

# LARC for Intermediate

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# Disclosures

Trainer/Speaker for Merck (Nexplanon)

Trainer for Actavis (Liletta)



# Objectives

- Compare current IUDs available
- Troubleshoot difficult LARC cases
- Managing side-effects
- Pearls, tips and tricks for success
- Resources for managing clients
- Instructions for using Pelvic Simulators
- Answer questions



# Long-Acting Reversible Contraception

Intrauterine Device (IUD)

Intrauterine Systems (IUS)

Implant



# ParaGard<sup>®</sup> (copper) IUD



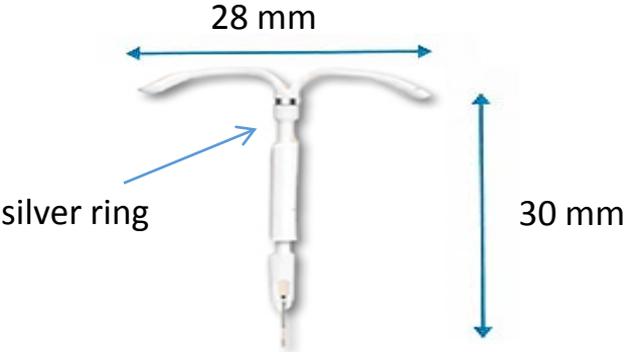
# Mirena<sup>®</sup> (levonorgestrel) IUD



# Skyla™ (levonorgestrel) IUD



# Mirena compared to Skyla



# Mirena compared to Skyla

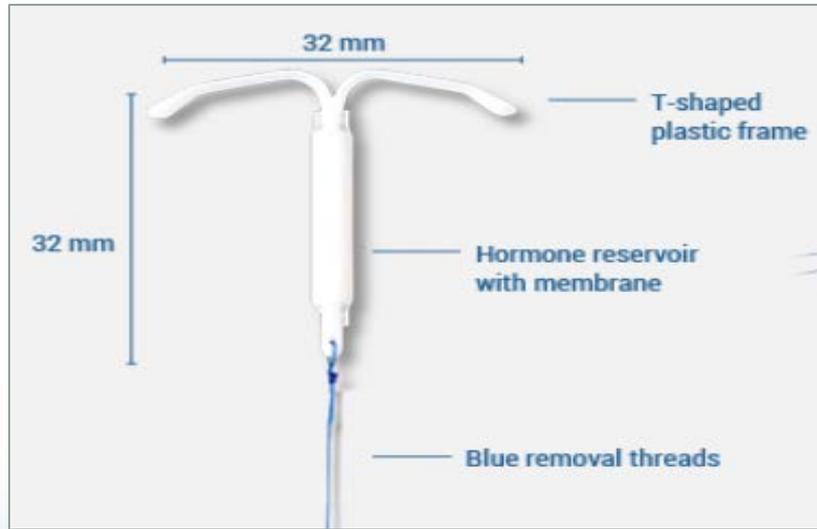
	Mirena	Skyla
Size	32mm x 32mm	28 mm x 30 mm
Levonorgestrel dose	52 mg	13.5 mg
String color	<u>black</u>	<u>black</u>
Approved length of use	5 years	3 years
Minimum uterine depth (per PI)	6 cm	<u>n/a</u>
Maximum uterine depth (per PI)	10 cm	<u>n/a</u>



# Liletta<sup>®</sup> (levonorgestrel) IUD



# Liletta compared to Mirena

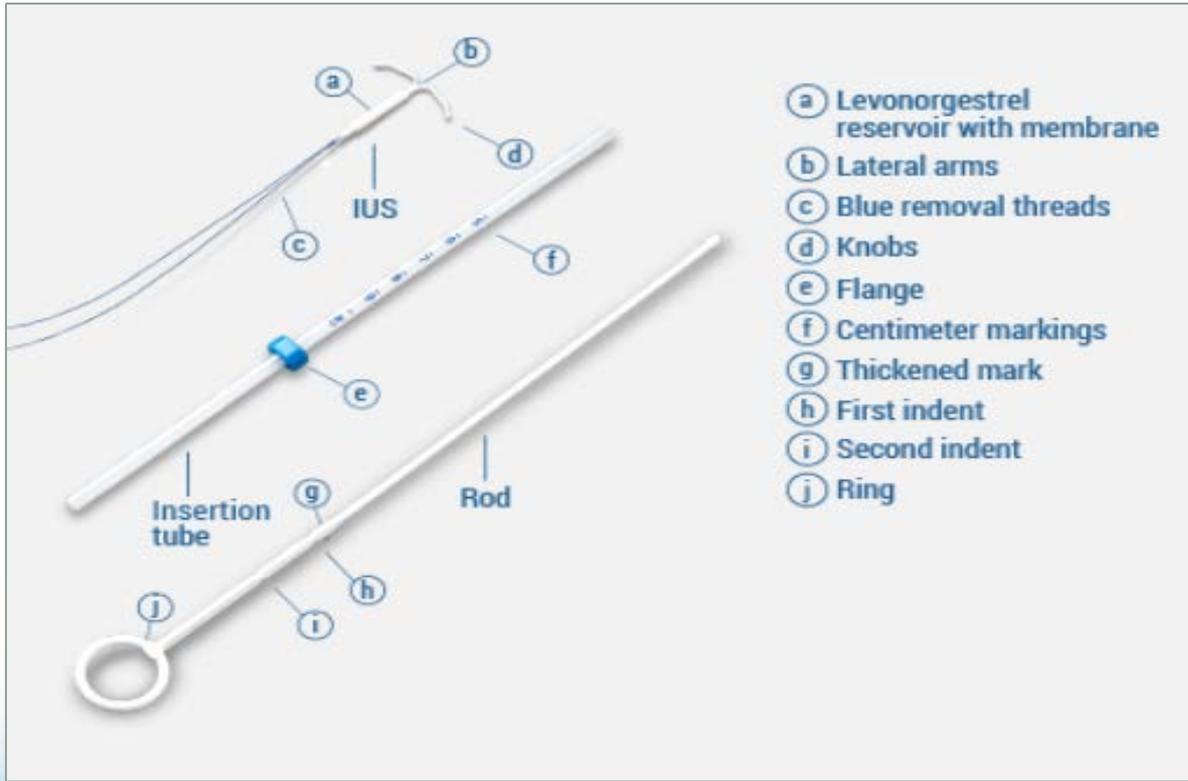


# Liletta<sup>®</sup> compared to Mirena<sup>®</sup>

	Liletta	Mirena
Size	32 mm x 32 mm	32mm x 32mm
Levonorgestrel dose	52 mg	52 mg
String color	<u>blue</u>	<u>black</u>
Approved length of use	3 years*	5 years
Minimum uterine depth (per PI)	5.5 cm	6 cm
Maximum uterine depth (per PI)	<u>n/a</u>	10 cm



# Liletta<sup>®</sup> (levonorgestrel) IUD



# IUD Myths

## MYTH:

It is easier to insert an IUD when a woman is menstruating.

## FACT:

Timing of menstruation does not impact IUD insertion success.



# IUDs: Timing of Insertion

Insert *anytime* in the menstrual cycle when you can be reasonably certain she is not pregnant.

## How to Be Reasonably Certain That a Woman is Not Pregnant

A health-care provider can be reasonably certain that a woman is not pregnant if she has no symptoms or signs of pregnancy and meets any one of the following criteria:

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



# IUDs: Timing of Insertion



**Copper IUD: Over 99% effective  
if inserted within 5 days of unprotected intercourse.**



# Oral EC Failure and Body Weight

**EC hormone absorption is slower in obese women than it is in women of normal weight.**

Plan B<sup>®</sup> One-Step is not likely to be effective for women with a BMI >26.

Ella<sup>®</sup> - effectiveness may decrease for women with a BMI >35.



Need More info about EC?

[ec.princeton.edu](http://ec.princeton.edu)



# IUD Myths

## MYTH:

An IUD should not be placed until the patient has confirmed negative Gonorrhea and Chlamydia results.

## FACT:

Same day testing is preferred and evidenced-based. If the patient has a positive result, treat per CDC guidelines.



# IUD Myths

## MYTH:

It is not necessary to use a tenaculum when inserting an IUD.

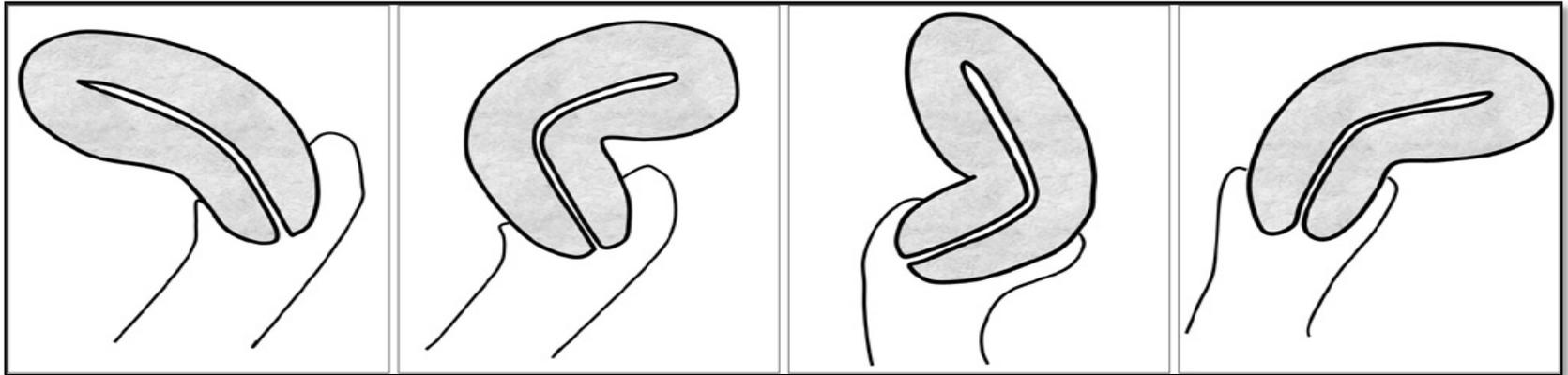
## FACT:

Not using a tenaculum increases the risk of malposition and expulsion.



# IUD Myths

**Always** use the tenaculum to straighten the cervical canal and uterus to ensure you are measuring the correct uterine length and placing the IUD at the fundus.



# Tenaculum Placement

Grasp the anterior lip of the cervix with a tenaculum about 1.5 to 2.0 cm from the os.

Close the tenaculum slowly and quietly to first or second notch.

Avoid using descriptors that provoke pain.



# Case #1

18 y.o. G0 is interested in getting a ParaGard IUD

- Failed attempt at ParaGard IUD insertion at another clinic
- Unable to pass through endocervical canal
- Patient reports the experience as being very painful
- Wants a ParaGard because she does not want any hormones.



# IUDs: Options for Difficult Nulliparous Insertions

- Recommend a different method?
- Referral to a more experienced provider?
- Misoprostol to soften/dilate cervix?
- Pain medications: oral/IV/paracervical
- Mechanical assistance: os finder, endometrial biopsy cannula (“Pipelle”), cervical dilators



# IUDs: Difficult Insertions

Factors related to complications or difficult IUD insertion (n=545):

- No previous history of a vaginal delivery
- Older nullips were at greatest risk of difficult insertion
- Vasovagal in 1.8% (8.7% nullip vs. 0.2% parous)
- Inexperienced physicians had 3x (1.5-6.2 95%CI) the failure rate



# IUDs: Difficult Insertions- Misoprostol?

No evidence to support benefit.

- 2 double-blind RCTs of nullips to receive misoprostol resulted in increased side effects with no decrease in pain or ease of insertions.
- Pre-insertion nausea (29% vs. 5%,  $p=.05$ ) and cramping (47% vs. 16%,  $p=.04$ ) in miso vs. placebo group. <sup>1</sup>
- One study found slightly decreased use of dilators in the miso group, while the other study showed no difference. <sup>1, 2</sup>

<sup>1</sup> Edelman, Alison B., et al. "Effects of prophylactic misoprostol administration prior to intrauterine device insertion in nulliparous women." *Contraception* 84.3 (2011): 234-239.

<sup>2</sup> Swenson, Carolyn, et al. "Self-administered misoprostol or placebo before intrauterine device insertion in nulliparous women: a randomized controlled trial." *Obstetrics & Gynecology* 120.2, Part 1 (2012): 341-347.



# IUDs: Difficult Insertions- Misoprostol?

- Failures in nulliparous women were infrequent.
- IUD placement was successful in all but one patient in one study, and IUD placement was successful in ~95% of patients in the other <sup>1, 2</sup>
- Expulsion rates were slightly higher in the misoprostol group in one study <sup>2</sup>

<sup>1</sup> Edelman, Alison B., et al. "Effects of prophylactic misoprostol administration prior to intrauterine device insertion in nulliparous women." *Contraception* 84.3 (2011): 234-239.

<sup>2</sup> Swenson, Carolyn, et al. "Self-administered misoprostol or placebo before intrauterine device insertion in nulliparous women: a randomized controlled trial." *Obstetrics & Gynecology* 120.2, Part 1 (2012): 341-347.



# IUDs: Difficult Insertions- Pain Control

## MYTH:

IUD insertion pain is reduced by ibuprofen, paracervical blocks, topical lidocaine, intrauterine lidocaine and misoprostol.

## FACT:

None of these methods has been found to reduce insertion pain. In fact, pain scores during insertion are *higher* with paracervical blocks and misoprostol.



# IUDs: Difficult Insertions- Pain Control

RCT of 103 women found that either 550 mg of naproxen or 50 mg of tramadol 1 hour before IUD insertion in multiparous women reduced procedure pain compared with placebo ( $p = .001$ ).

Mean pain scores on a 0- to 10-point scale:

Tramadol: 2.3

Naproxen: 2.9

Placebo: 4.9



# IUD Procedure Pain Control



Use “verbicane” and distraction.

# IUDs: Difficult Insertions- Mechanical Help

- Os finder when cervical opening difficult to identify and to gently dilate nulliparous os
- Pipelle to identify path of endocervical canal
- Adequate traction with tenaculum; on posterior lip if extreme retroversion



# IUDs: Difficult Insertions- Ultrasound Guidance

- May be helpful to ensure not creating false passage and/or post-procedure to confirm intrauterine placement
- Metal sound easy to see on abdominal ultrasound if not obese



# Case #2

32 y.o. G0 presents for routine pap smear

- LNG-IUD placed 1 year ago
- Mild cramping during insertion; no problems since then
- Did not have f/u string check
- During pap, incidentally notice IUD strings are missing
- Happy with IUD
- Has been amenorrheic for last 9 months



# IUDs: Missing Strings

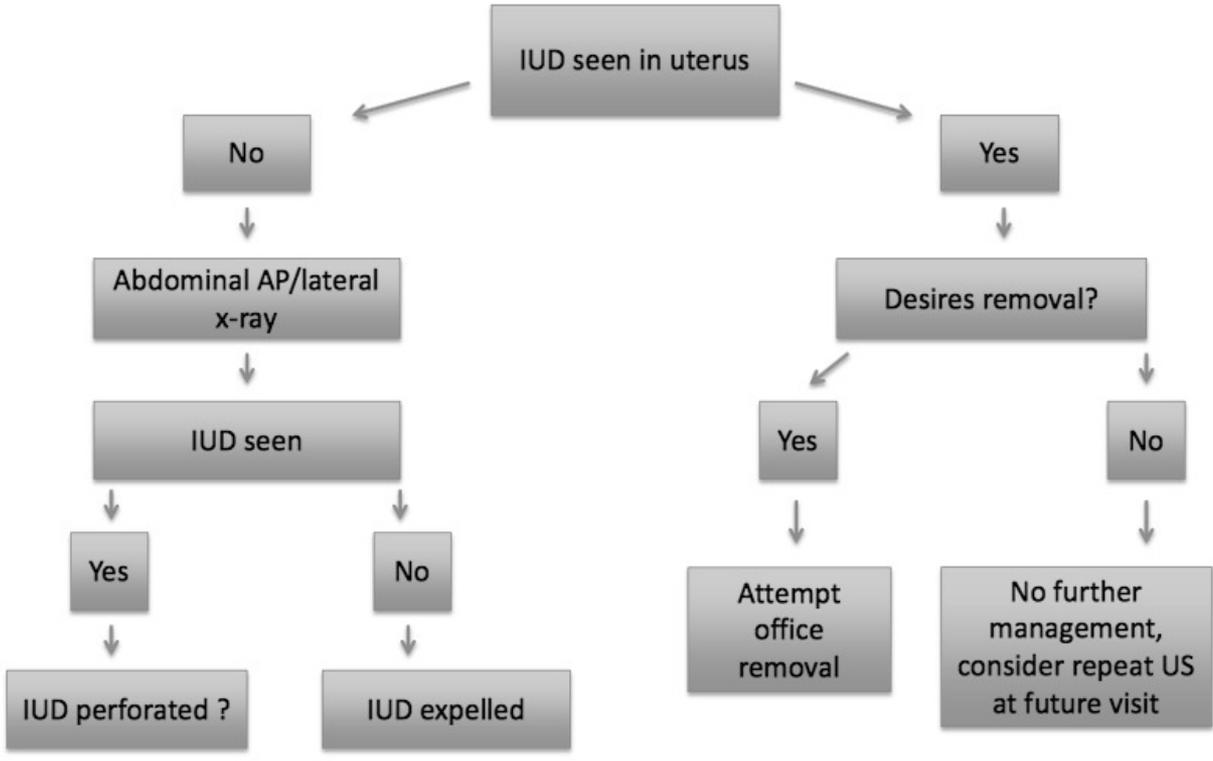
- 5 - 15% of women with IUDs have missing strings
- Most commonly strings retracted into cervix or uterine cavity
- Need to rule out perforation and expulsion

Marchi, Nádia M., et al. "Management of missing strings in users of intrauterine contraceptives." *Contraception* 86.4 (2012): 354-358.

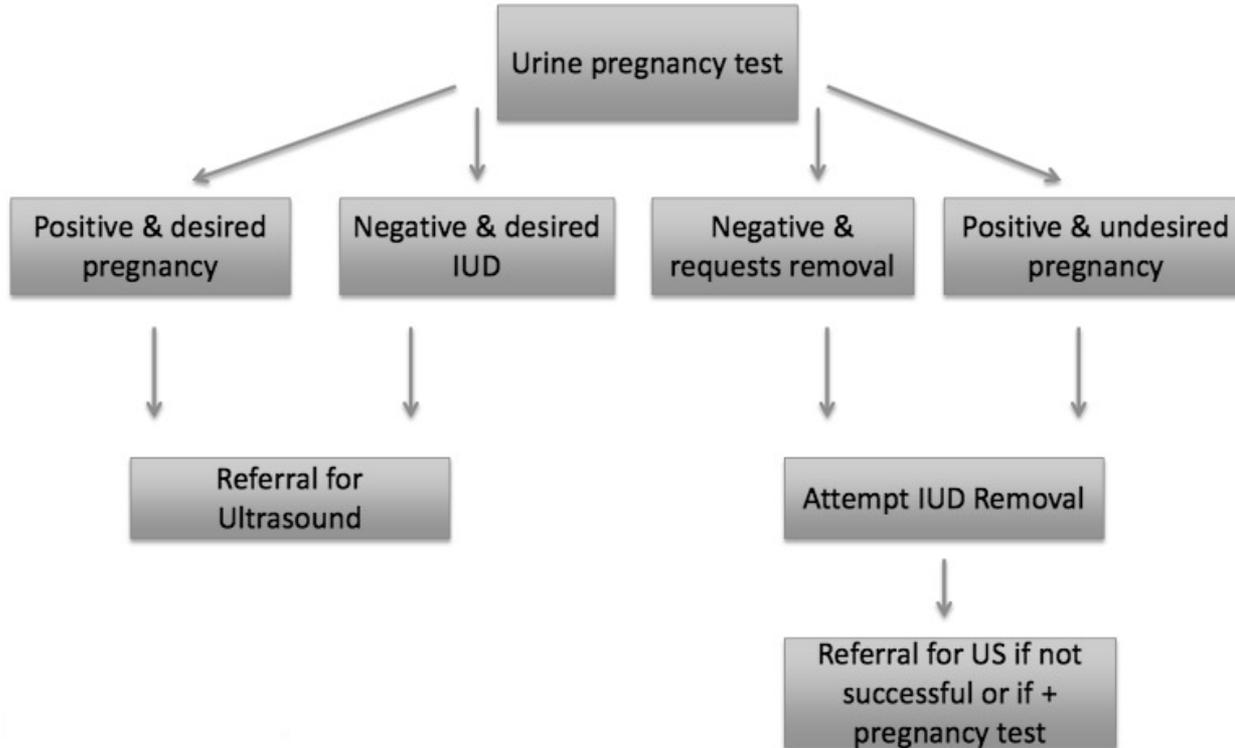
Tugrul, Semih, et al. "The duration of use, causes of discontinuation, and problems during removal in women admitted for removal of IUD." *Contraception* 71.2 (2005): 149-152.



# Ultrasound Available



# Ultrasound Not Available



## Case #3

The same patient returns 2 years later, she would like to have her IUD removed.

What are options for removal?



# IUDs: Missing Strings- In Office Removal

- Try coaxing strings with cytobrush
- Grasp strings in the endocervical canal using alligator forceps
- Grasp IUD itself within the uterus if strings are no longer within the canal (can try this with ultrasound guidance)

If procedure is painful, can consider a paracervical block or PO or IV sedation in more extreme cases



# IUDs: Missing Strings- Alligator Forceps



# IUDs: Missing Strings- IUD Hooks



# Missing Strings: Vaginal Misoprostol?

- Planned hysteroscopic removals
- Three case reports of misoprostol 200 mcg placed vaginally the night before and the morning of the planned procedure.
- On exam, IUD strings were visible in os.



# Case #4

24 year G1P1 with LNG-IUD placed 8 weeks postpartum

- Presents 1 month after insertion with cramping
- Exclusively breastfeeding
- US demonstrates empty uterus
- X-ray with IUD in abdomen



# IUDs: Perforation – Risk Factors

- Insertion Postpartum
- Insertion while Breastfeeding
- Inserted by provider doing < 50 insertions per year
- Risk not affected by type of healthcare provider or LNG vs. copper IUD



# IUDs: Perforation – Risk Factors

61,448 women in six European countries followed between 2006 - 2013 for more than 68,000 women-years of observation (70% LNG, 30% copper devices).

Perforation incidence<sup>a</sup> and RRs stratified by breastfeeding status and time since last delivery interval

Time since last delivery	Breastfeeding		RR (95% CI)
	Yes	No	
≤ 36 weeks	5.6 (3.9–7.9)	1.7 (0.8–3.1)	3.3 (1.6–6.7)
> 36 weeks	1.6 (0.0–9.1)	0.7 (0.5–1.1)	2.2 (0.3–16.3)
RR (95% CI)	3.4 (0.5–24.8)	2.3 (1.1–4.7)	

a Per 1000 insertions.



# Nexplanon<sup>®</sup> (etonogestrel) implant



# Nexplanon<sup>®</sup> (etonogestrel) implant

- Approved for 3 years use
- Some evidence to show it lasts for 4 years<sup>1</sup>
- FDA requires all providers to complete certification course prior to inserting and removing device.

<sup>1</sup> McNicholas, Colleen, et al. "Use of the etonogestrel implant and levonorgestrel intrauterine device beyond the US Food and Drug Administration–approved duration." *Obstetrics & Gynecology* 125.3 (2015): 599-604.



# Nexplanon<sup>®</sup> - Bleeding Profile

- **Frequent or prolonged bleeding** is common during first 3-6 months.
  - Then:
    - 1 out of 5: amenorrhea
    - 1 out of 5: prolonged, frequent bleeding
- ↓
- Only some will have “bothersome” bleeding



# Nexplanon<sup>®</sup> - “Bothersome Bleeding”

- Counseling and anticipatory guidance is very important!!!
- Avoid interventions until after 3 months post-insertion.
- If bleeding remains bothersome after three months consider:

## NSAIDs:

- Oral celecoxib: 200mg daily x 5 days
- Oral mefenamic acid: 500 mg tid x 5 days

## Combined hormonal method for three months:

- Monophasic pill continuously x 3 months
- NuvaRing continuously x 3 months

## Still not better?

- Can offer continuous pills or ring for duration of implant use

## Poor Results:

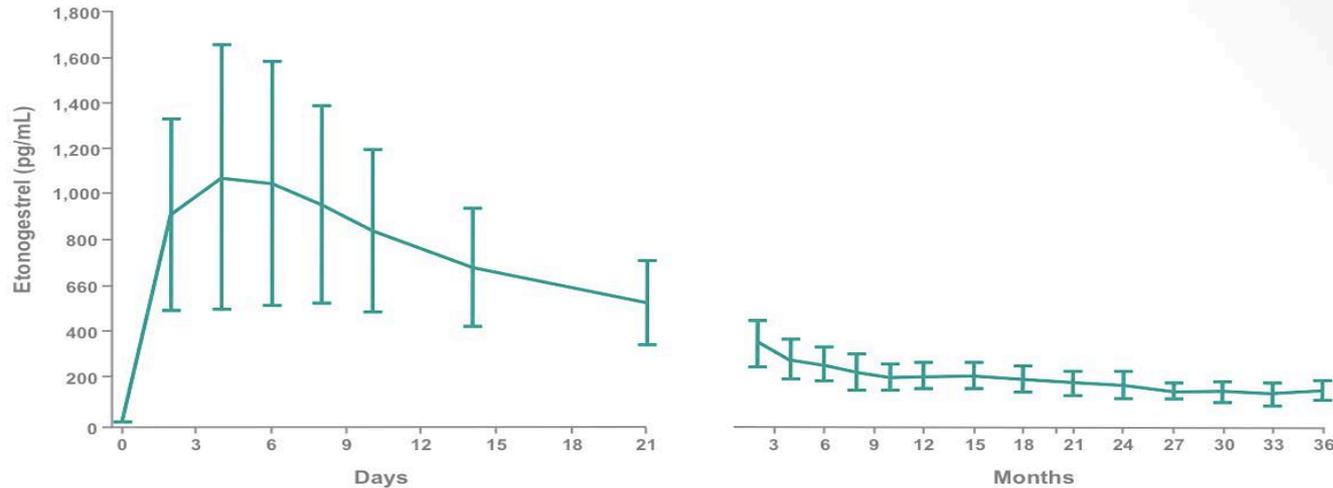
Doxycycline  
Progestin pills  
Depo-Provera  
Ibuprofen



# Nexplanon<sup>®</sup> - Serum Concentration

## Pharmacokinetic profile of NEXPLANON<sup>®</sup> (etonogestrel implant)

Mean ( $\pm$  SD) serum concentration-time profile of etonogestrel after insertion of NEXPLANON during 3 years of use



# Nexplanon<sup>®</sup> - Drug Interactions

## Drug interactions

Drugs or herbal products that induce enzymes, including CYP3A4, that metabolize progestins may decrease the plasma concentrations of progestins, and may decrease the effectiveness of NEXPLANON<sup>®</sup> (etonogestrel implant). In women on long-term treatment with hepatic enzyme-inducing drugs, it is recommended to remove the implant and to advise a contraceptive method that is unaffected by the interacting drug. Some of these drugs or herbal products that induce enzymes, including CYP3A4, include:

### Selection of drugs or products that may decrease the effectiveness of NEXPLANON<sup>®</sup>

Barbiturates	Griseofulvin	St. John's wort
Bosentan	Oxcarbazepine	Topiramate
Carbamazepine	Phenytoin	
Felbamate	Rifampin	



# Nexplanon<sup>®</sup> - Removal Tips

- Figure out where the implant wants to “pop out” by bringing it up toward you with hands
- Place Lidocaine *under* the implant
- Make incision in the correct direction



# Nexplanon<sup>®</sup> (etonogestrel) implant



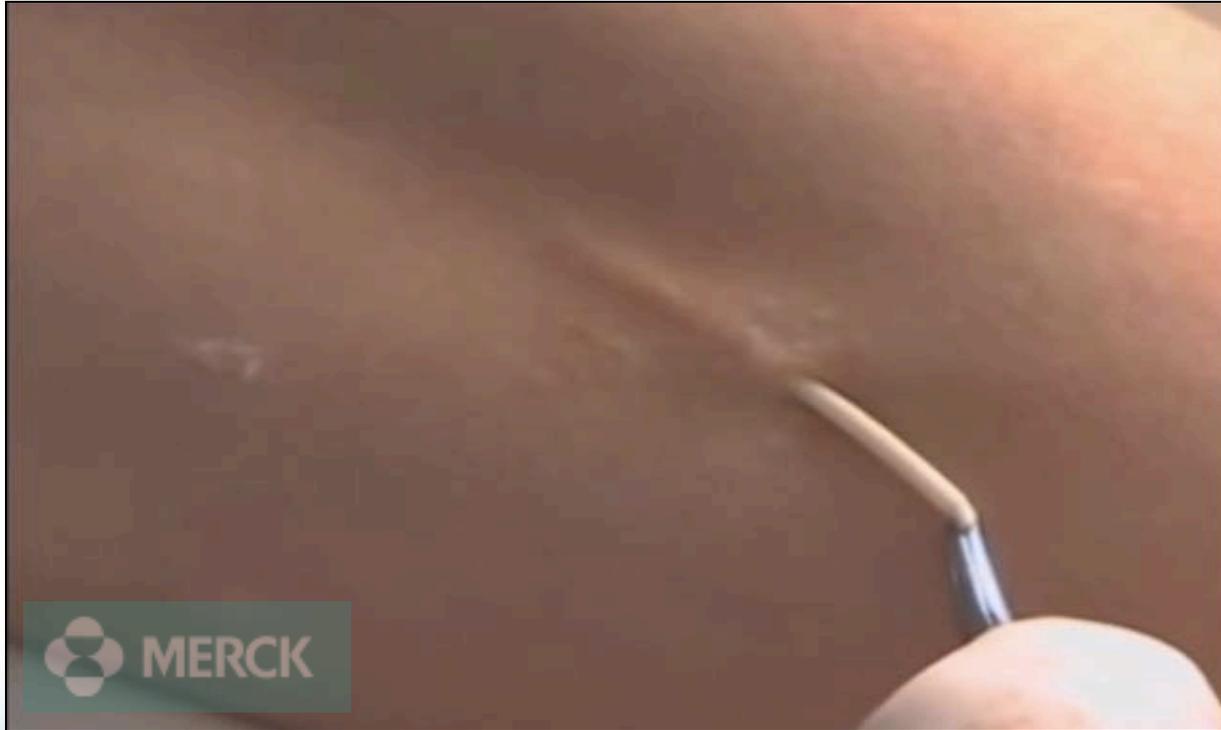
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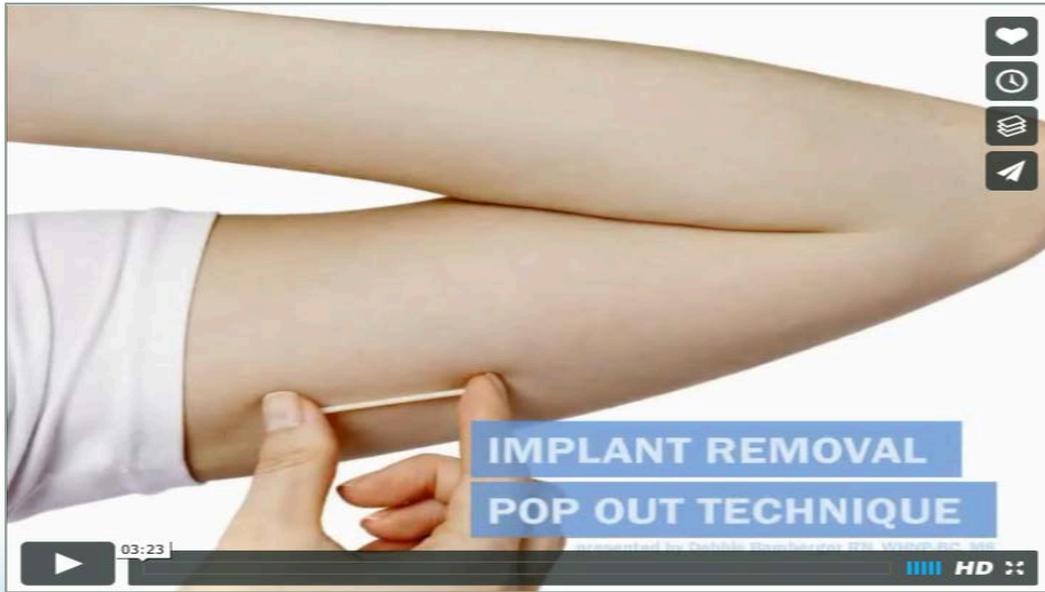


# Nexplanon<sup>®</sup> (etonogestrel) implant



# Nexplanon<sup>®</sup> (etonogestrel) implant

## UPSTREAM USA<sup>SM</sup>



# Case #5

17 year G0 presents for Emergency Contraception

- Using DMPA for 2 years and frequently misses dose
- Last DMPA was 18 week ago
- Had unprotected sex last night
- Provider is running behind schedule and patient is scheduled in a 10-minute nurse visit appointment slot.



# Case #5 – Options for this patient?

- Give EC with a return appointment for DMPA?
- Give EC and DMPA if pregnancy test is negative and remind her to use condoms x 7 days and come back on time for next dose?
- Tell her she needs to use a LARC because she is always late for her DMPA?



# Contraceptive Counseling

Where is she in her reproductive life plan?

*Are you planning a pregnancy in the next year?*

*Do you want to be pregnant in the future? If so, when?*



# Contraceptive CHOICE Project



# Contraceptive CHOICE Project

## Primary Objectives

- To increase the acceptance and use of long-acting reversible contraceptive (LARC) methods among women of childbearing age
- To measure acceptability, satisfaction, side-effects, and rates of continuation across a variety of reversible contraceptive methods, including long-acting reversible methods



# Contraceptive CHOICE Project

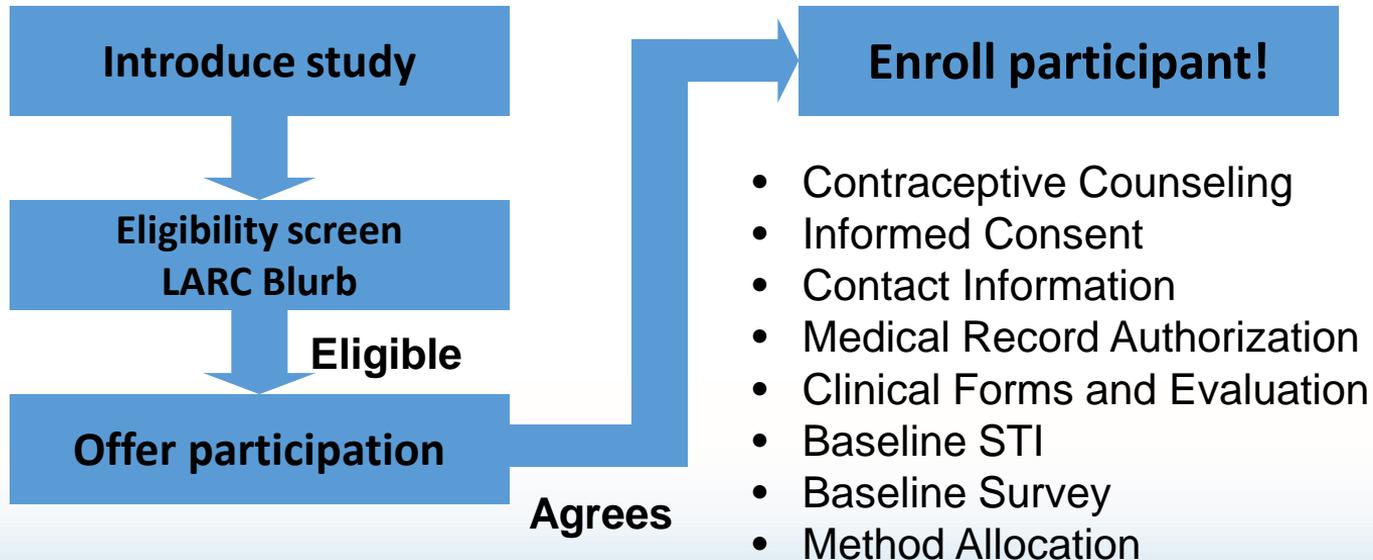
## Study Inclusion Criteria

- Females: 14-45 years old
- Primary residency in STL City or County
- Sexually active with male partner (or soon to be)
- Does not desire pregnancy during next 12 months
- Desires reversible contraception
- Willing to try a new contraceptive method



# Contraceptive CHOICE Project

## Screening and Enrollment



# Contraceptive CHOICE Project

## Contraceptive Counseling

- Counseling Framework with Standard Script
- Contraception 101 Lecture for Educators
- Tiered Method Approach



# Contraceptive CHOICE Project

	%
LNG-IUS	46.0
Copper IUD	11.9
Implant	16.9
DMPA	6.9
Pills	9.4
Ring	7.0
Patch	1.8
Other	<1.0

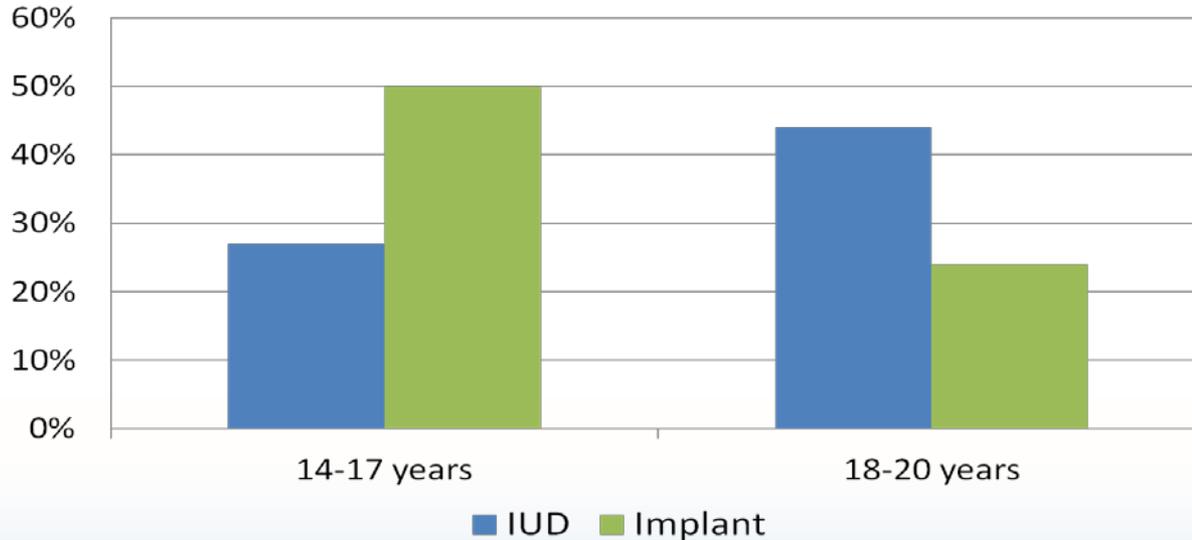
} 75%

Baseline chosen method  
of 9,256 participants



# Contraceptive CHOICE Project

## Choice of LARCs by adolescents



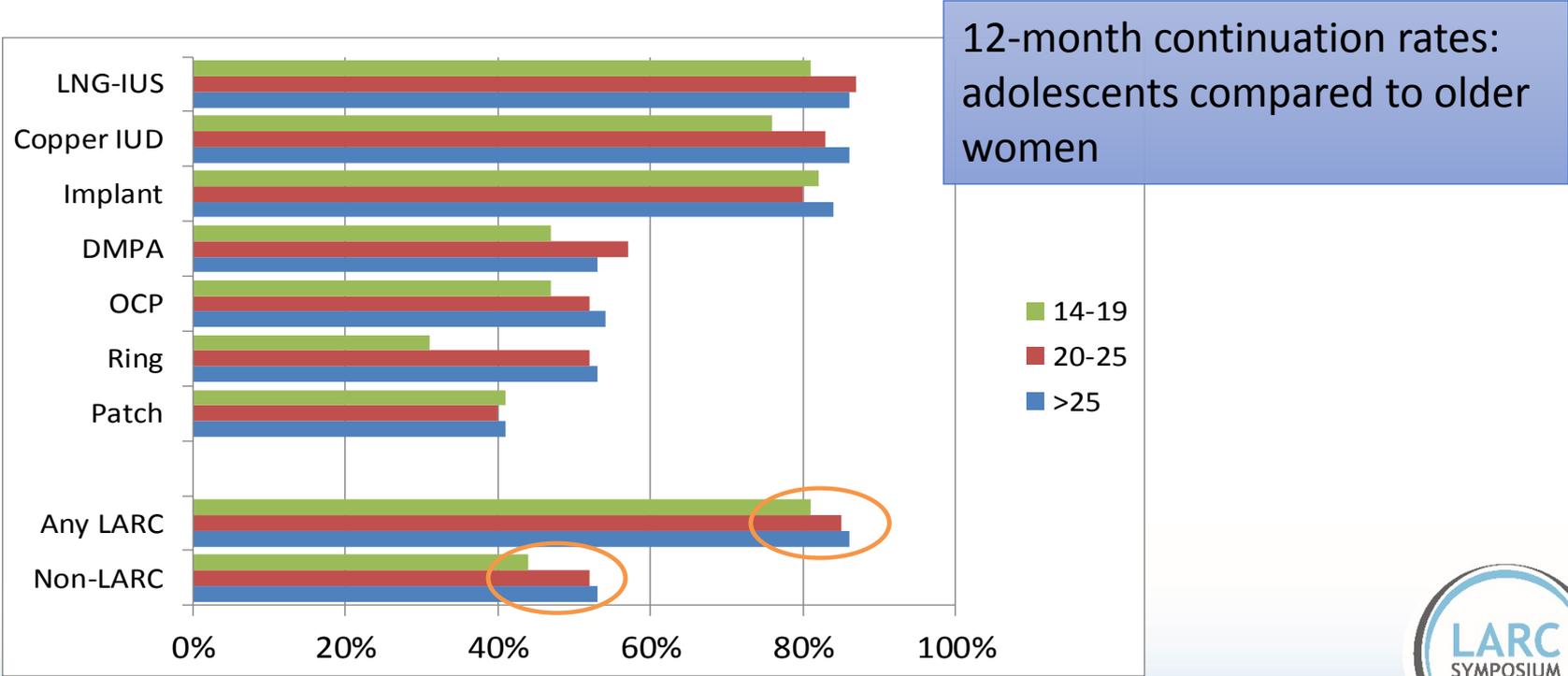
# Contraceptive CHOICE Project

Method	Continuation Rate (%)
LNG-IUS	87.5
Copper IUD	84.1
Implant	83.3
Any LARC	86.2
DMPA	56.2
OCPs	55.0
Ring	54.2
Patch	49.5
Non-LARC	54.7

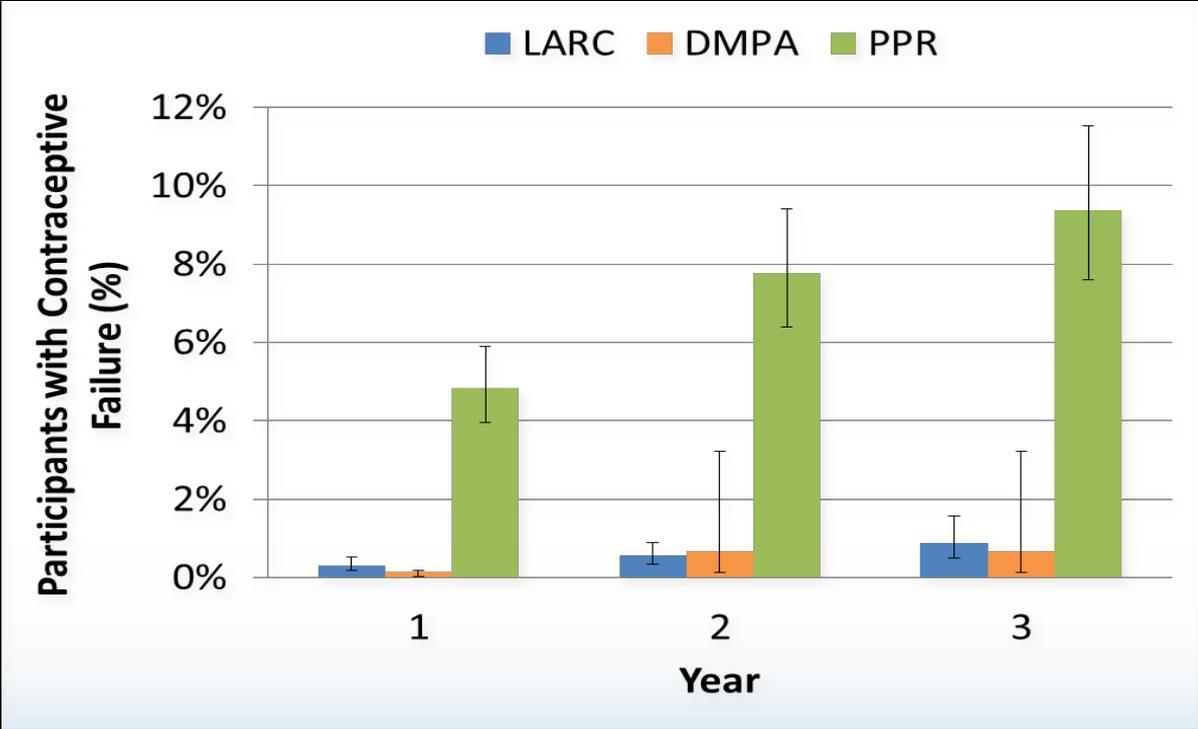
12-month  
continuation  
rates



# Contraceptive CHOICE Project



# Contraceptive CHOICE Project

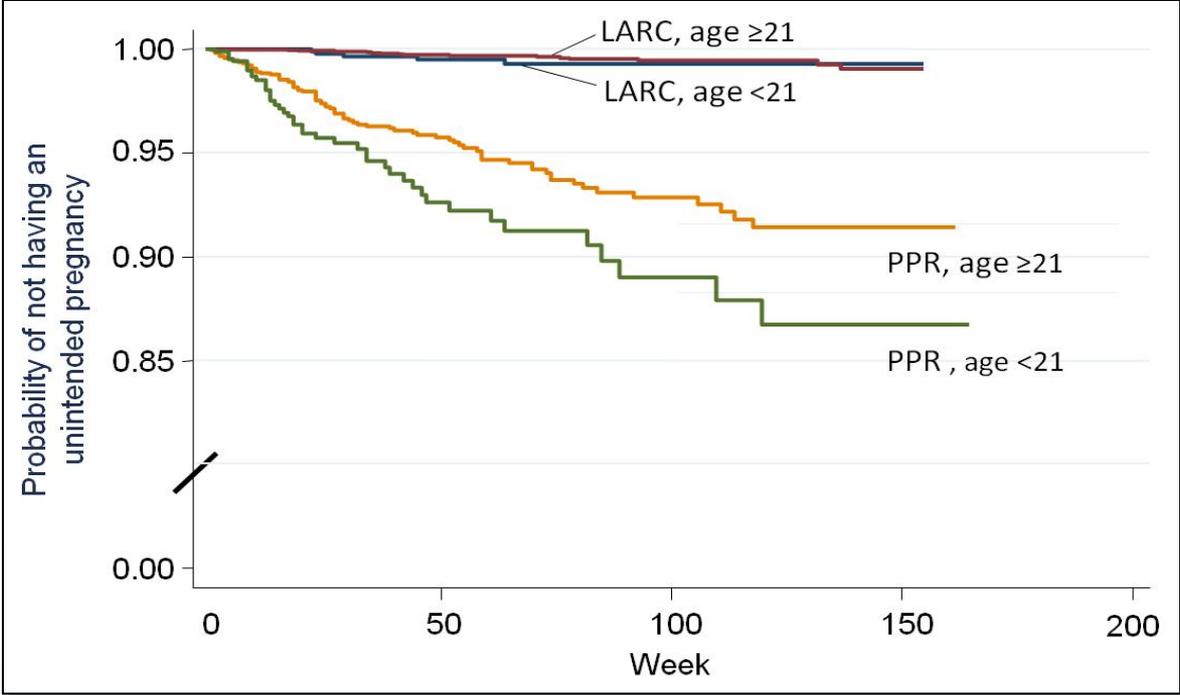


Unintended pregnancy by method

Winner NEJM 2012



# Contraceptive CHOICE Project



Method failure by age

Winner NEJM 2012



# Case #5 – Options for this patient?

- Offer EC (Including ParaGard)
- Provide Contraceptive Counseling
- Utilize support staff (RNs, Health Educators)

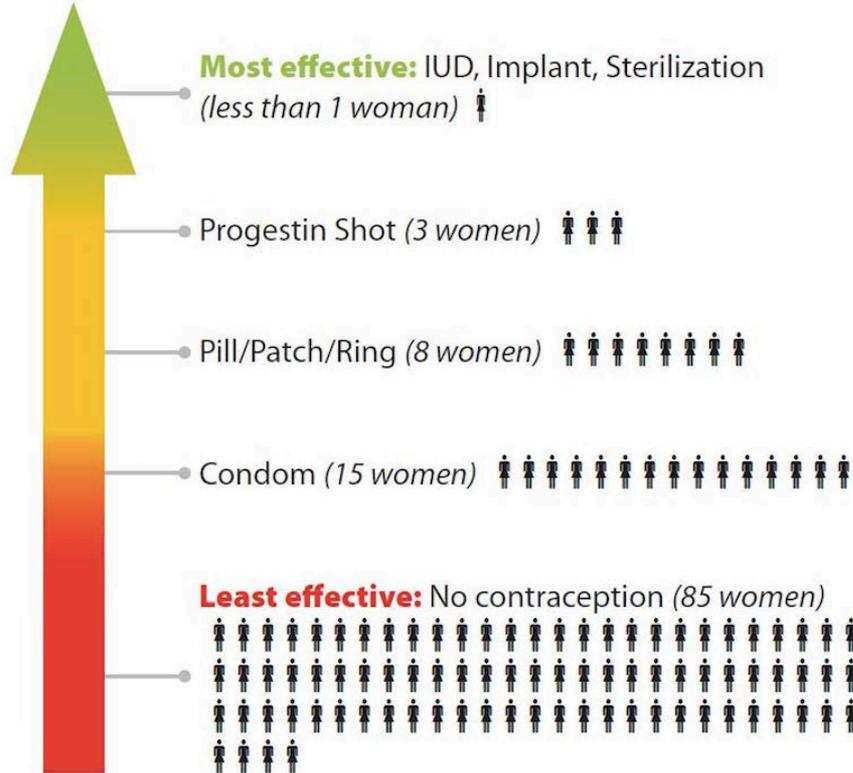


# LARC Resources



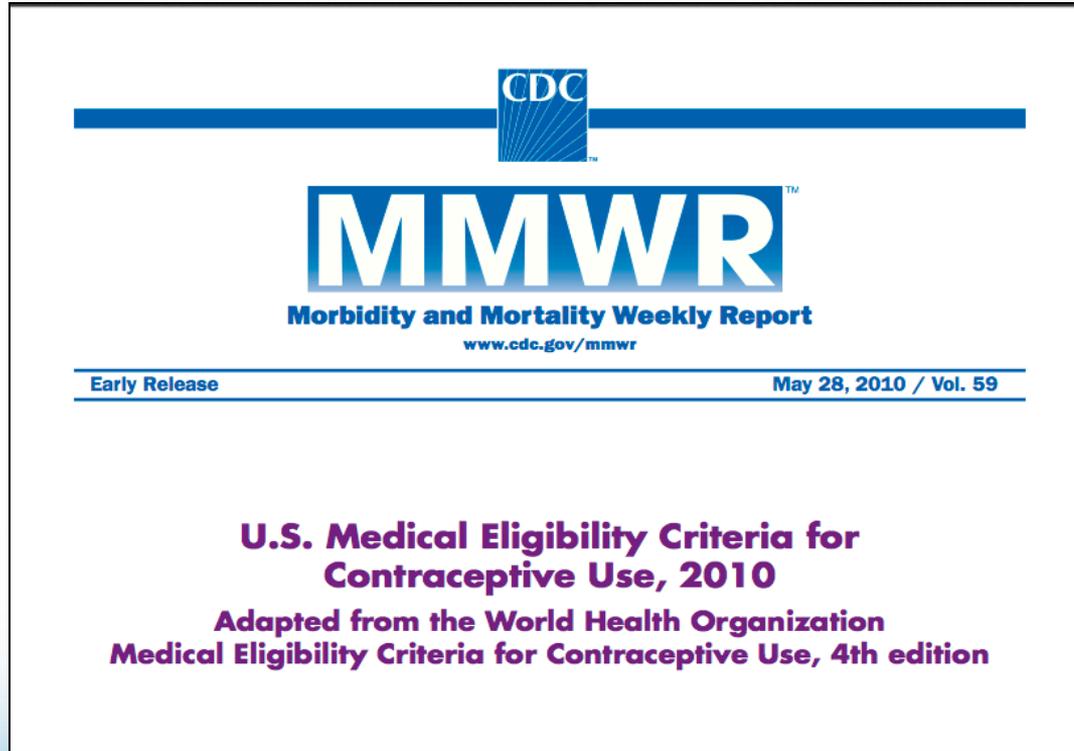
## Birth Control Method Effectiveness

How many women out of 100 get pregnant in 1 year with typical use?



# Tiered Counseling Visuals

# U.S. Medical Eligibility Criteria for Contraceptive Use, 2010



# U.S. Medical Eligibility Criteria for Contraceptive Use, 2010

## Summary Chart of U.S. Medical Eligibility Criteria for Contraceptive Use

Condition	Sub-Condition	CHC		POP		Injection		Implant		LNG-IUD		Cu-IUD	
		I	C	I	C	I	C	I	C	I	C	I	C
Age													
		Menarche to <45-1	Menarche to <45-1	Menarche to <18-2	Menarche to <20-2	Menarche to <20-2	Menarche to <20-2	Menarche to <20-2					
Anatomic abnormalities	a) Distorted uterine cavity									4	4		
Anemias	b) Other abnormalities									2	2		
	a) Thalassemia	1	1	1	1	1	1	1	1	2	2		
Benign ovarian tumors	b) Sickle cell disease*	2	1	1	1	1	1	1	1	2	2		
	c) Iron-deficiency anemia (including cysts)	1	1	1	1	1	1	1	1	1	1	2	2
Breast disease	d) Undiagnosed mass	1	1	1	1	1	1	1	1	1	1	1	1
	a) Benign breast disease	2*	2*	2*	2*	2*	2*	2*	2*	2	2	1	1
Breast disease	b) Family history of cancer	1	1	1	1	1	1	1	1	1	1	1	1
	c) Breast cancer†												
Breast disease	i) current	4	4	4	4	4	4	4	4	4	4	1	1
	ii) past and no evidence of current disease for 5 years	3	3	3	3	3	3	3	3	3	3	1	1
Breastfeeding (see also Postpartum)	a) <1 month postpartum	3*	2*	2*	2*	2*	2*	2*	2*				
	b) 1 month or more postpartum	2*	1*	1*	1*	1*	1*	1*	1*				
Cervical cancer	Awaiting treatment	2	1	2	2	2	2	4	2	4	2		
Cervical ectropion		1	1	1	1	1	1	1	1	1	1	1	1
Cervical intraepithelial neoplasia		2	1	2	2	2	2	2	2	2	1	1	1
Cirrhosis	a) Mild (compensated)	1	1	1	1	1	1	1	1	1	1	1	1
	b) Severe† (decompensated)	4	3	3	3	3	3	3	3	3	3	1	1
Deep venous thrombosis (DVT)/Pulmonary embolism (PE)	a) History of DVT/PE, not on anticoagulant therapy	4	3	3	3	3	3	3	3	3	3	1	1
	i) higher risk for recurrent DVT/PE	4	2	2	2	2	2	2	2	2	2	1	1
Deep venous thrombosis (DVT)/Pulmonary embolism (PE)	ii) lower risk for recurrent DVT/PE	4	2	2	2	2	2	2	2	2	2	1	1
	b) Acute DVT/PE	4	2	2	2	2	2	2	2	2	2	2	2
Deep venous thrombosis (DVT)/Pulmonary embolism (PE)	c) DVT/PE and established on anticoagulant therapy for at least 3 months	4*	2	2	2	2	2	2	2	2	2	2	2
	i) higher risk for recurrent DVT/PE	4*	2	2	2	2	2	2	2	2	2	2	2
Deep venous thrombosis (DVT)/Pulmonary embolism (PE)	ii) lower risk for recurrent DVT/PE	3*	2	2	2	2	2	2	2	2	2	2	2
	d) Family history (first-degree relatives)	2	1	1	1	1	1	1	1	1	1	1	1
Deep venous thrombosis (DVT)/Pulmonary embolism (PE)	e) Major surgery	4	2	2	2	2	2	2	2	2	2	1	1
	i) with prolonged immobilization	4	2	2	2	2	2	2	2	2	2	1	1
Deep venous thrombosis (DVT)/Pulmonary embolism (PE)	ii) without prolonged immobilization	2	1	1	1	1	1	1	1	1	1	1	1
	f) Minor surgery without immobilization	1	1	1	1	1	1	1	1	1	1	1	1
Depressive disorders	g) without prolonged immobilization	1*	1*	1*	1*	1*	1*	1*	1*	1*	1*	1*	1*
	h) Major surgery	1	1	1	1	1	1	1	1	1	1	1	1
Diabetes mellitus (DM)	a) History of gestational DM only	1	1	1	1	1	1	1	1	1	1	1	1
	b) Non-vascular disease	1	1	1	1	1	1	1	1	1	1	1	1
Diabetes mellitus (DM)	i) non-insulin dependent	2	2	2	2	2	2	2	2	2	2	1	1
	ii) insulin dependent*	2	2	2	2	2	2	2	2	2	2	1	1
Diabetes mellitus (DM)	c) Nephropathy/retinopathy/neuropathy†	3/4*	2	2	2	2	2	2	2	2	2	1	1
	d) Other vascular disease or diabetes of >20 years' duration†	3/4*	2	2	2	2	2	2	2	2	2	1	1

Condition	Sub-Condition	CHC		POP		Injection		Implant		LNG-IUD		Cu-IUD	
		I	C	I	C	I	C	I	C	I	C	I	C
Endometrial cancer†		1	1	1	1	1	1	1	1	4	2	4	2
Endometrial hyperplasia		1	1	1	1	1	1	1	1	1	1	1	1
Endometriosis		1	1	1	1	1	1	1	1	1	1	1	2
Epilepsy†	(see also Drug Interactions)	1*	1*	1*	1*	1*	1*	1*	1*	1	1	1	1
Gallbladder disease	a) Symptomatic												
	i) treated by cholecystectomy	2	2	2	2	2	2	2	2	2	2	1	1
Gestational trophoblastic disease	ii) medically treated	3	2	2	2	2	2	2	2	2	2	1	1
	iii) current	3	2	2	2	2	2	2	2	2	2	1	1
Gestational trophoblastic disease	b) Asymptomatic	2	2	2	2	2	2	2	2	2	2	1	1
	a) Decreasing or undetectable β-hCG levels	1	1	1	1	1	1	1	1	3	3	3	3
Gestational trophoblastic disease	b) Persistently elevated β-hCG levels or malignant disease†	1	1	1	1	1	1	1	1	4	4	4	4
	a) Non-migrainous	1*	2*	1*	1*	1*	1*	1*	1*	1*	1*	1*	1*
Headaches	b) Migraine												
	i) without aura, age <35	2*	3*	1*	2*	2*	2*	2*	2*	2*	2*	3*	1*
Headaches	ii) without aura, age >35	3*	4*	1*	2*	2*	2*	2*	2*	2*	2*	2*	1*
	iii) with aura, any age	4*	4*	2*	3*	2*	3*	2*	3*	2*	3*	2*	1*
History of bariatric surgery†	a) Restrictive procedures	1	1	1	1	1	1	1	1	1	1	1	1
	b) Malabsorptive procedures	COCs 3	3	3	3	3	3	3	3	3	3	1	1
History of cholestasis	a) Pregnancy-related	2	1	1	1	1	1	1	1	1	1	1	1
	b) Past COC-related	3	2	2	2	2	2	2	2	2	2	1	1
History of high blood pressure during pregnancy	a) Pregnancy-related	2	1	1	1	1	1	1	1	1	1	1	1
	b) Past COC-related	3	2	2	2	2	2	2	2	2	2	1	1
History of pelvic surgery	a) Mild (compensated)	1	1	1	1	1	1	1	1	1	1	1	1
	b) Severe† (decompensated)	4	3	3	3	3	3	3	3	3	3	1	1
Human immunodeficiency virus (HIV)	a) High risk	1	1	1	1	1	1	1	1	2	2	2	2
	b) HIV infected (see also Drug Interactions)†	1*	1*	1*	1*	1*	1*	1*	1*	2	2	2	2
Hyperlipidemia	AIDS (see also Drug Interactions)†	1*	1*	1*	1*	1*	1*	1*	1*	3	3	3	2*
	Clinically well on therapy	2	2	2	2	2	2	2	2	2	2	2	2
Hypertension	a) Adjuvantly controlled hypertension	2/3*	2*	2*	2*	2*	2*	2*	2*	2*	2*	1*	1*
	b) Elevated blood pressure levels (properly taken measurements)	3*	1*	1*	1*	1*	1*	1*	1*	1	1	1	1
Hypertension	i) systolic 140-159 or diastolic 90-99	3	1	2	2	1	1	1	1	1	1	1	1
	ii) systolic ≥160 or diastolic ≥100†	4	2	2	2	2	2	2	2	2	2	1	1
Inflammatory bowel disease (Ulcerative colitis, Crohn's disease)	c) Vascular disease	4	2	2	2	2	2	2	2	2	2	1	1
	d) Vascular disease	2/3*	2	2	2	2	2	2	2	2	2	1	1

**Abbreviations:** C=continuation of contraceptive method; CHC=combined hormonal contraceptive (pill, patch, and ring); COC=combined oral contraceptive; Cu-IUD=copper-containing intrauterine device; IUD=injection of contraceptive method; LNG-IUD=levonorgestrel-releasing intrauterine device; NA=not applicable; POP=progestin-only pill; P/0=patch/ring.

**Legend:**

- 1 No restriction (method can be used)
- 2 Advantages generally outweigh theoretical or proven risks
- 3 Theoretical or proven risks usually outweigh the advantages
- 4 Unacceptable health risk (method not to be used)



# US SPR

Centers for Disease Control and Prevention  
**MMWR**

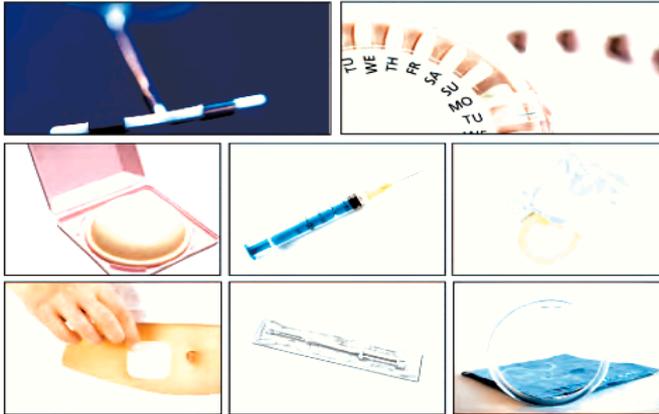
Morbidity and Mortality Weekly Report

Early Release / Vol. 62

June 14, 2013

## U.S. Selected Practice Recommendations for Contraceptive Use, 2013

Adapted from the World Health Organization Selected Practice  
Recommendations for Contraceptive Use, 2nd Edition



# Bedsider.org for *patients*

**BEDSIDER** [birth control methods](#) [where to get it](#) [reminders](#) [features](#) [questions](#)

**METHOD EXPLORER /**

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*What is all this stuff?*

The explorer is a place to learn about all your birth control options. We cover every available method, from the IUD (and others on our most effective list) to condoms, the pill, the patch, and more. Click on any method for more details. Want a more apples-to-apples way to compare? [View a side-by-side comparison.](#)

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But wait, there's more for providers! Our **Shareable Content** lets you download birth control images or detailed method information to use on your website—all at no cost. And our free **Interactive Tools** include appointment reminders, birth control reminders, and a health center finder. [Have a look >](#)



# beforeplay.org for *patients*

The screenshot displays the homepage of beforeplay.org. At the top left is the logo "before play .org". A navigation menu at the top right includes "BIRTH CONTROL", "PREGNANCY", "STDs", "SEXUALITY", and "GET TALKING".

The main banner features a photograph of a smiling man and a woman's hand on her hip. Text on the left reads: "I need her to know we should be careful." Below this is a "BIRTH CONTROL" section with the subtext "FIND OUT WHAT'S RIGHT FOR YOU." and a right-pointing arrow.

Below the banner is a section titled "JUST TALK ABOUT IT." with a speech bubble icon. The text reads: "Sexual well-being. Safe sex. Sexuality. It's all out from under the covers at Beforeplay.org, the hub for Colorado's statewide effort to reduce unintended pregnancy and promote honest, open conversation about sexual health."

The bottom of the page is divided into four colored panels, each with an image and text:

- BIRTH CONTROL:** Image of a couple kissing. Text: "18-29 year olds have sex an average of 112 TIMES PER YEAR."
- PREGNANCY:** Image of hands holding a baby. Text: "The typical U.S. woman wants ONLY 2 CHILDREN. To achieve this goal, she must use birth-control for roughly 3 decades."
- STDs:** Image of hands being washed in a sink.
- SEXUALITY:** Image of two men smiling.



# beforeplay.org for *providers*



## Providers & Health Educators

As a health care provider, guiding patients through the topics of birth control, pregnancy, STIs and overall sexual health is crucial. But it can also be a challenge to find resources that your patients can relate to. That's why beforeplay.org is here. It's our goal to help you provide the best possible care for the women and men in your practice through relevant and up-to-date clinical reproductive health service information.

### TALKING WITH YOUR PATIENTS

### ESSENTIAL TOOLS

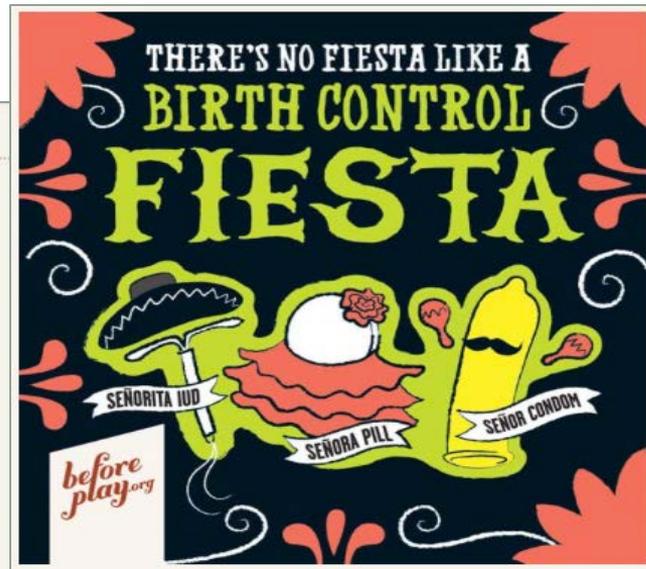
### BEFOREPLAY MATERIALS

The first step is a simple question that should be asked at every visit:  
What are you doing about birth control?

Be proactive in bringing up the topic of birth control rather than waiting for your patient to say something because things may have changed since his or her last visit. Female patients may have stopped using their method for a number of reasons, such as side effects, cost, new sexual situation, or a desire to get pregnant. By actively engaging in conversation with your patients, you can significantly reduce the risk of an unintended pregnancy by putting the birth control issue on your patient's radar.

And don't forget about men, who often get overlooked when it comes to birth control. Family planning isn't just for women, so it is a good idea to make sure the reproductive health needs of men, including birth control and STI prevention, are being met as well.

Essential tools for health care providers and educators are also available, including the most up-to-date guidelines for contraception, pre-conception and STD treatment, refreshers on key issues, and training opportunities.



# Long-Acting Reversible Contraception

## Questions?

