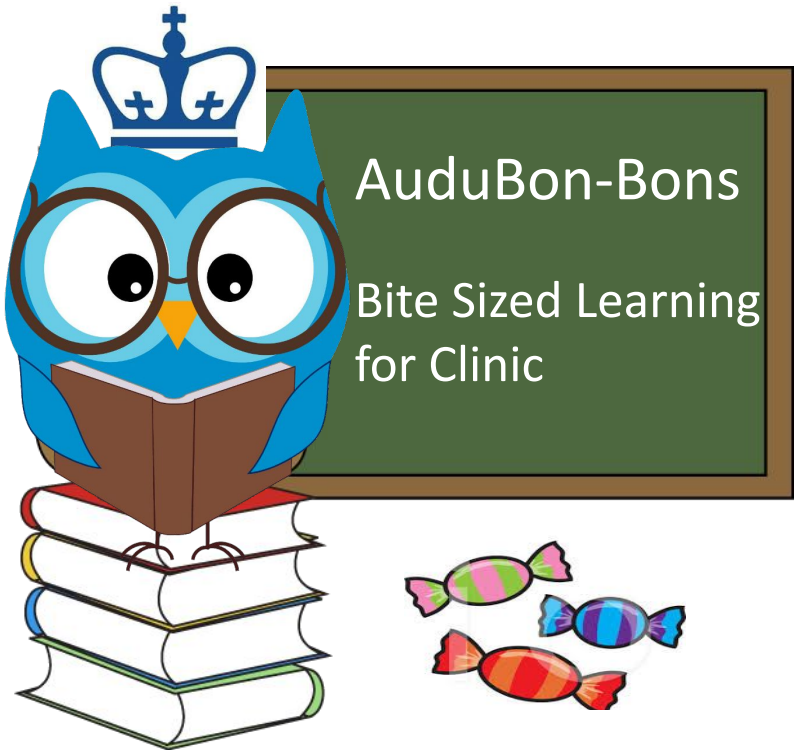
CONTRACEPTION COUNSELING: ORAL CONTRACEPTIVES



Week 17

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Reading Assignment:
Explore Bedsider.org and how they counsel patients
https://www.bedsider.org/methods/the_pill#details

LEARNING OBJECTIVES

- Understand what is the relevant evaluation of a patient seeking contraception
- Understand the benefits, disadvantages, and contraindications to oral contraceptives
- Understand how to counsel women regarding contraception choice

CASE VIGNETTE

- A 33 yo G10 P0282 woman presents for contraception counseling. She would like to start Yaz, which she has used in the past for dysmenorrhea and acne with good results.

FOCUSED HISTORY

- What elements of the patient's history are most important?
  - PMH: Type 1 diabetes (diagnosed at 8 yo)
  - PSH: C/S x 2, D&C x 5, D&E x 3
  - OB Hx: PTD @ 33 and 28 weeks; 8 terminations
  - GynHx: Dysmenorrhea; regular cycles; history of HSV and chlamydia; history of ASCH pap smear; no fibroids; history of ovarian cysts
  - Contraception history: Yaz; depo; Paragard; currently uses withdrawal
  - FH: none
  - SH: smokes ½ ppd x 20 years; social EtOH; occasional MJ use; married
  - All: none
  - Meds: Insulin (via pump), Ativan prn

PERTINENT PHYSICAL EXAM FINDINGS

- *Vital signs*: BP 150/80, P 88, RR 20, T 37.0, BMI 36 kg/m^2
- *Gen*: NAD, obese
- *Chest:* CTAB
- *CVS:* RRR
- *Abd:* obese, nontender, nondistended
- *GU*: Enlarged right adnexa; normal otherwise
- *Ext*: WWP

CONTRACEPTION COUNSELING: OVERVIEW

- Patient-centered approach
- Tiered counseling regarding methods, from most effective to least effective
- Factors to take into account:
  - Safety
  - Effectiveness
  - Availability (affordability)
  - Acceptability
    - Patient goals, pregnancy intentions, timing
    - Non-contraceptive benefits
    - Side effect profile
- Importance of shared decision making in contraception counseling

Effectiveness of Family Planning Methods

Most Effective

Less than 1 pregnancy per 100 women in a year

6-12 pregnancies per 100 women in a year

18 or more pregnancies per 100 women in a year

Least Effective

Reversible

Implant

0.05 %*

Intrauterine Device (IUD)

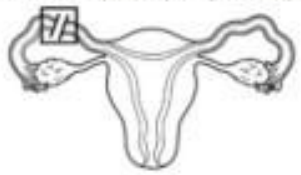
LNG - 0.2 % Copper T - 0.8 %

Permanent

Male Sterilization (Vasectomy)

0.15 %

Female Sterilization (Abdominal, Laparoscopic, Hysteroscopic)

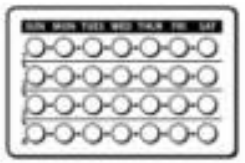


0.5 %

Injectable

6 %

Pill



9 %

Patch

9 %

Ring

9 %

Diaphragm

12 %

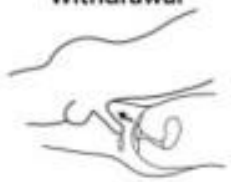
Male Condom

18 %

Female Condom

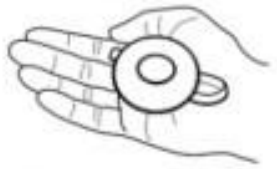
21 %

Withdrawal



22 %

Sponge

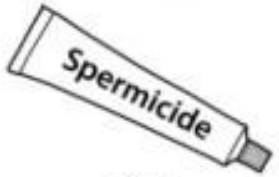


24 % parous women
12 % nulliparous women

Fertility-Awareness Based Methods

24 %

Spermicide



28 %

* The percentages indicate the number out of every 100 women who experienced an unintended pregnancy within the first year of typical use of each contraceptive method.

How to make your method most effective

After procedure, little or nothing to do or remember.

Vasectomy and hysteroscopic sterilization: Use another method for first 3 months.

Injectable: Get repeat injections on time.

Pills: Take a pill each day.

Patch, Ring: Keep in place, change on time.

Diaphragm: Use correctly every time you have sex.

Condoms, sponge, withdrawal, spermicides: Use correctly every time you have sex.

Fertility awareness-based methods: Abstain or use condoms on fertile days. Newest methods (Standard Days Method and TwoDay Method) may be the easiest to use and consequently more effective.

EVALUATION FOR OCP INITIATION

History:

- Gynecologic and contraceptive history
- Pertinent medical history
- Pertinent family history
- Pregnancy intentions

Physical exam:

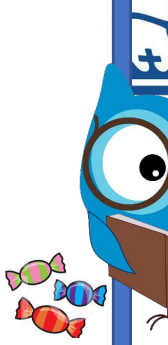
- Blood pressure
- Weight
- Pregnancy test

~~- Pelvic exam~~
~~- Breast exam~~
~~- Lab workup:~~
  - ~~STI testing~~
  - ~~Pap smear~~
  - ~~Lipid profile~~
  - ~~Glucose~~
  - ~~LFTs~~
  - ~~Thrombogenic mutations~~

BOX 2. How to be reasonably certain that a woman is not pregnant

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

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



COUNSELING: COMBINED ORAL CONTRACEPTIVES

- Ethinyl estradiol + progestin
  - 20-35 mcg EE
    - Low dose: less side effects, more breakthrough bleeding
    - High dose: more side effects, less breakthrough bleeding
  - 8 different progestin types
    - Androgenic: levonorgestrel and norgestrel
- Quick start instead of Sunday start: associated with higher adherence
  - Backup contraception x 1 week if >5 days from LMP
- At initial and follow-up visits, prescribe 1-year supply
  - Increases continuation rates

COUNSELING: COMBINED ORAL CONTRACEPTIVE

Benefits

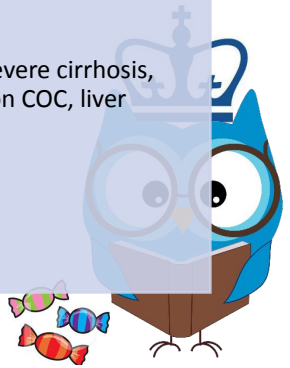
- Easy administration
- Immediately reversible
- Non-contraceptive benefits
  - Manage:
    - Dysmenorrhea (70-80% of women)
    - Endometriosis-related pain
    - Menorrhagia (40-50% of women)
    - Cycle control (cyclic, extended cycle regimens)
  - Advantages:
    - Ovarian cancer:
      - ↓27% with every use
      - ↓20% for every 5 years of use
      - After stopping: 15-20 yrs' protection
    - Endometrial cancer:
      - ↓50%
    - Benign breast disease: reduced incidence
    - Reduce acne, hirsutism
    - Reduce menstrual migraines
    - Reduce PMDD symptoms
    - Relieve vasomotor symptoms
    - Reduce ovarian cyst formation
    - Increased bone density in later life
    - No effect on weight gain

Disadvantages

- Daily administration
- Obesity potentially impairs effectiveness of COCs
- Increased risk of thrombogenesis
  - Obesity also independent risk factor for VTE
- Increased risk (8-24%) of breast cancer during use, absolute risk low (RR 1.09 for 1 year, and RR 1.38 for >10 years of use)
- Side effects
  - Breakthrough bleeding
  - Breast tenderness
  - Nausea and bloating
  - Headaches

Contraindications

- Risk factors for cardiovascular disease
  - CHTN; hx of HTN w/o ability to evaluate
- Current or hx DVT/PE
- Thrombogenic mutations
- Current or hx history of ischemic heart disease, vascular disease, complicated valvular disease
- Antiphopholipid antibody +
- Postpartum < 42 days; or > 21 and < 42 days with risk factors
- Breastfeeding
- Smoking
  - ≥35 + smoking
- Migraine w/o aura ≥ 35 yo; migraine w/ aura
- Breast cancer, active or hx
- Diabetes with:
  - >20 years' duration
  - Nephropathy/retinopathy/neuropathy
  - Vascular disease
- Hepatobiliary disease (acute hepatitis, severe cirrhosis, current gallbladder disease, cholestasis on COC, liver tumor/cancer)



COUNSELING: PROGESTIN-ONLY PILLS

- Norethindrone (0.35 mg) or norgestrel (0.075 mg)
- Quick start instead of Sunday start: associated with higher adherence
  - Backup contraception x 2 days if > 5 days from LMP
- At initial and follow-up visits, prescribe 1-year supply
  - Increases continuation rates

COUNSELING: PROGESTIN-ONLY PILLS

Benefits

- Used in women who cannot take estrogens
- Easy administration
- Immediately reversible
- Non-contraceptive benefits
  - Treat AUB
  - No estrogen-related side effects (nausea, headache, bloating)
  - Protective against endometrial and ovarian cancer, benign breast disease, PID

Disadvantages

- Requires consistent use
- Must be taken at the same time daily
  - If 3 hours late, must use backup x 48 hours
- Does not suppress ovulation
- Side effects
  - Bleeding disturbances
    - Irregular bleeding, frequent or prolonged bleeding, amenorrhea
  - Breast tenderness, dizziness, occasional headache

Contraindications

- Current breast cancer

FIRST-LINE RESOURCES

- U.S. Medical Eligiblity Criteria for Contraceptive Use, 2016 (WHO)

MEC categories for contraceptive eligibility	
1	A condition for which there is no restriction for the use of the contraceptive method
2	A condition where the advantages of using the method generally outweigh the theoretical or proven risks
3	A condition where the theoretical or proven risks usually outweigh the advantages of using the method
4	A condition which represents an unacceptable health risk if the contraceptive method is used.

- U.S. Selected Practice Recommendations for Contraceptive Use, 2016 (CDC)

TABLE C1. Examinations and tests needed before initiation of contraceptive methods

	Contraceptive method and class							
Examination or test	Cu-IUD and LNG-IUD	Implant	Injectable	CHC	POP	Condom	Diaphragm or cervical cap	Spermicide
Examination								
Blood pressure	C	C	C	A*	C	C	C	C
Weight (BMI) (weight [kg] / height [m]^2)	—†	—†	—†	—†	—†	C	C	C
Clinical breast examination	C	C	C	C	C	C	C	C
Bimanual examination and cervical inspection	A	C	C	C	C	C	A§	C
Laboratory test								
Glucose	C	C	C	C	C	C	C	C
Lipids	C	C	C	C	C	C	C	C
Liver enzymes	C	C	C	C	C	C	C	C
Hemoglobin	C	C	C	C	C	C	C	C
Thrombogenic mutations	C	C	C	C	C	C	C	C
Cervical cytology (Papanicolaou test)	C	C	C	C	C	C	C	C
STD screening with laboratory tests	—¶	C	C	C	C	C	C	C
HIV screening with laboratory tests	C	C	C	C	C	C	C	C

CASE VIGNETTE: MANAGEMENT

- Next steps?
  - Urine pregnancy test: negative
- What in her history and physical affects contraceptive choice and how you counsel?
  - *Vital signs*: BP 150/80, P 88, RR 20, T 37.0, BMI 36 kg/m^2
  - PMH: Type 1 diabetes (diagnosed at 8 yo)
  - PSH: C/S x 2, D&C x 5, D&E x 3
  - OB Hx: PTD @ 33 and 28 weeks; 8 terminations
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    - Contraception history: Yaz; depo; Paragard; currently uses withdrawal
  - FH: none
  - SH: smokes ½ ppd x 20 years; social EtOH; occasional MJ use; married
  - All: none
  - Meds: Insulin (via pump), Ativan prn

CASE VIGNETTE: MANAGEMENT

- Next steps?
  - Urine pregnancy test: negative
- What in her history and physical affects contraceptive choice and how you counsel? **WHO MEC Category 3** **WHO MEC Category 2**
  - *Vital signs*: **BP 150/80,** P 88, RR 20, T 37.0, **BMI 36 kg/m^2**
  - PMH: **Type 1 diabetes (diagnosed at 8 yo)** **WHO MEC Category 3/4**
  - PSH: C/S x 2, D&C x 5, D&E x 3
  - OB Hx: PTD @ 33 and 28 weeks; 8 terminations
  - GynHx: **Dysmenorrhea**; regular cycles; history of HSV and chlamydia; history of ASCH pap smear; no fibroids; **history of ovarian cysts**
    - **Contraception history: Yaz; depo; Paragard; currently uses withdrawal**
  - FH: none
  - SH: **smokes ½ ppd x 20 years**; social EtOH; occasional MJ use; married
  - All: none **WHO MEC Category 2**
  - Meds: Insulin (via pump), Ativan prn

CASE VIGNETTE: MANAGEMENT

- What would you recommend for the patient?
  - Assess patient goals: contraceptive benefit only? Non-contraceptive benefit? What side effects is she averse to? What method would she prefer? What are her pregnancy intentions (no near-future pregnancy?)
  - Tiered counseling: Sterilization/LARC -> SARC -> natural family planning methods
  - Discuss side effects and contraindications: patient-specific issues
- This patient desires oral contraceptives and is unsure regarding her future pregnancy plans
  - Prescribe POPs x 1 year; recommend Quick Start

BILLING AND CODING

- Diagnoses
  - Z30.9, Encounter for counseling regarding contraception
  - Z30.09, Counseling for birth control, oral contraceptive
  - If providing OCP pack in office:
    - S4993, Contraceptive pills for birth control

BILLING AND CODING

CPT Code: New outpatient visit

- At least 99203 (higher if attending sees patient with you)

NEW PATIENT VISIT

CPT Code	99201	99202	99203	99204	99205
Required Key Components *(3/3 required)					
History and Exam					
• *Problem-Focused*	X				
• *Expanded Problem-Focused*		X			
• *Detailed*			X		
• *Comprehensive*				X	X
Medical Decision Making (complexity)					
• *Straightforward*	X	X			
• *Low*			X		
• *Moderate*				X	
• *High*					X
Contributory Factors					
Presenting Problem (Severity)					
• *Self-Limited or Minor*	X				
• *Low to Moderate*		X			
• *Moderate*			X		
• *Moderate to High*				X	X
Counseling					
Coordination of Care					
Typical Face-to-Face Time (Minutes)	10	20	30	45	60

CPT Code: Established outpatient visit

- At least 99213 (higher if attending sees patient with you)

ESTABLISHED PATIENT VISIT

CPT Code	99211	99212	99213	99214	99215
Required Key Components **(2/3 required)					
History and Exam					
• *Problem-Focused*	N/A	X			
• *Expanded Problem-Focused*			X		
• *Detailed*				X	
• *Comprehensive*					X
Medical Decision Making (complexity)					
• *Straightforward*	N/A	X			
• *Low*			X		
• *Moderate*				X	
• *High*					X
Contributory Factors					
Presenting Problem (Severity)					
• *Minimal*	X				
• *Self-Limited or Minor*		X			
• *Low to Moderate*			X		
• *Moderate to High*				X	X
Coordination of Care					
Typical Face-to-Face Time (Minutes)	5	10	15	25	40

EVIDENCE

- Curtis KM, Tepper NK, Jatlaoui TC, et al. U.S. Medical Eligibility Criteria for Contraceptive Use, 2016. MMWR Recomm Rep 2016;65(No. RR-3):1–104. DOI: http://dx.doi.org/10.15585/mmwr.rr6503a1.
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- “Contraception.” *Guttmacher Institute*, 1 May 2019, www.guttmacher.org/united-states/contraception.