Comparative Contraception: Permanent and Reversible Options

Q&A with Anne A. Moore, DNP, APN-BC, FAANP, & Mark Hathaway, MD, MPH

The following questions were submitted during Comparative Contraception: Permanent and Reversible Options webinar presented by Anne A. Moore on June 9, 2015. Questions have been edited for clarity and responses provided by Anne Moore and Mark Hathaway. The slide deck from the webinar are available online through ARHP’s open-access tool, CORE.

Questions & Answers

Is the Mirena (LNG-52) immediately effective no matter when in the patient’s cycle it is put in?

Mark Hathaway: There’s newer data coming out on this, but short answer is no. If it’s put in at 5-7 days after menses you don’t need a backup, but if it’s put in at day 1-2, then yes, you need a backup. I use as a general rule of thumb: Copper T- no backup needed; all other methods use 7 days of backup.

Anne A. Moore: U.S. Selected Practice Recommendations for Contraceptive Use (SPR) has great guidance here!

Recently I heard of an adolescent patient who came in for an effective method of contraception and seemed to only receive one option from her provider- OCs. How do we work on changing behaviors of our providers who are not up-to-date on the current contraceptive methods available?

MH: Some providers are way behind on good family planning info, MEC guidance, etc. In a 2014 study even obstetrician-gynecologists showed huge gaps in their knowledge in this area. I don’t have any good answers for this. Sometimes I ask patients to tell me who gave them the “wrong” info and I give that clinician a courtesy call, but that’s very tricky and sensitive.
Can you give women who are using implants and experiencing prolonged bleeding a short course of COC to stop unwanted bleeding?

**MH:** Yes 5 days of a monophasic works. Can also use 0.9 or 1.0 mg of estrogen tabs for 5 days. NSAIDs 800mg tid po for 5 days may work as well.

Any advice regarding the treatment of irregular bleeding from NEXPLANON®? COCs vs estradiol? For how long? Any data as to effectiveness of either treatment option?

**MH:** See above...it may work or may not, but not harmful and may have a placebo effect.

**AM:** Refer to the SPR!

Why is the implant not emphasized or mentioned as much as the pill or IUDs?

**MH:** It’s newer on the market or newer in some areas. The CHOICE Project shows that women like it and stick with it (70-80% continuation rates).

In a public health setting, where resources are limited, do you feel that it is appropriate or helpful to require a trial of depo provera for a prospective Nexplanon candidate who has no history of use of hormonal method?

**AM:** No, definitely not. But I have heard from field experience that if a quick start is not available (i.e. the device is not on site) that DMPA is often given until the device is procured. The patient then returns to the clinic for their LARC method of choice. This facilitates quick start and promotes LARC.

**MH:** There is no evidence for a DMPA trial. Up front counseling for NEXPLANON® candidates regarding bleeding and reassurance is crucial to high continuation rates.

What are the current recommendations for delay of IUD insertion after diagnosis and treatment of STI or PID? SPR refers to CDC with general recommendation for 3 months rescreening- is this evidence based?

**MH:** No, but probably prudent. I haven’t found any evidence for this, but it is what ACOG recommends.
Do you have a problem with patients who are on LARC coming back for regular exams? With other methods they come back because they need refills but with this method they may ignore healthy women’s care.

**MH:** No. I always recommend annual checkups for men and women, but not because they need an annual cytology or gynecological exam. If under 26, they need STI screening.

**Please explain how ParaGard® inhibits development of the ova. I was under the impression that all ParaGard® cycles are ovulatory.**

**MH:** Its main MOA is on sperm motility. It may also affect uterine lining, but women still ovulate.

*The slide deck from this webinar is available on ARHP’s open-access tool, CORE. Please visit core.arhp.org to access CORE now. Learn more about other CME/CE opportunities from ARHP at www.arhp.org.*