CONTRACEPTIVE TECHNOLOGY UPDATE®
A Monthly Newsletter for Health Professionals

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Bulletin: New information emerges on risks associated with Ortho Evra

New information from two case control studies of the transdermal contraceptive (Ortho Evra, Ortho-McNeil Pharmaceutical, Raritan, NJ) indicates no increased risk of heart attack or stroke for women who choose the patch, but data conflict on the occurrence of venous thromboembolism (VTE).

Results from the first study, which have been published, suggest that risk of nonfatal VTE for the patch is similar to the risk for pills containing similar hormonal components.[1] According to the second study, whose interim results were released by the patch's manufacturer, findings indicate an approximate twofold increase in the risk of VTE in patch users compared with those using a comparable oral contraceptive.[2]

Julie Keenan, a spokeswoman for Ortho-McNeil, says data from the second study are going to be published later. She says the company decided to release the interim results now "so that physicians would have additional information to consider in making personal decisions with their patients," she says.

EXECUTIVE SUMMARY

Information from two case control studies of Ortho Evra indicates that while there is no increased risk of heart attack or stroke, data are conflicting when it comes to venous thromboembolism (VTE).

- Results from the first study suggest that risk of nonfatal VTE for the patch is similar to the risk for pills containing similar hormonal components.
- Findings from the second study, whose interim results were released by the patch's manufacturer, indicate an approximate twofold increase in the risk of VTE in patch users compared with those using a comparable oral contraceptive (OC).
- The Food and Drug Administration revised Ortho Evra's labeling last November with a bolded warning that the patch exposes women to higher total amounts of estrogen than a typical birth control pill containing 35 mcg estrogen.

The first study used a nested case-control design based on information from PharMetrics, a Watertown, MA-based company that collects and organizes information on claims paid by managed care plans.[1] The second study, conducted by i3 Drug Safety, a Basking Ridge, NJ, contract research organization, used information from a large medical insurance claims database for its report.[2]

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Editorial Questions

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Review the history

Clinicians have been fielding patients' questions following media reports of the April 2004 death of an 18-year-old woman who had been using the transdermal contraceptive and a resulting July 2005 Associated Press analysis of adverse event reports filed with the Food and Drug Administration (FDA). **(*Contraceptive Technology Update* reported on the media coverage in the article, "Media report on Ortho Evra patch sets off safety concerns in women," November 2005, p. 113; and the article, "Adverse event reports spark discussions on safety of Evra contraceptive patch," December 2004, p. 133.)**

The FDA revised the transdermal contraceptive's labeling last November when it added a bolded warning that the patch exposes women to higher total amounts of estrogen than a typical birth control pill containing 35 mcg estrogen. **(For a complete review of the FDA's action, see *CTU*, "FDA revises Evra safety labeling due to increased estrogen levels," January 2006, p. 1.)**

The dust has not yet settled when it comes to comparing VTE risk between the patch and the Pill, says **Andrew Kaunitz**, MD, professor and assistant chair in the obstetrics and gynecology department at the University of Florida Health Science Center/Jacksonville. In keeping with current package labeling, women at high risk for VTE continue not to be appropriate candidates for any combination hormonal contraceptive — whether it be an oral contraceptive, the patch, or the contraceptive vaginal ring (NuvaRing, Organon, West Orange, NJ). These women should consider using progestin-only or intrauterine methods, he advises.

Check published results

Susan Jick, DSc, co-director of the Boston Collaborative Drug Surveillance Program and an associate professor of epidemiology and biostatistics at Boston University School of Public Health, says her research team was contacted by Ortho-McNeil's parent company, Johnson & Johnson of New Brunswick, NJ, to examine the patch following concerns raised by the FDA. The investigators have conducted similar studies on VTE risk in oral contraceptives.[2,3]

The study was nested among all women ages 15 to 44 who started the contraceptive patch or

norgestimate-containing oral contraceptives with 35 mcg ethinyl estradiol after April 1, 2002. (The patch's progestin component is norelgestromin, the active metabolite of norgestimate.) Cases involved women with current use of one of these two study drugs and a documented diagnosis of VTE in the absence of identifiable clinical risk factors; up to four controls were matched to each case by age and calendar time.[1]

Investigators identified 68 newly diagnosed, idiopathic cases of VTE in the study population. In the case-control analysis, the odds ratio comparing the contraceptive patch to norgestimate-35 pill was 0.9 (95% confidence intervals [CI] 0.5-1.6). The overall incidence rate for VTE was 52.8 per 100,000 women-years (95% CI 35.8-74.9) among users of the contraceptive patch and 41.8 per 100,000 women-years among users of norgestimate-35 (95% CI 29.4-57.6).[1] The age-adjusted VTE incidence rate ratio for current use of the contraceptive patch vs. norgestimate-35 was 1.1 (95% CI 0.7-1.8).[1]

What are the strengths of the study? Jick cites four points: it was a formal epidemiological study; it was carefully conducted; it was conducted in a large population; and researchers used well-established methodology.

The current study differs from previous case-control comparisons in that earlier studies[3,4] looked at drugs that had been marketed for several years. Because the patch is relatively new to the market, the investigators controlled for the difference by only including women who began use of the norgestimate/ethinyl estradiol pill after April 1, 2002, when the patch was released on the U.S. market, Jick explains.

Use data in counseling

No changes in Evra prescribing practices are warranted based on the current information, according to **Vanessa Cullins**, MD, vice president for medical affairs at the New York-based Planned Parenthood Federation of America. While the twofold increase in VTE recorded in the second study's interim report may appear alarming, when one looks at the absolute numbers, the attributable risk is small, she says.

If the results of the second study hold true, the twofold increase in VTE among patch users in absolute numbers would translate into three to four more venous thromboembolism events per 10,000 women-years, explains Cullins. This number represents a very small increase and the benefits of using a contraceptive outweigh this risk for many healthy reproductive-age women who want to initiate or continue Evra, Cullins concludes. Additional research is needed to determine whether Evra users have higher rates of VTE, she notes.

Miriam Zieman, MD, adjunct associate professor of obstetrics and gynecology at Emory University in Atlanta, says until more data are released, clinicians should use more detailed counseling when it comes to the contraceptive patch.

"Until we have more research, we have to consider the possibility of an increased risk," she notes. "This possibility should be discussed during counseling, and women and their providers must weigh the possibility of an increased risk against the benefits that using the patch have for that individual."

References

1. Jick SS, Kaye JA, Russmann S, et al. Risk of nonfatal venous thromboembolism in women using a contraceptive transdermal patch and oral contraceptives containing norgestimate and 35 µg of ethinyl estradiol. *Contraception* 2006; 73:223-228.
2. Ortho Women's Health & Urology. Results of Two Epidemiological Studies Provide Important New Clinical Information about the Safety of ORTHO EVRA®. Press release. Issued Feb. 16, 2006.
3. Jick H, Jick SS, Gurewich V, et al. Risk of idiopathic cardiovascular death and nonfatal venous thromboembolism in women using oral contraceptives with differing progestogen components. *Lancet* 1995; 346:1,589-1,593.
4. Jick H, Kaye JA, Vasilakis-Scaramozza C, et al. Risk of venous thromboembolism among users of third generation oral contraceptives compared with users of oral contraceptives with levonorgestrel before and after 1995: Cohort and case-control analysis. *Br Med J* 2000; 321:1,190-1,195. ■

Contraception, weight gain: Weigh evidence and myths

Counter perceptions with evidence-based counseling

When it comes to weight, patients may discontinue use of hormonal contraception if extra pounds are encountered. Can the method be the culprit?

Add information from an updated review of studies examining the relationship between combined hormonal contraceptive use and weight change to your counseling database. The review continues to find no evidence that combination

EXECUTIVE SUMMARY

An updated review of studies examining the relationship between combined hormonal contraceptive use and weight change continues to find no evidence that combination hormonal contraceptives increase weight. While the evidence was not strong enough to be sure that these contraceptives do not cause some weight gain, no major effect on weight was found, researchers conclude.

- Weight gain may come into play when it comes to use of the contraceptive injection. A new study of adolescent contraceptive users found a significant relationship between baseline obesity status and subsequent weight gain in teens who used the injection.
- Teens who were obese (body mass index kg/m^2 30 or above) prior to use of the shot gained significantly more weight than obese girls starting the Pill or using no contraceptive method.

hormonal contraceptives increase weight.[1] The evidence was not strong enough to be sure that these contraceptives do not cause some weight gain, but no major effect on weight was found, researchers conclude.[1]

When it comes to the Pill and weight gain, women and providers continue to believe that an association exists.[1] Such beliefs can lead to avoidance of the method: Four out of 10 women in a 2001 survey said weight gain is a reason to avoid the Pill and they named increased weight as the No. 1 concern when asking about the Pill's side effects.[2] In a national study of adult women, weight gain was the most frequently cited reason for discontinuing oral contraceptive (OC) use.[3]

To perform the review update, initially published in 2003,[4] researchers searched computerized databases for all relevant randomized controlled trials to evaluate the association between combined hormone contraceptive use and change in body weight. Each of the trials included weight measurements for women who were using combination contraceptives for at least three cycles of treatment. Investigators could find no evidence that supported a causal association between combination contraceptives and weight gain.[1]

Women tend to gain weight over time,[5] says **Laureen Lopez**, PhD, a researcher at Family Health International in Research Triangle Park, NC, and co-author of the review. While on the Pill, they may associate the increase in pounds with Pill use, she surmises.

"One of the concerns is that people may go off a very effective contraceptive thinking that it causes weight when there does not appear to be evidence that it is causing it," Lopez notes.

What about DMPA?

For women who don't choose the Pill, patch (Ortho Evra, Ortho-McNeil Pharmaceutical, Raritan, NJ), or contraceptive vaginal ring (NuvaRing, Organon, West Orange, NJ), the progestin-only contraceptive injection (depot medroxyprogesterone acetate [DMPA], Pfizer, New York City) represents an attractive birth control option. The shot is popular among adolescents; about 10% of adolescent girls ages 15-19 years use DMPA as their contraceptive method.[6,7]

A just-published study that looked at adolescent girls initiating DMPA, OC, or no hormonal contraceptive method, found a significant relationship between baseline obesity status and subsequent weight gain.[8] Teens who were obese (body mass index kg/m^2 30 or above) prior to use of DMPA gained significantly more weight than obese girls starting the Pill or no contraceptive method. In addition, obese adolescents using DMPA gained more weight than did nonobese adolescents using DMPA, OC, or no hormonal contraception method.[8]

Among teens who were not obese, investigators reported no statistically significant effect of contraceptive method on weight. However, weight gain was greatest among nonobese teens using DMPA, with an average gain of 4 kg at 18 months. This amount of weight gain could be cause for concern in populations vulnerable to obesity, note researchers.

Previous studies have shown variable results when it comes to weight gain in adolescents using DMPA.[9-11] According to the DMPA package insert, women using DMPA gain an average of 5.4 pounds in the first year.[12] Clinicians need to understand the clinical and behavioral context within which weight gain occurs with DMPA so they can provide better counseling on the method, helping teens to achieve increased method satisfaction and prolonged use, researchers conclude.[8]

Added weight is becoming more common in adolescents: 15.5% of adolescents ages 12-19 were classified as overweight in 2000; an additional 14.9% of adolescents were at risk for becoming overweight.[13] More research should be directed at use of contraception in overweight adolescents, suggests **Andrea Bonny**, MD assistant professor of

pediatrics at Case Western Reserve University in Cleveland and lead author of the DMPA study.

Options for the obese?

Obese women have not been singled out for study in contraception; recent literature[14] suggesting that overweight women may be at increased risk for pregnancy while on the Pill may lead more researchers to examine weight's impact on method efficacy and side effects, says Bonny. **(Read more about the Pill study; see *Contraceptive Technology Update*, April 2005, "Does increased weight impact OC efficacy?" p. 45.)**

"It would be interesting to start looking at the pharmacokinetics and the pharmacodynamics and seeing if we could tailor drugs based on a woman's weight to maximize efficacy and minimize side effects," she says.

Limited research has been published on the effects of weight on newer methods such as the contraceptive path and ring. In the clinical trial of the transdermal contraceptive, women who weighed more than 198 pounds comprised 3% of the study population but experienced 30% of the pregnancies recorded in the investigation.[15] For the ring, weight does not appear to be a factor in effectiveness; results of a 2005 study indicate similar efficacy in women of all weights enrolled in the investigation.[16] **(Review the research; see *CTU*, September 2005, "NuvaRing not affected by heavier body weight," p. 103.)**

As the authors of *Contraceptive Technology* advise, the best contraceptive method is the one that is medically appropriate and is used every time by someone happy with the method.[12] By comparing the risks of contraception vs. the risks of pregnancy in the absence of contraception, clinicians can help very heavy women choose a safe, effective method that is appropriate for their needs.

References

1. Gallo MF, Lopez LM, Grimes DA, et al. Combination contraceptives: Effects on weight. *The Cochrane Database Systematic Reviews* 2006, Issue 1. Art. No.: CD003987.pub2. DOI: 10.1002/14651858.CD003987.pub2.

2. National Association of Nurse Practitioners in Women's Health. *Weight, Sexuality, and Women's Birth Control Decisions*. Washington, DC; January 2001. Accessed at: www.npwh.org/executive_summary.htm.

3. Rosenberg M. Weight change with oral contraceptive use and during the menstrual cycle: Results of daily measurements. *Contraception* 1998; 58:345-349.

4. Gallo MF, Grimes DA, Schulz KF, et al. Combination contraceptives: effects on weight. *Cochrane Database Syst Rev* 2003; (2):CD003987.

5. Flegal KM, Troiano RP. Changes in the distribution of body mass index of adults and children in the U.S. population. *Int J Obes Relat Metab Disord* 2000; 24:807-818.

6. Matson SC, Henderson KA, McGrath GJ. Physical findings and symptoms of depot medroxyprogesterone acetate use in adolescent females. *J Pediatr Adolesc Gynecol* 1997; 10:18-23.

7. Risser WL, Gefter LR, Barratt MS, et al. Weight change in adolescents who used hormonal contraception. *J Adolesc Health* 1999; 24:433-436.

8. Bonny AE, Ziegler J, Harvey R, et al. Weight gain in obese and nonobese adolescent girls initiating depot medroxyprogesterone, oral contraceptive pills, or no hormonal contraceptive method. *Arch Pediatr Adolesc Med* 2006; 160:40-45.

9. Moore LL, Valuck R, McDougall C, et al. A comparative study of one-year weight gain among users of medroxyprogesterone acetate, levonorgestrel implants, and oral contraceptives. *Contraception* 1995; 52:215-219.

10. Matson SC, Henderson KA, McGrath GJ. Physical findings and symptoms of depot medroxyprogesterone acetate use in adolescent females. *J Pediatr Adolesc Gynecol* 1997;10:18-23.

11. Risser WL, Gefter LR, Barratt MS, et al. Weight change in adolescents who used hormonal contraception. *J Adolesc Health* 1999; 24:433-436.

12. Pfizer. *Depo-Provera Contraceptive Injection. Physician Information*. Accessed at: www.pfizer.com/pfizer/download/uspi_depo_provera_contraceptive.pdf.

13. Ogden CL, Flegal KM, Carroll MD, et al. Prevalence and trends in overweight among US children and adolescents, 1999-2000. *JAMA* 2002; 288:1,728-1,732.

14. Holt VL, Scholes D, Wicklund KG, et al. Body mass index, weight, and oral contraceptive failure risk. *Obstet Gynecol* 2005; 105:46-52.

15. Zacur HA, Hedon B, Mansour D, et al. Integrated summary of Ortho Evra/Evra contraceptive patch adhesion in varied climates and conditions. *Fertil Steril* 2002; 77(2 Suppl 2):S32-35.

16. Westhoff C. Higher body weight does not affect NuvaRing's efficacy. Presented at the American College of Obstetricians and Gynecologists Annual Clinical Meeting. San Francisco; May 2005. ■

Review options in treatment of PMDD

The woman sitting in front of you says for about 10 days of every month, she experiences depression, marked anxiety, sudden mood shifts, persistent irritability, and bloating. While the symptoms disappear with the onset of her menstrual cycle, when they are present they are severe enough to interfere with her relationships and work activities.

What is your diagnosis?

Look at premenstrual dysphoric disorder

EXECUTIVE SUMMARY

Premenstrual syndrome (PMS) and premenstrual dysphoric disorder (PMDD) are marked by the cyclic nature of symptoms that begin in the late luteal phase of the menstrual cycle and remit shortly after the onset of menstruation. PMDD is distinguished from PMS by the severity of symptoms, predominance of mood symptoms, and role dysfunction, particularly in personal relationships and marital/family relationships.

- Three drugs carry specific indications for treatment of PMDD: fluoxetine, paroxetine controlled-release, and sertraline.
- The Food and Drug Administration has issued an approvable letter for Yaz, an oral contraceptive, for treatment of PMDD in women who desire contraception.

(PMDD). Both premenstrual syndrome (PMS) and premenstrual dysphoric disorder are marked by the cyclic nature of symptoms that begin in the late luteal phase of the menstrual cycle and remit shortly after the onset of menstruation. PMDD is distinguished from PMS by the severity of symptoms, predominance of mood symptoms, and role dysfunction, particularly in personal relationships and marital/family relationships.[1] **(To read more about PMDD, see the *Contraceptive Technology Update* article, "Clinical quandary: Is it PMS or PMDD? Find answer by listening to patients," April 2001, p. 37.)**

The Food and Drug Administration (FDA) has issued an approvable letter for Yaz, an oral contraceptive to be manufactured by Berlex Laboratories of Montville, NJ, for treatment of PMDD. Berlex filed for FDA approval of Yaz as an oral contraceptive and as a treatment for the symptoms of PMDD among women who desire contraception, says **Kim Schillace**, Berlex's director of public relations. According to Berlex's parent company, Berlin-based Schering AG, the company anticipates a decision on the drug in the first quarter of 2006.[2] If final approval is received, it will represent the first oral contraceptive to carry a PMDD indication.

Yaz contains 20 mcg ethinyl estradiol and 3 mg drospirenone, with a dosing regimen of 24 days of active pills, followed by four days of inactive pills, Schillace reports. To assess its impact in PMDD treatment, researchers conducted a multicenter, double-blind, randomized clinical trial in which 450 women with PMDD symptoms were randomly assigned a placebo pill or the study drug.[3] Women in the study were evaluated with interviews, the Daily Record of Severity of Problems (DRSP), and other survey instruments at baseline and through three menstrual cycles. Scientists defined response as a 50% or more decrease in DRSP score; such response occurred in 48% of the active-treatment group and 36% of the placebo group.[3]

Three drugs carry specific indications for treatment of PMDD: fluoxetine (Sarafem, Eli Lilly; Indianapolis), paroxetine controlled-release (Paxil CR, GlaxoSmithKline; Philadelphia) and sertraline (Zoloft, Pfizer, New York City). Sarafem received its FDA approval in 2000, with PMDD indications given to Zoloft in 2002 and Paxil CR in 2003. The agency gave further approval in 2004 for an intermittent dosing regimen for Paxil CR. The revised labeling allows the drug to be taken once daily during the two-week period prior to the onset of menstrual cycle rather than throughout the month. Research indicates such a dosing regimen is effective against PMDD symptoms.[4]

There are several reasons that effective treatments for PMDD are needed, says **Jean Endicott**, PhD, director of the premenstrual evaluation unit at Columbia Presbyterian Medical Center in New York City. Premenstrual symptoms can significantly affect health-related quality of life and may result in increased health care utilization and decreased occupational productivity.[5]

"First, the symptoms of PMDD are, by definition, severe enough to cause major problems in a woman's functioning in her social relationships, her work, her parenting, and even taking care of her daily routine tasks," states Endicott. "Second, even though the symptoms are time-limited, occurring during the week to 10 days prior to the onset of menses, they recur over and over for many years and can greatly disrupt a woman's life."

The consequences of untreated PMDD can be severe. Women are at high risk for developing a period of major depressive disorder if the condition is not addressed, says Endicott.

"Why should a woman be expected to continue to suffer from a condition that is treatable?" observes Endicott. "Women used to be told that 'nothing can be done, just live with it.' Now there are a number of effective treatments, and if one does not work, another may."

References

1. Steiner M, Pearlstein T, Cohen LS, et al. Expert guidelines for the treatment of severe PMS, PMDD, and comorbidities: The role of SSRIs. *J Womens Health* (Larchmt) 2006; 15:57-69.

2. Schering AG. FDA clarifies status of YAZ™ PMDD application. Press release. Jan. 25, 2006.

3. Yonkers KA, Brown C, Pearlstein TB, et al. Efficacy of a new low-dose oral contraceptive with drospirenone in premenstrual dysphoric disorder. *Obstet Gynecol* 2005; 106:492-501.

4. Pearlstein TB, Bellew KM, Endicott J, et al. Paroxetine controlled release for premenstrual dysphoric disorder: Remission analysis following a randomized, double-blind, placebo-controlled trial. *Prim Care Companion J Clin Psychiatry* 2005; 7:53-60.

5. Borenstein JE, Dean BB, Endicott J, et al. Health and economic impact of the premenstrual syndrome. *J Reprod Med* 2003; 48:515-524. ■

Do OCs impact libido? More research needed

A patient tells you she heard a news story that said that oral contraceptives (OCs) have lasting effect on hormone levels, dulling a woman's sexual desire. What is your response?

New findings from a small retrospective study indicate that use of birth control pills is associated with elevated sex hormone-binding globulin (SHBG) levels and reduced bioavailable testosterone. This effect may persist even after discontinuation of pill use, researchers note.[1]

The study examined SHBG levels in 124 premenopausal women who had reported sexual dysfunction for at least six months; 62 of the women were current Pill users who had been taking OCs for longer than six months (called continued users), 39 who had used OCs for longer than six months and then discontinued use, and 23 women who had never used the method. All patients were offered use of transdermal testosterone therapy to improve sexual function. Sex hormone-binding globulin levels were measured at four points during the study: at baseline, while using oral contraceptives, at a mean of 80 days after discontinuing pills, and then again at more than 120 days after discontinuation.[1] According to the research, SHBG levels in the women who continued to use pills were four times higher than those in the never-user group. Despite a decrease of more than 50% in SHBG values after discontinuation of Pill use, SHBG levels in women discontinuing pills remained elevated for more than 120 days (mean of 234 days) in comparison with those who had never used the method.[1]

Researchers note six limitations of the study: its retrospective approach; the small size of the study population; the use of a variety of combined OCs for different lengths of time by study participants; the use of various laboratories to analyze blood samples, rather than one central lab; the difference in blood test result reporting by the various laboratories; the use of testosterone transdermal patches by many of the study participants; and the fact that all women in the study had sexual dysfunction. Further research is needed to determine if long-term sexual, metabolic, and mental health consequences might result as a consequence of chronic SHBG elevation, the authors conclude.

What would be the next step in this line of research? **Claudia Panzer**, MD, lead author of the new study and a former endocrinologist at Boston University Medical Center, believes an ideal investigation would include a group of women who never used OC who at baseline have androgen and SHBG levels drawn and complete sexual function questionnaires. Women then would initiate pill use and would undergo scheduled blood tests and questionnaires, with pill use stopped, blood tests repeated, and further questionnaires completed, says Panzer, who now is affiliated with Rose Medical Center in Denver.

EXECUTIVE SUMMARY

Findings from a small retrospective study indicate that use of birth control pills is associated with elevated sex hormone-binding globulin (SHBG) levels and reduced bioavailable testosterone. This effect may persist even after discontinuation of pill use, researchers note.

- Despite a decrease of more than 50% in SHBG values after discontinuation of Pill use, SHBG levels in women who discontinued pills remained elevated for more than 120 days (mean of 234 days) in comparison with those who had never used the method, researchers report.
- While a minority of women experience a decrease in libido with Pill use, many women report more interest in sex due to their use of an effective method of birth control.

How does the Pill work?

To understand the results of the new study, it helps to review how the Pill functions. To prevent ovulation, the Pill suppresses follicle-stimulating hormone (FSH) and luteinizing hormone (LH). The progestins in oral contraceptives suppress LH, which results in decreased androgen synthesis and ultimately an overall decrease in ovarian androgen (testosterone) production.[2]

The Pill also increases SHBG levels, which translates into increased binding of testosterone. The estrogen component of OCs increases plasma levels of SHBG, while the progestin component has the opposite effect. The overall balance promotes liver production of SHBG, resulting in a net increase in SHBG levels. In turn, the increase in SHBG lowers the bioavailability of circulating androgens.[2]

Do OCs affect libido?

More research definitely is needed when it comes to the impact of the Pill on libido, says **Cynthia Graham**, PhD, clinical psychologist with the Kinsey Institute for Research in Sex, Gender, and Reproduction at Indiana University in Bloomington and the University of Oxford, England. She has been involved in research regarding the effects of oral contraceptives on sexuality.[3-4]

Graham and fellow researchers are analyzing data from a prospective study of 61 women who were randomized to one of two low-dose oral contraceptives and assessed for a period of time for changes in mood, menstrual cycle symptoms, and sexual functioning. Researchers are particularly interested in whether such side effects are related to the degree of reduction in free testosterone, she says. The research group plans to publish its findings upon analysis completion, Graham adds.

She notes that it is just a minority of women who report negative effects of the Pill on their sexual feelings. Many women actually say they feel more interested sexually because they are using a very effective method of birth control, says Graham.

References

1. Panzer C, Wise S, Fantini G, et al. Impact of oral contraceptives on sex hormone-binding globulin and androgen levels: A retrospective study in women with sexual dysfunction. *J Sex Med* 2006; 3:104-113.

2. Understanding OC progestins: Is "androgenicity" clinically relevant? *Contraception Report* 1999; 10:4-8.

3. Sanders SA, Graham CA, Bass JL, et al. A prospective study of the effects of oral contraceptives on sexuality and well-being and their relationship to discontinuation. *Contraception* 2001; 64:51-58.

4. Graham CA, Ramos R, Bancroft J, et al. The effects of steroidal contraceptives on the well-being and sexuality of women: A double-blind, placebo-controlled, two centre study of combined and progestogen-only methods. *Contraception* 1995; 52:363-369. ■

Boost teens' knowledge when it comes to STDs

You deliver some bad news to your next patient, a 16-year-old student: She has a chlamydia infection. She then asks, "What is chlamydia?"

If this scenario replays in your exam room on a regular basis, you are not alone. Findings from a new study indicate that most sexually active teenage girls know relatively little about sexually transmitted diseases (STDs) until they are diagnosed with one.[1]

Teens may learn about HIV in school-based health education, but they are not getting companion information on other STDs, says **Julie Downs**, PhD, lead author of the new research and director of the Center for Risk Perception in Communication at Carnegie Mellon University in Pittsburgh. Without knowledge of such diseases as chlamydia and genital herpes, teens may operate under a false sense of confidence, Downs explains. **(A 2005 national report underscores teens' lack of knowledge of STDs; see "New report: U.S. failing to stem spread of sexually transmitted diseases among adolescents," in the August 2005 *STD Quarterly* supplement, p. 1.)**

"When we interview teens in research, they may say, 'I was really concerned about HIV and I was concerned about getting pregnant,' but some of them will say 'but anything else, you just take a pill,'" Downs comments. "That is not really true."

Downs and fellow researchers surveyed 300 adolescent girls in the Pittsburgh area and administered

EXECUTIVE SUMMARY

Findings from a new study indicate that most sexually active teen girls know relatively little about sexually transmitted diseases (STDs) until they are diagnosed with an infection.

- Researchers surveyed 300 adolescent girls about their knowledge of HIV/AIDS, chlamydia, gonorrhea, genital herpes, genital warts, hepatitis B, trichomoniasis, and syphilis. Those who reported having had an STD infection had knowledge of that infection, but they did not know about other diseases. With the exception of HIV/AIDS, the teens did not know many basic facts about STDs.
- Teens with little knowledge about STDs are more likely to engage in risky sexual behavior and to delay infection treatment.

a test to gauge teens' knowledge of eight STDs: HIV/AIDS, chlamydia, gonorrhea, genital herpes, genital warts, hepatitis B, trichomoniasis, and syphilis. Girls who reported having been diagnosed with an STD knew more about that particular disease than other girls, but they did not know more about the other diseases, researchers found.[1] With the exception of HIV/AIDS, the teens did not know many basic facts about STDs, researchers report.[1]

Teens with little knowledge about STDs are more likely to engage in risky sexual behavior and to delay infection treatment.[2,3] Such treatment delay is particularly important when it comes to chlamydia, the most prevalent STD in the United States.[4] Untreated chlamydial infection can spread into the uterus or fallopian tubes and cause pelvic inflammatory disease (PID), which can lead to permanent damage to the fallopian tubes, uterus, and surrounding tissues.[5]

Boost teens' STD IQ

Providers miss opportunities to provide STD, HIV, and pregnancy prevention counseling to high-risk youth during preventive health care visits, according to an analysis of a national adolescent survey.[6]

How can you help to boost teens' STD IQ?

Assessing a teen's knowledge of STDs comes into play during questioning about reproductive health issues, says **Karen Hacker**, MD, MPH, executive director for the Institute for Community Health and assistant professor in the department of medicine at the Harvard Medical School, both in Cambridge, MA. Hacker presented on the topic of talking to teens about drugs, alcohol, and sex at the 2005 *Contraceptive Technology* conference in Boston.

Use the mnemonic device HEADS (**H**ome, **E**ducation, **A**ctivities, **D**rugs, **S**exuality) to cover important points in a teen's medical history, she suggests. Many adolescent providers also look to the American Medical Association's (AMA) *Guidelines for Adolescent Preventive Services* (GAPS), a comprehensive set of recommendations for teen care, says Hacker. **(See resource box, this page, to access free materials from the AMA.)** By getting to know about different aspects of a teen's life, the provider is then able to move into more sensitive subjects, she notes. **(For more tips on taking a medical history, see *Contraceptive Technology Update*, "Questions, trust are vital in teen medical history," July 1999, p. 80.)**

When the topic of sex is broached, Hacker says she varies her approach based on age. If it is a young teen, she may ask, "Have you learned anything about sex education in school? Have you thought about that?" before she asks, "Have you engaged in any sexual activity?" If the response is "no," Hacker says, "If you want any information, I'd be happy to respond. If not, come back when you do." Handouts also can provide take-home information. Also direct teens to teen-friendly information on the web. **(See *CTU*, "Update teen knowledge with Internet resources," August 2005, p. 97.)**

If a teen has come in specifically for birth control, Hacker says she tends to take a more direct route in her queries, asking questions such as, "If you are sexually active, how many partners have you had in your lifetime?" to understand their level of risk-taking. She spends time explaining the difference between pregnancy prevention and STD prevention, and she notes that while many methods are effective contraceptives, they do not provide STD protection.

The advent of urine-based STD testing has made it easier to screen teens, says Hacker. If teens have come in for emergency contraception, she takes that opportunity to say, "While we are checking your urine for a pregnancy test, in the meantime it would be good to check you for STDs, too." This comment also provides a segue into an explanation that emergency contraceptive pills, such as oral contraceptives, do not prevent STDs.

According to **Robert Hatcher**, MD, MPH, professor of gynecology and obstetrics at Emory

RESOURCE

Visit the American Medical Association web site, www.ama-assn.org, to review materials affiliated with its *Guidelines for Adolescent Preventive Services* (GAPS). Under "AMA Agenda," click on "Advocacy Efforts," Next, click on "Improving the Health of the Public," "Promoting Health Lifestyles," "Adolescent Health," and "Downloads and Resources." Documents of GAPs patient questionnaires in English and Spanish for younger adolescents, middle/older adolescents, and parents/guardians are available, as well as a monograph of the GAPS program. Click on "Patient Handouts" for a link to the association's "Parent Package," a set of documents designed to help providers share important information about adolescence with parents and adolescent patients. Each of the 15 topics addressed in these handouts contains up-to-date facts, parenting tips, and other resources.

University School of Medicine in Atlanta, the single most important time to bring up the prevention of STDs is when clinicians and counselors are stressing the dual use of condoms and a woman's chosen contraceptive, such as pills, the contraceptive ring, or the contraceptive patch.

References

1. Downs JS, Bruine de Bruin W, Murray PJ, et al. Specific STI knowledge may be acquired too late. *J Adolesc Health* 2006; 38:65-67.

2. Yacobi E, Tennant C, Ferrante J, et al. University students' knowledge and awareness of HPV. *Prev Med* 1999; 28:535-541.

3. Fortenberry JD. Health care seeking behaviors related to sexually transmitted diseases among adolescents. *Am J Public Health* 1997; 87:417-420.

4. Centers for Disease Control and Prevention. *Sexually Transmitted Disease Surveillance, 2004*. Atlanta: U.S. Department of Health and Human Services, September 2005.

5. Centers for Disease Control and Prevention. *Chlamydia: CDC Fact Sheet, 2004*. Accessed at: www.cdc.gov/std/chlamydia/STDFact-Chlamydia.htm#complications.

6. Burstein GR, Lowry R, Klein JD, et al. Missed opportunities for sexually transmitted diseases, human immunodeficiency virus, and pregnancy prevention services during adolescent health supervision visits. *Pediatrics* 2003; 111(5 Pt 1): 996-1,001. ■

Rocky road forecast for family planning in 2006

By **Cynthia Dailard**
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This promises to be a rocky year for federal family planning policy — with potentially serious implications for the millions of low-income women who rely on Medicaid, Title X of the Public Health Service Act, and other federal programs for their family planning care. It also may have serious ramifications for family planning providers who rely on these programs to sustain their operating budgets and the delivery of care.

The federal budget reconciliation bill signed into law by President Bush in February contains at least two changes to Medicaid statutory requirement that are likely to threaten the provision of family planning services and supplies to many low-income women. Most notably, the law ends the longstanding federal Medicaid statute that has required that all state Medicaid programs cover family planning for all program enrollees by allowing states to offer stripped-down benefit packages — possibly without family planning services and supplies — to certain categories of Medicaid enrollees that states cover at their option. These categories include many pregnant women (those with incomes above 133% of the poverty level), parents, childless adults, and possibly others.

Additionally, the law is likely to subject many low-income women seeking family planning through Medicaid to new cost-sharing requirements. Historically, the federal Medicaid statute has prohibited states from requiring cost-sharing for family planning. While the new law would continue to exempt family planning services from cost sharing requirements, it would allow states to impose cost-sharing for some brand-name family planning drugs, although the cost-sharing has to be low enough to be considered "nominal." Even a minimal cost-sharing requirement can, for some women, become a barrier to care. Overall, the nonpartisan Congressional Budget Office has projected that by 2015, 20 million Medicaid beneficiaries may be required to pay new or increased cost-sharing for prescription drugs and that new premiums and requirements to prove U.S. citizenship will prevent 100,000 people from participating in Medicaid.

Meanwhile, the president's budget proposal for fiscal year 2007, released in February, suggests that more onerous Medicaid cuts may be on the horizon.

The budget includes vague language promising a

COMING IN FUTURE MONTHS

■ Scientists eye spray-on contraceptive

■ Will clinicians see HPV vaccine in 2006?

■ Menorrhagia: Review treatment options

■ Male contraceptives: What's the research status?

■ Up the radar for lymphogranuloma venereum

"new waiver initiative that emphasizes market-driven approaches to health care" to allow changes to Medicaid beyond those allowed by the reconciliation law. Additional Medicaid reform proposals also are expected to emerge near the end of the year, when the Medicaid Commission is slated to release its long-term recommendations for the program.

The president's budget also contains some unwelcome news for publicly funded family planning providers. Once again, the president has proposed level funding the Title X program, which now is set at $283 million. Federal block grants, which in some states provide important sources of family planning funds, fared similarly or worse: The budget recommends level funding for Maternal and Child Health Block Grant ($693 million) and a half-billion-dollar cut to the Social Services Block Grant (SSBG). This 29% cut, which is justified on the grounds that the program overlaps substantially with other programs and because it fails to ensure that the funds are directed toward activities that achieve results, could have serious repercussions for family planning providers who work in those 10 states that devote significant SSBG funding to family planning care.[1] These states are Illinois, Indiana, Iowa, Maine, Mississippi, New Hampshire, New Jersey, Pennsylvania, Texas, and Vermont.

At the same time, the president recommended that total funding for abstinence-only education programs rise from $177 million to $204 million, and he established a goal to raise total funding for abstinence education programs to $270 million by the administration's end. These programs are prohibited under law from discussing contraception in any positive way.

New legislation in play

In January, family planning opponents in Congress, led by Sen. David Vitter (R-LA), introduced the Title X Family Planning Act. The proposed legislation, which would amend Title X of the Public Health Service Act, seeks to disqualify family planning providers that perform abortions with their own nonfederal funds from receiving Title X family planning funding. The legislation clearly is designed to defund many Planned Parenthood clinics, as it specifically exempts hospitals from its reach.

While still serving in the House, Vitter attempted to offer similar language to an appropriations bill in 2001, but his timing was bad. On the heels of Sept. 11, House Republican leaders put the kibosh on highly controversial legislative initiatives. In contrast, the Washington, DC-based Family Research Council is highlighting the bill as one of its priorities for enactment for this election year.

Whether Vitter and the Bush administration will prevail on any or all of these fronts is unknown. One thing, however, is clear: The stakes for low-income women and the providers of subsidized family planning care are incredibly high.

Reference

1. Alan Guttmacher Institute. Public Funding for Contraceptive, Sterilization and Abortion Services, FY 1980-2001. Accessed at: www.guttmacher.org/pubs/fpfunding/index.html. ■

CE/CME Instructions

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

Get ready for National Women's Health Week

Start making plans for the 2006 National Women's Health Week Celebration, May 14-20. The weeklong event is part of a national effort by the Department of Health and Human Services and an alliance of organizations to raise awareness about manageable steps women can take to improve their health.

Take part in the nation's largest preventive care checkup event: National Women's Check-Up Day, scheduled for Monday May 15. Join other community health centers, hospitals, and health care providers across America in offering preventive health screenings to women.

Starting in March 2006, providers can register events on-line as well as check other events scheduled during the week. Go to the official web page for the event at www.womenshealth.gov/whw, and click on "Participate." The web site has free logos and web banners that may be used in promoting local events. ■

CE/CME Questions

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

- **Identify** clinical, legal, or scientific issues related to development and provisions of contraceptive technology or other reproductive services.
- **Describe** how those issues affect service delivery and the benefits or problems created in patient care in the participant's practice area.
- **Integrate** practical solutions to problems and information into daily practices, according to advice from nationally recognized family planning experts.

13. According to the depot medroxyprogesterone acetate (DMPA) package insert, on average, how many pounds do women gain in the first year of use?

A. 2
B. 3
C. 5.4
D. 6

14. What is the progestin component used in the contraceptive patch Ortho Evra?

A. Levonorgestrel
B. Desogestrel
C. Gestodene
D. Norelgestromin

15. What are three drugs with approved indications for treatment of premenstrual dysphoric disorder?

A. Fluoxetine, paroxetine controlled-release, and sertraline
B. Fluoxetine, escitalopram, and sertraline
C. Fluoxetine, paroxetine controlled-release, and bupropion
D. Venlafaxine, paroxetine controlled-release, and sertraline

16. To prevent ovulation, the Pill suppresses which two hormones?

A. Follicle-stimulating hormone and sex hormone-binding globulin
B. Follicle-stimulating hormone and luteinizing hormone
C. Luteinizing hormone and testosterone
D. Luteinizing hormone and prolactin

Answers: 13. C; 14. D; 15. A; 16. B.

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

S·T·D QUARTERLY™

Senior citizens and HIV: Age is no defense when it comes to infection with AIDS

While senior citizens may be wise in many subjects, when it comes to knowledge of HIV risk, they may be operating in the dark. Results of a survey of women ages 50 and older indicate seniors have limited knowledge when it comes to sexual transmission of HIV.[1]

Only 13% of the 514 women surveyed knew that condoms provide effective protection against HIV About half of the women believed vasectomies provide some protection against HIV, while half of the women said diaphragms prevent the spread of the deadly disease. None of the women surveyed correctly answered all of the nine survey questions.[1]

According to the Centers for Disease Control and Prevention, Americans ages 45 and older accounted for 26% of new diagnoses from 2001 to 2004; 18% of those diagnoses occurred in those ages 45-54.[2] **(*Contraceptive Technology Update* reported on seniors and HIV risks in the September 1998 *STD Quarterly* article, "Age: the blind spot when it comes to HIV/AIDS," p. 1.)**

"Unfortunately, sexually transmitted diseases are a reality, no matter what age you are," says **Lisa Bernstein**, MD, assistant professor of medicine in the Emory University School of Medicine in Atlanta and lead author of the survey article. "If you are not taking steps to protect yourself with barrier protection, you are going to be at risk," she adds.

The Senate Special Committee on Aging held a hearing last May to explore the rising rate of HIV infection in seniors older than age 50. Among the factors contributing to the rise in HIV among seniors identified during the hearing include:

- lack of condom use due to the elimination of pregnancy threat after menopause;
- reluctance of health care providers and seniors to discuss topics of a sexual nature;
- lack of awareness of HIV/AIDS and prevention due to generational issues;
- success of antiretroviral therapy helping HIV-positive people live longer.[3]

Although older Americans account for a relatively small proportion of new HIV infections, it is important that seniors get information and services to help protect them from infection, says **Jennifer Ruth**, CDC spokeswoman. Many older Americans face unique prevention challenges, such as a discomfort in discussing sexual behaviors with

EXECUTIVE SUMMARY

When educating patients on risks for HIV/AIDS, don't forget to include seniors in the discussion. Results of a survey of women ages 50 and older indicate seniors have limited knowledge when it comes to sexual transmission of HIV.

- According to the Centers for Disease Control and Prevention, Americans ages 45 and older accounted for 26% of new diagnoses from 2001 to 2004; 18% of those diagnoses occurred in those ages 45-54.
- Findings from a 2004 study by AARP show that many older adults are engaged in regular sexual activities and count it as one of life's important pleasures.

physicians and partners, as well as a discomfort in discussing condom use, she observes.

"While risk behaviors are more common among younger adults, doctors should talk with all patients about sexual and drug-related risks," says Ruth. "Regardless of age, prevention efforts must continue to focus on changing risk behaviors that lead to HIV infection and helping those living with HIV learn their status."

Seniors are active

Findings from a 2004 study by the AARP show that many older adults are engaged in regular sexual activities and count it as one of life's important pleasures.[4] About 1,700 adults ages 45 and older were surveyed on attitudes and other factors affecting their health, sexuality, and quality of life. The study served as a follow-up to an initial 1999 look at senior sexual health.[5]

When AARP conducted its 1999 study, the erectile dysfunction drug sildenafil (Viagra, Pfizer, New York City) had been on the market less than a year; just 5% of men reported using it. Two more treatments have followed: vardenafil hydrochloride (Levitra, Bayer Pharmaceutical; West Haven, CT) and tadalafil (Cialis, Eli Lilly; Indianapolis). In the 2005 study, about 20% of men said they had used some type of drugs or treatments to address problems with sexual performance. Most men said the treatments had increased their sexual satisfaction. Women in all age groups reported that their own sexual satisfaction was enhanced by their partners' use of the drugs.[3]

Be prepared to ask

Responses to the 2005 AARP survey indicate seniors have a greater openness to speaking to health professionals about sex. More seniors reported health professionals as their leading source of sex information (37%; up from 26% in 1999).However, the survey conducted by Bernstein's group showed that health professionals ranked last when it comes to seniors' information sources for information about HIV/AIDS; television was the most commonly identified source of information.

Be prepared to broach the topic of sex with your 50-plus patients, says Bernstein. Take a very good sexual history, she advocates.

When speaking with a patient about sexual activity, Bernstein may follow questions about a patient's lifestyle, such as queries about drinking and smoking, with such questions as, "Are you married?" or "Do you have a significant other?" If they are married, she will ask, "Are you still engaging in sex?" and if they are not married, she will say, "If you have a significant other, are you having sex with that person?"

> "Regardless of age, prevention efforts must continue to focus on changing risk behaviors that lead to HIV infection and helping those living with HIV learn their status."

Bernstein approaches her questions about HIV in a nonjudgmental way, saying that she asks them of everyone due to the reality of the HIV/AIDS epidemic. She asks whether the patients have been tested for HIV and if they know the HIV status of their partner.

"I tell them the only person who is going to protect them is them and that they have to take this responsibility to have this conversation with their partner and to protect themselves from any potential infection," Bernstein notes.

Providers need to be watchful for such symptoms as weight loss, wasting, fatigue, and dementia; health care providers often misdiagnose HIV/AIDS in older people since such symptoms occur naturally in older people or can indicate Alzheimer's disease.[6] Women who present with such symptoms such as hot flashes, night sweats, and depression may be treated for menopausal symptoms rather than tested for HIV infection.[6]

Stay vigilant

The important thing to realize is that 50-plus patients still are sexually active, Bernstein says. The problem is that they don't realize that they're at risk for HIV/AIDS, she notes.

"Many of these women have no knowledge because they think of AIDS as something that affects their children or grandchildren and not themselves," she notes. "Their hypothesis is that since they are postmenopausal, they can't get pregnant, and they think they can't get anything."

Explain what steps patients can take to protect themselves, such as barrier protection, states Bernstein.

"Sometimes it is embarrassing and I have had patients turn bright red on me, but they walk out of the office with a list of condoms that they can buy," she notes.

References

1. Henderson SJ, Bernstein LB, George DM, et al. Older women and HIV: How much do they know and where are they getting their information? *J Am Geriatr Soc* 2004; 52: 1,549-1,553.
2. Centers for Disease Control and Prevention. Trends in HIV/AIDS diagnoses — 33 states, 2001-2004. *MMWR* 2005; 54:1,149-1,153.
3. U.S. Senate Special Committee on Aging. Chairman Smith calls attention to HIV threat among America's seniors. Press release. May 12, 2005. Accessed at: aging.senate.gov/public/index.cfm?FuseAction=PressReleases.Detail&PressRelease_id=524&Month=5&Year=2005.
4. American Association of Retired Persons. Sexuality At Midlife and Beyond. 2004 Update of Attitudes and Behaviors. Washington, DC; 2005.
5. American Association of Retired Persons. *AARP Modern Maturity Sexuality Study*. Washington, DC; 1999.
6. The Foundation for AIDS Research. *Seniors Hidden HIV Risk Group*. Accessed at: www.amfar.org/cgi-bin/iowa/news/record.html?record=105. ■

HIV diagnoses: Racial differences still exist

EXECUTIVE SUMMARY

New figures from the Centers for Disease Control and Prevention show that despite an approximate 5% annual decline in the 2001-2004 rate of diagnoses among African Americans, the epidemic continues to make a severe impact on that ethnic group.

- In 2004, the rate of new HIV diagnoses among African Americans was 8.4 times higher then the rate among whites (76 compared to nine per every 100,000).
- From 2001-2004, African Americans accounted for more than half of all diagnoses (51%), while representing 13.5% of the total population.
- The report marks the first time data have been included from New York state, which initiated name-based reporting in 2001.

New figures from the Centers for Disease Control and Prevention (CDC) show that despite an approximate 5% annual decline in the 2001-2004 rate of diagnoses among African Americans, the epidemic continues to make a severe impact on that ethnic group.[1,2]

In 2004, the rate of new HIV diagnoses among African Americans was 8.4 times higher then the rate among whites (76 compared to nine per every 100,000).[1] From 2001-2004, African Americans accounted for more than half of all diagnoses (51%), while representing 13.5% of the total population.[1]

Reducing the toll among African Americans will require a diverse and comprehensive approach, says **Joseph Prejean**, PhD, an epidemiologist at the CDC's Division of HIV/AIDS Prevention. Unfortunately, there is no simple solution to overcoming such factors as stigma, racism, and poverty; such barriers cannot be changed overnight or by the government alone, he observes.

"Reducing HIV among African Americans will require a collaborative response, as some of our greatest successes have been in partnership with affected communities," states Prejean. "CDC is currently working with community leaders across the country to prioritize prevention needs and determine how to accelerate progress."

As the impact of HIV on this population has grown, so have prevention efforts, reports Prejean. CDC now gives more than $30 million directly to African American community-based organizations, and more funds are directed to African Americans than any other racial/ethnic group, he notes.

NY data now included

The current CDC reports highlight new HIV trend data for 2001-2004. The data come from a subset of 33 states with longstanding, name-based HIV reporting. The new figures are important, as information from New York state, which implemented name-based reporting in 2001, is included for the first time. While the report is not a complete picture of the U.S. epidemic, the addition of New York data provide a more representative look, notes **Lisa Lee**, PhD, senior epidemiologist at CDC's Division of

HIV/AIDS Prevention.

"New York accounted for 20% of the diagnoses in this analysis and had a significant impact on overall trends," states Lee. "HIV diagnoses declined 9% each year among injection drug users and 4% among heterosexuals, partly due to the influence of trends in New York state."

A number of high-morbidity areas that lack long-standing confidential, name-based HIV reporting, including California and Illinois, are not included in the CDC report. To improve the nation's ability to monitor the HIV epidemic, CDC recommends that all states and territories adopt confidential, name-based HIV reporting systems.[3] The agency is working with states to develop a new system for monitoring new HIV infections more directly through the use of a testing method that distinguishes recent from long-standing infections. Data are expected from that system in 2006, say CDC officials.

What do figures show?

On a national scale, the report indicates that men of all races and ethnicities account for 71% of new HIV diagnoses from 2001-2004; women represent 29%. Among men, African American men continued to face the highest rate of new HIV diagnoses in 2004 (131.6/100,000) — more than seven times that of white males (18.7) and more than twice the rate among Hispanic males (60.2). Among women, African American women had the highest rate of diagnoses in 2004 (67/100,000) — more than 20 times higher than the rate among white females (3.2) and more than four times higher than among Hispanic females (16.3).[1]

By transmission category, men who have sex with men (MSM) continued to represent the majority of new HIV diagnoses (44% from 2001-2004), with a slight increase in the most recent year.[1] During this same time period, HIV diagnoses declined among injection drug users and heterosexuals.

While the November 2005 report from the CDC reported an annual decline in the overall rate of HIV diagnoses for African Americans, the February 2006 article took a more in-depth view of the figures.[1,2] It shows about a 4% decrease in the estimated annual rate of HIV diagnoses for each year among African American men, with a nearly 7% decrease in the annual rate of HIV diagnoses among African American women.[2]

CDC researchers presented new information at a February conference, showing annual declines in African American women in heterosexual transmission and injection drug use categories, as well as significant declines in the annual rate of diagnosis among African American men in similar categories.[4] However, there were no significant declines among African American men who have sex with men.[4]

"These results underscore the impact of the HIV/AIDS epidemic on non-Hispanic blacks and the need to continue monitoring trends particularly among MSM, the largest transmission category," the researchers note.[4]

References

1. Centers for Disease Control and Prevention. Trends in HIV/AIDS diagnoses — 33 states, 2001-2004. *MMWR* 2005; 54;1,149-1,153.

2. Centers for Disease Control and Prevention. Racial/ethnic disparities in diagnoses of HIV/AIDS — 33 states, 2001-2004. *MMWR* 2006; 55:121-125.

3. Centers for Disease Control and Prevention. *Fact Sheet. New HIV Diagnoses, 33 States, 2001-2004*. Atlanta: December 2005.

4. Durant T, Satcher A, Prejean J, et al. Trends in HIV Diagnosis among Non-Hispanic Black Americans, 2001-2004. Presented at the 13th Conference on Retroviruses and Opportunistic Infections. Denver; February 2006. ■

Make plans for ACNM annual meeting in May

Circle May 26-June 1 for the 51st annual meeting of the American College of Nurse-Midwives (ACNM) Annual Meeting in Salt Lake City. Sessions will include a primary care update, a workshop on endometrial biopsy indications and techniques, and information on advanced billing and coding.

To register on-line, go to the ACNM web site, www.midwife.org , and click on "Annual Meetings." Fees for ACNM members are $395 for early-bird registration, $480 for advance registration, and $530 for on-site registration; nonmember fees are $485, $555, and $605, respectively. Fees must be received by March 17 to qualify for the early-bird discount, with May 5 as the advance registration deadline. After May 5, registration must be done on-site. ■