is NOT an extended regimen oral contraceptive?
   A. Seasonale
   B. Natazia
   C. Quasense
   D. Jolessa

3. Which of the following is NOT a noncontraceptive benefit of combined oral contraceptives?
   A. Treatment of dysmenorrhea
   B. Treatment of acne
   C. Decreased risk of melasma
   D. Decreased risk of endometrial and ovarian cancer

4. Which of the following is an example of reproductive coercion?
   A. Repeated pressure to have sex
   B. Forcing sex without a condom
   C. Intentionally exposing a partner to sexually transmitted infections
   D. Sabotaging a woman's contraceptive method

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.



VERY, VERY important myths about IUDs:

1 MYTH: IUDs cause abortions. NO, this is not true. Major organizations in reproductive health throughout the world, and textbooks in reproductive health, strongly state that IUDs do not disrupt an implanted pregnancy and therefore do not cause abortion. IUDs work in several ways to prevent pregnancy.

- The hormonal IUD, called Mirena, works most often by blocking sperm from passing through mucus in a woman's cervix. This prevents fertilization, or when a man's sperm enters a woman's egg. Mirena occasionally prevents ovulation, when a woman's ovary releases an egg. Less often, Mirena may block implantation. This is when a fertilized egg attaches to the inside of a woman's uterus.
- The copper IUD, called ParaGard, works by preventing fertilization. Copper is a spermicide. The copper in the ParaGard IUD kills sperm when they are inside the uterus, and they cannot reach a woman's egg. ParaGard may block implantation of a fertilized egg in the rare instances where fertilization occurs.

2 MYTH: IUDs cause cancer. This is not true! The hormonal IUD called Mirena prevents endometrial cancer. The copper IUD called ParaGard has been shown to prevent both endometrial and cervical cancer.

3 MYTH: Women with fibroids cannot use an IUD. For most women with fibroids, this is not true. In fact, the Mirena IUD can be used to treat bleeding and pain in women with fibroids. In rare cases, a fibroid can change the shape of the uterine cavity and it may not be possible to insert an IUD.

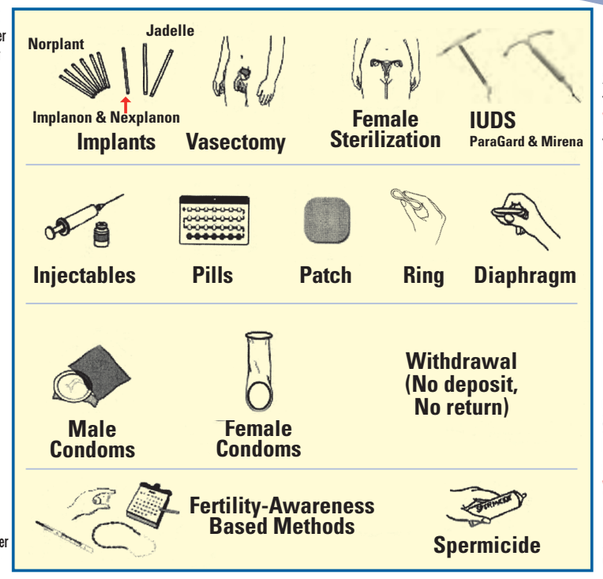
4 MYTH: Women cannot use an IUD until they have had a baby. SIMPLY NOT TRUE! Both the World Health Organization (WHO) and the Centers for Disease Control (CDC) have said the IUD is a good choice for birth control in women who have not had a baby. Also, teens who have never been pregnant CAN USE IUDs! **Get It and Forget It** birth control is a great way for teenagers to prevent pregnancy for many years.

5 MYTH: IUDs cost too much. Over time, IUDs and implants are definitely the least expensive reversible methods of birth control. Some insurance programs help cover the cost of IUD and implants, and so do some college and community health services.

6 MYTH: IUDs cause infections. Actually, women using Mirena IUDs in research studies were found to have a lower risk of pelvic infection, or PID, compared to women not using an IUD. Placing an IUD does involve a very small risk of infection. This risk is only 0.1% and is only during the two weeks following IUD placement. After two weeks, there is no higher risk of pelvic infection in women using an IUD.

Pelvic infections are serious, and can cause problems with pain and infertility. Infections cause infections, IUDs do NOT cause infections. These infections are usually sexually transmitted and can be prevented by perfect condom use. All women at risk of infection should use condoms every single time they have sex.

COMPARING TYPICAL EFFECTIVENESS OF CONTRACEPTIVE METHODS



How to make your method most effective

After procedure, little or nothing to do or remember.
Vasectomy: Use another method for first 3 months and until there are no motile sperm on 2 semen analyses.
Injections: Get repeat injections on time
Pills: Take a pill each day
Patch, Ring: Keep in place, change on time
Condom, Diaphragm: Use correctly every single time you have sex
Fertility-awareness based methods: Abstain or use condoms on fertile days. Newest methods (Standard Days Method and Two Day Method) may be easier to use and consequently more effective.
Withdrawal, spermicide: Use correctly every time you have sex.

Adapted from WHO 2007 and Contraceptive Technology, *20th Edition*

If you have questions about the "Get It and Forget It" methods, also called the Long Acting Reversible Contraceptives, you can go to managingcontraception.com, bedsider.org or plannedparenthood.org

"Insanity is doing the same thing over and over again and expecting different results."
—ALBERT EINSTEIN

For the past 50 years, half of all pregnancies in the United States have been unintended. We now need to move on to the more effective "Get It and Forget It" methods: implants and IUDs.

"GET IT AND FORGET IT"

Women are 20 times more likely to become pregnant in one year if they use contraceptive pills, patches or rings rather than using an intrauterine device (IUD) or contraceptive implant.

Winner, B., Peipert, J., Zhao, Q., Buckel, C., Madden, T., Allsworth, J., & Secura, G. (2012). Effectiveness of long-acting reversible contraception. N Engl J Med, May 24 (21); 3: 1998-2007.

Now may be the time for you to look at IUDs and implants, or "Get It and Forget It" birth control.

There are two IUDs available in the United States. Both are small plastic devices easily placed inside the uterus by a clinician. They work for a long, long time and can be taken out any time you are ready to become pregnant. The Mirena IUD is also called the hormonal IUD, or levonorgestrel IUD. It may be used for up to 7 years and it is actually the most effective way to reduce menstrual bleeding, pain, and cramping. The ParaGard IUD, or Copper T IUD, works for 12 years and is also the most effective form of emergency contraception. It is much more effective than emergency contraceptive pills. The contraceptive implant is placed under the skin of your upper arm, and provides excellent protection against pregnancy for 3 to 4 years. Return of fertility is rapid after stopping use of all 3 Get It and Forget It contraceptives.

VERY, VERY important facts about IUDs and implants:

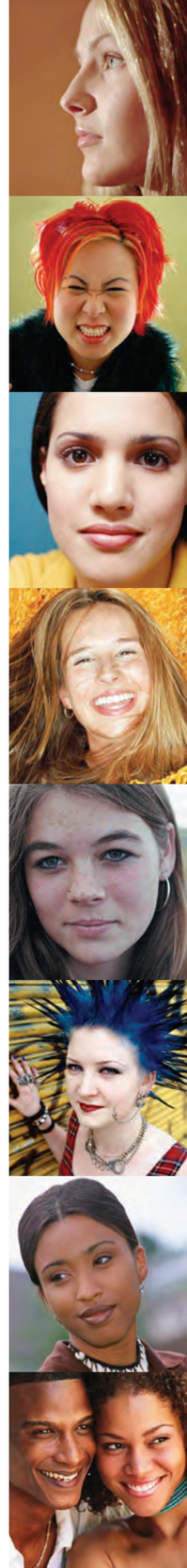
1 The two IUDs and the two implants, Nexplanon and Implanon, are the most effective methods of birth control ever developed that allow a woman to become pregnant as soon as they are removed. These methods are called Long Acting Reversible Contraception, or LARC methods. "Reversible" means that these methods of birth control stop working as soon as they are removed. We like calling them **Get It and Forget It** methods. IUDs are as effective at preventing pregnancy as having a tubal sterilization ("getting your tubes tied") or relying on a man's vasectomy. **Women are 20 times more likely to become pregnant if they use contraceptive pills, patches or rings rather than if using an IUD or implant.** This is explained largely by the fact that once you have an IUD or implant placed you don't have to think about it for years. This is why we call IUDs and implants the **GET IT AND FORGET IT!** methods.

2 The IUD is the method of birth control chosen most often throughout in the world and its use is on the rise in the United States. Only about 5% of women in the United States choose the IUD. However, 18% of women who are ObGyn's (Obstetrician/Gynecologists) use IUDs. This suggests that women who know the very most about birth control choose and use IUDs much more often than other women. In St Louis, 75% of women who are given the choice of using any contraceptive method for free are choosing to use an IUD or an implant as part of the Contraceptive CHOICE Project. This program is already showing a fall in teen births at the Barnes Jewish Hospital.

3 Over time, the IUD and implant cost less than any other reversible method of birth control available. For many women there is an initial cost of purchasing the IUD or implant and having it inserted in a medical office. However, over time, IUDs and implants cost much less per year than pills, patches, rings or injections. Some women who do not have insurance that covers birth control pay $50 to $90 a month for each package of brand-name birth control pills! Some thoughts about getting around the high cost of having an IUD or implant placed:

- If you want an IUD or implant but can't afford it, start saving today!
- Hospitals, doctor's offices, college health clinics, community health clinics as well as IUD and implant manufacturers may offer financial help.
- The websites on the back of this pamphlet can help you find a way to start a **Get It and Forget It** method. Some of them may be able to help you find other ways to lower the cost.
- Keep in mind that the most important cost of any contraceptive is the cost to you if you become pregnant. There is a very low risk of pregnancy when using an IUD or implant. A person using these methods is much less likely to have to deal with the emotional and financial expenses associated with an unwanted pregnancy.

If a woman or man is sexually active then please do not forget that perfect use of condoms every time is the only way to be protected from sexually transmitted infections. Women and men at risk of infection should always use a condom.



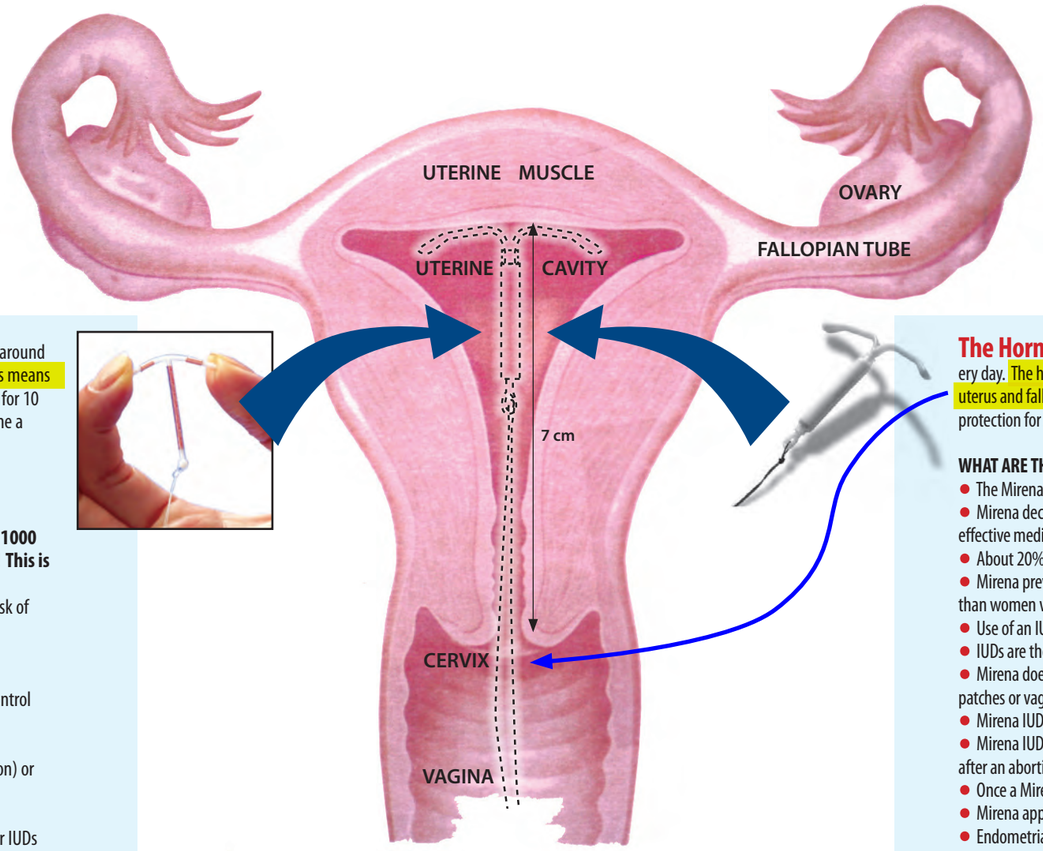
Once in place, IUDs and implants work for years and are sometimes called

"GET IT AND FORGET IT" METHODS

IUDs and implants are immediately reversible when removed. Sometimes they are called the Long Acting Reversible Contraceptives or LARC methods.

Implanon & Nexplanon Implants

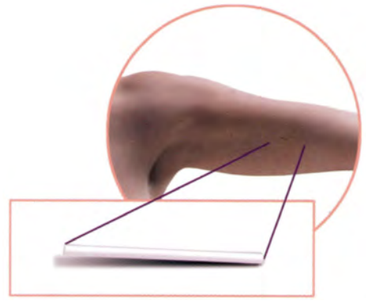
Contraceptive implants are placed under the skin of the upper arm, where they remain effective for 3 to 4 years, maybe longer. This birth control method stops ovulation more completely throughout the first 3 years after insertion than any currently available contraceptive. Unpredictable spotting and bleeding improves over time. The total days of bleeding a woman has are decreased by implants.



In the remarkable St. Louis Contraceptive CHOICE Project, 69% of adolescents aged 14 to 17 years chose to use an IUD or an implant. Of these young teenagers using a LARC method, 63% chose to use the Implanon implant.

Renee Mestad, et al, *Contraception*, 2011

There may be some bruising or pain after placement of an implant. Infections at the site of the implant are rare.



The Copper IUD:

ParaGard is a flexible T-shaped plastic device with three sleeves of copper wrapped around the IUD. ParaGard prevents pregnancy because the copper ions released by the device act as a spermicide. This means sperm are unable to reach the fallopian tubes, and unable to enter a woman's egg. ParaGard is FDA-approved for 10 years of use. Excellent research shows that ParaGard is highly effective for 12 years. It can be removed any time a woman wants to become pregnant.

WHAT ARE THE ADVANTAGES OF THE COPPER IUD?

- The copper T 380 A IUD is effective for at least 10-12 years.
- ParaGard may be used as emergency contraception if inserted within 5 days of unprotected intercourse. **If 1000 women have a copper IUD inserted as an emergency contraceptive, only 1 will become pregnant! This is the most effective emergency contraception available to women.**
- ParaGard prevents ectopic, or "tubal", pregnancies. In fact, women using ParaGard have a 10 times lower risk of ectopic pregnancy than women who are not using any contraception.
- Use of an IUD is convenient, safe, and private.
- IUDs are the most COST EFFECTIVE REVERSIBLE CONTRACEPTIVES ever developed!
- The copper IUD has no hormones. It may be used by women who cannot use estrogen–containing birth control pills, patches or vaginal rings.
- ParaGard IUD may be used in women who are breastfeeding.
- ParaGard IUD may be inserted immediately following the delivery of a baby (vaginally or by cesarean section) or immediately after an abortion.
- Once a ParaGard IUD is removed, fertility returns right away.
- Here is a fascinating and unexpected advantage of copper IUDs: A number of studies of women with copper IUDs have shown a decreased risk of uterine and cervical cancer.
- Most women who have a ParaGard placed will continue to have regular periods. For some women, having a monthly period is important and the ParaGard IUD is an excellent choice for them.

WHAT ARE THE DISADVANTAGES OF THE COPPER IUD?

- Women may have up to a 35% increase in menstrual bleeding while using ParaGard, as well as increased cramps.
- If you already have heavy, painful periods and want an IUD, ParaGard may make these symptoms slightly worse and may not be the best choice for you.
- Most women feel mild to moderate discomfort during the IUD insertion. Rarely, a woman may feel very strong cramps during the IUD insertion. This discomfort improves quickly after the IUD has been placed. A woman may want to take an anti-inflammatory such as ibuprofen one hour before her appointment and then every 6 hours the day of placement.

About 2 percent of women who have had either a Paragard or Mirena placed will expel the IUD in the first year. This means the IUD may be pushed out of the uterus. Women at higher risk of expulsion include women who have never had a baby, have heavy and/or painful periods, or have the IUD placed right after delivery of a baby or after an abortion. Symptoms of expulsion include cramping, vaginal discharge, bleeding, being unable to feel the IUD strings, or being able to feel the hard plastic of the IUD at the cervix or in the vagina. Because expulsions can also happen without symptoms, your provider will discuss how to check the IUD strings so you know the IUD is in place.

In this diagram, the distance from the opening of the cervix up to the top of the uterine cavity measures 7.0 centimeters (just less than 3 inches). Before having a baby, 70% of women 15-25 years of age have a uterus this large or larger. A uterus this size has adequate room for a Mirena or ParaGard IUD.

HOW IS AN IUD PLACED?

Whether you choose the Mirena or ParaGard IUD, they are inserted the same way. A pelvic exam is performed to determine the size of your uterus, and its position in your pelvis. A speculum is then placed in the vagina in order to see your cervix, similar to when you have a pap smear. For some women, a local anesthesia may be injected to numb the cervix before the cervix is dilated, or opened. The IUD is gently passed through the cervix and into the uterine cavity. The IUD insertion itself takes 3 to 5 minutes. There will be soft strings that are attached to the IUD and that are left long enough to extend through your cervix and into your vagina (but not outside of your vagina). These allow you and/or your provider to check that the IUD is still in place, and also allow your provider to remove the IUD. Your provider may ask to see you for a return office visit 4 to 6 weeks after the IUD was placed to check that the IUD is still in place, and talk to you about any concerns you may have.

HOW IS AN IUD REMOVED?

If you decide to have your IUD removed, your provider will place a speculum in your vagina to see the cervix. Then she or he will grasp the IUD strings with a small instrument. With a gentle pull the IUD can be removed in SECONDS, with minimal or NO cramping. You can get pregnant right away after IUD removal. Be sure to have a plan for switching to another birth control if you do not want to become pregnant.

The Hormonal IUD:

The Mirena IUD releases small amounts of a progesterone-like hormone called levonorgestrel every day. The hormone released by the IUD causes cervical mucus to thicken. Sperm is prevented from reaching the inside of the uterus and fallopian tubes. This means that sperm from a man cannot enter a woman's egg. The Mirena IUD provides pregnancy protection for 5-7 years but can be removed any time a woman wants to become pregnant.

WHAT ARE THE ADVANTAGES OF THE HORMONAL IUD?

- The Mirena IUD is effective for at least 5-7 years.
- Mirena decreases menstrual cramping and dramatically decreases menstrual blood loss. In fact, the hormonal IUD is the most effective medical therapy for heavy menstrual bleeding. Women using this IUD experience a reduced flow by 90-95%.
- About 20% of women experience an absence of menstrual bleeding after one year of using the hormonal IUD.
- Mirena prevents ectopic, or "tubal", pregnancies. In fact, women using Mirena have a 10 times lower risk of ectopic pregnancy than women who are not using any birth control.
- Use of an IUD is convenient, safe, and private.
- IUDs are the most COST EFFECTIVE REVERSIBLE CONTRACEPTIVES ever developed!
- Mirena does not contain estrogen, and may be used by women who cannot use estrogen–containing birth control like pills, patches or vaginal rings.
- Mirena IUD may be used by women who are breastfeeding.
- Mirena IUD may be placed immediately following the delivery of a baby (vaginally or by cesarean section) or immediately after an abortion.
- Once a Mirena IUD is removed, fertility returns right away.
- Mirena appears to have a 50% protective effect against pelvic infections.
- Endometrial cancer is one of the most common reproductive cancers in women. It can be prevented if postmenopausal women on estrogen therapy use Mirena.
- **Mirena IUDs are often prescribed for women with:**
  - Heavy menstrual bleeding
  - Adenomyosis
  - Fibroids
  - Cramping or pain with periods
  - Anemia
  - Endometrial hyperplasia
  - Endometriosis
  - Dysfunctional uterine bleeding (DUB)

WHAT ARE THE DISADVANTAGES OF THE HORMONAL IUD?

- If you choose to have a Mirena IUD placed your periods WILL change.
- You should NOT start this method of birth control unless it is OK if your periods change.
- Bleeding patterns after Mirena IUD placement are unpredictable. Women may bleed more often at first, and over time bleeding may become infrequent and very light.
- Women who choose the Mirena IUD should be encouraged to be patient for the first 6 to 8 months, their spotting and bleeding WILL decease over time.
- If not having periods is unacceptable, the hormonal IUD may not be the best choice for you. The good news for many women is that 20% of women will stop having periods after 1 year of Mirena IUD use. This is an expected side effect and is not "unhealthy".
- Mirena contains a hormone. While most of this hormone stays in the uterus, a small amount can make its way into the bloodstream and cause side effects. These may include acne, hair loss, mood changes and even depression. These side effects occur in VERY FEW women.
- Most women feel mild to moderate discomfort during the IUD insertion. Rarely, a woman may feel very strong cramps during the IUD insertion. This discomfort improves quickly after the IUD has been placed. A woman may want to take an anti-inflammatory such as ibuprofen one hour before her appointment and then every 6 hours the day of placement.

Mirena can cause cramping and increased days of bleeding in the weeks or months after the IUD is placed, but this gets better over time. Women considering Mirena may find the advice of a North Carolina Nurse Practitioner who has inserted over 200 IUDs in the last year helpful: "I tell women, you may not like it for several months, but you're going to love it for many years!"

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"Locura es hacer la misma cosa una y otra vez esperando obtener diferentes resultados."

—ALBERT EINSTEIN

Durante los últimos 50 años, la mitad de los embarazos en los Estados Unidos han sido involuntarios. Ahora tenemos que pasar a los métodos más eficaces como "Obtenlo y Olvídalo": los implantes y los DIU.

Mitos muy importantes sobre el DIU:

1 MITO: Los DIUs causan abortos. Esto no es cierto. Las principales organizaciones de salud reproductiva en todo el mundo y los libros de texto de salud reproductiva, afirman fuertemente que los DIU no interrumpen un embarazo implantado y por lo tanto no provocarán un aborto. Los DIUs funcionan de varias maneras para prevenir el embarazo.

2 MITO: Los DIUs causan cáncer. Esto no es cierto! El DIU hormonal llamada Mirena previene el cáncer de endometrio. El DIU de cobre llamada ParaGard se ha demostrado prevención de cáncer de endometrio y del cuello uterino.

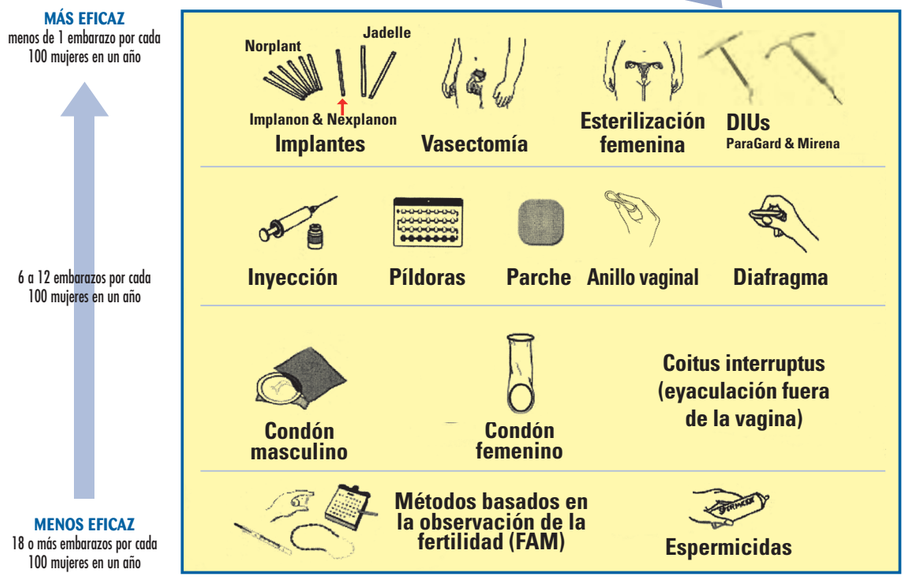
3 MITO: Las mujeres con fibromas no pueden usar un DIU. Para la mayoría de las mujeres con fibromas, esto no es cierto. De hecho, el DIU Mirena puede ser utilizado para tratar el sangrado y el dolor en mujeres con fibromas.

4 MITO: Las mujeres no pueden usar un DIU hasta que hayan tenido un bebé. Simplemente no es cierto! La Organización Mundial de la Salud (OMS) y los Centros para el Control y la Prevención de Enfermedades (CDC) han dicho que el DIU es una buena opción para en las mujeres que no han tenido un bebé. Además, los adolescentes que nunca han estado embarazadas pueden usar el DIU!

5 MITO: El DIU cuesta demasiado. Con el tiempo, los DIUs y los implantes son definitivamente los métodos reversibles menos costosos.

6 MITO: Los DIUs causan infecciones. En realidad, varios estudios de investigación de las mujeres que utilizan Mirena se encontraron que estas usuarias tenían un menor riesgo de enfermedad inflamatoria pélvica, o EIP, en comparación con mujeres que no usan un DIU. La colocación de un DIU implica un pequeño riesgo de infección. Este riesgo es sólo el 0,1% y sólo durante las dos semanas después de la colocación del DIU. Después de dos semanas, no hay mayor riesgo de infección pélvica en las mujeres que utilizan el DIU.

COMPARACIÓN DE LA EFECTIVIDAD TÍPICO DE LOS MÉTODOS ANTICONCEPTIVOS



? Si usted tiene preguntas sobre los métodos "Obtenlo y Olvídalo," también llamados anticonceptivos reversibles de larga duración (ARLD), usted puede ir a las paginas de web managingcontraception.com, bedsider.org, o plannedparenthood.org

"OBTENLO Y OLVÍDALO"

Las mujeres tienen 20 veces de probabilidades de quedar embarazadas en un año si usan píldoras anticonceptivas, parches o anillos vaginales en lugar de utilizar un dispositivo intrauterino (DIU) o un implante anticonceptivo. Ahora puede ser el momento para que usted pueda pensar en los DIUs y los implantes.

Winner, B., Peipert, J., Zhao, Q., Buckel, C., Madden, T., Allsworth, J., & Secura, G. (2012). Effectiveness of long-acting reversible contraception. N Engl J Med, May 24 (21); 3: 1998-2007.

Hay dos tipos de DIUs disponibles en los Estados Unidos. Ambos son pequeños dispositivos de plástico que son fácilmente colocados dentro del útero por los profesionales de salud. El DIU Mirena, puede ser utilizado por un máximo de siete años. El DIU ParaGard, o el DIU T de Cobre, trabaja por 12 años. El implante anticonceptivo se coloca bajo la piel, en la parte superior del brazo y ofrece una protección excelente contra el embarazo por 3 a 4 años.

Hechos importantes sobre los DIUs y los implantes:

1 Los dos DIUs y los dos implantes, Nexplanon e Implanon, son los más eficaces de los métodos anticonceptivos que se haya desarrollado, y permiten a una mujer quedar embarazada tan pronto cuando son retirados. Nosotros los llamamos métodos "Obtenlo y Olvídalo"

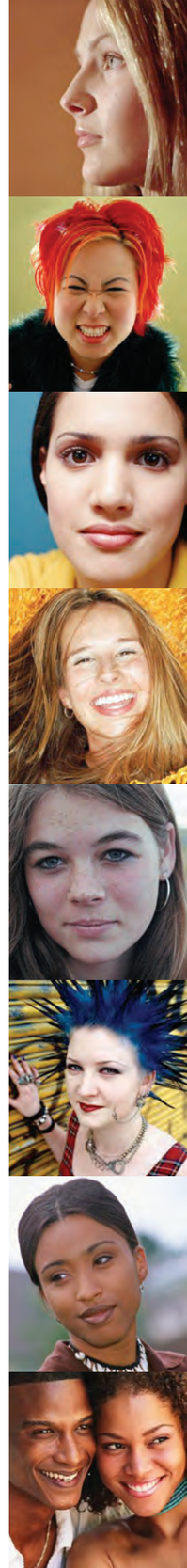
2 El DIU es el método anticonceptivo elegido con mayor frecuencia en todo el mundo, y su uso está aumentando en Estados Unidos. En St. Louis, dice que al 75% de las mujeres que se les da la opción de usar un método anticonceptivo de forma gratuita, están optando por usar un DIU o un implante como parte del Proyecto Anticonceptivo CHOICE.

3 Con el tiempo, los DIUs y los implantes cuestan menos que otros métodos reversibles de anticoncepción disponible.

***Tenga en cuenta que el costo más importante de cualquier anticonceptivo, es el costo para usted si quedara embarazada. Existe un riesgo muy bajo de embarazo cuando se utiliza un DIU o un implante. Una persona que utilice uno estos métodos, tiene mucho menos probabilidad que tenga que hacer frente a los gastos emocionales y financieros asociados con un embarazo no deseado.

Si una mujer o un hombre es sexualmente activa, por favor no olvide el uso adecuado del condón todo el tiempo, pues es la única manera de estar protegido contra las infecciones de transmisión sexual. Mujeres y hombres en situación de riesgo de infección siempre debe usar un condón.

Camaryn Chrisman Robbins, MD, MPH; Jeffrey F. Peipert, MD, MPH and Robert A. Hatcher, MD, MPH Translation: McLain S. Mallory & Yuri E. Cuellar De la Cruz 7-9-12



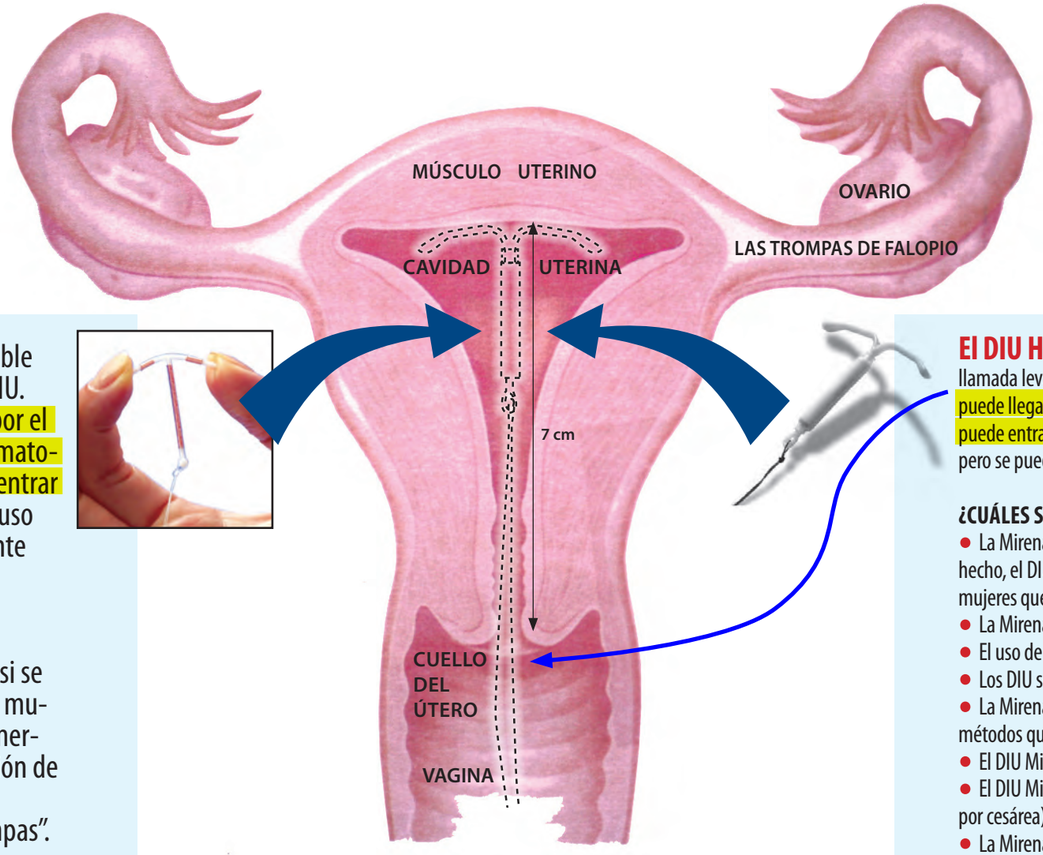
Una vez colocado, los DIUs y los implantes funcionan por años y a veces se llaman à

MÉTODOS "OBTENLO Y OLVÍDALO"

à Los DIUs y los implantes son inmediatamente reversibles cuando se sacan. A veces se llaman los métodos anticonceptivos reversibles de larga duración (ARLD).

Los Implantes Implanon y Nexplanon

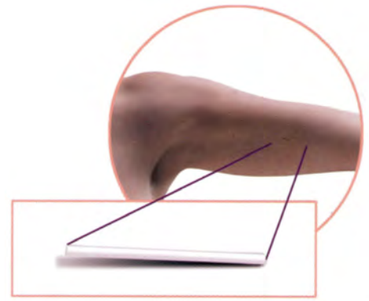
Los implantes anticonceptivos se coloca bajo la piel de la parte superior del brazo, donde permanecerán en vigencia por 3 a 4 años. Este método anticonceptivo detiene la ovulación completamente los 3 primeros años después de la colocación, a diferencia de los otros métodos anticonceptivos disponibles. Es impredecible el manchado y sangrado mejora con el tiempo. El número total de días de sangrado se redujo en las mujeres que usan implantes.



En este diagrama, la distancia desde la abertura del cuello uterino hasta la parte superior de la cavidad uterina mide 7centímetros (poco menos de 3 pulgadas). Antes de tener un bebé, 70% de las mujeres de 15-25 años de edad tiene el útero de este tamaño o más grande. Un útero de este tamaño tiene espacio adecuado para el DIU Mirena o el DIU ParaGard.

En el notable Proyecto Anticonceptivo CHOICE, los adolescentes jóvenes eligen sobre todo los implantes. Los adolescentes mayores generalmente eligen un DIU.

Renee Mestad, et al, *Contraception*, 2011



El DIU de Cobre: El ParaGard, es un dispositivo de plástico flexible en forma de T con tres manguitos de cobre enrollado alrededor del DIU. El ParaGard evita el embarazo debido a los iones de cobre liberados por el dispositivo actúan como un espermicida. Este significa que los espermatozoides no pueden llegar a las trompas de Falopio y son incapaces de entrar en un óvulo femenino. El ParaGard esta aprobado por la FDA para su uso por 10 años. Evidencia excelente muestra que el ParaGard es altamente eficaz durante 12 años.

¿CUÁLES SON LAS VENTAJAS DEL DIU DE COBRE?

- El ParaGard puede ser usado como anticoncepción de emergencia si se inserta dentro de los 5 días siguientes al coito sin protección. Si 1000 mujeres tienen un DIU de cobre insertado como un anticonceptivo de emergencia, sólo una mujer se queda embarazada! Esta es la anticoncepción de emergencia más efectivo disponible para las mujeres.
- El ParaGard impide un embarazo ectópico o embarazo "de las trompas".
- El uso de un DIU es conveniente, seguro y personal.
- Los DIU son los más rentables anticonceptivos eficaces reversibles que se haya desarrollado!
- El ParaGard DIU puede ser utilizado en mujeres que están amamantando.
- El ParaGard DIU puede ser colocado inmediatamente después del nacimiento de un bebé (vaginal o por cesárea) o inmediatamente después de un aborto.
- Hay ventaja interesante e inesperada de los DIU de cobre: Una serie de estudios de las mujeres con el DIU de cobre han mostrado una disminución del riesgo de cáncer de útero y cuello uterino.
- La mayoría de las mujeres que tienen un ParaGard seguirán teniendo períodos regulares.

¿CUÁLES SON LAS DESVENTAJAS DEL DIU DE COBRE?

- Las mujeres pueden tener hasta un 35% de incremento en el sangrado menstrual durante el uso de el ParaGard, además de un aumento de los calambres.

¿CÓMO SE COLOCA UN DIU?

Si usted elige el DIU Mirena o ParaGard, se insertan de la misma manera. Un examen pélvico se realiza para determinar el tamaño de su útero y su posición en la pelvis. Se coloca un espéculo en la vagina para poder ver el cuello del útero, igual a una prueba de Papanicolaou. El DIU se pasa suavemente a través del cuello uterino y en la cavidad uterina. La colocación del DIU toma 3-5 minutos. Su profesional de salud le puede pedir a usted hacerle un control después de 4-6 semanas después que el DIU fue colocado para comprobar que sigue en su lugar y para hablar con usted acerca de cualquier preocupación que pueda tener.

¿CÓMO SE SACA UN DIU?

Si usted decide sacar su DIU , su profesional de salud colocará un espéculo en la vagina para ver el cuello uterino. Después él o ella agarrará los hilos del DIU con un pequeño instrumento. Jalando suavemente se puede sacar el DIU en cuestión de segundos. Usted puede quedar embarazada inmediatamente después de sacar el DIU.

El DIU Hormonal: El DIU Mirena libera pequeñas cantidades de una hormona progesterona, llamada levonorgestrel. La hormona liberada por el DIU hace que el moco cervical se espese. El esperma no puede llegar al interior del útero y las trompas de Falopio. Esto significa que el esperma de un hombre no puede entrar al óvulo de una mujer. El DIU Mirena ofrece protección contra el embarazo durante 5-7 años, pero se puede sacar en cualquier momento si una mujer desea quedar embarazada.

¿CUÁLES SON LAS VENTAJAS DEL DIU HORMONAL?

- La Mirena disminuye los cólicos menstruales y reduce drásticamente la pérdida de sangre menstrual. De hecho, el DIU hormonal es el tratamiento médico más efectivo para el sangrado menstrual abundante. Las mujeres que utilizan este DIU experimentan una reducción del 90-95% en el flujo de sangrado.
- La Mirena impide el embarazo ectópico, o "de las trompas"
- El uso de un DIU es conveniente, seguro y personal.
- Los DIU son los más económicos anticonceptivos reversibles que se haya desarrollado!
- La Mirena no contiene estrógeno y puede ser utilizado en mujeres que este contraindicado usar los métodos que contienen estrógeno como píldoras, parches o anillos vaginales.
- El DIU Mirena puede ser utilizado por mujeres que están amamantando.
- El DIU Mirena se puede colocar inmediatamente después del nacimiento de un bebé (por vía vaginal o por cesárea) o inmediatamente después de un aborto.
- La Mirena parece tener un efecto 50% de protección contra infecciones pélvicas
- El cáncer de endometrio es uno de los cánceres reproductivos más comunes en las mujeres. Se puede prevenir si las mujeres posmenopáusicas en tratamiento con estrógenos utilizan Mirena.
- **El DIU Mirena se prescriben a menudo para las mujeres con:**
  - Sangrado menstrual abundante
  - Cólicos o dolor con las reglas
  - Endometriosis
  - Adenomiosis
  - Anemia
  - Sangrado uterino disfuncional (SUD)
  - Fibromas
  - Hiperplasia endomentrial

La Mirena puede causar calambres y aumento de días de sangrado en las semanas o meses después de que el DIU se coloca, pero esto mejora con el tiempo. Las mujeres que piensan en la Mirena pueden considerar el consejo de un profesional de salud de Carolina del Norte que ha insertado más de 200 dispositivos intrauterinos en el año pasado: "Les digo a las mujeres, quizás no le guste durante varios meses, pero lo va a amar por muchos años!"

¿CUÁLES SON LAS DESVENTAJAS DEL DIU HORMONAL?

- Si usted decide utilizar el DIU Mirena, sus reglas van a cambiar.
- Las patrones de sangrado después de la colocación del DIU Mirena son impredecibles. Las mujeres pueden sangrar con más frecuencia al principio, y con tiempo el sangrado puede llegar a ser poco frecuente y muy ligero.
- Las mujeres que eligen el DIU Mirena deben ser alentados a ser pacientes durante los primeros 6 a 8 meses. Su manchado y sangrado disminuirá con el tiempo.
- La Mirena contiene una hormona. Aunque la mayor parte de esta hormona se mantiene en el útero, una pequeña cantidad puede hacer su camino en el torrente sanguíneo y causar efectos secundarios. Estos pueden incluir acné, pérdida de cabello, cambios de humor e incluso depresión. Estos efectos secundarios se producen en muy pocas mujeres.

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