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*Periodic Well-Woman Visit:
Individualized Contraceptive Care*

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ASSOCIATION OF REPRODUCTIVE HEALTH PROFESSIONALS



May 2004

Periodic Well-Woman Visit: Individualized Contraceptive Care

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A Paradigm Shift in Gynecologic Care

Although annual gynecologic examinations are still recommended by some, the new paradigm for a well-woman visit incorporates fundamental changes and new guidance from professional groups. Many clinical experts now agree that:

- pelvic exams may not be required annually
- pelvic exams are not required for initiating hormonal contraception
- not all women 30 years of age and older require annual cervical cytology screening
- women should be encouraged to pay attention to symptoms or changes in their breasts rather than being taught breast self-exam

These changes are supported by solid medical evidence, but are unsettling to some clinicians and their patients. Clinicians face the challenges of time pressure, fiscal and practice demands, and an expanding array of safe and effective contraceptive options that need to be explained to their patients. Some women, in turn, are skeptical that new guidelines have been driven by the cynical efforts of health insurance carriers to reduce costs.

This issue of *Clinical Proceedings* features results from a roundtable discussion on changes in the periodic well-woman visit by experts in women's health care, including ob/gyn and family practice physicians and advanced practice clinicians. These experts provide suggestions for helping women make choices that facilitate contraceptive success, and discuss counseling tools and strategies to accomplish this objective. I would like to thank all those who participated in the roundtable and review of the evidence for their contributions.

Sincerely,

Wayne C. Shields
ARHP President and CEO

LEARNING OBJECTIVES

After completing this *Clinical Proceedings*, participants will be able to:

1. Discuss clinical steps in examining asymptomatic women during the gynecologic visit.
2. Identify methods of communication that best facilitate effective clinician-patient discussion about contraception during the gynecologic visit.
3. Understand useful contraceptive counseling messages.
4. Understand the significance of provider/patient communication and interaction during the clinical gynecologic exam.
5. Understand common health considerations, challenges, and myths that are associated with gynecologic care that may impact patient's contraceptive choices.

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INTRODUCTION

Women's health care is changing rapidly. Although annual gynecologic examinations are still recommended, not all women require annual cervical cytology screening.^{1,2} For this reason, experts have suggested that the term "annual visit" be replaced by "periodic well-woman visit." Goals of this periodic well-woman visit are to promote wellness and implement preventive health screening; facilitate early detection of breast and gynecologic cancers, other gynecologic and non-gynecologic problems, and sexually transmitted infections (STIs); promote healthy pregnancy and positive perinatal outcomes; and prevent unintended pregnancy.

Today, US women have a greatly expanded array of contraceptive choices for the prevention of unintended pregnancy. Hormonal contraceptive options now include low-estrogen-dose combination estrogen/progestin oral contraceptive (OC) formulations and four longer-acting options—the depot medroxyprogesterone acetate injection, the transdermal contraceptive patch, the levonorgestrel intrauterine system, and the combination hormonal contraceptive vaginal ring.^{3,4} A dedicated extended OC regimen designed to decrease menstrual bleeding to four times per year is available for women who desire less frequent menses.⁵ Emergency contraceptive pills also are available to prevent pregnancy after known or suspected contraceptive failure or unprotected intercourse.^{6,7} Finally, for women who have completed childbearing and desire a permanent, irreversible method of contraception, a new hysteroscopic tubal occlusion procedure in which a microcoil (Essure[®]) is inserted into each fallopian tube offers a non-surgical alternative to conventional tubal sterilization.⁸

Our patients' expectations of us as providers of gynecologic care have changed as well. More than ever, patients place a premium on good communication, and this includes effectively communicating information on contraceptive options to patients. Clinicians who engage the patient will be more successful in motivating her to make positive contraceptive choices, increasing the likelihood that she will return for future visits (either well-woman or problem) and will refer friends and co-workers. The challenge for clinicians is to provide effective contraceptive counseling *and* accomplish all of the non-contraceptive goals of the well-woman visit within the limited time constraints of a well-woman visit. An added challenge is to deliver this care in an atmosphere that is respectful, caring, and open to a variety of patient lifestyle choices, practices, and cultures.

How can the health care provider achieve these goals?

A recent nationwide survey found that in 1998–99, 40 percent of obstetrician/gynecologists responding felt that they did not have adequate time with their patients—a significant increase from 1996–97, when only 29 percent reported feeling time constraints.⁹ In 1998–99, only 59 percent of respondents felt that they could maintain the kind of continuing relationship with patients over time that promoted the delivery of high-quality care.

In November 2003, the Association of Reproductive Health Professionals (ARHP) convened a multi-disciplinary panel of experts in women's health care and reproductive services to discuss these issues. In the remainder of this *Clinical Proceedings*, the participants will suggest ways in which health care providers can make optimum use of the time allocated for each patient, delegating certain tasks to other staff members as appropriate.

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5. Seasonale[®] (levonorgestrel/ethinyl estradiol tablets) 0.15 mg/0.03 mg prescribing information. Available at <http://www.seasonale.com/pi/default.asp>. Accessed December 23, 2003.
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PERIODIC WELL-WOMAN VISIT

The basic components of the periodic well-woman visit for asymptomatic patients aged 19 and older include a history, physical examination, selected laboratory tests, and counseling (Table 1).^{1,2} Recognizing that it is not possible for busy clinicians to cover all of the items recommended by professional association guidelines in today's managed care environment, participants in a multidisciplinary panel of experts focused on items they consider essential. They also suggested a number of time-saving tips for screening and assessment techniques to help provide the most appropriate care for each patient within the shortest possible time (Sidebar A).

PATIENT HISTORY

Key elements that should be covered in the patient's personal, sexual, medical, and family history include the

reason for the visit, her menstrual history, whether pain or bleeding is present during or after intercourse, any other medical conditions, smoking and abuse history, the family medical history, her sexual orientation, and whether she is currently sexually active. Women who are sexually active and at risk for pregnancy should be questioned about the use of birth control and measures to prevent STIs, and whether or not they may be pregnant.

Time-Saving Tip

Many clinicians save a considerable amount of time by having the patient complete a self-administered questionnaire in the waiting room. The health care provider is obligated to read this history, make written and oral comments on any positive findings, and inquire about any incomplete responses. Also available is a patient interview software that gathers complete present

TABLE 1. Basic Components of the Periodic Well-Woman Visit: Asymptomatic Patients Aged 19 or Older^{1,2}

History:	Personal, family, sexual, medical, smoking, abuse/neglect
Physical Exam:	Height, weight, blood pressure, neck, breasts, abdomen, pelvic, and skin* Aged 40 or older: add oral cavity, axillae
Laboratory Tests:	As appropriate: cervical cytology, screening for sexually transmitted infections Aged 19–39: thyroid-stimulating hormone screening*; for aged 50 or older, screen every 5 y Aged 40 or older: add mammography Aged 45 or older: add lipid profile assessment (every 5 y), colon cancer screening, fasting glucose testing (every 3 y) Aged 65 or older: add bone density screening (every 2 y in absence of new risk factors)
Counseling:	Reproductive-age women: discuss contraceptive options, including emergency contraception; teach breast self-examination†

*For individuals at increased risk.

†Not recommended by the USPSTF or the Canadian Task Force; considered optional by the American Cancer Society.

Adapted from: Primary and preventive care: periodic assessments. ACOG Committee Opinion No. 292. American College of Obstetricians and Gynecologists. *Obstet Gynecol* 2003;102:1117-24.

SIDEBAR A: Time-Saving Tips for the Periodic Well-Woman Visit: Ages 19 and Older

History:	Self-administered history completed in waiting room; health care provider reads, makes written and oral comments on any positive findings, and inquires about any incomplete responses
Physical:	Staff member records height, weight, blood pressure, reviews allergies, medications, and primary care provider at check-in Clinician encourages patient to identify priorities and issues that are important to her at this visit, and together they select those that can be covered in the amount of time available
Laboratory Tests:	Post or provide patient handout explaining new guidelines for Pap smear screening; pelvic examination not required to initiate hormonal contraception [®]
Counseling:	Provide handouts/wall charts describing contraceptive options; refer to Web site for breast self-examination instruction, if requested by patient If not all counseling issues are completed during the visit: 1) schedule return visit; 2) schedule telephone appointment; 3) refer to hotline or Web site for specific issues; 4) offer reading/printed material; 5) refer to another source of care (e.g., clinic, health counselor, abuse treatment center)



illness and past histories, translates the information into clinical terminology, and organizes the positives and negatives for each organ system.³

The following text relates to components of the periodic well-woman visit only. Additional assessments are appropriate in response to positives elicited during the history or examination, and during problem-related visits.

PHYSICAL EXAMINATION

The American College of Obstetricians and Gynecologists (ACOG) recommends that the physical examination performed as part of the periodic well-woman visit include measurement of height, weight, blood pressure, examination of the neck (adenopathy, thyroid), breasts, abdomen, and skin, if the woman is at increased risk of skin cancer as the result of increased recreational or occupational exposure to sunlight; family or personal history of skin cancer; or clinical evidence of precursor lesions.^{1,2} The panel of experts also thinks that listening to the heart and lungs should be an option for selected patients, such as smokers or those with a history of mitral valve prolapse. Calculation of the patient's body mass index (BMI) can help determine whether or not she is overweight, and her waist-to-hip ratio can provide an indication of cardiovascular risk. A number of BMI and waist-to-hip ratio calculators are available on the Internet, such as the one at Aetna'sSM IntelliHealth (www.intelihealth.com) under "interactive tools."⁴ For reimbursement purposes, the new Health Care Financing Administration (HCFA) documentation guidelines state that a general multi-system exam should include findings for at least 8 of 12 organ systems: constitutional (e.g., vital signs, general appearance); eyes; ears, nose, mouth, and throat; cardiovascular; respiratory; gastrointestinal; genitourinary; musculoskeletal; skin; neurologic; psychiatric; hematologic/lymphatic/immunologic.⁵

Time-Saving Tips

Have a staff member record the patient's height, weight, and blood pressure, review allergies and medications, and verify the patient's primary care provider before escorting the patient to an examining room. The abuse history can be taken in advance if it is conducted in a private space and the questions are asked orally by a nurse or person trained to conduct such interviews.

The clinician should encourage the patient to identify the priorities and issues that are important to her, and together they should select those that can be covered

in the amount of time available at this visit. Other, less urgent issues can be addressed during a scheduled return visit, by phone or e-mail consultation, printed materials, or the patient can be referred to a hotline or Internet website for specific issues, suggestions, or printed materials.

Experts emphasize that a pelvic examination is not required in order to prescribe hormonal contraception.⁶

Pelvic Examination

Components of the pelvic examination for an asymptomatic woman are listed in Table 2. However, experts emphasize that a pelvic examination is not required in order to prescribe hormonal contraception.⁶ Visual inspection of the external genitalia, vaginal speculum examination, and screening for sexually transmitted infections are recommended for all sexually active women under the age of 25 years, but are necessary only for older women who are undergoing screening for lower genital tract cancer or STIs. Although a routine bimanual pelvic exam is included in the ACOG recommendations for women aged 19 years and older and for teens aged 13 to 18 years of age when indicated by the medical history,^{1,2} some experts question the need. The US Preventive Services Task Force (USPSTF) concluded that there is insufficient evidence to recommend for or against bimanual pelvic examination in

Table 2. Components of the Pelvic Examination: Asymptomatic Women*

Component	Comment
Vaginal speculum	Recommended for all sexually active women under age 25; necessary only for older women undergoing screening for lower genital tract cancer or STIs.
Bimanual	USPSTF states that there is insufficient evidence to recommend for or against bimanual pelvic examination in asymptomatic women at increased risk of developing ovarian cancer. ⁷
Rectal	USPSTF strongly recommends screening of women 50 years of age and older for colorectal cancer. ⁹ Experts recommend digital rectal exam for women aged 50 or older as part of pelvic exam.

*Not required to initiate or renew a prescription for hormonal contraception.⁶

asymptomatic women at increased risk of developing ovarian cancer.⁷ In addition, the American Academy of Family Physicians (AAFP) does not recommend the use of ultrasound of the pelvis or serum tumor markers in women without a family history of multiple relatives affected by ovarian cancer.⁸ For this latter group, the AAFP concludes there is insufficient evidence to recommend for or against routine screening.



The USPSTF recommends that clinicians screen men and women 50 years of age or older for colorectal cancer.⁹ Therefore, some experts suggest that digital rectal examination and fecal occult blood screening be included in the periodic health examination of women 50 years of age or older as part of the pelvic examination. For anyone aged 40 or older with a family history of early colorectal cancer, the AAFP recommends a fecal occult blood test annually, sigmoidoscopy, and barium enema or colonoscopy.⁸ Although ACOG does recommend colon cancer screening in women aged 40 or older; it does not specifically recommend rectal examinations in this age group.^{1,2}

LABORATORY TESTS

Cervical Cytology Screening

Since 1943 when the Papanicolaou (Pap) smear was introduced, the incidence of invasive cervical cancer in US women has decreased significantly.¹⁰ (Sidebar B). This decrease has been attributed, at least in part, to organized early detection programs. The routine of an annual visit to the clinician for a Pap smear has been widely accepted by women of all ages since the 1960s, when initiating and continuing hormonal contraception (i.e., oral contraceptives) became linked to obtaining a Pap smear.¹¹ Today, both the American Cancer Society (ACS) and the new ACOG guidelines (see Table 3) recommend that cervical cancer screening begin approximately three years after a woman's first sexual intercourse or by age 21, whichever comes first.^{12,13} Unlike ACS, which states that women younger than 30 can be tested every two years if a liquid-based method is used, ACOG thinks that there are very limited data to support this approach and recommends annual cervical cancer screening up to age 30.^{12,13}

SIDEBAR B. The Papanicolaou (Pap) Smear: The Most Effective Cancer Screening Test Ever Devised^{10,13}

- Cervical cancer was the leading cause of cancer death in US women as recently as the 1930s.¹³
- Since the introduction of the Pap test in 1943, death from cervical cancer among US women has been reduced by more than 70 percent.¹⁰
- Because the conventional Pap test is associated with a high false-negative rate, liquid-based, thin-layer preparation techniques have been developed to increase the sensitivity of Pap tests in detecting abnormalities.¹⁰ Most health insurance programs currently cover liquid-based thin-layer techniques. In the absence of cost concerns, the liquid-based approaches to cervical cytology appear preferable to conventional slide-based Pap tests.

A Major Change in the ACOG Guidelines for Women Aged 30 or Older

The new ACOG guidelines recognize that screening frequency can be individualized beginning at the age of 30 years in a woman known to have a negative history and several recent cervical cytology tests (Table 3).¹³ When cervical cytology alone is used, women who have negative results on three consecutive annual tests can be rescreened every two to three years.¹³ When both cervical cytology and the Food and Drug Administration (FDA)-approved test for high-risk human papillomavirus (HPV) types are used, women with a negative result on both tests should be rescreened no more often than every three years. If only one test is negative, more frequent screening is needed. Although not all women will require annual Pap smears, the ACOG guidelines emphasize the importance of annual gynecologic examinations, even if cervical cytology is not performed.

Although not all women will require annual Pap smears, the ACOG guidelines emphasize the importance of annual gynecologic examinations, even if cervical cytology is not performed.

There is good evidence to support less frequent Pap smears for women aged 30 years or older. Data from eight cervical cancer screening programs with more than 1.8 million women showed that there was little difference in the incidence of cervical cancer with screening every year compared with every three years.¹⁴ However, there was significantly less protection against cervical cancer when the screening interval was extended to once every 5 or 10 years (Figure 1).

More recently, an analysis of cervical cancer screening results for 31,728 US women aged 30 to 64 years who had three or more consecutive negative tests found that the prevalence of biopsy-proven cervical intraepithelial neoplasia of grade 2 was 0.028 percent and that of grade 3 neoplasia was 0.019 percent; none of the women had invasive cancer.¹⁵ Compared with annual screening, Pap testing performed once three years after the last negative test in these women was associated with an excess risk of cervical cancer of approximately 3 in 100,000. An observation made by the authors is that, for a woman aged 30 years or older, the risk of cervical cancer associated with less frequent Pap testing (every three years) is low and roughly the same as the risk of breast cancer among men aged 45 to 64 years.¹⁵

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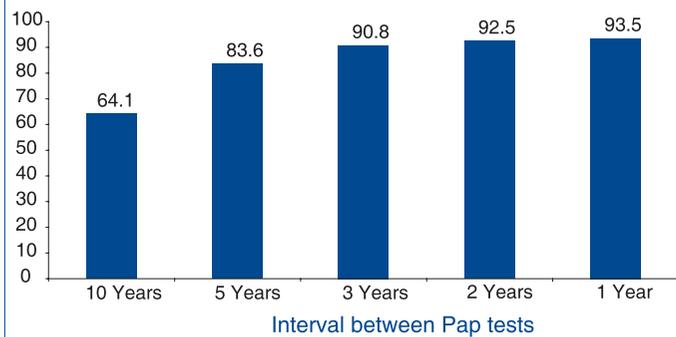


TABLE 3. Screening Recommendations for Cervical Cancer*¹³

First screen:	Approximately 3 years after first sexual intercourse or by age 21, whichever comes first.
Women up to age 30:	Annual cervical cytology screening.
Women age 30 or older:	Two acceptable screening options.
1) <i>Cervical cytology alone</i>	If negative results on 3 consecutive annual tests, rescreen with cervical cytology alone every 2–3 years.
2) <i>Cervical cytology + FDA- approved test for high-risk types of HPV</i>	If negative results on both tests, rescreen with combined tests every 3 years. If only one test is negative, more frequent screening is needed.
Exceptions:	More frequent screening may be required for higher-risk women who are infected with HIV, are immunosuppressed, were exposed to DES (diethylstilbestrol) <i>in utero</i> , have had previous abnormal Pap tests, or were previously diagnosed with cervical cancer.
Hysterectomy with removal of cervix:	If for benign reasons, with no history of abnormal or cancerous cell growth, routine cytology testing may be discontinued. If a history of abnormal cell growth (classified as CIN 2 or 3), screen annually until 3 consecutive, negative, vaginal cytology tests; then routine screening may be discontinued.
When to discontinue screening:	ACS – non-high-risk women at age 70; USPSTF – by age 65; ACOG notes that due to limited studies of older women, it is difficult to set an across-the-board upper age limit for cervical cancer screening.

*Regardless of the frequency of cervical cancer screening, annual gynecologic examinations, including pelvic examinations, are still recommended.

FIGURE 1. Reduction (%) in Cumulative Incidence of Cervical Cancer with Different Intervals Between Pap Tests¹⁴



Will Women Accept Less Frequent Pap Test Screening?

Providers of women’s health care will be challenged to convince women that less frequent Pap smears will not significantly increase their risk of cervical cancer. Results of eight focus group interviews of women from urban practices, a university health center, and a rural family practice residence identified a number of barriers to risk-based cervical cancer screening (Sidebar C).¹¹ As the result of years of promotion by the lay press and various organizations of the annual Pap smear as a key component

of women’s health care, the women surveyed believe that annual screening is necessary and reduces cervical cancer mortality. Their reluctance to consider risk-based cervical cancer screening is based on a lack of knowledge about risk factors for cervical cancer, its natural history, and the effectiveness of annual versus triennial screening. Moreover, some women are suspicious that the recommendations for less frequent Pap smear screening were driven by organized medicine and the insurance industry, not by science. Women’s reluctance to change their beliefs was colored by experiences with the health care system, such as impersonal providers and staff, poor communication, limited access, and bad experiences during a particular visit. Clearly, educational efforts by clinicians and their staff will be important in changing women’s attitudes toward annual Pap testing. Some experts expect that clinicians may continue to offer annual cervical cytology for all patients having periodic well-woman visits until insurance companies restrict reimbursement for this service.

Screening for Sexually Transmitted Infections

The new ACOG recommendations, a recent update by the US Preventive Services Task Force, and the revised American Association of Family Physicians policy recommendations for periodic health examinations



recommend routine screening of all sexually active women aged 25 years or younger (regardless of marital status) for chlamydial infection and of other asymptomatic women at increased risk of infection (i.e., a history of multiple sexual partners or a sexual partner with multiple contacts, sexual contact with individuals with culture-proven STI, a history of repeated episodes of STIs, or attendance at clinics for STIs).^{1,2,8,16} AAFP also recommends screening of high-risk individuals for chlamydial infection beginning at the age of 18 years.⁸ Routine screening for chlamydial infection is recommended by the USPSTF for all pregnant women aged 25 years or younger and others at increased risk for infection, because there is fair evidence that screening

and treatment improve pregnancy outcomes.¹⁶ However, the task force makes no recommendation for or against screening of asymptomatic, low-risk pregnant women aged 26 years or older because the benefits are small. Routine screening of sexually active adolescents for gonorrheal infection is recommended in the new ACOG guidelines, and both ACOG and the USPSTF recommend such screening for other asymptomatic women at high risk for infection.^{1,2,7}

Regarding screening for human immunodeficiency virus (HIV), ACOG recommends testing in patients who are at high risk, defined as having any of the following:

- Seeking treatment for STIs
- Drug use by injection
- History of prostitution
- Past or present sexual partner who is HIV positive or bisexual or injects drugs
- Long-term residence or birth in an area with high prevalence of HIV infection
- History of transfusion from 1978 to 1985
- Invasive cervical cancer^{1,2}

Such testing should be offered to all women seeking evaluation prior to conception.

COUNSELING

In addition to contraceptive counseling, which will be discussed in detail in the next section, health care providers have traditionally taught or reviewed techniques for breast self-examination (BSE).

Breast Self-Examination

In 2001, the Canadian Task Force on Preventive Health Care concluded that there was good evidence that BSE causes harm and in a 2002 update, the USPSTF concluded that the evidence was insufficient to recommend for or against teaching or performing routine BSE.^{17,18} The American Cancer Society's updated guidelines issued in 2003 make BSE optional.¹⁹ Further support for these changes was provided by a subsequent Cochrane Review and a meta-analysis.^{20,21} The Cochrane experts' review of data from two large (nearly 400,000 women) population-based studies from Russia and Shanghai that compared BSE with no intervention found no statistically significant differences in breast cancer mortality.²⁰ Almost twice as many biopsies with benign results were performed in the BSE group compared with the no BSE group. The reviewers concluded that "...the data do not suggest a beneficial effect of screening by breast self-examination whereas there is evidence for harms. At present, breast self-examination cannot be recommended."

SIDEBAR C. Barriers to Risk-Based Cervical Cancer Screening¹¹

- Women strongly believe that annual (or even more frequent) screening is important.
- Women perceive annual screening to be successful in reducing cervical cancer mortality.
- Annual visit to a clinician for a Pap smear appears to be a firmly entrenched paradigm.
- Reluctance of women to consider risk-based cervical cancer screening is based on lack of knowledge about.
 - risk factors for cervical cancer
 - its natural history
 - effectiveness of annual vs triennial screening, and
 - suspicion that changes in recommendations are motivated by economic factors, not by science

SIDEBAR D. Screening Recommendations for Sexually Transmitted Infections^{1,2,7,13,16}

- Routine screening for chlamydial infection strongly recommended for **all** sexually active women aged 25 years or younger^{13,16} and other asymptomatic women at increased risk for infection.^{8,13,16}
- Routine screening for chlamydial infection is recommended for **all** pregnant women aged 25 years or younger and others at increased risk for infection.¹⁶
- Routine screening for gonorrheal infection is recommended for **all** sexually active adolescents^{1,2} and other asymptomatic women at high risk for infection.*^{1,2,7}

*"High risk" is defined as history of multiple sexual partners or a sexual partner with multiple contacts, sexual contact with individuals with culture-proven STI, history of repeated episodes of STIs, or attendance at clinics for STIs.¹³



A meta-analysis of the 20 observational studies and three clinical trials that reported on breast cancer death rates or rates of advanced breast cancer according to BSE practice found no difference in death rate in studies on women who detected their cancer during an examination, and none of the trials of BSE training showed lower mortality in the BSE group.²¹ Compared with no self-examination, more women practicing BSE sought medical advice and underwent biopsies. The conclusion of this meta-analysis, like that of the Cochrane Review, was that regular BSE is not an effective method of reducing breast cancer mortality.

The experts think that it is no longer necessary to teach BSE during the periodic well-woman visit. Rather, they agree with the suggestion that women should be encouraged to pay attention to symptoms or changes in their breasts.²² Nevertheless, if a woman requests it, a staff member should be available to provide instruction in BSE, or the patient can be directed toward resources that instruct women in BSE such as the American Cancer Society or breastcancer.org.^{23,24}

Time-Saving Tip

It is no longer necessary to teach BSE.

Other Counseling Issues

If other counseling cannot be completed given the time constraints of a periodic well-woman visit, the multi-disciplinary panel of experts who met in November 2003 suggests the following options:

- Schedule a return visit.
- Schedule a telephone appointment.
- Use e-mail exchange between patient and provider.
- Refer to hotline or Web site for specific issues (Sidebar E).
- Offer reading lists or printed material.
- Refer to another source of care (e.g., clinic, health counselor, abuse treatment center).

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SIDEBAR E. Web Sites Dealing with Specific Issues

Smoking

- Fiore MC, Bailey WC, Cohen SJ, et al. Treating Tobacco Use and Dependence: Clinical Practice Guideline. Washington, DC: US Dept of Health and Human Services; June 2000. Public Health Service publication no. 000032. Available at <http://www.surgeongeneral.gov/tobacco>. Accessed March 27, 2003.
- Campaign for Tobacco Free Kids: <http://www.tobaccofreekids.org>
- American Legacy Foundation: <http://women.americanlegacy.org>
- CDC smoking and tobacco research database: <http://www.cdc.gov/tobacco/search>

Drug Issues

- National Institute on Drug Abuse: <http://www.nida.nih.gov>
- Center for Counseling and Health Resources: <http://www.aplaceofhope.com>

Weight Management

- World Health Organization. Report of a WHO Consultation on Obesity, 3-5 June 1997, Geneva, WHO/NUT/NCD/98.1. <http://www.who.int>
- CDC module on screening for overweight children and adolescents: <http://www.cdc.gov/nccdphp/dnpa/growthcharts/training/modules/module3/text/intro.htm>

Health and Safety Topics

- CDC health and safety topics: <http://www.cdc.gov/az.do#top>

Mental Health Issues

- CDC mental health work group: <http://www.cdc.gov/mentalhealth>
- National Institute of Mental Health: <http://www.nimh.nih.gov>
- American Psychiatric Association: <http://www.psych.org>
- American Psychological Association: <http://www.apa.org>
- American Psychiatric Nurses Association: <http://www.apna.org>

Violence

- The National Consensus Guidelines on Identifying and Responding to Domestic Violence Victimization in Health Care Settings: <http://endabuse.org/programs/healthcare/files/Consensus.pdf>
6. Stewart FH, Harper CC, Ellertson CE, et al. Clinical breast and pelvic examination requirements for hormonal contraception. Current practice vs evidence. *JAMA* 2001;285:2232-9.
 7. U.S. Preventive Services Task Force. *Guide to Clinical Preventive Services, 2nd edition*. Baltimore, MD: Williams & Wilkins, 1996.



daily attention, and 67 percent and 76 percent, respectively, say that the method should not require frequent doctor, clinic, or provider visits.

NEW LONGER-ACTING HORMONAL CONTRACEPTIVE OPTIONS

To address these needs, four new longer-acting, hormonal contraceptive options have been introduced in the United States since 2000: the monthly contraceptive injection (currently not available), the levonorgestrel-releasing intrauterine system (LNG-IUS), the transdermal contraceptive patch, and the vaginal ring (Table 4).³⁻⁶

These methods provide a high degree of contraceptive efficacy while eliminating the need for daily attention.

Effective clinicians seek and will embrace approaches that facilitate efficient review of these new options with patients, recognizing that the pill is not the solution for all patients seeking reversible methods of contraception. Although there is a great deal of interest in these newer methods among women, this interest is accompanied by widespread ignorance. Even if a woman ultimately decides that she is happy with her existing method of contraception, she will appreciate the fact that her health care provider made an effort to review newer methods with her.

The challenge for the clinician is to review contraceptive options quickly and effectively. It is not possible to discuss all contraceptive choices during a single visit; the focus needs to be on choices that are practical for the individual patient. For example, it will not be productive to discuss cervical caps and intrauterine contraception with a teenager who has recently become sexually active. Focusing on methods that make no sense for her will make it less likely that she will leave with the most appropriate method and a good understanding of her contraceptive priorities.

Women are at risk of becoming pregnant because they are having sexual intercourse with a male partner. Therefore, it is important for primary care providers to ask their male patients who are sexually active with women if

TABLE 4. New Longer-Acting Methods of Contraception Introduced in the United States Since 2000³⁻⁶

Type	Duration of Use	Pregnancy Rate/100 Woman-Yrs
Lunelle® (medroxyprogesterone acetate/estradiol cypionate) Injection ³	1 month*	0.00 ^a
Mirena® (levonorgestrel-releasing intrauterine system)	5 years	0.20 ^b
Ortho Evra® (norelgestromin/ethinyl estradiol transdermal contraceptive system)	1 week	0.88 ^c
NuvaRing® (etonogestrel/ethinyl estradiol vaginal ring)	3 weeks	0.65 ^d

*Not available in the United States since 2003.

they are using contraception or know what their partner is using. Both men and women should receive information about emergency contraception and how to obtain it (Sidebar F).

TABLE 5. Comparing Contraceptive Choices: Efficacy⁷

Male Condom	OCs	IUD/IUS
Spermicides	Patch	3-month injection
Female Condom	Ring	1-month injection*
Cervical Cap		Implants**
Diaphragm		Female sterilization
Withdrawal		- Tubal ligation
Fertility Awareness		- Micro-coil tubal occlusion
		Male sterilization

← **Less Effective** **Effective** **Most Effective** →

*Not available in the United States since 2003.
 **Not available in the United States.
 Adapted from ARHP. Comparing Key Factors of Birth Control. Updated June 10, 2003. Available at <http://www.arhp.org>.

Women are at risk of becoming pregnant because they are having sexual intercourse with a male partner. Therefore, it is important for primary care providers to ask their male patients who are sexually active with women if they are using contraception or know what their partner is using.

COMPARING CONTRACEPTIVE CHOICES

When reviewing contraception with patients, it is helpful to categorize options according to efficacy, length of protection and convenience, cost, and return to fertility after cessation of use.

Contraceptive Efficacy

Rather than discussing pregnancy rates, a qualitative approach that categorizes the contraceptive efficacy of different methods



SIDEBAR F. Facts About Emergency Contraception (EC)

EC is Underused

- Only 1 percent of US women report ever having used EC, yet each year, 2 to 3 percent of reproductive-age women have an abortion.¹
- Of 595 obstetrician/gynecologists and 195 family practitioners, internists, and general practitioners surveyed in 2001²
 - 89 percent and 50 percent, respectively, had ever prescribed EC, but infrequently (<6 times by 49 and 30 percent, respectively).
 - Only 25 percent and 15 percent, respectively, offered EC prospectively to patients to have on hand.
 - Only 25 percent and 14 percent, respectively, discussed EC with sexually active female patients as part of routine contraceptive counseling always or most of the time.
 - 41 percent and 27 percent, respectively, said that personal opposition to EC was a very to somewhat important reason they did not discuss EC.

Emergency Contraceptive Pills (ECPs)

- Two types
 - Combined estrogen/progestin pills (C-ECP)
 - Progestin-only pills (P-ECP)
- Two dedicated products
 - *Preven[®] Emergency Contraceptive Pills* (Gynetics Inc. Somerville, NJ)
Four tablets, each containing levonorgestrel 0.25 mg/ethinyl estradiol 0.05 mg.
Dosage: Initially, two pills taken as soon as possible but within 72 hours of unprotected intercourse,* followed by a second dose of two pills 12 hours later. Should not be taken if the patient has a positive pregnancy test result.
Reduction in expected number of pregnancies – 75 percent.
Preven[®] Emergency Contraceptive Kit[®]
Contains four ECPs, pregnancy test, and patient information book/product labeling.
 - *Plan B[®]* (Barr Laboratories, Pomona, NY)⁴
Two tablets each containing levonorgestrel 0.75 mg.
Dosage: First tablet should be taken as soon as possible within 72 hours of intercourse.* Second tablet taken 12 hours later.
Alternatively, both tablets may be taken at one time.⁵
Reduction in expected number of pregnancies – 89 percent.
**NOTE:* Although the FDA-approved labeling for these ECPs states that the first dose should be taken within 72 hours of unprotected intercourse, recent studies indicate that ECPs are effective if taken within five days of unprotected coitus.^{5,6}

- Cost savings with ECPs:⁷

	Managed Care		Public Payer	
	C-ECP	P-ECP	C-ECP	P-ECP
Single use after unprotected intercourse	\$142	\$119	\$54	\$29
Advance provision to woman using barrier contraceptive, spermicide, withdrawal, or periodic abstinence	\$263–\$498		\$99–205	

Initiating Regular Contraception After the Use of Emergency Contraceptive Pills⁸

Condoms, diaphragms, spermicidal foam, or films can be used immediately.

Oral contraceptives, ring, or patch should be started within five days of the beginning of the next menstrual cycle (according to the instructions for the product being used). Alternatively, OCs, the ring, or patch may be initiated the day after completion of EC (the “Quick Start” approach).⁹

Injectable contraceptives – should be given within seven days of the beginning of the next menstrual cycle.

Intrauterine contraception – should be inserted during the next menstrual cycle (if woman intends intrauterine contraception as a long-term method and meets intrauterine contraception screening criteria).



Natural Family Planning – should be started after onset of menstruation if there are no bleeding irregularities.

Sterilization – it is recommended that clients be discouraged from making this decision under the stressful conditions that typically surround ECP use.

Copper-T 380A IUD (Paragard®. FEI Products, LLC. North Tonawanda, NY)

NOTE: The progestin-releasing intrauterine system (LNG-IUS) has not been investigated for emergency contraception.

- 99 percent effective in preventing if inserted up to five days after unprotected intercourse.¹⁰
- An option for women who¹⁰
 - want immediate, long-term contraception
 - are breastfeeding
 - have difficulty ingesting ECPs because of vomiting
- Not cost-effective as an emergency contraceptive alone, but savings grow as use continues over time.⁷

1. Delbanco SF, Mauldon J, Smith MD. Little knowledge and limited practice: emergency contraceptive pills, the public, and the obstetrician-gynecologist. *Obstet Gynecol* 1997;89:1006-11.
2. Kaiser Family Foundation. National Survey of Women's Health Care Providers on Reproductive Health: Emergency Contraception. Menlo Park, CA: The Henry J. Kaiser Family Foundation. June 2003 (Publication #3346). Available at www.kff.org.
3. Preven® Emergency Contraceptive (levonorgestrel and ethinyl estradiol tablets) prescribing information. Available at <http://www.preven.com/prodinfo/.prescinfo.asp>. Accessed December 23, 2003.
4. Plan B® (levonorgestrel) tablets 0.75 mg package insert. Available at http://www.go2planb.com/section/about/package_insert/. Accessed December 23, 2003.
5. von Hertzen H, Piaggio G, Ding J, et al. Low dose mifepristone and two regimens of levonorgestrel for emergency contraception: a WHO multicentre randomized trial. *Lancet* 2002;360:1803-10.
6. Ellertson C, Evans M, Ferden S, et al. Extending the time limit for starting the Yuzpe regimen of emergency contraception to 120 hours. *Obstet Gynecol* 2003;101:1168-71.
7. Trussell J, Koenig J, Ellertson C, Stewart F. Preventing unintended pregnancy: the cost-effectiveness of three methods of emergency contraception. *Am J Public Health* 1997;87:932-7.
8. World Health Organization. Emergency contraception: a guide for service delivery. Available at http://www.int/reproductive-health/publications/FPP_98_19.
9. Westhoff C, Morroni C, Kerns J, Murphy PA. Bleeding patterns after immediate vs. conventional oral contraceptive initiation: a randomized, controlled trial. *Fertil Steril* 2003;79:322-9.
10. Association of Reproductive Health Professionals. Choosing a Birth Control Method. Updated October 27, 2003. Available at <http://www.pubcomm.com/choosing/question8.pl?method=ec>.

Emergency Contraception - Patient Information Web Sites

- NOT-2-LATE.com. The Emergency Contraception Website. Operated by the Office of Population Research at Princeton University and by the Association of Reproductive Health Professionals. Describes all forms of emergency contraception and maintains a directory of clinicians willing to provide emergency contraception.
- Planned Parenthood® Federation of America, Inc. Emergency Contraception. Available at <http://www.plannedparenthood.org/ec>.
Provides information on emergency contraception, toll-free telephone numbers to schedule an appointment for EC at a Planned Parenthood center (1-800-230-PLAN [7526]) and for a list of providers in the woman's area (1-888-NOT-2-LATE). Residents of California, Georgia, Illinois, Indiana, Massachusetts, Missouri, Oregon, and Washington may place online orders for EC.
- iVillage®. Birth Control from A-to-Z. Available at <http://www.ivillagehealth.com/features/birthcontrolaz/pages>. Provides information on emergency contraception and other birth control methods.



from most effective to least effective is the most efficient way to communicate the information to patients (Table 5).⁷ In this way, the woman for whom an unintended pregnancy would pose problems can focus on the effective or extremely effective methods, depending on her plans for subsequent childbearing. If a woman is using contraception to space her pregnancies, a less effective method might be appropriate. In this context, the initial focus of discussions about barrier contraceptives should be male condoms and spermicides, because few women choose diaphragms, female condoms, or cervical caps. Other methods should be discussed as well, because they can be and often are chosen above barrier methods between pregnancies.

Length of Protection and Convenience

Contraceptive methods can also be categorized according to the length of protection and convenience (Table 6).⁷ Women who are less concerned about an unplanned pregnancy may be comfortable using barrier contraceptive methods that are linked to each sex act. Oral contraceptives would be a better choice for a woman who desires greater contraceptive efficacy and is comfortable with the need for daily pill taking. For those who express concerns about their ability to use OCs consistently and correctly, methods that provide weekly or monthly protection, such as the transdermal patch, or vaginal ring might be attractive options. If pregnancy is not desired within the next one or two years, the three-month injection can be considered.⁸ Methods such as the LNG-IUS or copper-T IUD are

TABLE 6. Comparing Contraceptive Choices: Length of Protection/Convenience⁷

▲ Longest	IUD (copper-T)	10 or more years
	LNG-IUS	5 years
	Implants*	3 or more years
Intermediate	3-month injection	3 months
	1-month injection**	1 month
	Vaginal ring	3 weeks
	Transdermal patch	1 week
▼ Shortest	Oral contraceptive	Continuous if taken daily
	Barrier methods† Spermicides	1 act of coitus 1 act of coitus

*Not available in the United States since 2003.
**Not available in the United States.
†Male and female condoms, diaphragms, cervical caps.
Adapted from: ARHP. Comparing Key Factors of Birth Control. Updated June 10, 2003. Available at <http://www.arhp.org>

highly convenient options that provide long-term contraception and would be appropriate for women who desire long-term protection and those who have no future childbearing plans but do not want permanent surgical contraception.

Cost

The cost of a contraceptive method is an important consideration for many patients. Although the LNG-IUS and the copper-T IUD have a high initial cost, these methods become highly cost-effective as the length of use increases (Table 7).^{7,9} Among the other available

hormonal methods, OCs are the least costly, followed by the transdermal patch and the vaginal ring; however, most often pharmacies keep these costs about the same.

Return to Fertility After Stopping Use

Plans for future pregnancy are another consideration in the selection of a hormonal method of contraception. For some women who may wish to become pregnant within the next year or so, the vaginal ring and transdermal patch offer a rapid return to fertility within one month of cessation of use and are cost-effective methods (Table 8).⁷ Likewise, OC users experience a rapid return to fertility after discontinuation of use. As stated earlier, the return of fertility is delayed 6 to 18 months after cessation of use of the three-month injection.⁸

TABLE 7. Comparing Contraceptive Choices: Cost^{7,9}

Method	Unit Cost	5-Year Cost
LNG-IUS*	\$395 (device)†	\$395†
Copper IUD*	\$181(device)†	\$181†
3-Month Injections	\$60-\$75 (3 months)	\$1,200-\$1,500
Vaginal Ring	\$25-\$35/ring; \$40-\$45/month	\$2,400-\$2,700
Transdermal Patch	\$38-\$42/3 patches (1 month)	\$2,250-\$2,500
OCs	\$20-\$25/month	\$1,200-\$1,500
Barrier Methods	\$.50-\$3.00/use	‡
Spermicides	\$10.00 (8-oz. cream/gel)	‡

*High initial cost offset by length of use (e.g., 5 or 8 years).

†Professional insertion fee is additional charge.

‡Cost depends upon the frequency of intercourse.

Adapted from ARHP. Comparing Key Factors of Birth Control. Updated June 10, 2003. Available at <http://www.arhp.org>.



TABLE 8. Comparing Contraceptive Choices: Return to Fertility After Stopping Use⁷

Return to Fertility	Contraceptive Method
Immediate	Implants*† Barrier Methods Spermicides
Rapid	Vaginal Ring Transdermal Patch LNG-Intrauterine System* IUD (copper-T)* OCs
2 – 3 months	Monthly Injections†
6 – 18 months	3-Month Injections

*Requires visit to clinician to stop use.
†Not available in the United States.
Adapted from: ARHP. Comparing Key Factors of Birth Control. Updated June 10, 2003. Available at <http://www.arhp.org>

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- American Medical Women’s Association (AMWA) and Ortho-McNeil Pharmaceutical, Inc. Survey, “Women and OB/GYNs Speak Up.” Roper Starch Worldwide 2001.

- Kaunitz AM, Garceau RJ, Cromie MA, and the Lunelle Study Group. Comparative safety, efficacy, and cycle control of Lunelle® monthly contraceptive injection (medroxyprogesterone acetate and estradiol cypionate injectable suspension) and Ortho-Novum® 7/7/7 oral contraceptive (norethindrone/ethinyl estradiol triphasic). *Contraception* 1999;60:179-87.
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- Hatcher RA, Creinin M, Darney P, et al.. *A Pocket Guide to Managing Contraception*. 2001-2002. 4th edition. Tiger, GA: The Bridging the Gap Foundation, 2001.

HELPING WOMEN MAKE CHOICES THAT FACILITATE SUCCESSFUL CONTRACEPTIVE USE

Although a thorough discussion of the full range of options may be an ideal goal, it is not a practical one because of time constraints on patient visits. Health care providers can support contraceptive success by providing a broad overview of choices and then narrowing down the discussion based on each woman’s needs and situation. Patients who desire additional information and have Internet access can be referred to an online tool developed by the Association of Reproductive Health Professionals, “*Choosing a Birth Control Method*,” which is available at www.arhp.org/choosing.¹ If English is not the patient’s first language, product and client information should be provided in her native tongue, if possible, and use of an interpreter might also be helpful.

By considering a number of medical and lifestyle factors, clinicians can help their patients to focus on those contraceptive methods that are best suited to their individual needs (Table 9). However, they should not profile patients based on socioeconomic status, race, or presumptive factors. Perhaps the most important factors

are the patient’s experiences with contraception and current expectations or preferences. If the patient has a preconceived idea of the method that she would like to use, the clinician needs to address it. Emphasize that most women use different methods at different stages of life, and that it may be useful to change methods. Life

TABLE 9. Factors to Consider for Patient-Focused Contraceptive Choice

- Previous experiences with contraception
- Current expectations, preferences
- Age
- Health status
- Degree of contraceptive efficacy desired
- Lifestyle
- Changing needs
- Peer/partner issues
- Financial/access issues



changes may also warrant reconsideration of the contraceptive choice. Are there new health issues? Has the patient started college or a new job? Is the patient getting married, planning to have a baby in the near future, or recently had a baby? Is the patient becoming perimenopausal? The clinician's goal is to facilitate lifetime contraceptive success.

The clinician's goal is to facilitate lifetime contraceptive success.

The ARHP participants have suggested some questions that will help health care providers assess the patient's contraceptive needs, previous experiences with contraceptive methods, and other issues that may make a particular method more suitable than another (Table 10). The age difference between the patient and her partner is an especially important issue for women less than 18 years of age, because those with a partner who is six or more years older have a pregnancy rate nearly four times greater than those whose partner is no more than two years older.²

TABLE 10. Questions that Facilitate Contraceptive Counseling

- What are your contraceptive goals? Do you ever plan to get pregnant? When?
- Are you currently having sex with a male partner? How old is he?
- Are you ever forced to have sex when you don't want to?
- How are you and your partner protecting yourselves from pregnancy/STIs/HIV/AIDS?
- Have you tried any contraceptive methods? If so, which one(s)?
- What did you like/dislike about the methods?
- Are you a good pill taker?
- For user-controlled methods, how often did you forget to use the method?
- Are there any methods you have heard about and would like to try?
- How important is spontaneity?
- Is cost a barrier? Does your health insurance plan cover any contraceptive method?
- Do you know about emergency contraception?

PATIENT SCENARIOS

The following patient scenarios illustrate how contraceptive options can be tailored according to age, family planning goals, contraceptive needs, medical conditions, and lifestyle. For an in-depth review of medical eligibility criteria for use of both hormonal and non-hormonal methods of contraception, refer to the ACOG Practice Bulletin: "The Use of Hormonal Contraception in Women with Coexisting

Medical Conditions"^{3,4} and the WHO publication, "Improving Access to Quality Care in Family Planning. Medical Eligibility Criteria for Contraceptive Use."⁵

Patient Not Currently Sexually Active

Health care providers need to be sensitive to the fact that some women will never need birth control because of their sexual orientation. More often, however, a patient who is not presently sexually active may be at some point. She should be reminded that barrier over-the-counter contraceptives are available at the nearest drug store, and that many are open 24 hours a day, seven days a week. She should also receive information about emergency contraception and various prescription methods of contraception. If she is having irregular menses, heavy bleeding, or cramping, the clinician may want to suggest, after appropriate evaluation, use of combination hormonal contraceptive methods for their non-contraceptive benefits in these conditions.⁶

Young Woman Planning to Initiate Sexual Activity

An otherwise healthy young woman is planning to initiate or has already initiated sexual activity and consults you about contraception. For young women less than 18 years of age, a few states require that health care providers ask the age of her sexual partner, so check the local requirements. Asking the patient if she is "sexually happy" may also let her know that you are concerned about coercion and abuse. Because patients in this age group are at elevated risk for STIs, a discussion of her risks of STIs, abstaining until she is older, and/or protecting herself is crucial. She should also be told about emergency contraception and given a prescription to have on hand should she need to use it. A young woman who is having sporadic sexual activity is still at risk for pregnancy. The sporadic nature of when she has sex may mean that she or her partner is not prepared with barrier methods at the time she does have sex. Therefore, a method that is not coitally related may be the most appropriate choice.

Many women desire hormonal contraception before or shortly after initiating sexual activity. Experts emphasize that a pelvic examination is not required in order to prescribe hormonal contraception.⁷ The beneficial effect of OCs on facial acne or dysmenorrhea may motivate some young women to try the pill. It is important for the patient to know that her methods of contraception can and may change through different phases of her life.

Sexually Active and Using Contraception

Clinicians see a number of sexually active women who are using some form of contraception, most often the pill, condoms, or spermicides. The challenge is to assess how the patient is doing with these methods, give her an opportunity to learn about newer, longer-acting methods, and proceed either with reinforcement of correct use of



current methods or changing to alternatives. Successful OC users will appreciate information about the expanded array of contraceptive options should they desire to change.

Postpartum Patient Resuming Contraception

Although patients are often counseled not to resume sexual activity until six weeks postpartum, many resume it much earlier. Contrary to popular beliefs, ovulation can occur as early as three to four weeks postpartum in non-lactating women, and its onset can be unpredictable in breastfeeding women.^{3,4,8-10} Therefore, new mothers should leave the hospital with condoms and a prescription for emergency contraception (levonorgestrel only [Plan B] preferred for breastfeeding women).

ACOG suggests a variety of contraceptive options for postpartum women, who remain at increased risk of thromboembolism for several weeks after childbirth (Table 11).³⁻⁵ Product labeling for combined oral contraceptives (COCs), the patch, and the ring advises deferring use until four weeks postpartum in non-breastfeeding women, who remain in a hypercoagulable state for weeks after childbirth. However, because ovulation can occur in as little as 25 days, some clinicians initiate the use of COCs as early as two weeks after childbirth, although no data support or refute the safety of this approach.^{3,4} Product labeling for depot medroxy-progesterone acetate (DMPA) advises initiation of use within the first five days postpartum if not breastfeeding. However, both progestin-only pills (POPs) and DMPA may be initiated immediately postpartum because they do not contain estrogen.^{3,4} Product labeling for the levonorgestrel IUS states that the device should not be inserted until six weeks postpartum or until involution of the uterus is complete, to reduce the incidence of perforation and expulsion.¹¹

For breastfeeding women, COCs are not recommended as the first choice because the estrogenic component can reduce the volume of milk production and the caloric and mineral content of breast milk. However, use of COCs by well-nourished breastfeeding women does not appear to result in infant development problems, and their use can be considered once milk flow is well established.

Unlike COCs, progestin-only contraceptives do not impair lactation and, in fact, may increase the quality and duration of lactation. In nursing women using POPs, very small amounts of progestin are passed into the breast milk, and no adverse effects on infant growth have been observed.

TABLE 11. Appropriate Contraceptive Methods Currently Available for Post-partum Patients^{3,4}

Status	Methods
Breastfeeding*	
Immediately	POP, DMPA
4 – 6 weeks	Condoms, spermicides
6 weeks or once uterine involution has occurred	LNG-IUS, copper-T IUD
When milk flow well established	OC, patch, ring
Not Breastfeeding	
Immediately	POP, DMPA
2 – 3 weeks	Condom, spermicides, OC, patch, ring
6 weeks or once uterine involution has occurred	LNG-IUS, copper-T IUD

Note: Emergency contraception can be provided to all postpartum women (levonorgestrel only [Plan B] preferred for breastfeeding women).

POP = progestin-only contraceptive; DMPA = depot medroxyprogesterone acetate injection; LNG-IUS = levonorgestrel intrauterine system

*ARHP experts concur with ACOG guidelines^{3,4} that POPs and DMPA represent appropriate contraceptives for breastfeeding women immediately postpartum.

Product labeling for POPs suggests that fully breastfeeding women begin use six weeks postpartum and advise partially breastfeeding women to begin at three weeks.^{3,4} Similarly, DMPA use does not adversely affect breastfeeding. Product labeling for DMPA advises initiation at six weeks postpartum if the woman is breastfeeding exclusively. However, when DMPA use is initiated immediately after childbirth, it does not adversely affect lactation or infant development. Because progestin-only methods do not contain estrogen, the ARHP experts concur with the ACOG guidelines that either POPs or DMPA represents appropriate contraception for breastfeeding women immediately postpartum.^{3,4}

Product labeling for the LNG-IUS states that the device should not be inserted until six weeks postpartum. Small quantities of levonorgestrel have been identified in the breast milk of lactating women using the LNG-IUS, and in a study of 14 breastfeeding women using the LNG-IUS, mean infant serum levels of levonorgestrel were approximately 7 percent of maternal serum levels.¹¹

Because progestin-only methods do not contain estrogen, the ARHP experts concur with the ACOG guidelines that either POPs or DMPA represents appropriate contraception for breastfeeding women immediately postpartum.

Patient Wanting Contraception to Space Children

In this situation, clinicians need to assess whether or not the patient desires another pregnancy and, if so, when. Some women may want a highly effective method of



contraception because they are not sure they want another child. However, others who may want another child within the next year or so may be comfortable with an over-the-counter barrier method such as a condom and/or spermicides, or natural family planning. These women should receive pre-conception counseling about adequate intake of folic acid and other issues. For those who want to become pregnant within one year or less, the three-month injection would be uniquely inappropriate because of the delayed return of fertility after discontinuation of use (Table 8). The copper-T IUD or the levonorgestrel IUS also would not be appropriate for short-term use because of their cost.

Adequate pregnancy spacing is associated with improved outcomes. A recent retrospective cohort study using the Michigan Maternally Linked database examined livebirth outcomes documented between 1989 and 2000 to evaluate low birth weight in relation to interpregnancy (i.e., delivery to conception) interval.¹² Of 565,911 infants identified, 5.5 percent had low birth weight. The risk for low birth weight was lowest when the interpregnancy interval was 18 to 23 months and increased with shorter or longer intervals. This relationship persisted after analysis controlled for known risk factors for low birth. These findings underscore the important role effective contraception can play in improving perinatal health.

OC User with History of Pill Failure, Abortion, or Both

Many women report that they have difficulty using OCs consistently and correctly. In one nationwide survey of US women two months after they had initiated or resumed OC use, 47 percent reported that they missed one or more pills per cycle, and 22 percent missed two or more pills.¹³ Those who had no regular pill taking time were nine times more likely to miss two or more pills per cycle than those who did, and those who read and understood little or none of the package information were nearly four times more likely to miss two or more pills.¹³

When the patient reports that she keeps forgetting to take her pills, the clinician has the opportunity to ask what circumstances surround her missing pills. It is important not to give advice at this point! One teenage patient kept missing her pills but wanted to continue using this method of contraception because it had improved her acne. Her clinician told her that she was smart and creative and would probably think of something more creative than what the clinician might suggest to help her remember her pills. She dropped into the office several weeks later and gleefully reported that she was consistently taking her pills. When asked how she had been so successful, she replied that she and her girlfriend beaped each other every morning. Rather than saying

“I’m proud of you,” her astute clinician asked, “How does it feel to be in control of those pills? It must feel really good to be in charge of your contraception and reproductive health.”

Let patients know that they are smart, creative, and will solve the problem themselves.

When a patient who has been taking her pills consistently reports that she has relapsed, this should be viewed as an opportunity, not a failure. The clinician can remind her that she was able to succeed at taking her pills each day and ask her to analyze those situations in which she forgot her pill and how she would change the situation the next time. Determine where she is now (missing pills) and where she wants to be (using the pill successfully). Review longer-acting options, including the patch, ring, DMPA, and IUDs. Remind all patients, particularly those who are inconsistent with their contraceptive use, about emergency contraception.

Active-Duty Female Military Recruit Seeking Extended Cycles

Active-duty female military recruits may experience difficulties changing, obtaining, and disposing of menstrual hygiene materials, especially when deployed to war zones such as Iraq or Afghanistan. Hormonal methods that reduce menstrual frequency or induce amenorrhea might offer substantial benefits in this setting. Options include extended or continuous use of COCs or the three-month DMPA injection.¹⁴ For women deployed to a remote region for extended time periods, clinicians may wish to inquire about contraceptive supply issues that may determine the patient’s ability to continue her chosen method while deployed. Extended use of other options such as the patch or vaginal ring is under investigation.

Patient Who Has Completed Childbearing

If a patient feels that she has completed childbearing, she can be offered either permanent or reversible methods of contraception that are equally effective. For some clinicians and women, a new non-surgical method of permanent birth control (Essure[®]) in which a micro-insert is placed in the proximal section of each fallopian tube lumen using a hysteroscopic approach may provide a more attractive alternative to the traditional surgical methods of tubal sterilization.¹⁵ In clinical trials, this method was 99.8 percent effective after two years of follow-up, and women were able to return to their regular activities within one to two days on average.¹⁵ Women should also be advised that both the copper-T IUD and the LNG-IUS have annual failure rates as low as female or male sterilization (Table 5). This information is particularly important for the younger patient who thinks that she has finished childbearing. Combination hormonal methods (low-dose OCs, patch, vaginal ring) are another



option for healthy reproductive-age women over age 35 who do not smoke. Compliance with OCs is much greater in this age group compared with women less than 20 years of age and, with the patch, is high in all age groups.¹⁶

Patients with Specific Medical Needs

Recognizing that selection of the appropriate contraceptive method for women with medical problems may be complicated, both ACOG and the World Health Organization (WHO) have issued practice guidelines to facilitate contraceptive counseling for such patients.³⁻⁵ A number of conditions in which use of progestin-only pills, DMPA, an IUD, or the LNG-IUS may be safer than combination hormonal contraception are listed in Table 12.^{3,4} In addition to these conditions, WHO has rated contraceptive options for women with other cardiovascular disorders, neurologic conditions, reproductive tract infections and disorders, HIV/AIDS, endocrine conditions, gastrointestinal conditions, and anemias and those taking concurrent medications that might alter contraceptive efficacy.⁵ Health care providers should consult these publications before prescribing contraception for a patient with underlying medical problems.

Perimenopausal Woman

Clinicians are becoming increasingly aware that many women in their mid- or late 40s begin to undergo physiologic changes associated with perimenopause, including sporadic ovulation and the continuing risk of pregnancy. These women often experience menstrual irregularities, anovulatory dysfunctional uterine bleeding, vasomotor instability, and loss of bone density, and are at an age when gynecologic cancers become increasingly prevalent. Low-dose combination (<35 µg estrogen) OCs provide not only highly effective contraception but also a number of non-contraceptive benefits for healthy, non-smoking perimenopausal women (Table 13).^{6,17,19} Other combined hormonal contraceptive options that will regulate bleeding in perimenopausal women without contraindications to the use of combination OCs include the transdermal contraceptive patch and the contraceptive vaginal ring.¹⁸ However, clinicians should

be aware that clinical trials have not specifically assessed use of the patch or ring for this purpose. Although it is anticipated that use of these newer combination contraceptives will be associated with a pattern of non-contraceptive benefits similar to that of OCs, long-term experience is not available. For women with abnormal

TABLE 12. Indications for Methods Other Than Combined Hormonal Contraception³

In women with the following conditions, use of progestin-only pills, DMPA*, an IUD, or the LNG-IUS may be safer than combination hormonal contraception.

- Migraine headaches with vascular disease or older than 35 years
- Older than 35 years and smoke cigarettes
- History of thromboembolic disease
- Coronary artery disease
- Cerebrovascular disease
- Less than two weeks postpartum†
- Hypertension with vascular disease or older than 35 years
- Diabetes with vascular disease or older than 35 years
- Systemic lupus erythematosus with vascular disease, nephritis, or antiphospholipid antibodies
- Hypertriglyceridemia

*Because of its long duration of action and potential for hypoestrogenic effects, DMPA may be less appropriate than other progestin-only contraceptives for some women with these listed conditions.

†An IUD may not be an appropriate contraceptive choice. See suggestions for post-partum women (Table 11).

TABLE 13. Benefits of Perimenopausal Oral Contraceptive Use^{6,17,19}

Established factors

- Effective contraception
- Regulation of menses*
- Treatment of anovulatory bleeding abnormalities (e.g., dysfunctional uterine bleeding, menorrhagia, and/or dysmenorrhea)*
- Relief of vasomotor symptoms*
- Decreased long-term risk of endometrial and ovarian cancers*
- Treatment of skin disorders (e.g., acne† and other androgenic skin disorders such as hirsutism)

Emerging factors

- Decreased risk of postmenopausal hip fracture*
- Prevention of osteopenia and osteoporosis
- Prevention of colorectal cancer
- Decreased risk of bacterial vaginosis

*Not listed as an indication on OC package labeling.

†OCs approved by the Food and Drug Administration for the treatment of acne are triphasic norgestimate/35 µg ethinyl estradiol (Ortho Tri-Cyclen®) and 1 mg norethindrone acetate/ethinyl estradiol 20, 30, 35 µg (Estrostep®).



uterine bleeding in whom use of estrogen is contraindicated, the LNG-IUS is another option. When inserted after endometrial evaluation during perimenopause, the LNG-IUS can remain in place into the menopausal years, and low-dose estrogen can be added to relieve climacteric symptoms.¹⁸

Healthy, non-smoking women who are doing well with use of combined hormonal contraception may continue into their mid-50s, particularly if they have ongoing contraceptive needs. If there is no ongoing need for contraception, a woman may want to try to discontinue the combination hormonal method in her early 50s and then transition to menopausal hormone therapy or stay off medication, depending on the presence or absence of menopausal symptoms. Perimenopausal women who experience vasomotor or other symptoms during the placebo week may benefit from decreasing the “pill-free interval” or taking OCs on an extended-use regimen. Checking gonadotropin levels is not helpful in determining when a perimenopausal-age woman using combined hormonal contraception no longer needs birth control.^{17,18}

FOLLOW-UP

After a woman initiates a new method of contraception, short-term follow-up can increase successful use of the method. A “recheck” visit occurring within six weeks to several months of when she begins using the new method provides an opportunity to review compliance issues (particularly for OC, patch, and ring users), concerns about side effect (particularly bleeding changes), and in the case of IUD users, to ensure the device remains in place. This can be done as a 15-minute “express” (i.e., no examination) office visit in which the patient is asked if she is satisfied with her contraceptive method, if there is anything she would change, if she is having bleeding problems or any other side effects. A post-initiation follow-up visit appears particularly useful for teenage patients, who often use contraception sporadically and may be ambivalent about pregnancy. Women who are restarting a method of contraception previously used successfully may not require short follow-up. Users of the three-month injection need to know exactly when to return for a repeat injection, and that it will be administered by nursing personnel, not the clinician. Women who have initiated a hormonal method of contraception (i.e., OC, patch, ring) may also be followed up with a consultation by telephone or e-mail. Depending on the patient, a postcard can be sent as a reminder that it has been three months since her visit and that she should call the office if she has any questions or concerns. Nurses and medical assistants should be trained to deal with basic questions about use of the patch, ring, OC, or three-month injectable. These can be documented in the patient’s chart, and the clinician can be consulted as needed.

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COUNSELING TOOLS AND STRATEGIES

Clinicians who are able to communicate effectively with their patients can facilitate lifetime contraceptive success. A challenge for clinicians is to package effective counseling into the time allotted for office visits. A poll conducted by ARHP in 1996 found that almost 70 percent of women spend fewer than 15 minutes with a clinician during visits for contraception.¹ In a subsequent poll conducted in 1998–99, 40 percent of obstetrician/gynecologists who responded said that they did not have adequate time with their patients.²

FACTORS AFFECTING CONTRACEPTIVE CONTINUATION

Studies have documented that the quality of care a patient receives at the time she adopts a contraceptive method affects her subsequent contraceptive use. A retrospective study of contraceptive discontinuation among 1,945

Indonesian women found that those who reported being given the method of their choice were significantly more likely to be using contraception one year later.³ Discontinuation rates were 72 percent among those not given their method of choice, compared with 9 percent among those who received their method of choice. Other studies in West Africa, China, and India suggest that women who receive more counseling or information at the initiation of use have lower rates of discontinuation than those who receive little counseling.^{4,5} Pre-treatment and ongoing counseling about hormonal effects and possible side effects appears to be especially important.^{4,5}

A recent assessment in the Philippines found that the overall quality of care has a substantial impact on contraceptive continuation.⁶ A number of aspects of care were identified and given score ranges at baseline to assess the quality of family planning services received when a contraceptive method was adopted (Table 14). The variable combining the five aspects of care proxies

total quality and was scored as low, medium, or high to differentiate among levels of overall care. The medium level was defined as quality within one-half of a standard deviation of the mean; values falling outside the range of medium quality were considered the low and high levels of total quality. At follow-up 16 to 24 months after initiating use of a method, the percentage of women continuing use of a modern method of contraception increased as the level of quality of care increased from low (53 percent) to medium (59 percent) to high (65 percent) (Figure 3). After accounting for the effects of fertility intentions and background variables, the odds of use of a modern method of contraception among women who had received medium- or high-quality care were 31 percent and 64 percent higher than among those who received low-quality care.

How can busy clinicians provide high-quality care and effectively communicate with the patient in the limited amount of time provided for contraceptive counseling?

TABLE 14. Aspects of High-Quality Care⁶
Aspect of Care (score range)

Needs assessed (0–3)

- Asked whether she wanted to conceive a child
- Asked how long she wanted to wait before the next birth
- Asked about previous family planning experiences

Information received (0–7)

- Shown or told how adopted method works
- Told how to use the method adopted
- Warned of potential side effects
- Instructed on how to handle problems
- Informed of warning signs
- Told of option to switch methods
- Informed of methods that protect against STIs

Method choice (0–4)

- Asked which method she preferred
- Told about at least one additional method besides the method adopted
- Received information without any single method being promoted by provider
- Given her method of choice

Interpersonal relations (0–7)

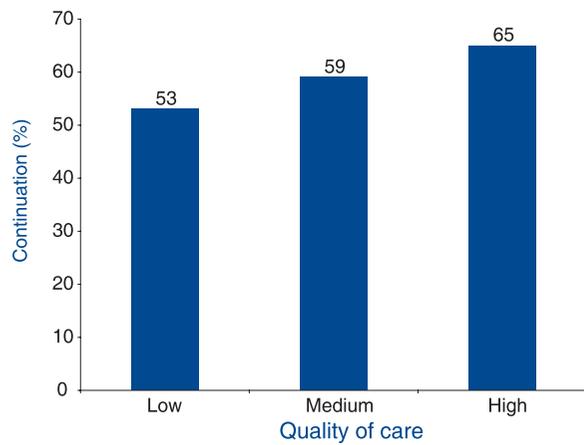
- Permitted to ask questions
- Given adequate answers to all questions
- Treated in a friendly manner
- Shown respect for privacy
- Received care in a clean environment
- Received satisfactory care
- Given information, education, and communication material

Continuity of care (0–3)

- Scheduled for a follow-up visit
- Informed of alternative sources of care
- Given an appointment card showing the date of follow-up visit



FIGURE 3. Continuation of Modern Contraceptive Methods According to Quality of Care⁶



MOTIVATIONAL INTERVIEWING

Health care providers can deploy a variety of approaches to facilitate successful contraceptive use. Many young women feel that they are ineffective and unable to master anything—life seems out of control. When a young patient says that she won't be able to remember to take the pill every day, the clinician should try to build on her past successes. For example, she's doing well in high school, and she has learned to drive a car, therefore, how easy it will be for her to master using the pill. If the health care provider expects success in people, then they will be successful. The word "try" should not be used, because it may suggest attempts and failure. Respect the patient's present view and be empathetic, letting her know that her clinician cares about her. Avoid arguing with the patient; this only creates resistance to change.

If the health care provider expects success in people, then they will be successful.

There are five stages of change (Table 15). First, the health care provider needs to determine whether or not the patient sees a need to change her behavior. For example, you may have seen the patient in her car smoking a cigarette or have detected the odor of cigarettes on her clothing. You can say that you know she's smoking and wonder if she has been thinking about quitting. She may reply that she has important tests coming up and she's not sure that it would be a good time. You can advise her that when she's ready to stop smoking, you'll be there to help her.

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TABLE 15. The Five Stages of Change

- First, we see no need to change our behavior.
- Then, we begin to see a need for change.
- We act and begin to change.
- We integrate the change.
- We may relapse; learn new skills, and start again.

SIDEBAR G. Approaching the Male About Contraception

Although the focus of this *Clinical Proceedings* is the periodic well-woman visit, men who see the primary care provider should be informed about contraceptive options including:

- Condoms
- Emergency contraception for their partner
- Vasectomy

In addition, young single, sexually active men should be made aware of paternity and statutory rape laws in the state in which they reside. Sensitivity regarding sexually active men not engaged with women should be maintained. STI issues should be discussed as well with all men.

Clinicians might consider providing men with a printed handout that briefly discusses the methods of contraception available to women. The handout should include a phone number for appointments.



SUMMARY AND RECOMMENDATIONS

Recent changes in the recommendations for cervical cancer screening and breast self-examination have prompted clinicians to revise the components of the annual gynecologic visit. Not all women age 30 or older will require annual cervical cytology, and teaching breast self-examination (unless requested by the patient) is no longer recommended. In addition, experts agree that a pelvic examination is not required before hormonal contraception can be prescribed.

Although these changes will reduce the time required for the physical examination in many cases, the expanded array of contraceptive choices has increased the time required for contraceptive counseling—an important component of any office visit in view of the persistently high rate of unintended pregnancies in the United States. Health care providers are now able to offer women longer-acting hormonal contraceptive options that can simplify their lives and provide an alternative for women who have difficulty with daily pill taking. The transdermal contraceptive patch, the vaginal ring, and the LNG-IUS offer weekly, three-weekly, and five-year protection. Many women may change contraceptive methods several times during their reproductive years, and use of hormonal contraception often continues

through perimenopause and into the menopausal years. To facilitate lifetime contraceptive success, clinicians need to be prepared to efficiently review the new and existing options with patients.

Two dedicated hormonal products for emergency contraception are also available but continue to be underused. Women as well as men who are involved in a sexual relationship should be informed about emergency contraception and how to obtain it. Many experts suggest that patients be given a preemptive prescription for emergency contraception.

The key to facilitating lifetime contraceptive success is to provide high-quality care at the time the patient initiates use of a contraceptive method or switches to another method. Two aspects of care are particularly important if rates of contraceptive continuation are to be increased: (1) helping the patient initiate the method of her choice and (2) providing initial and ongoing counseling about hormonal effects and possible side effects. Patients initiating a new method of contraception should return for follow-up within six weeks to three months. This is especially important for teenage patients, who often use contraception sporadically and may be ambivalent about pregnancy, sexuality, and their contraceptive choice.

RECOMMENDATIONS

- Not all women aged 30 years or older require annual cervical cytology.
- Breast self-examination does not need to be taught unless requested by the patient.
- A pelvic examination is not required for hormonal contraception to be prescribed.
- Women should be informed about new options for longer-acting hormonal contraceptives.
- Women and men should be informed about emergency contraception and how to obtain it.
- Women should receive the contraceptive method of their choice and be told that they always have the option of switching to another method.
- Providing initial and ongoing information about hormonal effects and possible side effects increases the likelihood of contraceptive continuation.
- Patients initiating a new method of contraception should return for follow-up within six weeks to three months.



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Periodic Well-Woman Visit: Individualized Contraceptive Care

POST-TEST

Please circle the best answer for each question.

- Which of the following is required in order to prescribe hormonal contraception?
 - Pelvic examination
 - Clinical breast examination
 - Pap test
 - None of the above
- For women up to 30 years of age, cervical cancer screening using the Pap test should be performed
 - Annually
 - Every 2 years
 - Every 3 years
 - At every pelvic examination
- Comparisons of regular breast self-examination (BSE) and no BSE have found
 - More breast cancer mortality in no BSE groups
 - No differences in breast cancer mortality in BSE and no BSE groups
 - Fewer biopsies with benign results in no BSE groups
 - Lower death rates among women who detected their cancer during BSE
- Which of the following hormonal contraceptive options would not be appropriate for a woman considering a pregnancy within 1 or 2 years?
 - Oral contraceptives
 - Vaginal ring
 - Transdermal patch
 - Depot medroxyprogesterone acetate injection
- Recent studies indicate that emergency contraceptive pills are effective if taken within how many days of unprotected coitus?
 - 2 days
 - 3 days
 - 5 days
 - 7 days
- Which of the following counseling steps are warranted for a young woman under 18 years of age who is planning to initiate sexually activity?
 - Ask about age of partner
 - Counsel regarding STI risks
 - Availability of emergency contraception
 - All of the above
- Use of which of the following contraceptive options can be used immediately postpartum, regardless of breastfeeding status?
 - Progestin-only pills
 - Vaginal ring
 - Transdermal patch
 - Spermicides
- Which of the following would **NOT** be an appropriate option for an OC user who consistently reports pill-taking problems, does not want future pregnancies, but does not want permanent birth control?
 - Condom + spermicide
 - Levonorgestrel IUD
 - Transdermal patch
 - Vaginal ring
- Which of the following is **NOT** a benefit of low-estrogen dose (<35 µg) combination OC use by healthy, nonobese, nonsmoking perimenopausal women?
 - Regulation of menses
 - Relief of vasomotor symptoms
 - Decreased risk of benign fibroadenomas
 - Decreased risk of postmenopausal hip fractures
- Which of the following is **FALSE** about measures to facilitate lifetime contraceptive success?
 - Women who receive the method of their choice are more likely to continue its use.
 - Women should be offered only those methods that the clinician is able to provide.
 - Clinicians need to provide effective contraceptive counseling in the time allotted for office visits.
 - Schedule an “express” office visit within 6 weeks to several months after contraceptive initiation to ask the patient if she is happy with her method.
- Which of the following need to be discussed with young, single, sexually-active men?
 - Condoms
 - Emergency contraception for their partner
 - STI issue awareness
 - All of the above



PROGRAM EVALUATION

On a scale of 1 to 5, with 5 being the best, please rate this *Clinical Proceedings*[®] in terms of the following:

1. Extent to which stated program objectives are met.
 - a. Discuss clinical steps in examining asymptomatic women during the gynecologic visit.
5 4 3 2 1
 - b. Identify methods of communication that best facilitate effective clinician-patient discussion about contraception during the gynecologic visit.
5 4 3 2 1
 - c. Understand useful contraceptive counseling messages.
5 4 3 2 1
 - d. Understand the significance of provider/patient communication and interaction during the clinical gynecologic exam.
5 4 3 2 1
 - e. Understand common health considerations, challenges, and myths that are associated with gynecologic care that may impact patient's contraceptive choices.
5 4 3 2 1
2. Relevance to clinical practice
5 4 3 2 1
3. Increased understanding of the topic
5 4 3 2 1
4. Extent to which stated program objectives are met
5 4 3 2 1
5. Effectiveness of teaching/learning methods
5 4 3 2 1
6. Usefulness of materials such as this that are supported by educational grants from industry
5 4 3 2 1

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