

Contraception

(Beyond Birth Control Pills, Female Sterilization, and Male Condoms)

David Glenn Weismiller, MD, ScM, FAAFP

Professor

Department of Family and Community Medicine
Kirk Kerkorian School of Medicine at the University of Nevada
Las Vegas, NV



1

Disclosure

I have no financial interests or relationships to disclose.



2

David Glenn Weismiller, MD
Contraception

Learning Objectives

- Describe principles of patient selection regarding contraceptives.
- Discuss the indications/contraindications for various contraceptive methods.
- Appraise recommendations for use of long-acting reversible contraceptives.
- State the options and indications regarding methods of emergency contraception.

3

State of World Population (SoWP) 2022

UNFPA, The United Nations Sexual and Reproductive Health Agency



“Human rights crisis has profound consequences for societies, women and girls and global health.”

<http://www.unfpa.org/swp2022>

4

Five Key Facts from The 2022 SoWP

- **Every year, almost half of all pregnancies are unintended.**
 - Between 2015 and 2019, there were roughly 121 million unintended pregnancies globally each year.
- **Globally, an estimated 257 million ♀who want to avoid pregnancy are not using safe, modern methods of contraception.**
 - In 47 countries, about 40 percent of sexually active women did not use contraceptives to avoid pregnancy.
- **Nearly a quarter of all women cannot say no to sex (where data is available).**
 - Contraceptive use is 53 percent lower among women who have experienced intimate partner violence.
 - Studies show that rape-related pregnancies are equally or more likely to occur than pregnancies from consensual sex.
- **Over 60 percent of unintended pregnancies, and almost 30 percent of all pregnancies, end in abortion.**
 - Forty-five percent of all abortions performed globally are unsafe.
 - Unsafe abortions hospitalize about 7 million women a year globally and cause 5 to 13 percent of all maternal deaths, one of the leading causes of maternal death.
 - In developing countries, unsafe abortions cost an estimated \$553 million per year in treatment costs alone.
- **In humanitarian emergencies, e.g., the ongoing war in Ukraine, many women lose access to contraception and experience sexual violence.**
 - Some studies about humanitarian emergencies have shown that over 20% of refugee women and girls will face sexual violence.
 - Estimated 4.8 million unintended pregnancies will occur in Afghanistan by 2025 due to health system disruptions and gender inequality.
 - In the first 12 months of the COVID-19 pandemic, the estimated disruption in contraceptive supplies and services lasted an average of 3.6 months, leading to as many as 1.4 million unintended pregnancies.

5

“This report is a wakeup call. The staggering number of unintended pregnancies represents a global failure to uphold women and girls’ basic human rights. For the women affected, the most life-altering reproductive choice—whether or not to become pregnant—is no choice at all. By putting the power to make this most fundamental decision squarely in the hands of women and girls, societies can ensure that motherhood is an aspiration and not an inevitability.”

---UNFPA Executive Director Dr. Natalia Kanem

6



PAUSE
relax
TAKE A DEEP BREATH

7

The Case of Maya

“I Need to Start Something ...NOW.”

Maya is a **26-year-old** graduate student who presents for an "urgent birth control consult." She is currently on **Day 12** of her menstrual cycle. She tells you, "A condom broke on Saturday night (roughly 36 hours ago), and I realized I can't keep relying on just condoms. I need something better, and I'd like to leave here today with a plan."

8

Her Clinical Profile

- **Medical History:** Occasional migraines. When asked for detail, she notes, "About twice a year, I see these weird 'shimmering zig-zags' in my vision for 20 minutes before a really bad headache hits."
- **Physical Exam:** Weight: 175 lbs (79.5 kg). Height: 5'6" (167.5 cm). **BMI: 28.2 kg/m².**
- **Contraceptive History:** She tried "the pill" at age 19 but stopped after four months because she "spotted the whole time" and thought her body was rejecting it.
- **Current Preferences:** She's nervous about IUDs because her roommate had a painful insertion, but she's also worried she'll forget a daily pill.

9

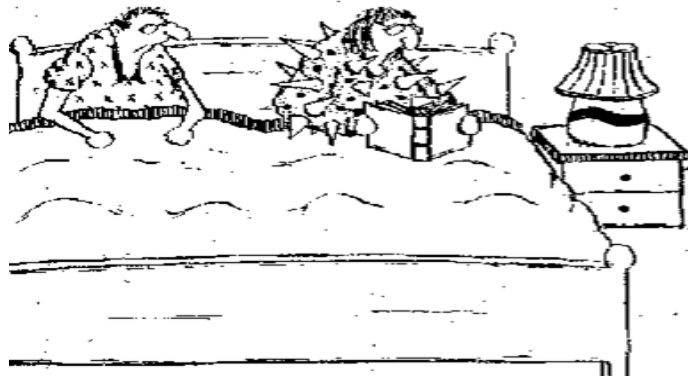
The Challenges?

- Maya represents the '**Triple Threat**' of primary care contraception:
 - she needs Emergency Contraception,
 - she has a contraindication you might miss,
 - she's already a 'dissatisfied' former user.
- *By the end of this talk, you'll know exactly how to get Maya protected before she walks out your door today."*

10



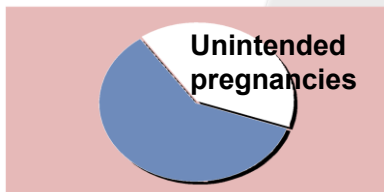
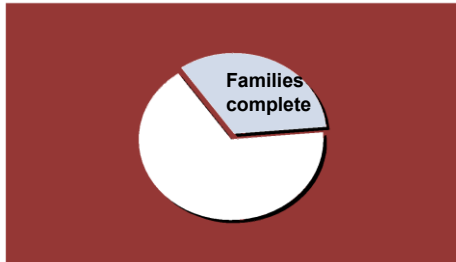
11



***Helen tries out her new
“Not-Tonight-Honey” nightgown***

12

Why Contraception?



- 40% of US pregnancies (>2M) are unintended
 - In women $\geq 40y$ the rate is 51%
 - About a third of unintended pregnancies occur in women who consider their families **complete**
- **Health Benefits**
- **Risk(s) of Pregnancy**

1. Mosher WD, Martinez GM, Chandra A, Abma JC, Willson SJ. Use of contraception and use of family planning services in the United States, 1982-2002. Advance data from vital and health statistics; no 350. Hyattsville, Maryland: National Center for Health Statistics, 2004. 2. Chandra A, Martinez GM, Mosher WD, Abma JC, Jones J. Fertility, family planning, and reproductive health of U.S. women: Data from the 2002 National Survey of Family Growth. National Center for Health Statistics. *Vital Health Stat*. 23(25). 2005. 3. Henshaw S. Unintended Pregnancy in the United States. *Family Planning Perspectives*. 1998;30(1):24-29 & 46.

13

Contraceptive Options

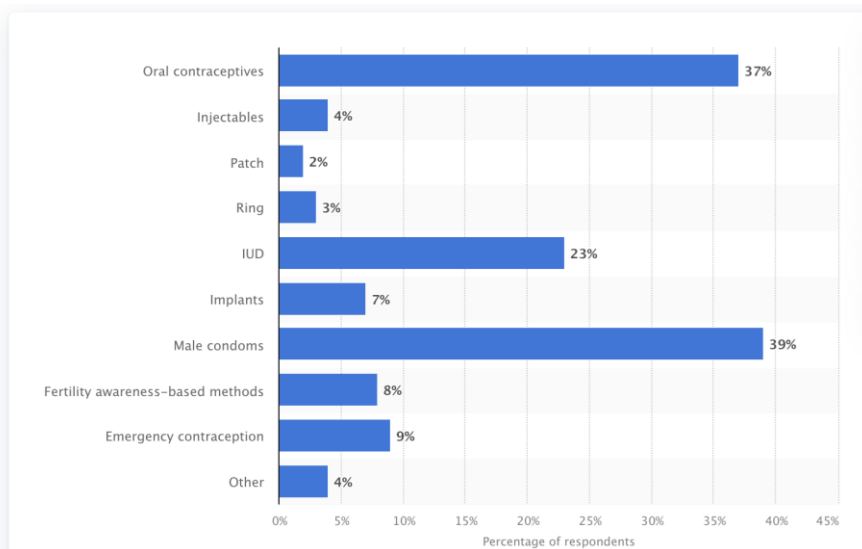


- **Irreversible**
 - Tubal ligation*/Salpinxectomy
 - Vasectomy
- **Abstinence**
 - Reasonable, acceptable option; particularly in younger patients
 - A lot of education
- **Reversible**
 - Oral contraceptives*
 - Combined pills*
 - Progestin-only pills
 - Other hormonal options
 - Implant
 - Injection
 - Vaginal ring
 - Patch
 - Intrauterine Devices
 - Barrier methods
 - Male condom*
 - Female condom
 - Natural Family Planning

*** Three most commonly used in US**
Pregnancy poses a greater risk than any contraceptive method

14

Percentage of Sexually Active Women that Used Select Methods of Contraception Within the Past 12 Months as of 2020



15

Principles

- All methods can fail
- Two methods are better than one
- Methods used wrong fail more
- Always need a backup plan
- No plan offers an 85% chance of getting pregnant



16

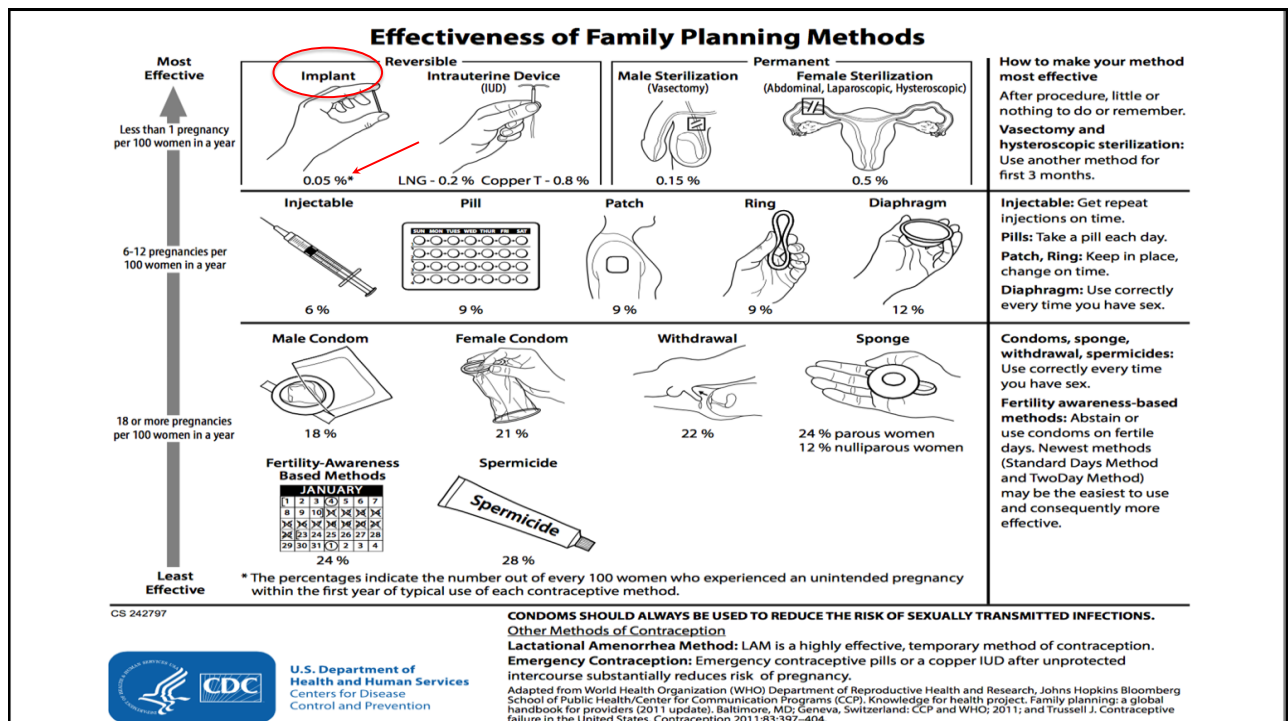
Question #1

Which One of the Following Contraception Options Is the Most Effective in Preventing Pregnancy?

- A. Etonogestrel Implant (Nexplanon)
- B. Male Sterilization (Vasectomy)
- C. Copper T IUD
- D. Depomedroxyprogesterone acetate



17



18

Contraceptive Counseling



19

Shared Decision Making

- For years, the gold standard was "LARC-first" counseling (pushing IUDs and implants because they are the most effective). However, the pendulum has swung toward **Shared Decision-Making (SDM)**.

The Practice Shift

"Effectiveness" isn't every patient's top priority. Some care more about cycle control, privacy, or the ability to stop the method without a clinic visit.



The Goal

A patient who is happy with a "less effective" method (like the pill) is more likely to use it correctly than a patient who felt pressured into an IUD they didn't want.

20

Contraceptive Counseling

1. *What are your contraceptive goals? Do you ever plan to get pregnant? When?*
2. *Are you currently having sex with a partner who produces sperm?*
3. *Have you tried any contraceptive methods? If so, which one(s)?*
4. *What did you like/dislike about the method(s)?*
5. *Are you a good pill taker?*

21

Contraceptive Counseling

6. *For user-controlled methods, how often did you forget to use the method?*
7. *Are there any methods you have heard about and would like to try?*
8. *How important is spontaneity of use?*
9. *Is protection from STIs important considering your life situation?*
10. *Is cost an issue? Does your health insurance plan cover any contraceptive method?*

22

Pregnancy Status Uncertain



23

Quick Start Method

The old-school advice to "**wait until your next period**" to start contraception is a major barrier that leads to unintended pregnancies while waiting for the calendar to turn.

- **The Rule:** If the pregnancy status is uncertain, may consider same day start of a nonintrauterine contraceptive method for immediate coverage and should order follow-up pregnancy testing in 2-4 weeks. (SOR:C)
- **Practical Tip:** If they are mid-cycle, just advise backup (condoms) for the first 7 days. If they've had unprotected sex recently, provide Emergency Contraception (EC) and start the regular method simultaneously.

24

How to Be Reasonably Certain That a Person Is Not Pregnant

A clinician can be reasonably certain that a person is not pregnant if:

Patient has no signs or symptoms of pregnancy, **and**:

Patient meets **at least one** of the following criteria:

- Is ≤ 7 days after start of normal menses
- Has not had intercourse since the start of last normal menses
- Has been correctly and consistently using a reliable method of contraception
- Is ≤ 7 days after spontaneous or induced abortion
- Is within 4 weeks postpartum
- Is fully or nearly fully breastfeeding (ie, exclusively breastfeeding or the majority of feeds [$\geq 85\%$] are breastfeeds), amenorrheic, and < 6 months postpartum

*Note: If the patient meets both criteria, there is a negative predictive value of 99% to 100% of pregnancy, and the patient does **NOT** need a pregnancy test before initiating contraception*

Curtis KM, Nguyen AT, Tepper NK, et al.; Contributors. U.S. selected practice recommendations for contraceptive use, 2024. MMWR Recomm Rep. 2024;73(3):8.

25



COMBINED HORMONAL CONTRACEPTION

26

Question #2

Which One of the Following Conditions Presents an Unacceptable Health Risk for Combined Oral Contraceptive Use?

- A. Migraine with aura
- B. Endometrial hyperplasia
- C. Breastfeeding 1-6 months post partum
- D. Chronic hepatitis C
- E. Previous laparoscopic banding weight-loss surgery



CONTINUING EDUCATION COMPANY

27

Combined Hormonal Options

- **Pill**
 - Monophasic pills recommended as the first choice for women starting combined OCPs (Cochrane 2011).
 - 25-year mortality from all causes same for OCP users vs nonusers.
- **Ring (Annovera, Nuva Ring)**
- **Patch**
 - Highly efficacious in women < 90 kg
 - Safety warning (FDA)
 - ~ 60% more estrogen per cycle than 35 mcg pill (11/2005)
 - > 3x risk of VTE compared to combined OCP
- **Inhibit ovulation at pituitary and hypothalamus**
- **Estrogen**
 - Ethinylestradiol (most common), mestranol (a prodrug of ethinylestradiol), and estradiol
 - Estetrol (E4), naturally produced during pregnancy, being produced from plant source
- **Progestogen**
 - Drospirenone – no risk of hyperkalemia

28

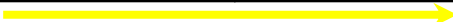
Descending Order of Androgenic Potency

Progestogens

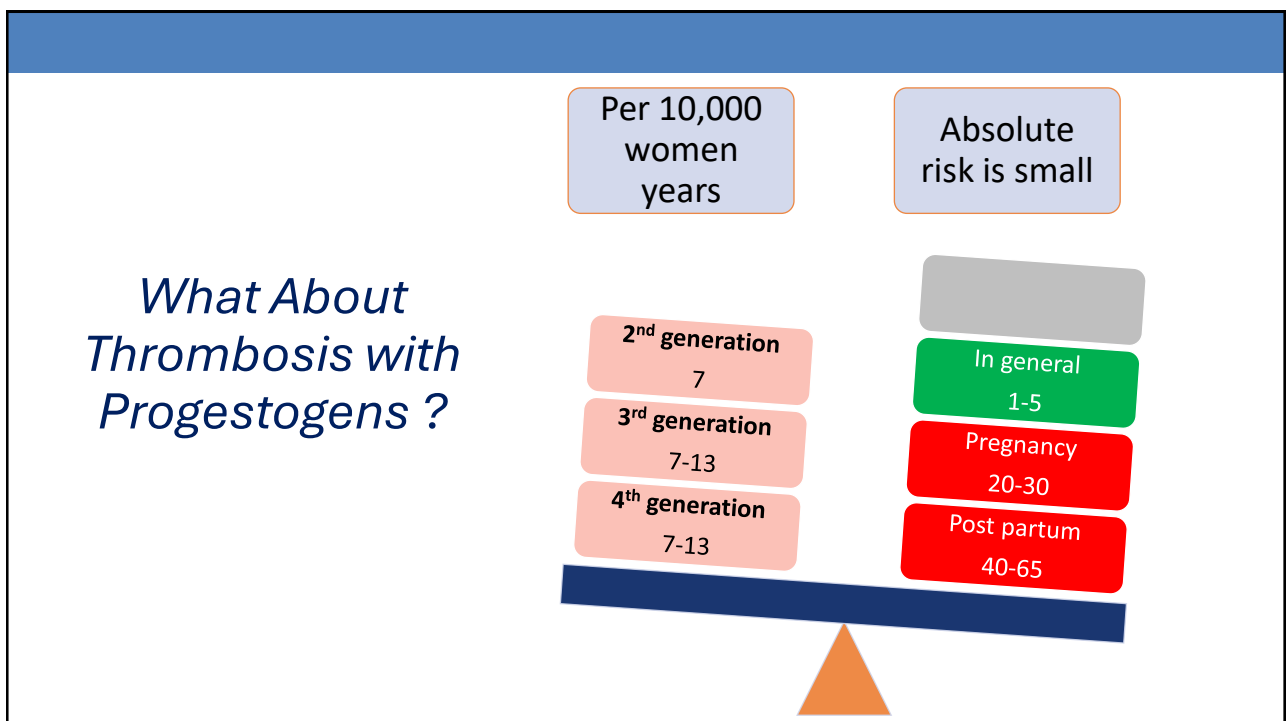


<u>First</u> “Original pills”	<u>Second</u> Levonorgestrel Alesse Levlite Nordette Levlen Norgestrel LoOvral Norethindrone acetate Loestrin Norethindrone Ortho-novum 1/35 Ovcon 35 Ethinodiol diacetate Demulen 1/35	<u>Third</u> Norgestimate Ortho-Cyclen Ortho-Tri-cyclen Desogestrel Mircette Desogen Orthocept Cyclessa	<u>Fourth</u> Drospirenone Yasmin Yaz Anti-androgenic
---	--	--	--

Slightly higher risk of thrombosis



29



30

Estetrol (E4)

➤ Mithra Pharmaceuticals

▪ *Nextstellis*

- 3 mg Drospirenone
- 14.2 mg estetrol (E4)
 - Naturally produced during pregnancy, being produced from plant source

▪ Minimal impact on specific markers (of concern)

- TG
- Cholesterol
- Glucose
- Weight

31

Combined Hormonal Contraception Benefits

• **Decrease Cancer**

- Ovarian and endometrial (OR 0.57; NNT 60)* cancers
 - Protective effects persist up to 20 years after discontinuation.
- Colorectal cancer (OR 0.86; NNT 132)*

* Gierisch JM et al. *Cancer Epidemiol Biomarkers Prev.* 2013 Sep 6 [e-pub ahead of print]. (<http://dx.doi.org/10.1158/1055-9965.EPI-13-0298>)

32

OCPs and Cancer

- Oral Contraception Study
 - Started 1968
 - Royal College of General Practitioners
 - Investigate long-term effects of OCP
 - 46,022 women followed up to 44 years

Am J Obstet Gynecol. 2017 Feb 8. pii: S0002-9378(17)30179-5. doi: 10.1016/j.ajog.2017.02.002.

33

Lifetime Cancer Risk and Oral Contraceptives The Royal College of General Practitioners Oral Contraception Study

- **Reduction in cancers**
 - Bowel 19%
 - Endometrial 34%
 - Ovarian 33%
- Protective effects shown to last for at least 30 years after pill use ended
- Risk of all types of cancer in women who have taken pill – using pill during reproductive years DOES NOT produce new cancer risks for women later in life, when cancers become more common in the population as a whole

Am J Obstet Gynecol. 2017 Feb 8. pii: S0002-9378(17)30179-5. doi: 10.1016/j.ajog.2017.02.002.

34

What Do I SAY to Patients in My Practice?

- "Data about breast cancer risk indicates a slightly increased risk among current users of combined hormonal contraceptives, an effect that disappears 5-10 years after stopping. Notably, combined hormonal contraception has a significant protective effect on the risk of ovarian cancer, and the protection increases with duration of use (relative risk decreased by 20% for each five years of use). A significant risk reduction has been confirmed for BRCA 1 and 2 mutation carriers. The risk of endometrial cancer is reduced by about 50% in ever users, a benefit which is more significant with increasing duration of use. There is also a decreased risk of colon cancer. An ASSOCIATION has been found between increased risk of cervical cancer and long-term OCP use. Current OC use has been associated with an excess risk of benign liver tumors and a modestly increased risk of liver cancer. None of the extensive prospective cohort studies with prolonged follow-up has observed an increased overall risk of cancer incidence or mortality among ever users of combined hormonal contraception. Indeed, several have suggested critical long-term benefits. Specifically, the protective effect of OC can be used as chemoprevention in young women who are BRCA mutation carriers."
 - "If you decide that combined hormonal contraception is right for you, I feel comfortable advising that the decision is unlikely to place you at a higher risk of developing cancer."
- David Glenn Weismiller, MD, ScM, FAAPF

35

Combined Hormonal Contraception Benefits

- **Decrease Cancer**
 - Ovarian and endometrial (OR 0.57; NNT 60)* cancers
 - Protective effects persist up to 20 years after discontinuation.
 - Colorectal cancer (OR 0.86; NNT 132)*
- **Decrease Endometriosis**
 - Use strong progestin component
- **Decrease PID**
 - Cervical mucus alterations; reduced menstrual blood flow
 - Less retrograde menstruation
- **Decrease functional ovarian cysts (use high estrogen content)**
- **Decrease fibrocystic disease**
- **Decrease iron deficiency anemia**
- **Decreased risk of ectopic pregnancy**
- **Increase bone mass**
 - Reduces risk of postmenopausal hip fractures
- **Improve symptoms of PCOS**
 - High estrogen/progestin ratio

* Gierisch JM et al. *Cancer Epidemiol Biomarkers Prev.* 2013 Sep 6 [e-pub ahead of print]. (<http://dx.doi.org/10.1158/1055-9965.EPI-13-0298>)

36

Prerequisite Preventive Services?

Stewart Et Al. Systematic Review

- Consensus statement reviewing and summarizing relevant medical literature and policy statements
- No evidence supporting necessity of CBE and pelvic examination
- The available evidence supports prescribing hormonal contraception based only on:
 - Blood pressure measurement
 - Review of medical history

JAMA, 2001; 285:2232-2239

37

Medical History

- **Chronic diseases**
 - Hypertension
 - DM
 - Hyperlipidemia
 - Migraine
 - Immune deficiency states
 - Cancer
- **Gynecologic history**
 - Infections
 - Pap
- Previous contraceptive methods, successes and failures
- VTE
- Tobacco use

38

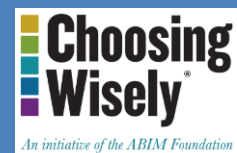
Bottom Line

- *Requiring prerequisite preventive services, such as cervical cytology; breast examination; or evaluation for sexually transmitted infections, diabetes mellitus, dyslipidemia, liver disease, or thrombophilia, can introduce unnecessary barriers to contraceptive care.*

Gavin L, Moskosky S, Carter M, et al.; Centers for Disease Control and Prevention (CDC). Providing quality family planning services: recommendations of CDC and the U.S. Office of Population Affairs. MMWR Recomm Rep. 2014; 63(RR-04): 1-54.

39

Recommendations from the Choosing Wisely Campaign American Academy of Family Physicians



- Do **not** require a pelvic exam or other physical exam to prescribe oral contraceptive medications.

American Academy of Family Physicians. Choosing Wisely: Pelvic exam or physical exams to prescribe oral contraceptive medications. 2014. <http://www.aafp.org/patient-care/clinical-recommendations/all/cw-oral-contraceptives.html>.

40

Drug Interactions with Combined Hormonal Contraception

ENZYME INDUCERS

Expect contraceptive failure

- Rifampin [SOR:A]
- Anticonvulsants – except valproic acid
- Griseofulvin
- HIV medications

GLP-1 / GIP AGONISTS

Delayed absorption, not CYP450

- Tirzepatide lowers pill exposure ~20%
- Use a non-oral method, **or** add a barrier method for **4 weeks** after starting and after each dose increase*

NO EFFECT

No backup needed

- Semaglutide, liraglutide, dulaglutide
- Antibiotics other than rifampin
- Valproic acid

**The delay is largest after the first dose and diminishes over time which is why the backup window is tied to initiation and each dose step rather than the whole course.*

Source: Mounjaro/Zepbound prescribing information; Skelley JW, et al. J Am Pharm Assoc. 2024;64(1):204-211.

41

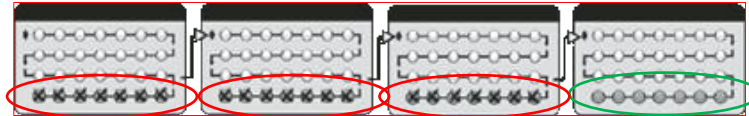
Extended vs. 28-Day Cycle OCPs Cochrane 2014

- **Oral contraceptives used in a long cycle**
 - an extension of the intervals between the pill-free periods to > 21 days
 - completely without a hormone-free interval
- **Important Benefits -**
 - number of bleeding days and of menstrual-related problems are reduced
 - endometriosis-related pain and risk of recurrence of endometrioma after surgical treatment (diminished by OC's taken continuously)
 - risk of endometrial hyperplasia is not increased.
 - coagulation system, metabolism of lipids, carbohydrates affected the same way as with conventional use.

42

Instructions

Extended Use



- Take 84 hormonal pills in a row, one each day. (These are the hormonal pills in **4 monthly packs**.) Users of 28-pill packs do not take the nonhormonal (placebo) pills.
 - (Disp: 4 packages Sig: 1 po q day. (Take continuously.) Refills: 3)
- After 84 hormonal pills, wait seven days and start the next pack of pills on the 8th day. (Users of 28-pill packs can take the nonhormonal pills in the 4th pack and start the hormonal pills the day after the last nonhormonal pill.) Expect some bleeding during this week of not taking the hormonal pills.

43

Instructions



Continuous Use (COC)

- A woman should take one hormonal pill daily for as long as she wishes to use COCs.
- If bothersome irregular bleeding occurs, stop taking pills for 3 or 4 days and then start taking hormonal pills continuously again.

44

Types of Continuous Birth Control Pills

Categories	Brands	What's in it	Comments
91-day	Seasonale Quasense Seasonique* LoSeasonique*	84 active pills (12 weeks of continuous birth control) plus seven inactive pills. - Seasonale and Quasense, placebo *Seasonique and LoSeasonique, low-dose estrogen	- Withdrawal bleeds usually during Week 13 - Lower dose of estrogen in last week of the pills helps make period lighter and shorter – typically ~ 3 days.
365-day (only one FDA approved)	Amethyst (90 mcg levonorgestrel and 20 mcg ethinyl estradiol)	Only active pills 28 day pack (Disp 1 with 12 refills = 364 days)	No withdrawal bleeds (No periods)
Mini Continuous-Cycle Pills	<i>Extended-cycle pill packs have more hormone pills than the typical 28-day pill packs (fewer hormone fluctuations because they contain more hormone pills).</i>		
- 24-day	Yaz Beyaz Safryal	24 days of active pills, only four placebo pills	Mini-extended cycle
- 26-day	Lo Loestrin Fe	26 days of estrogen/progestin pills; two days of estrogen-only pills, and two days of placebo pills	Studies show extra two days of estrogen can lead to lighter and shorter periods.

45

Low Dose Pills? 20-25ug EE

- Useful for management of perimenopause
 - Transition off of any contraception?
- Management of acne
 - Less androgenic or antiandrogenic
- AUB – Anovulatory
 - Irregular or infrequent periods
 - Progesterone deficient/estrogen dominant state
 - Flow ranging from light to excessively heavy bleeding
 - 14% of women with recurrent anovulatory cycles develop cancer or hyperplasia

46

Migraine with Aura and Estrogen



One of the most common areas of “Clinical Over-caution.”

47

WHO

Category 1: A condition for which there is no restriction for the use of the contraceptive method.

Category 2: A condition for which the advantages of using the method generally outweigh the theoretical or proven risks.

Category 3: A condition for which the theoretical risk or proven risks usually outweigh the advantages of using the method.

Category 4: A condition that represents an unacceptable health risk if the contraceptive method is used.

Risk

- **Migraine with aura – (WHO Cat 4)**

- The increased stroke risk is specifically associated with **Migraine with Aura**.
- Migraine *without* aura and no other risk factors (like smoking), COCs are generally considered safe (Category 2).
- Nonmigraine headaches, COCs considered safe (Category 1).

Issue	WHO Category
Endometrial hyperplasia	1
Breastfeeding 1-6 months post partum	3 (CDC - 2)
Chronic hepatitis C (Combined oral contraceptives are not recommended for use in women with acute hepatitis C.)	1
Previous laparoscopic banding weight-loss surgery	1

48

The Takeaway

*Don't deny effective contraception based on a simple headache; **get a specific history of visual or sensory changes.***

49

Question #3

A 34-year-old sexually active female consults you about contraception options. She has late-stage kidney disease and her nephrologist has notified you that she will likely be recommended for kidney transplantation soon.

Which One of the Following Would You Recommend for Safety and Efficacy?

- A. Condoms
- B. Combined hormonal oral contraceptive pills
- C. Medroxyprogesterone acetate (Depo-Provera injections)
- D. An IUD
- E. An etonogestrel/ethinyl estradiol vaginal ring (NuvaRing)



CONTINUING EDUCATION COMPANY

50

Organ Transplant and Pregnancy

- Pregnancy should be avoided during the 12 months following transplantation - increased risk of preterm delivery and graft rejection.
- Female fertility typically **increases** post-transplant
- Use of an IUD
 - avoids interactions with medications
 - does NOT increase the risk of infection
 - NOT affected by typical immunosuppressive therapies
- Remaining options - incorrect because of higher failure and discontinuation rates. *CDC cites failure rates with typical use:*
 - 9% for combined OCPs and the etonogestrel/ethinyl estradiol vaginal ring,
 - 6% for injectable progesterone
 - 0.2% for levonorgestrel IUDs, and 0.08% for the copper IUD
 - Barrier method failure rates exceed 18%
 - Combined OCPs and vaginal ring also have potential estrogen-related side effects
 - injectable progesterone use increases the risk of osteoporosis

51

• Pill

- Must be taken q day at SAME time (2 h window)
 - Back-up if > 3 h late

FDA advisory panels back making Opill birth control pill available over the counter

Advisers to the agency voted unanimously in favor of making the pill available without a prescription, despite concerns from FDA scientists about the quality of the data.

Wednesday May 10, 2023

Progestin Only Options

- Making birth control OTC could prevent more than 37,000 unintended pregnancies in one year
- Dispensed in 91-day packs
 - 84 days of active hormone pills followed by seven inactive pills and/or low-dose pills

52

- **Pill**
 - Must be taken q day at SAME time (2 h window)
 - Back-up if > 3 h late
- **Implant**
 - q 3 years
 - < 125% IBW
- **IUS**
 - q 3-8 years
- **DMPA**
 - q 3 months
- No effect on BP; risk of VTE, CVA, MI [SOR: B]
- **Most common side effect: Irregular bleeding**



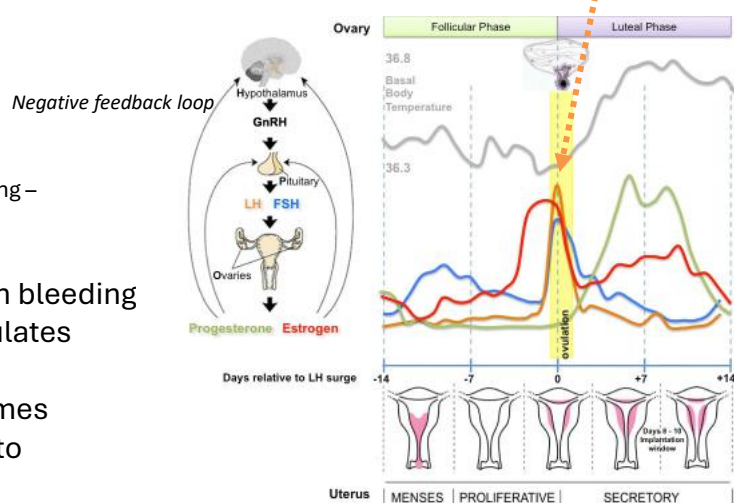
Progestin Only Options

53

Progestogens

- All simulate the endogenous progesterone
 - They suppress the LH surge
 - Down stream effects on uterine lining – unsuitable for implantation
 - Cervical mucous thickening
- Key side effects of breakthrough bleeding
 - prolonged progestin downregulates both the progestin and estrogen receptors – endometrium becomes dyssynchronous – not listening to estrogen or progesterone

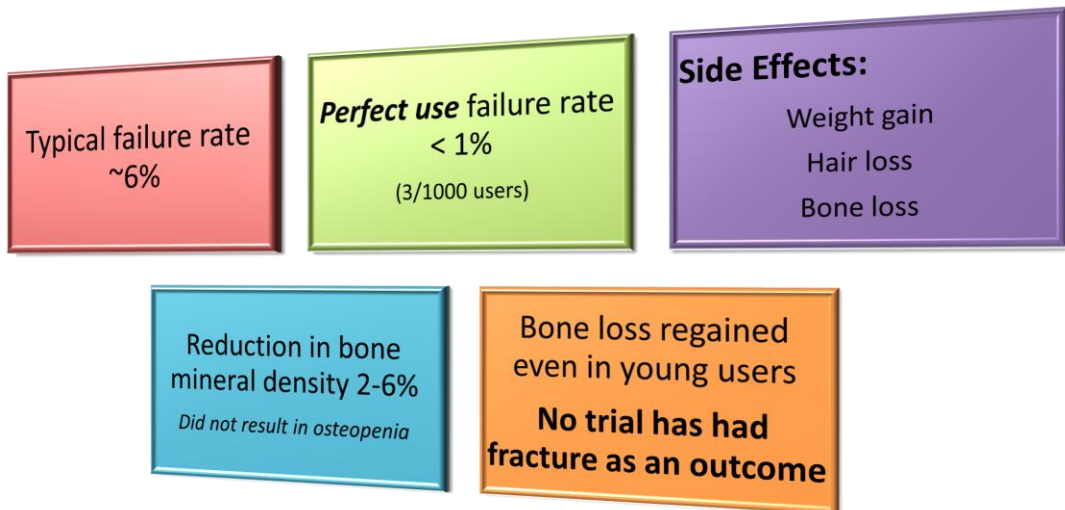
Endogenous progesterone inhibits the LH surge



Hill, M.A. (2026, April 15) *Embryology Menstrual cycle.png*. Retrieved from https://embryology.med.unsw.edu.au/embryology/index.php/File:Menstrual_cycle.png

54

Depot Medroxyprogesterone Acetate (DMPA)



55

DMPA

ACOG

No longer recommends limiting injections to two years

No routine monitoring of bone density

Recommend:

1300 mg calcium and 600 IU of vitamin D3 daily

Participate in weight-bearing exercise

Depot medroxyprogesterone acetate and bone effects. Committee Opinion No. 602. American College of Obstetricians and Gynecologists. Obstet Gynecol 2014;123:1398–402.

56

Self-Administration of Subcutaneous DMPA

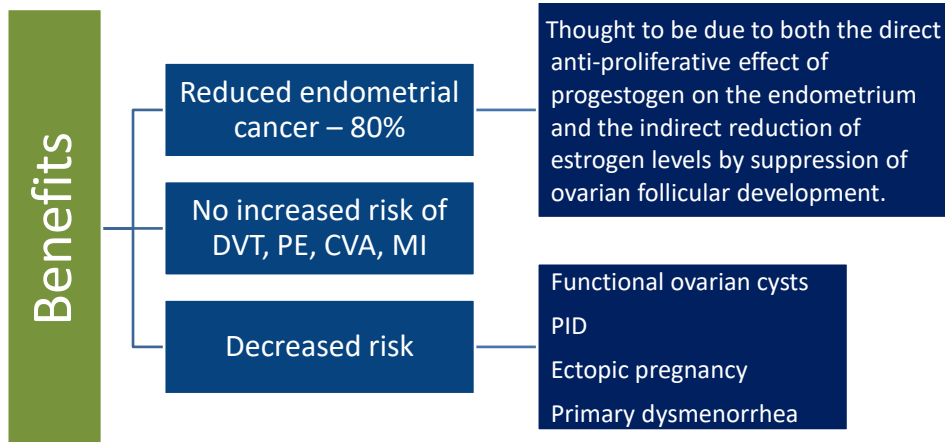
- WHO (2019)- recommended self administration
- CDC (2012) – adopted WHO recommendation
 - moderate-certainty evidence of safety and effectiveness
 - higher continuation rates compared with provider administered
- User controlled method that has the potential to improve contraceptive access and increase reproductive autonomy.

Curtis KM, Nguyen A, Reeves JA, Clark EA, Folger SG, Whiteman MK. Update to U.S. Selected Practice Recommendations for Contraceptive Use: Self-Administration of Subcutaneous Depot Medroxyprogesterone Acetate. MMWR Morb Mortal Wkly Rep 2021;70:739–743. DOI: <http://dx.doi.org/10.15585/mmwr.mm7020a2external icon>

57

DMPA

- One Week to Take Effect if Given AFTER First Five Days of the Period Cycle
- Return to Fertility: 3-18 Months (Avg. 9-10 Months)



58

DMPA (150 mg) and Meningioma

(ACOG – “Warrants Counseling”)

MENINGIOMA RISK

With prolonged use, typically > 4 years

5 per 10,000

using DMPA

1 per 10,000

not using DMPA

Risk particularly noted in users over age 31

Progesterone link

Meningiomas often carry progesterone receptors, and high doses of the hormone can encourage tumor growth.

Reversibility

Growth may slow or stop, or the tumor may shrink, after stopping high-dose progestogens.

No routine MRI

Not needed to screen for a brain tumor in current or past DMPA users who feel well.

Interpret results with caution; the studies have several limitations

Xiao T, Kumar P, Lobbous M, et al. Depot Medroxyprogesterone Acetate and Risk of Meningioma in the US. *JAMA Neurol.* 2025;82(11):1094–1102. doi:10.1001/jamaneurol.2025.3011

59

Progestin-Only Methods More Appropriate than Combined

Smoking or obesity AND over age 35

SOR B, A

Hypertension with vascular disease, or over age 35

SOR B

Lupus with vascular disease or nephritis

SOR A

Migraine with focal aura

SOR B

VTE current, or history with pregnancy or estrogen, unless anticoagulated

SOR A

Coronary artery or cerebrovascular disease

SOR C

60

Progestin-Only vs. Combined OCP and Lactation

Espey Et Al. Obstet Gynecol 2012;119(1):5-13

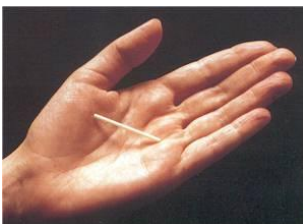
Objective: Estimate the effect of progestin-only compared with combined hormonal contraceptive pills on rates of breastfeeding continuation in postpartum women

Results: No difference in breastfeeding continuation rates, contraceptive continuation, and infant growth parameters at 8 weeks

Conclusion: Choice of combined hormonal or progestin-only contraceptive pills administered 2 weeks postpartum did not adversely affect breastfeeding continuation.

61

LONG-ACTING REVERSIBLE CONTRACEPTIVES



- ❖ *Intrauterine Devices/System*
- ❖ *Intradermal Implant*

62

Types of IUDs

IUD (Copper)	Available Since	FDA Approved Years Effective	Use and FDA Approved	Possible side effects
Copper (Paragard; 32mmx36mm)	1988	10	Approved only in parous women, but available to all women regardless of parity Can be used as Emergency Contraception when inserted within 5 days	- Abnormal menstrual bleeding - Higher frequency or intensity of cramps/pain
IUD (Hormonal)				
Mirena (32mmx32mm)	2001	8 (2022)	Approved only in parous women, but available to all women regardless of parity	- Inter-menstrual spotting in the early months - Reduces menstrual blood loss significantly - Hormone-related: headaches, nausea, breast tenderness, depression, cyst formation.
Skyla (<i>slightly smaller than Mirena; 28mmx30mm</i>)	2013	3	Approved for women regardless of parity	
Liletta* (32mmx32mm)	2015	8* (2022)	Approved for women regardless of parity	
Kyleena (<i>lower hormone levels than Mirena; 28mmx30mm</i>)	2016	5	Approved for women regardless of parity	

*Actavis in conjunction with Medicines360, a non-profit women's pharmaceutical company, developed Liletta specifically to be low cost and available to public health clinics enrolled in the national 340B Drug Pricing Program, which provides reduced cost pharmaceuticals to providers that serve low-income populations.

63

Question #4

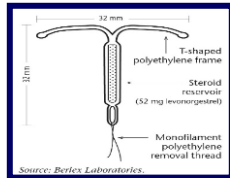
Which of the Following Statements Is True Regarding the Use of an Intrauterine Contraceptive for Family Planning?

- IUD use is associated with pelvic inflammatory disease
- One of the mechanisms of action of an IUD is via inhibiting fertilization
- The risks of an IUD in adolescents generally outweigh the benefits.
- IUDs are contraindicated in nulliparas

64

Intrauterine Contraceptives

Mechanisms of Action



Levonorgestrel-Releasing Intrauterine System (LNG-IUS, Mirena® Skyla® Kyleena®)

- ❖ Inhibits fertilization
- ❖ Thickens cervical mucous
- ❖ Inhibits sperm function
- ❖ Thins and suppresses the endometrium



Copper-Releasing Intrauterine Contraceptive (ParaGard® T380A)

- ❖ Inhibits fertilization
- ❖ Releases copper ions (Cu^{2+}) that reduce sperm motility
- ❖ May disrupt the normal division of oocytes and the formation of fertilizable ova

65

Considerations for IUDs

IUD insertion, not IUD use, is associated with PID

Cochrane review · Grimes and Mohllajee systematic reviews · ACOG Practice Bulletin 2011

IUDs do not cause future infertility

Nulliparas can use an IUD

Uterus sounds to a depth of at least 6 cm

Adolescents: advantages generally outweigh the risks

US MEC guidelines

Counsel on the risk of uterine perforation at insertion

66

Considerations for IUD Use

- **Medical Conditions** – *may be an optimal method*
 - Diabetes
 - Thromboembolism
 - AUB/dysmenorrhea
 - Breastfeeding
 - Breast cancer
 - Liver disease

67

Guidelines for IUDs

Organization	Recommendation
ACOG 2007	Asymptomatic women may use an IUD within 3 months of treated pelvic infection or septic abortion.
ACOG 2007	All adolescents should be screened for GC and chlamydia prior to insertion.
Cochrane 2007	No benefit from doxycycline or azithromycin prior to insertion.
CDC 2010	Evidence is insufficient to recommend removing an IUD in acute PID. If the IUD stays in place, follow the patient closely.

68

IUDs

Do NOT increase the risk of ectopic pregnancy

May be offered to women with a history of ectopic pregnancy

Decrease the risk of endometrial cancer

LNG-IUS: first-line option for menorrhagia

In a retrospective study, 80% of women prescribed the LNG-IUS chose not to undergo hysterectomy, against 9% receiving usual care

Remove if pregnant or menopausal

-ACOG Practice Bulletin No. 121. Long-Acting Reversible Contraception: Implants and Intrauterine Devices. *Obstet Gynecol* 2011;118:184-95. (Reaffirmed 2015)

-Rauramo I. et al. *Obstet Gynecol* 2004; 104:1314-21.

69

When to Insert an Intrauterine Contraceptive?

- Any time during menstrual cycle
- Any other time during a woman's cycle if:
 - She used appropriate contraception
 - She was not sexually active, or
 - Her pregnancy test was negative
- Any time after a pregnancy, a spontaneous abortion, a miscarriage, or an induced abortion if a woman has not engaged in unprotected intercourse

WHO. Medical Eligibility Criteria for Contraceptive Use. 5th ed. 2015. Available at: http://www.who.int/reproductivehealth/publications/family_planning/MEC-5/en/
FFPRHC Guidance (April 2004). *J Fam Plann Reprod Health Care*. 2004;30:99-108; FFPRHC Guidance (January 2004). *J Fam Plann Reprod Health Care*. 2004;30:29-41.

70

Use of Misoprostol Before Insertion?

2007

- Study suggests use allowed for easier insertion

2013

- No benefit and increased side effects

CDC

- Misoprostol is NOT recommended for ROUTINE use before IUD insertion.
- Misoprostol MIGHT be helpful in select circumstances e.g., recent failed insertion

Curtis KM, Jatlaoui TC, Tepper NK, et al. U.S. Selected Practice Recommendations for Contraceptive Use, 2016. *MMWR Recomm Rep* 2016;65(No. RR-4):1–66

71

Paracervical Block for IUD Insertion

WHAT

- **1% lidocaine**, 10–20 mL total
- Buffer with **8.4% bicarbonate**, 1 mL per 10 mL (9:1–10:1); some clinicians use 3:1
- 22-gauge spinal needle
- Max 200 mg (20 mL of 1%) per 90 min

WHERE

- 2 mL at the tenaculum site (12 o'clock)
- Rest at the **cervicovaginal junction**
- 2-site: **4 and 8 o'clock**
- 4-site: **2, 4, 8, 10 o'clock**

HOW

- Advance superficial to **3 cm deep**
- Aspirate before injecting
- Inject slowly, over ~60 seconds
- **Wait ~3 minutes** before insertion

ACOG 2025: offer every patient a local anesthetic (spray, cream, or paracervical block) [**SOR B**]

2026 RCT: median pain 30 with block vs 45 with saline, on a 100-mm visual analog scale

Curtis KM, Jatlaoui TC, Tepper NK, et al. U.S. Selected Practice Recommendations for Contraceptive Use, 2016. *MMWR Recomm Rep* 2016;65(No. RR-4):1–66. | 1% lidocaine paracervical block RCT. *Contraception* 2026. doi:10.1016/j.contraception.2026.111393 | ACOG Clinical Consensus. Pain Management for In-Office Uterine and Cervical Procedures. 2025.

72

Key Recommendations for Practice

Clinical Recommendation	Evidence Rating
Nulliparous women and adolescents can be offered an IUD, although the 20-mcg per 24 hours levonorgestrel-releasing IUD (Mirena) is not approved by the U.S. Food and Drug Administration for use in nulliparous women	C
Women who are at high risk of STIs but have no active signs or symptoms of genital tract STI should be tested for STIs at the time of IUD insertion. Insertion of the IUD may occur on the same day as STI testing, without waiting for test results. If results are subsequently found to be positive, treatment can be administered at that time and the IUD left in place .	C
For women with a known STI that causes cervical infection, it is recommended that IUD insertion be delayed for at least three months after resolution of the infection.	C
Prophylactic antibiotics should not routinely be administered before IUD insertion. Antibiotic prophylaxis does not have a major effect on reducing the risk of pelvic infection, and does not alter the need for IUD removal in the months after insertion.	B
Misoprostol (Cytotec) should not be administered before IUD insertion. Although an earlier study showed easier insertion with misoprostol, subsequent studies showed no benefit and increased side effects.	B
If a woman with an IUD becomes pregnant, the IUD should be removed.	C

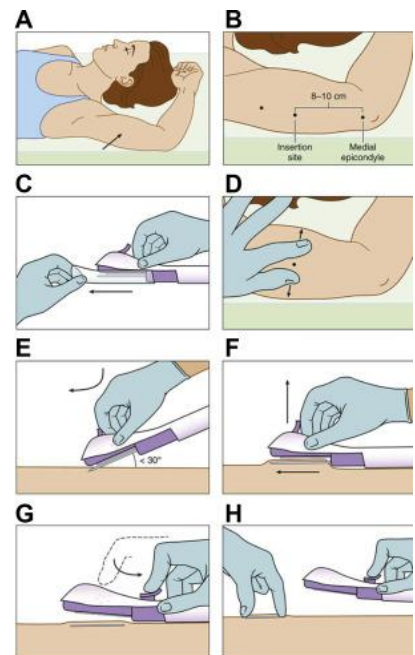
73



January 16, 2026

INTRADERMAL IMPLANT

Gilbert BG. Contraceptive implant insertion and removal. *Prim Care*. 2021;48(4):545-554. Published online October 7, 2021



74

Question #5

In Considering the Use of an Intradermal Implant, Which One of the Following Statements Is True?

- A. Implants are associated with an increased risk of ectopic pregnancy
- B. The time to remove an implant is about 15 minutes
- C. The intradermal implant works by suppressing ovulation
- D. The duration of use is 5 years



75

Intradermal Implant

- 68 mg of etonogestrel – period of up to three years
 - Heavier women may need a new implant every two years
- Mechanism of action
 - Suppresses ovulation
 - Occurs within 1 day of insertion
 - Ovulation in <5% of users after 30 months of use
 - Increases viscosity of the cervical mucous
- Side Effects: Irregular bleeding
 - HA, acne, dysmenorrhea, emotional lability
 - NO significant side effect on BMD or lipid metabolism



76

Contraceptive Implant

Effect	Outcome
Weight Change	Mean cumulative weight gain – ▪ End of first year: +2.8 lbs. ▪ End of second year: +3.7 lbs.
Bone Mineral Density	No significant change

ADMINISTRATION

- If no hormonal contraceptive has been used in past month:
 - Insert within 5 days of initiation of menses
- If switching from combination contraceptives, insert within 7 days of last active tablet, or during the ring-free or patch-free period
- If switching from a progestin-only method:
 - Any day if using the progestin-only pill
 - Same day as intrauterine device or implant removal
 - On due date for next contraceptive injection

77

Nexplanon REMS: The Deadline Has Passed Risk Evaluation and Mitigation Strategy

WHO IT COVERS

- Every clinician who **inserts or removes** Nexplanon
- Experienced providers included, not just new trainees
- Certification is required to order, dispense, insert, and remove
- Residents and students must certify to place it in training

IF YOU MISSED IT

- The **streamlined online route is closed**
- You must now complete **full training**: 90-minute online didactic plus in-person practical, then enroll
- Until certified, you **cannot** procure, insert, or remove
- Start at nexplanonrems.com

IF YOU ARE CERTIFIED

- Report insertion- and removal-related events **immediately** to the REMS program
- **1-833-NXP-REMS (1-833-697-7367)**
- The 5-year label now applies, was 3 years, with efficacy across BMI ranges

Verify your status: Organon also cites February 23, 2027, so confirm at nexplanonrems.com

Certification closed August 23, 2026; uncertified clinicians cannot provide Nexplanon until they re-train

RHAP Contraceptive Pearl: New FDA REMS Requirement on Nexplanon, 2026 | ACOG, Nexplanon REMS FAQ | Organon HCP notice, 2026 | FDA sNDA approval, January 16, 2026

78

Strategies to Reduce Barriers and Increase Use of Implants and IUDs

1 OFFER TO EVERY CANDIDATE

Implants and IUDs for all appropriate candidates, including nulliparous women and adolescents; safe and effective postmenarche **[SOR B]**

2 INSERT THE SAME DAY

Adopt same-day insertion protocols rather than sending patients back for a second visit

3 DROP THE PREREQUISITES

Chlamydia, gonorrhea, and cervical dysplasia screening **should not** be required before insertion; obtain on the day if indicated

4 REMOVE ACCESS BARRIERS

- Assure **confidentiality** for adolescents, within local law **[SOR B]**
- Prescribe a **12-month supply** of non-procedural methods **[SOR C]**

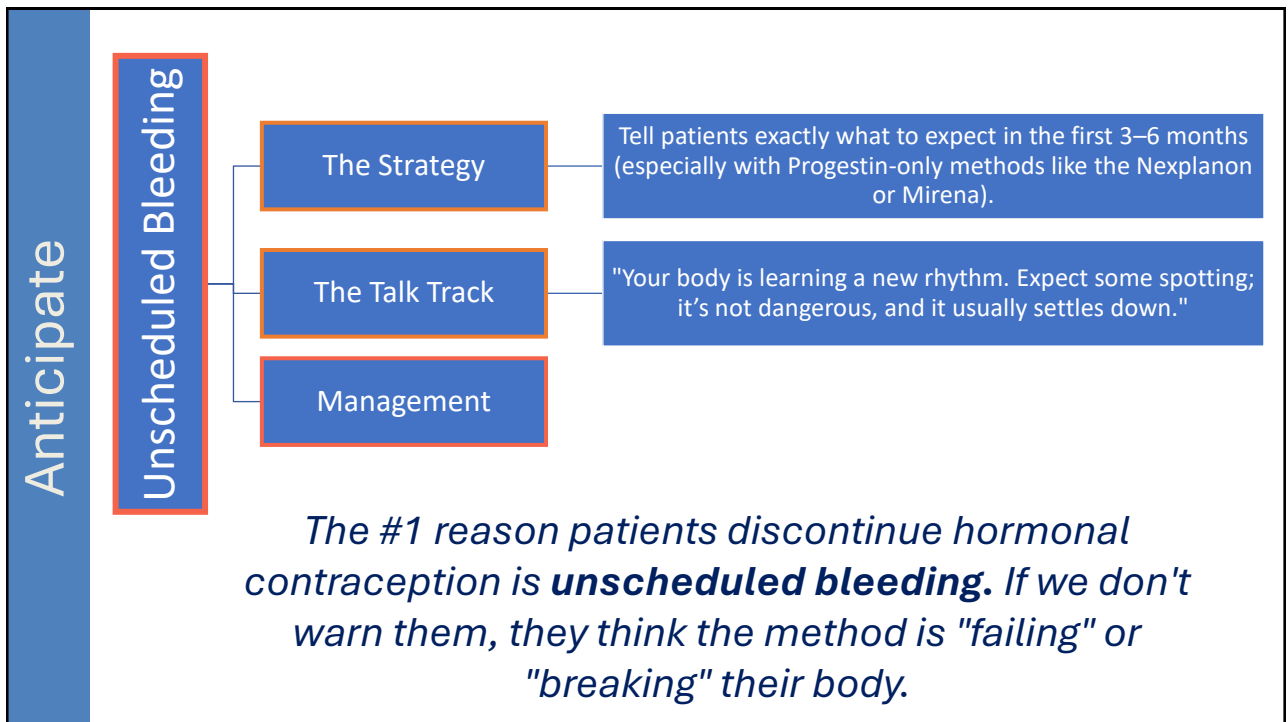
ACOG Committee Opinion No. 642. Increasing use of Contraceptive Implants and Intrauterine Devices to Reduce Unintended Pregnancy. *Obstet and Gynecol* 2015;126:e44-8. (Reaffirmed 2018) | SORT: Key Recommendations for Practice. *Am Fam Physician*. 2025.

79

Management of Unscheduled Bleeding

“THE BLEEDING GAP”

80



81

Managing Unscheduled Bleeding by Method			
First exclude other causes: pregnancy, infection, cervical pathology; PALM-COEIN, where contraception is the I for iatrogenic			
LNG-IUD	DMPA / IMPLANT	PROGESTIN-ONLY PILL	COMBINED HORMONAL
- Confirm fundal placement Naproxen 500 mg twice daily x 5 days - If ineffective: oral estradiol 2 mg daily x 6 weeks - At 5+ years: consider removal and replacement	Watchful waiting: DMPA improves by 6 months, resolves by 12 - Implant pattern is set after 3 months COC 20-30 mcg EE for 2-6 weeks works fastest - Estrogen contraindicated: NSAID, or tranexamic acid 500 mg twice daily x 5 days	- Switch to a drospirenone POP (24/4) - Then a short NSAID course - Then discuss alternative methods	Increase EE 20 to 35 mcg, or change the progestin - Cyclic: shorten hormone-free interval to 4-5 days - Continuous: add a 4-5 day hormone-free interval - Trial of low-dose doxycycline
Counsel at initiation: LNG-IUD bleeding settles for most within 12 months; DMPA trends to amenorrhea by 6 to 12 months [SOR B]			
Adapted from Schrager S, Fox K, Lee R. Abnormal Uterine Bleeding Associated With Hormonal Contraception. Am Fam Physician. 2024;109(2):161-166 (corrected March 2026)			

82

Norethindrone for Implant-Related Bleeding

CLINICAL QUESTION

Does Oral Norethindrone Reduce Prolonged Uterine Bleeding Related to Etonogestrel Implant Use?

BOTTOM LINE

Norethindrone 10 mg daily reduced the duration of prolonged bleeding in the first year after implant placement

HOW MUCH

8 fewer bleeding days on average in the first 30 days after starting treatment

THE CATCH

Recurrences were frequent and occurred earlier on average than with placebo

Level of Evidence = 1b (individual randomized controlled trial)

83

ACOG Breastfeeding: Maternal and Infant Aspects Committee Opinion

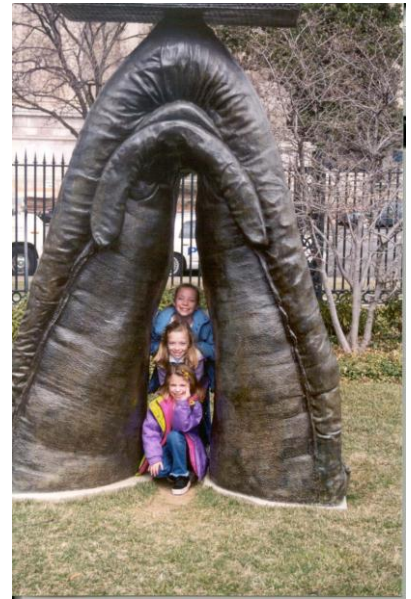
- All family planning choices are available to the postpartum lactating woman.
- Choice and clinical ramifications merit additional counseling.
- Support women in choosing breastfeeding.
 - Accurate information
 - Problems arise
- Early discussion of contraception and follow-up
 - ***Options to be explained in detail***
 - Nonhormonal methods
 - Hormonal Methods
 - Lactational Amenorrhea Method

84

Barrier Methods



2023



Sculpture Garden
National Gallery of Art Washington, DC
1998

85

Barrier Methods Key Points

- **Sponge**
 - Does not protect against STIs (according to manufacturer)
 - Non-menstrual toxic shock syndrome (sponge, diaphragm, cap)
 - 2 cases/100,000 users per year
- **Diaphragm**
 - Increased incidence of UTI
- **Latex condom**
 - Use only water-based lubricants



86

Benefits of Condoms

- **Decrease spread of STIs**

- Gonorrhea – 90%
- Chlamydia – 60%
- HIV – 80%
- HPV

- May reduce the risk for HPV-associated diseases (e.g., genital warts and cervical cancer)
- Use associated with higher rates of regression of CIN and clearance of HPV infection in women; regression of HPV-associated penile lesions in men
- Limited number of prospective studies have demonstrated a protective effect of condoms on the acquisition of genital HPV.

- HSV

- 37% of couples do not use condoms as advised

Marfatia YS, Pandya I, Mehta K. Condoms: Past, present, and future. Indian J Sex Transm Dis AIDS. 2015 Jul-Dec;36(2):133-9. doi: 10.4103/0253-7184.167135. PMID: 26692603; PMCID: PMC4660551.

87

Natural Family Planning Methods

Five Principle Types of Natural Family Planning

Method	Description
Basal Body Temperature Charting	Identifies the luteal phase of the menstrual cycle by postovulatory increase in basal body temperature; all other days are considered fertile
Calendar Calculation	Predicts the fertile period by menstrual dating
Cervical mucus monitoring	Identifies beginning and end of the fertile period from cervical secretions
Symptothermal method	Based on cervical mucus monitoring; calendar calculations or basal body temperature charting monitoring provides redundancy
Lactational amenorrhea	Maximizes suppression of ovulation during breastfeeding; effectiveness limited to six months postpartum

88

LAM

Lactational Amenorrhea Method

- Highly effective temporary family planning method for BF women in the first months after delivery
 - Natural protection against pregnancy for up to 6 months pp
 - 2% risk of pregnancy
 - Provides time to choose more permanent method

89

LAM

Three Critical Criteria

- **Must meet all three criteria** before using as protection against pregnancy
 - ✓ Less than six months postpartum
 - ✓ Amenorrheic
 - ✓ Fully breastfeeding (without use of supplements)
- If/when one of the three conditions change – begin another FP method
 - also, use another method if 2% risk of pregnancy is too high for woman

Method	Failure Rate	
	Typical use	Perfect use
Combined OCP	9%	0.3%
Tubal Ligation	0.5%	0.5%
Male condom	18%	2%
Depo-Provera	6%	0.3%

90

LAM

Plusses

- No adverse drug effects
- No medication or device cost; cannot “run out” of method
- Immediately reversible
- Acceptable to all major religions
- Expands couples’ communication and forms of sexual expression

Minuses

- No non-contraceptive benefits of some other methods
- Requires periodic abstinence
- Requires intensive education

91

Effectiveness of Natural Family Planning Compared with Other Family Planning Methods

Contraceptive Method	<i>Percentage of women with an unintended pregnancy within the first year of use</i>	
	Typical use	Perfect Use
None	85	---
Male Condom	18	2
Combined hormonal contraception	9	<1
Depo-Provera	6	<1
LARC	<1	<1
NFP		
• Standard Days Method	8 to 25	5
• Billings Ovulation Method	3 to 22	3
• TwoDayMethod	14	4
• Marquette Model	11 to 14	1 to 2
• Symptothermal method	2-8	<1
• Creighton Model	2-5	≤1
• LAM	---	0-8

92

Emergency Contraception

Not "One Size Fits All"

Many providers still rely solely on Plan B (Levonorgestrel), but it has significant limitations that patients rarely hear about.

93

EC Indications ACOG

- Inadequately protected or unprotected intercourse in women who do not desire pregnancy (*SOR A*)
- No evidence that EC is unsafe for women with contraindications to OCPs or for those with medical conditions
- Should be offered up to 120 hours after unprotected intercourse (*SOR B*)

94

Postcoital Treatments for Preventing Pregnancy

Regimen	Formulation	Pregnancy rate after use	Access	FDA LABELED USE AS EC
Ulipristal (Ella) <i>Selective progesterone receptor modulator</i>	1 tablet, containing 30 mg of ulipristal acetate	1.3%	Requires a prescription <i>More effective for longer (up to 5 days); works better with higher BMIs.</i>	Yes
Plan B One-Step <i>Progestin only</i>	1 tablet containing 1.5 mg of levonorgestrel	2.2%	Available OTC without age restriction. <i>Loses efficacy with BMI > 26kg/m²; may be INEFFECTIVE with BMI > 30kg/m²</i>	Yes
Combined progestin-estrogen pills	Variety formulations can be used ¹	2.5-2.9%	Requires a prescription	No ²
Copper IUD	N/A	0.1%	Requires office visit and insertion by clinician. 99% effectiveness regardless of weight	No
LN-IUS	Levonorgestrel	0.3%		

1. Variety of formulations of combined OCPs can be used for EC. List of appropriate formulations: <http://ec.princeton.edu/questions/dose.html#dose>
 2. Although not FDA labeled for use as EC; safe and effective when used as EC and can be used off-label for this indication¹.

95

Starting Regular Contraception POST EC?

- Because EC may work by delaying ovulation, women who have taken EC pills at risk of becoming pregnant later in same menstrual cycle.
 - Use barrier contraceptive immediately
- If Ulipristal acetate is used – delay using hormonal contraception until no sooner than 5 days.
 - 2 pharmacodynamic studies suggest that co-administration of ulipristal acetate and progestins may reduce the contraceptive effect of either product
 - No clinical studies demonstrating increased rate of pregnancy
- Any regular contraceptive method can be started immediately after use of levonorgestrel or combined estrogen-progestin EC, woman should abstain from sexual intercourse or use barrier contraception for 7 days.

96

Contraception for How Long?

- Contraceptive use for unintended pregnancy prevention should be considered until menopause, or at least until 50 to 55 years of age (SOR C)
- No FSH

Division of Reproductive Health, National Center for Chronic Disease Prevention and Health Promotion, Centers for Disease Control and Prevention (CDC). U.S. Selected Practice Recommendations for Contraceptive Use, 2013: adapted from the World Health Organization selected practice recommendations for contraceptive use, 2nd edition. MMWR Recomm Rep. 2013; 62(RR-05): 1-60.

97



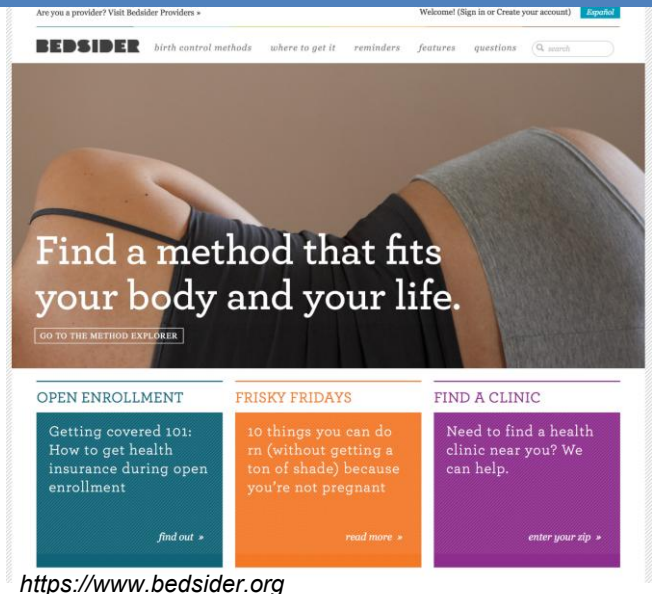
Barriers to Practice

- Time, time, time...
- Patient fears and expectations
- Pharmaceutical cost/reimbursement
 - Same day insertion procedures
 - 3rd party payor
 - Federal Government
- Myths

98

Resource

Online birth control support network for women 18-29 operated by Power to Decide, the campaign to prevent unplanned pregnancy.



99

The Case of Maya

"I Need To Start Something...NOW."

Maya is a **26-year-old** graduate student who presents for an "urgent birth control consult." She is currently on **Day 12** of her menstrual cycle. She tells you, "A condom broke on Saturday night (roughly 36 hours ago), and I realized I can't keep relying on just condoms. I need something better, and I'd like to leave here today with a plan."

100

Her Clinical Profile

- **Medical History:** Occasional migraines. When asked for detail, she notes, "About twice a year, I see these weird 'shimmering zig-zags' in my vision for 20 minutes before a really bad headache hits."
- **Physical Exam:** Weight: 175 lbs (79.5 kg). Height: 5'6" (167.5 cm). **BMI: 28.2 kg/m².**
- **Contraceptive History:** She tried "the pill" at age 19 but stopped after four months because she "spotted the whole time" and thought her body was rejecting it.
- **Current Preferences:** She's nervous about IUDs because her roommate had a painful insertion, but she's also worried she'll forget a daily pill.

101

Contraception: 5 Essentials for Monday Morning

- **Patient Values > Efficacy:** Shared Decision-Making means the "best" method is the one the patient *actually* wants to use.
- **The "Quick Start" Rule:** If they aren't pregnant, start **today**. No more waiting for "Day 1" of a period.
- **Aura is the Dealbreaker:** Screen for "shimmering lights" or "zig-zags." If it's Migraine with Aura, **No Estrogen (MEC 4)**.
- **BMI & Emergency Contraceptive (EC):** Plan B fails many patients. Use **Ella (Ulipristal)** for BMI > 26 kg/m² or a **Copper/LNG IUD**.
- **Predict the "Bleeding Gap":** Warn them about 3–6 months of spotting. If they expect it, they won't quit it.

Maya

102

"We used to be 'Gatekeepers' of contraception, making patients wait for periods or perfect BMI profiles. Today, we are 'Facilitators.' Our job is to remove the barriers—the calendar, the myths, and the weight limits—so patients like Maya leave protected."



Summary

103

Key Primary Care Updates

Topic	Old Way	The "Improved Care" Way
Counseling	Pushing the most effective method	Shared decision-making based on patient values
Timing	"Wait for your period"	Quick Start (Start the same day)
Migraines	No estrogen for any headache	Screen for Aura specifically; use CDC/WHO MEC
EC	Everyone gets Plan B	Tailor by BMI; offer Ella or IUDs
Side Effects	Address them when they happen	Anticipatory guidance on bleeding patterns

104

More Key Primary Care Updates

Topic	Old Way	The "Improved Care" Way
IUD pain	Ibuprofen and reassurance	Offer a local anesthetic to everyone: spray, cream, or paracervical block
Cervical prep	Misoprostol before insertion	Skip it: not for routine use
GLP-1 users	No interaction to consider	Tirzepatide cuts pill exposure ~20%; barrier or non-oral method for 4 weeks after each dose step
Bleeding	"Give it time"	Treat by method: naproxen, estradiol, or a short COC course
Nexplanon	Trained once, trained forever	REMS certification now required to order, insert, or remove

105

References

1. ACOG Practice Bulletin 152. Emergency Contraception. Obstet Gynecol 2015;126:e1-11. (Reaffirmed 2022)
2. Nguyen AT, Curtis KM, Tepper NK, et al. U.S. Medical Eligibility Criteria for Contraceptive Use, 2024. MMWR Recomm Rep 2024;73(No. RR-4):1-126. DOI: <http://dx.doi.org/10.15585/mmwr.rr7304a1>
3. WHO. *Medical Eligibility Criteria for Contraceptive Use*. 5th ed. 2015. Available at: http://www.who.int/reproductivehealth/publications/family_planning/MEC-5/en/
4. Van Vliet HAAM, Grimes DA, Lopez LM, Schulz KF, Helmerhorst FM. Triphasic versus monophasic oral contraceptives for contraception. *Cochrane Database of Systematic Reviews* 2011, Issue 11. Art. No.: CD003553. DOI: 10.1002/14651858.CD003553.pub3.
5. Paradise SL, Landis CA, Klein DA. Evidence-Based Contraception: Common Questions and Answers. Am Fam Physician. 2022 Sep;106(3):251-259. PMID: 36126006.
6. Speer L. Low Incidence of Pregnancy With Same-Day-Start Contraception. Am Fam Physician. 2024 Sep;110(3):online. PMID: 39283864.
7. Klein DA, Forlini CE, Kremsreiter P. Provision of Quality Contraceptive Services: Updates From National Guidelines. Am Fam Physician. 2025 Aug;112(2):176-186. PMID: 40834374.

106