Contraception Is Health Care Webinar Transcripts
March 19, 2025

Nicole Nguyen:

Hi everyone. Good afternoon and thank you for joining us today for our webinar titled Contraception Is Healthcare. We hope you are all doing well and staying safe. My name is Nicole Nguyen. I'm the program manager of the family planning program at the California Prevention Training Center and the C-A-P-T-C under contract with the California Department of Healthcare Services Office of Family Planning is sponsoring today's event. So welcome. So before we get started with the webinar, if you're new to us, I like to go over some quick housekeeping slides. So first please check your audio and select your desired settings to join either through your computer audio or to call in through your phone. If your internet is a bit shaky, I highly recommend that we call in.

Laura Ellerbe:

Nicole, we're not seeing your slides.

Nicole Nguyen:

Oh, I'm sorry. Let me show that. I'm so sorry. Let me do that right now.

Nicole Nguyen:

Okay, there you go. Can you see my slide now?

Laura Ellerbe:

Yes, yes.

Nicole Nguyen:

I'm so sorry about that. Yeah. Oh, let me go back. So yes, so just for some housekeeping. So yes, so please make sure you check your audio and select your desired settings through your computer audio or to call and through your phone. Like I said, if we, your internet is a little bit shaky, we highly recommend that you call in through your phone for the best possible sound and then check to see that you're able to see the viewer screen with the slides on your left and the go-to control panel on the right. And then this little orange box with the white arrow. This is how you can hide or show your dashboard if you don't want to see it or if you accidentally clicked it, decide you can make it appear again. And then under that is the audio tab so you can change your audio preference at any time.

Nicole Nguyen:

And then third, please submit all your questions and comments via the questions box. So today, webinar will take about 90 minutes and we'll include time at the end for the presenter to answer all your questions. So please send them in throughout the webinar and our speakers will address as many of them as possible. At the very end, the webinar will be recorded and we'll send out a follow-up email

with the recording and the slide deck with an evaluation in the end. So please fill that out because your feedback is extremely important for us to help guide us in developing our feature content. And then before I introduce our presenters, I also want to acknowledge that we are working with the University of Nevada Reno School of Medicine to provide CMEs for this event. So this webinar qualifies for 1.5 CME credits and only available to those who watch the entire webinar live today. So those who watch the recording afterward will unfortunately not be eligible for the CME credits. And the link to access your certificate will be included in the follow-up email along with the recording slides and the evaluation.

Nicole Nguyen:

And then of course, for transparency, we want to disclose that all presenters, planners, and anyone in position to control the content of this continuing medical education have indicated that neither they nor their spouse or legally recognized domestic partner has any financial relationship with commercial interests related to the content of this activity. And then I also want to note that while this webinar is sponsored by Office of Family Planning and the Family PACT program, the information discussed today will not dive into any Family PACT specific policies or benefits or relate to Family PACT clients. So if you have any questions about the Family PACT program itself, please send those questions into the question box and we'll try to answer them follow up through email when this webinar ends.

Nicole Nguyen:

All right, so now I'm really excited to introduce our presenter. We are thrilled to have Dr. Carrie Cwiak join us today. Dr. Cwiak is a professor of gynecology and obstetrics and epidemiology at Emory University. She's the chief of the Obstetrics and Gynecology inpatient service line for Emory Healthcare and Vice Chair of Quality for the Department of Gynecology and Obstetrics. She's also the director of the Complex Family Planning Fellowship. She received her medical degree from St. Louis University School of Medicine and completed her residency in obstetrics and gynecology at the University of Connecticut Health Center. She completed her complex family planning fellowship and a master's in public health degree in epidemiology at Emory. And she has been a very active in training fellows, residents and medical students speaking and writing to educate trainees and providers advocating for the people of Georgia and collaborating in research and abortion contraception, sexual and reproductive health, and general obstetrics and gynecology. So with that, thank you so much for joining us today, Dr. Cwiak and the floor is yours. Thank you so much. Make you a presenter and then you can share your screen with us.

Carrie Cwiak:

Okay, there we go. You can see my screen?

Nicole Nguyen:

Yes.

Carrie Cwiak:

Perfect. Terrific. Well, thank you so much for inviting me to speak with you all today. This is a very important topic. It's a very timely topic and you may wonder why we are all together talking about it. It's because sometimes we need to remind people, our colleagues, our patients, our friends and family, that

contraception is indeed healthcare and we need to make sure it remains that way and the access remains. I have some disclosures. Emory receives research funding for contraceptive trials, and I also receive royalties for contraceptive textbooks, but they don't interact directly with my content today because I'll be talking in general about all contraception. So let's think about how we can talk about our work and talk about how contraception is healthcare. We need to look at the reproductive desires in the us. Where is the need for contraception? In fact, it's all over.

Carrie Cwiak:

How do we determine what a person's reproductive desires are and what contraceptive method they might want to use? Well, that's through person-centered counseling and I'm sure that you provide that type of counseling all the time. We want to think about how we weigh the risks and the benefits and how we're weighing those appropriately between pregnancy and contraception. And importantly, we want to not only tout the benefits but respond to patient concerns that they may have about contraception, especially in this day and age. I do want to note that I will use inclusive terms unless the study defines a population otherwise. And then I'll have the specific term there that they use to characterize the population. And that's because I recognize that people capable of pregnancy have a uterus but may identify as male or non-binary. Furthermore, if I talk about disparities in race, ethnicity, et cetera, I recognize that this reflects biases in healthcare and access to healthcare in society rather than genetic differences inherent in those groups.

Carrie Cwiak:

So, let's dive into reproductive desires in the United States. If we look at pregnancy rates first in this graph, we have highlighted the pregnancy rates that we see among women aged 24 or younger. And this is up to the latest year that we have data 2020. And you can see for all of those groups, even for the youngest age group below 15 that already had a very low birth rate, luckily we see a progressive decline as we get closer to 2020. Now when we look at that same graph, and so now you can see what was before in gray, now we see highlighted in orange. This is specifically for women age 25 and older for the same time period. We see the younger group similarly decreasing somewhat in birth rate, but we see birth rates relatively increasing in 30 to 34, 35 to 39 and above 40 age range. And this really results in patients having potentially more comorbidities when they're pregnant. Certainly, they might have more complexities about their pregnancy, and they might be looking to more assisted reproductive technologies as people are waiting until they are older to get pregnant.

Carrie Cwiak:

This is the latest publication in 2023 looking at pregnancies in the United States by desire. And we're looking at these pregnancies in a little bit of a different lens, kind of moving away from the binary of whether it's intended or unintended. And so thinking about a desire for pregnancy, the largest proportion of pregnancies were reported to have occurred at about the right time by people, and that's nearly half. And similarly, the largest proportion of births were also reported to have occurred about the right time per people reporting that the largest proportion of abortions were pregnancies that were reported as occurring too soon and followed by those that had not been wanted pregnancies at all. And we see between 2009 and 2015, both of these rates decrease. This is because we are increasing access during this time to effective methods of contraception, specifically long-term effective methods of contraception and improved access.

Carrie Cwiak:

It doesn't mean that it's the only method that people can use, but certainly, that made a significant difference for people, especially if they weren't looking for just a permanent method. And we recall the incredible difference the access made by the Affordable Care Act to this. And the authors really restate this and remind us that any new barriers to contraceptive access could jeopardize an individual's ability to exercise control over their reproductive lives. And even though I showed you that the unintended pregnancy rates, whether unwanted or mistimed, are decreasing steadily because of increased access to contraception, unfortunately, that's not an equitable improvement among all groups. And so, you can see here that in this study in which they did specifically define it as unintended pregnancy, we see that it's increasingly concentrated among low-income women. And we also see very similar disparities when we look at race and ethnicity in terms of access to contraception.

Carrie Cwiak:

What about the demand for contraception? How needed is it by people in the U.S.? If we look at the year 2018, there were over 72 million U.S. women of reproductive age, 46 million of those were sexually active and not seeking to become pregnant. So potentially people that would have demand for contraception, especially because we know that sexually active couples who do not use contraception have about an 85% chance of being pregnant over the course of a year. And the average number of children U.S. adults think is ideal is 2.7. And so you can understand that with this wide range of reproductive years that we have and the average number of children, people expect to have to achieve this, a sexually active woman must use contraception for about 30 years.

Carrie Cwiak:

At the same time again, in 2018, 65% of U.S. women in this reproductive age range were using contraception. The most common methods stayed the same. We see tubal surgery followed by pills and male condoms, and yet now we see a significant increase in the IUD such that it's at the same rate of use of male condoms. That's really new. 21% relied on methods used at the time of intercourse. So condoms, withdrawal, emergency contraception, natural family planning. In fact, withdrawal used to be one of the most common methods, and over 99% of sexually experienced U.S. women have used at least one method in their lifetime. So this is a very common need that we have among our patients in order to achieve their reproductive desires.

Carrie Cwiak:

How do we determine then when we see someone if they are seeking to talk about pregnancy, seeking to get pregnant, or seeking to talk about contraception or use contraception? We think about person-centered counseling in this model of counseling that puts two types of counseling together. So if you think about the extremes, you have consumerist counseling where someone comes in and says, I've collected this information and this is the method that I want. Give it to me certainly that in its extreme maximizes patient autonomy. Then we have directive counseling where of course if you did that in the extreme, you would say, this is what I think you should use that method. And rather than being strictly direct, what it allows us to do in this day and age is increase the awareness of safe options and the factual information for our patients. When we marry those two together, that's when we get shared decision-making in which we create a scaffold of information by which a patient can make their own decision based on their own values and preferences.

Carrie Cwiak:

And why is this important? Because one of our medical ethical principles is reproductive justice, the human right to maintain personal, have children not have children and parent those children we have in safe and sustainable communities. And coming from Atlanta, the birthplace of this concept of reproductive justice and sister song, I can't talk to you all without talking about that important element of justice. And so what we're really looking to do is determine how we can best help our patients achieve their reproductive desire at the time they want to do so. Now, hopefully you have been made aware of the quality family planning guidelines that were revised in 2024. This is from the U.S. Office population affairs. And the reason why I want to note it is because it's actually an excellent guideline. It goes through a lot of these same concepts. It's really a great tool to use when you are teaching your staff or for yourself just getting a refresher on how to provide reproductive health services. But I want to just point out the specifics about how they specifically mentioned, I just got, I'm sorry,

Carrie Cwiak:

Somehow, I just went off my slides. Let's try that again. So sorry about that.

Nicole Nguyen:

Carrie, do you need us to share your slide for you?

Carrie Cwiak:

Potentially. You all see that slide now, right?

Nicole Nguyen:

Yes, yes.

Carrie Cwiak:

We can see the slide deck, so I should be able to; there we go. There we go. Right?

Nicole Nguyen:

Yes. Okay.

Carrie Cwiak:

Sorry. I don't know how that happened; I must have swiped it and not meant to, so I apologize for that. Okay. So moving beyond preconception health back to our regularly scheduled program. So in comparison to the first time we saw the guidelines with the 2014 edition, this document aims to move beyond the doubt notion of primary care solely for the promotion of healthy pregnancy and birth. By instead recommending that all individuals, regardless of pregnancy intention, be offered primary care services in accordance with a sexual and reproductive health framework. And so it's really just moving beyond that concept of just if I'm seeing you and you're not pregnant, I must be seeing you for preconception health. Really recognizing that reproductive health recognizes the health of the patient, not merely the avoidance of disease or avoidance in pregnancy. And now

Carrie Cwiak:

This is looking too big, right? Something happened with the, you might need to share my slides for me. I'm so sorry. Oh wait, maybe it's just that one. Maybe it's the one that got messed up. I apologize about that. Okay, so when we screen all our patients for reproductive desires, and sorry about this, mess up with the slide, but what it does is it increases the counseling rate. So the fact that they're even receiving that counseling from us, and it increases patient satisfaction. And one tool to use that you all might be familiar with is path that stands for parenthood, pregnancy, attitude, timing, and how important is pregnancy prevention? And so an example, let's see if it's not going to pop up there, but do you think you might want to have more children in the future? When might that be for you? Do you want to talk about contraception now? And oftentimes when we talk to patients about when they might want to be pregnant, they may not know that exactly, they just may know that it's not right now.

Carrie Cwiak:

So sometimes it's better to just focus on what they want today rather than thinking about if they can specifically pinpoint a time when they want to be pregnant. Alright, there we go. Back to the normal screen size. Let's hope I've solved that problem. Person-centered contraceptive care. We marry these ideas together, focuses on providing contraception in alignment with each individual's values, preferences, needs and desires. That is a major shift. No longer are we solely prioritizing efficacy and the use of most effective methods because those methods don't work for everyone. They work for a lot of people, but they don't work for everyone. So we really need to provide information and access to a full range of methods without prioritizing one method or the other. I am going to show you a specific tool that we use and the reason why we do, I talk to our patients specifically about the bedside or information and direct them to the website. We even have a QR code on our clinic doors where they can get to it directly on their phone. And I mentioned this to them because I say it's not coming from a pharmaceutical company, it's not going to prioritize one particular method over the other. And yet it's going to give them all of the methods that they may potentially be interested in including a range of non-hormonal methods that they may want to use at the time of intercourse as we know that many people do.

Carrie Cwiak:

Okay, so let's think about the risks versus benefits. Certainly when we think about risks, many times this comes in the form of hormonal methods for contraception, but what are we truly measuring? We're not weighing the risks of no use of contraception to the risk of contraception. Importantly, we're weighing the use of contraception to pregnancy because as I mentioned, if you don't use contraception over the course of the year, you have an 85% chance of getting pregnant. So that's truly what we're weighing is the risk of an unwanted or a missed time pregnancy for you as opposed to the use of contraception. And so importantly, it's important to look at the risks of mortality with pregnancy. And even though we have made strides in obstetric care to provide safe quality care for patients, unfortunately that doesn't take away significant maternal mortality, especially in my state in Georgia, which has the second highest maternal mortality in the us. We still see significant levels of mortality and morbidity associated with pregnancy. And again, it's not equitably shared by all. We see a disparate amount among non-Hispanic black patients.

Carrie Cwiak:

We also have long-term impacts on pregnancy that we need to consider. And this information is from the turn away study where they measured long-term outcomes for people who had sought abortion but were not able to obtain it, and so had to continue with an unwanted pregnancy or a missed time pregnancy. And we see negative medical and social outcomes more likely. So pregnancy complications directly as a result of pregnancy, like eclampsia and hemorrhage. But we see also more chronic medical concerns like headaches or migraines, joint pain, hypertension. And again, sorry for the slide. It got a little messed up. What we don't see is that we also see negative social outcomes, more likely to have domestic violence in the relationship, have poor cognitive development for the children. They do have negative financial outcomes like bankruptcy and eviction. And so Nicole, I might need to go back to, I may need to go to you sharing my slides. I just don't know why I'm getting this strange scale like that. I apologize.

Nicole Nguyen:

Yes, no problem. So Nic, I'm going to make you the presenter. Okay, Nic, try now you're able to share.

Carrie Cwiak:

Are you able to see the slide about the preconception health?

Laura Ellerbe:

Give it a second

Carrie Cwiak:

Or maybe I could share that again. I don't know. I want to make sure. Oh, here we go. I'm back to normal scale. Yeah, I don't know what popped off. I'm so sorry. Let me go back to

Laura Ellerbe:

Sharing. Yes, let me do that.

Carrie Cwiak:

Luckily, we have a little bit of time built in.

Laura Ellerbe:

Okay, go ahead and see if we can share something. There you go.

Carrie Cwiak:

All right, let me see. Okay, so this is what I mentioned about the long-term impact of pregnancy. And again, this is from the turn-away study because, again, if you consider people who had to continue their pregnancy when they didn't intend to, that's really when you have the real chance to measure the outcomes that might be more likely in their situation. Weighing the risks, specifically the health risks,

one of the most common risks associated is venous thromboembolism, either deep venous thrombosis or pulmonary embolism. And we see a baseline rate just from being a reproductive age woman is about five to 10 per 10,000 women. We see relative increases significantly in the peripartum period. So this includes not only right before delivery but also within 24 to 48 hours after delivery, over 20 times an increase in venous thromboembolism. If you think about during the pregnancy, still seeing a significant increase from baseline over four times, compare that to low dose combined oral contraceptives, it's less, it's 3.4 times the baseline rate.

Carrie Cwiak:

And so, the most common cardiovascular complication that we see with combined hormonal contraception via thromboembolism is still less likely to occur with these low-dose contraceptives that we use today versus during pregnancy. And when I say low dose, I mean those less than 50 micrograms. That's where this data came from. And really, if you think about it nowadays, it's really unlikely for us to need a 50 microgram, certainly not more, but not using a 50 microgram pill in a patient. And so, we really want to think about the safety first of contraception if we are suggesting that as a method for people to accomplish their reproductive desires. And again, I'm focusing mostly on the things that do cause complications. And so I'll talk a lot more about combined hormonal and hormonal methods, less so about the non-hormonal methods because we don't see those same risks.

Carrie Cwiak:

But is contraception even safe in the first place? So again, safer than an unwanted frequency, the rates of VTE are lower. And if you think about the medical eligibility criteria, looking at the themes across the MEC, we see that progestin only and non-hormonal methods are safe for most people. In fact, for progestin only methods, the only absolute contraindication we have is current and recent breast cancer. On the other hand, estrogen containing methods, even though they must be used in caution for people with increased cardiovascular risk so that we're not increasing their complications even further, they can be used by many patients. And you'll see certainly when you look at the medical eligibility criteria that we're talking about, that entire category of estrogen containing methods that combine hormonal contraceptives, so the pill or the patch or the ring, because they all contain estrogen. What about the long-term impact to people's health?

Carrie Cwiak:

If we look at the long-term studies, we have to recognize that early studies included combined oral contraceptives with much higher doses. As I mentioned before, there's no reason we should be using above 50 micrograms. And I can't tell you the last time I used a pill with a 50 microgram dose of ethanol estradiol. More recent studies show that mortality is the same or less with long-term combined oral contraceptives. In particular, one study that looked at over 46,000 combined, oral contraceptive users observed for up to 39 years noted that users had a 12% lower risk of death than never users. A lot of that probably has to do with avoiding maternal mortality but also avoiding cancer risk. The absolute reduction among COC users was about 52 per a hundred thousand. Now again, when we're looking at long-term studies, we're more likely to see the methods that have been around for a long time combined oral contraceptives and Depo-Provera that actually have a lot of the long-term data.

Carrie Cwiak:

But you can go back once again to the medical eligibility criteria and kind of think of these contraceptive methods and categories. And so even though you are looking specifically here at combined oral contraceptives, what are the things that these have in common with the other hormonal methods? And one of them certainly is cancer protection. So any method that has progestin is going to decrease the lining of the uterus and not allow it to build up its lining in response to estrogen. And any method that is systemic, meaning not acting locally like the IUDs is going to work primarily by inhibiting ovulation. And so with a few exceptions, those are most of the systemic methods. And so we see that hormonal methods significantly decrease endometrial and ovarian cancer. We see this protective effect even with the more recent lower doses. I think that was a big question: what about with the very low dose combined hormonal contraceptives?

Carrie Cwiak:

It's because they're still progestin dominant. They still keep the lining of the uterus thin and they still significantly inhibit ovulation. We see a lower risk consistently with longer duration of use, and importantly, we see persistent protection, a decrease in that risk after discontinuation of the method specifically for breast cancer risk, another hormonally sensitive or potentially hormonally sensitive cancer. We see no increased risk with combined methods or with the LNg IUD use. And six out of seven studies show no increase with Depo-Provera use with one study showing that potentially there's a small increase. And so something to consider when you have potentially individuals that might have an increased risk for developing personal breast cancer.

Carrie Cwiak:

What about menstrual suppression? Well, up to 30% of women consider their menstrual bleeding to be bothersome, and people with heavy menstrual bleeding are 45% more likely to use medical services and 27% less likely to be able to work. So not only are we impacting people's health with menses, but potentially impacting their ability to function and their quality of life. And so importantly, what hormonal methods do, whether you are using them primarily for contraception or using them for menstrual suppression, they decrease menstrual blood loss significantly with associated dysmenorrhea and potentially with the risk of anemia. That often comes from heavy menstrual flow. Hormonal methods across the board have been shown to be effective than nonsteroidal anti-inflammatory drugs, and they offer a cost-effective fertility sparing option to surgery. We do recognize that many of our patients are going to want to have surgery for their abnormal uterine bleeding or their heavy menstrual bleeding.

Carrie Cwiak:

And yet for patients who want to maintain their fertility, obviously something like an endometrial ablation or a hysterectomy is not an option for them. So we need to have fertility sparing options that can help them treat their menstrual disorders or to suppress their menses for other reasons. And what about additional health benefits? I don't know if you were aware. I learned this actually by writing the latest chapter in contraceptive technology for injectables that Depo-Provera use actually decreases uterine fibroid incidents. And for those who do already have fibroids, it decreases growth and recurrence. And for all of these, the rates of the impact range from 20 to 60% of a decrease. We see that combined oral contraceptives, including the most recent ones with lower doses of ethanol, estradiol, or other estrogens, decrease incidences of functional ovarian cysts. Combined oral contraceptives have

also been shown to decrease the incidence of fibro cystic breast changes, cysts and fiber adenomas, and of course, our estrogen-containing methods decrease acne and hirsutism offering an additional benefit for people who want to use their contraception for that benefit or want to use it as an adjunct to their other treatment.

Carrie Cwiak:

But what about specifically patient concerns? Unfortunately, we are dealing with a lot of stigma in terms of how people consider a lot of the treatments that are available in healthcare today. And stigma. Essentially, it's a negative attitude, prejudice, or false belief associated with certain traits, diseases, or treatments. And in this case, we can think about specifically what's the stigma that is being drawn toward contraception In terms of the psychology of stigma, processing information is complex in general, and so a shortcut for the brain to quickly categorize things as good or bad is often helpful. You heard me just talk about categorizing methods earlier in order to say, well, this is how you learn what this one does and what that one does, and you can group some of them together. So, creating these shortcuts is just a natural thing of nature for the brain.

Carrie Cwiak:

But this means that when we create these black-and-white dichotomies, biases may show up where we decide that something is not a gray area but perhaps all bad, or we want to promote it as all good. Our biases can show up in the media, it can encourage negative perceptions. And unfortunately, oftentimes these perceptions, especially in social media, can be presented as facts. I don't know if you're aware of the recent study that looked at social media and looked at the nutrition information and found that 2% of nutritional complaints, or sorry, nutritional claims were actually valid, which is pretty sad. Unfortunately, what happens is the impact can be lack of access. When people decide that they don't want to access healthcare or don't want to talk to us about certain methods if they're afraid of what they've already heard, this also may lead to a risk to their personal safety, lower quality of care or quality of life.

Carrie Cwiak:

And so what we need to do is call out bias, be proactive about it. We need to consider our language. We need to make sure that we are talking equally about the benefits of contraception as well as the risks, especially when they oftentimes come in with this perception that contraception is risky. How many times have you heard patients say that they know contraception causes cancer? And when you say, when actuality, they decrease the risk of cancer, they're pleasantly surprised to hear that. And so we have to think about the fact that oftentimes people are coming in with these misperceptions from the start, and our job is to educate them, provide them that information and they can decide to adopt that or not. So just thinking about what we see on social media, unfortunately we have people that are touting that contraception is smashing the nutrients in our body and we need supplements to repair that birth control ruin this person's body forever, that we have a physician talking about what birth control does adversely to your body.

Carrie Cwiak:

And then an example here of a patient who, this is what I wish I knew before getting off birth control about this idea about there must be some rebound effect or withdrawal from contraception. And so

how do we appropriately answer our patient's questions when they come to us? I alluded to this already, but one of the pitfalls to avoid or some of the pitfalls to avoid is that we shouldn't be denying method risks. We should be importantly talking about them, but weighing those risks against the risks of pregnancy when they don't want to be pregnant. When people want to be pregnant, then they have an obvious benefit to weigh those risks of pregnancy against. But if they're trying to avoid pregnancy, then they're taking on a risk that is not necessarily in lines with their reproductive life desires. We should not overlook personal preferences. Some people like to have a regular period and maintain that.

Carrie Cwiak:

Some people like to have as little bleeding as possible, and so we need to think about that. Let's not disregard past experiences. I oftentimes ask what people have used in the past and if they've had any problems with it, if they do mention something that I think well maybe might not have been related, then I might mention that they might not necessarily see the same experience. But certainly, if they've talked about an IUD expulsion waking on Depo-Provera, we need to think about how to address that specifically and think about if there are increased risk of that happening again if they use the same method and do not ignore concerns for side effects that they believe are potential or they believe are actual when they're occurring.

Carrie Cwiak:

And so I talked a little bit about this before too, but really people want to know about how contraception works, especially when one of the areas of stigma is this stopping pregnancy, is this interfering with pregnancy? And so it's important to recognize how contraception does work. And going back to those categories that I talked about before, if you are hoping that your contraceptive method or your patient's hoping that their contraceptive method decreases ovarian cancer risk, then you can see here if it inhibits ovulation significantly like the implant or the injection or the combined methods or emergency contraceptive pills, that's how it works significantly. Then we have those methods that incapacitate sperm when they actually get into the uterus. So we have our locally acting IUDs, the progestin in the copper, and then we have obviously the methods that block the egg and the sperm from getting together, which includes the progestin methods that create a significant thickening of the cervical mucus.

Carrie Cwiak:

So the sperm doesn't enter the uterus like the progestin IUD or the progestin only pills, one of the progestin only pills, I should say barrier methods and then the permanent care contraception for male and female patients. I mentioned that it's only one of the progestin only pills because you may be aware that since we have the newer progestin, the sperone only pill that has been well studied and shows that that significantly inhibits ovulation. And so that's another method that patients might find as more effective than just the traditional norethindrone progestin only pill. And of course, people are concerned about if contraception will ruin their body, will contraception lead to infertility? It's important reassure people that ovulation menses and their baseline fertility return within the first few months after use of most systemic hormonal contraceptives and the IUDs and even faster when you're talking about again, norethindrone that wears off pretty quickly in the body even when you have continuous use.

Carrie Cwiak:

So you're skipping your placebo with combined methods. So to not have a withdrawal bleed or long-term use, we're seeing this quick return to ovulation, menses and their baseline fertility. The exception is that when you use injectables, you can see that ovulation, menses and baseline fertility can all be delayed for a short time after stopping Depo-Provera. The average time to conception is about 10 months after the last injection. So if you think if most people got their injection and oftentimes they're thinking in three months that they're going to stop that one, then it's about seven months after they decide to stop that method. Obviously, some people decide that beforehand. And so technically it's average time 10 months after the last injection. And what about side effects? So common events are common. These things happen commonly among our patients. Among our patients who are of reproductive age, they experience weight gain, they experience mood changes, they experience decreased libido.

Carrie Cwiak:

These are also multifactorial. They could have a number of reasons why these things are happening. What are they also doing commonly? They're often using contraception and because it's something that may feel a little foreign to them or maybe a little foreign to them using a medication or a method for contraception, they may equate these two, but we actually don't see strong evidence that these things are increased in hormonal contraceptive users overall. Now, this doesn't mean that no one's going to experience side effects, and certainly we know that side effects are common in the first few months after people start a method that makes sense. They're getting used to the method, so they may experience those side effects in the first three months, and there are going to be individuals that will experience new or perhaps exacerbated side effects like maybe exacerbated headaches during the use.

Carrie Cwiak:

And we need to recognize that and validate that and respond to it. But if you look across the board from a population basis, we're not seeing a large impact of increasing these side effects. Now, even when we look at Depo-Provera, if you look at the studies that actually look at actual increase of weight, that's the weight increase when it was actually measured rather than asking people for self-report, which is in fact what a lot of studies did to study weight gain on Depo Provera, we see that only a few studies, three of 18 studies noted an actual increase and they average that to be about five pounds at one year of use. So this doesn't mean that this is the only weight gain that people see, and it could mean that they gain, certainly it could mean that they gain more than that. Could it be multifactorial and not just related to the depo?

Carrie Cwiak:

Yeah, it's a possibility. And so it's helpful to counsel people about all the potential causes of their weight gain. But also it's important to note that progressive weight gain was more likely in those that gained weight with a first injection. So when I'm talking to patients about potentially used in the injection, first of all, if they say one of their biggest concerns is weight gain, then I do specifically point out that the one method that's been associated with weight gain is the injection. And so that potentially that's not the one that they want to use. And then if they are contemplating using the injection, then I talk about the fact that it looks like the studies show that if you gain weight with a first injection, you might continue to gain weight while you're on Depo-Provera. However, if you don't gain weight with the first injection, it's not as likely that you're going to gain weight later on throughout your use.

Carrie Cwiak:

And so sometimes that's helpful to people to give them that predictive idea with the injection. So some patient friendly resources I already mentioned to you, the Bedsider. Another one that shows a wide range is Planned Parenthood in terms of the birth control methods, planned parenthood.org. And then Euki, that's EUKI. That's the app that is available on a smartphone for patients not only talks about contraception, but as with the other two that I showed you talks about sexuality. This one specifically has sections for abortion and STIs. And then also American Sexual Health Association (ASHA) is a great resource for patients, especially talking about STIs, but also just talking about sexual health in general for patients.

Carrie Cwiak:

So, what can you do to promote contraception as healthcare for your patients who want to avoid pregnancy at this time? Certainly, we can all promote person-centered care, asking them if they want to discuss contraception or if they want to discuss pregnancy today, find out what their goals are for the visit in the first place. And then if they want to talk about one of those topics, then you discuss the facts about contraception, sexuality, and pregnancy, directing them to accurate resources and importantly, those that are patient-friendly, easy to use, and non-directive, that's not going to tell them that they need to use a particular method over the other. In addition, ask proactive questions about patient concerns. I used to commonly say, do you have questions? And a more open way to ask our patients is What questions can I answer for you? Because it really just invites them to ask questions rather than think that they may be a bother if they happen to have questions after we've stopped our counseling and to remind them to just say, let me know if you have questions in the future.

Carrie Cwiak:

I do remind patients if you start a method and you don't like it, even if it's a long-term method, if you want to switch it, you can switch it. If you're having concerns, contact me by MyChart because I have the portal access available for them. So oftentimes, I'll invite them to send me an electronic message, or I'll say, come on in if you have questions, especially if they want to talk about bleeding changes and how to manage that. And so just staying proactive and making sure that they know that you are in contact with them if they need anything, if they have questions about their contraception, and now it's time for questions.

Nicole Nguyen:

All right, so thank you so much for that. So yes, if you check the questions, you can see them coming in. So I encourage our audience to continue submitting all your questions into the questions box, and Carrie will try to get to them as many of them as possible. I just want to say that if there are more questions coming in, Carrie has graciously agreed to stay on for an extra 15 minutes. So, if you have to leave straight at 1:30, please do. But if you're able to stay on and we get a lot of questions, Carrie has been gracious enough to stay on and she'll continue to answer questions until 1:45.

Carrie Cwiak:

Yeah, we'll see how much we get through. So the first question is, what contributes to the increase of IUDs? Probably a number of things. There was certainly an increased educational initiative to increase awareness so that people even knew that they were available to them and that they were not the IUDs.

This is not your grandmother's IUD, not the Dacon shield that caused so many issues, and today's IUDs are safe. They're actually associated like the implant associated with the lowest risk of complications of all methods, and people actually do have the highest satisfaction rates associated with them. So I think the important thing is not should we be telling everybody they should use it, but certainly we want to make sure that everybody has that information so that they can decide if that's the best thing for them.

Carrie Cwiak:

Wearables. So, to tell you the truth, I don't know a lot about this unless you're talking about a significant deviation from the normal range of body temperature; then, showing patterns in body temperature overall is not going to help your health. If you're talking about for tracking ovulation, then in terms of tracking basal body temperature, then remember when you're doing that for tracking ovulation, it has to be retrospective, meaning that you have to take at least three months of data to see if you can see a personal pattern for yourself if your temperature consistently changes and at what time between one menses to the next. So it potentially can be helpful. One of the things that I talk about for patients who are using the coly related methods is that well, actually just like any method, as long as you're not combining two estrogen doses, two methods are more effective than one. And so if they want to think about using the wearable and tools to measure their basal body temperature and therefore utilize that for natural family planning, then potentially they should think about using abstinence or another barrier method at the time that they might be most fertile at the time of ovulation.

Carrie Cwiak:

And so you're saying that at Oura specifically, they've shared compelling articles on the topic of reproduction. I think it's something that could be helpful to look at for our patients, especially as they're looking for more natural options. But personally, I just haven't looked into that information a lot. If we look at natural family planning methods across the board, the risk of pregnancy in the first year of use is about 25%. So that's a little less than withdrawal, but certainly better than nothing. So it can be, like I said, it can be utilized with other methods or something that people may prefer when they want to have a regular period and don't want to be adding hormones to their body.

Carrie Cwiak:

Has anyone looked at the side effects of increased cardiovascular effects of higher instances of clotting events, past COVID-19, post-COVID-19, I'm sorry, on contraceptive users? So I think that's important because when you have a risk factor that raises your baseline risk of a cardiovascular event, it's important to recognize that we're not taking away that risk, and then if we add contraception on top of it that contains estrogen, we are potentially increasing that baseline risk that patient already has. And so the two can be a really dangerous combination. For instance, if you have a patient with migraines with aura, it's really important that they avoid estrogen-containing methods, but progestin-only methods, and of course, non-hormonal methods, by and large, do not have an increased risk of cardiovascular complications. We see potentially some small increased risks with Depo-Provera that may be because of its relatively higher dose of Provera than the other methods.

Carrie Cwiak:

This has been shown in studies with people with uncontrolled hypertension where they have an increased risk of stroke and people with significant cardiovascular risk factors. So when you look at the

medical eligibility criteria, you'll oftentimes see that the injectables are a category three, which is kind of a relative contraindication, basically saying if there's nothing else available or acceptable to the patient, that's when you may use that, but that may not be the safest method for the patient. And I would say that since we know that COVID increased the risk of VTE, that's a consideration for using both at the same time. How much, what studies have quantified, I can't speak to specifically. Is there more of a risk increase for cancer using the arm implant birth control method? This is a great question. So, it's a progestin-only method. It works primarily by inhibiting ovulation, and so it's expected to significantly increase ovarian and endometrial cancer risk. And I say expected to because, again, the long-term cancer studies are really those done with the combined oral contraceptives and Depo-Provera. But the reason why they provide that cancer protection is because of the significant inhibition of ovulation and the significant inhibition of any activity in the endometrial lining, and the implant provides both of those. And so we would expect to see the same kind of benefit and certainly not an increased risk. Can you comment on new information about brain tumor use with Depo-Provera?

Carrie Cwiak:

This is, I'm trying to think if it was the glioblastoma, and I'm not sure if I'm going to remember the particular type. The important thing to recognize is this is a rare instance. It was not a significant increase of this type, although there was some association, it just wasn't a significant increase, especially in an observational study. So I wouldn't think that it would change that It should change your practice patterns. Now, in terms of who you provide it to, what are the guidelines surrounding BRCA one and two positive patients and combined hormonal contraceptives? So in fact, there was a specific study looking again at combined oral contraceptives and BRCA one and two positive patients and did not show an increased risk in developing breast cancer. But certainly, if one has breast cancer that's already present, utilizing a hormonal method could potentially stimulate that present cancer. But in terms of observational long-term studies so far, it doesn't look to show an increased risk.

Carrie Cwiak:

What would you feel about 5% hydroxy progesterone daily for, I'm guessing you're thinking oral hydroxy progesterone for a 50-year-old woman. Let me see who protects against severe menses? Patient doesn't want to use estrogen. Let me just read through this and I'll kind of summarize it. Strong family history of cancer. Okay, so the question really is, is there any risk there for cancer with the five milligram medroxyprogesterone acetate? And so I assume you're talking about the five milligram like Provera or oral medroxyprogesterone acetate pill. So again, it is a progestin. Certainly if there's a concern for current or recent breast cancer, then I would consider it also contraindicated. But if you are utilizing it to protect them from endometrial development of polyps and hyperplasia and those associated disease states, then that it certainly can be used and it's going to decrease their risk of cancer. I haven't looked specifically to see what if there are studies about the inhibition of ovulation with the 5% hydroxy progesterone acetate pill, but if it inhibited ovulation, then you should also notice a decrease in cancer risk.

Carrie Cwiak:

In fact, when you look at the levonorgestrel IUD, as I mentioned, that's not specifically something that is intended to significantly inhibit ovulation. It may inhibit ovulation like in 20% of cycles because it's intended to work locally by blocking sperm from entering the uterus and incapacitating sperm if they do enter. But even with that 20% decrease in ovulation, we do see protection from ovarian cancer with the

levonorgestrel IUD. So we should see the same thing with other methods that similarly decrease ovulation and again, decrease the activity of the endometrial lining. But specifically, I can't speak to studies about that. When you talk about the decreased risk of endometrial ovarian cancer, this is all across the board. It's wonderful. So again, continuous use, cyclic use continuous methods like progestin only methods, short-term users, long-term users, people that used it when they were young people that used it up to menopause.

Carrie Cwiak:

It's consistent and it's great. It's one of those epidemiologic studies that you love to see because it's more protection the longer you are on the method. So the more suppression that you have, and again, great to see that it's persistent, even after you stop that method, the decreased risk is persistent. What about in our class two or class three obese patients? Isn't BMI a precaution for the use of COC? So if you look at the medical eligibility criteria, obesity in and of itself is not a contraindication to any method. You certainly want to think about if they have multiple cardiovascular risk factors, then are you really needing to think about the entire picture of that patient? And perhaps an estrogen containing method is riskier for them, especially if they consider the possibility that they may have a little less efficacy with use of some of the low dose methods.

Carrie Cwiak:

But remember what we're comparing the risks to. So if you have a sexually active patient, her higher risk is to have an unintended pregnancy, a pregnancy when she doesn't want to be pregnant. If she's okay with being pregnant, then that's a different story. But if she doesn't want to be, if wants to avoid pregnancy and avoid the associated risk, then certainly even using a low dose combined method is going to be effective for them. The other thing that they might want to think about is using a local acting method. So, for like the IUD, because that's not impacted, the efficacy is not impacted by their obesity. The other thing I want to point out with this question is to remember what I said about the baseline risks. There are people coming to us whether they have no medical conditions and they're just of reproductive age, or they have complex medical conditions already. There are people who are already coming to us with a baseline risk of VTE or an increased baseline risk because of the conditions they already have. And so we need to determine if the studies help us see whether our contraceptive methods are making things worse. But if they really haven't shown that, then, of course, we need to protect them and help them achieve their reproductive desires.

Carrie Cwiak:

It seems that post-COVID covid, many people have. Oh, okay. So this is the same about the increased risk of clotting post covid. Again, it's the same question of whether we are going to see an increased cardiovascular risk for contraceptive users. I think the other thing to think about is that luckily we have many options that are available for patients. I recall when I was, gosh, this was over 20 years ago when I was a fellow; there was so much focus that we had on estrogen-containing methods, and can you use it? What if they have migraines, but their menstrual migraines? And it was really because we had very little that we could use. But now we have effective long-term methods that either use no hormone at all or use a very low dose of progestin-only. We have non-hormonal methods that people can use with rates of failure that are not as high as we thought they were.

Carrie Cwiak:

As I mentioned, the risk of failure and the risk of unintended pregnancy with withdrawal is 21% in the first year of use. For some people, that's going to be too high, but for other people that's not. And that's certainly better than using nothing or just using natural family planning with its 25% failure rate, but also condoms associated with lower failure rates than previously thought 12% and 13%. And so it's important to let people know that they do have choices and they can make these decisions based on their preferences and if they have specific concerns for certain risks. But if we're not seeing a strong effect by and large, then we still should be able to use those methods in those patients.

Carrie Cwiak:

So, this is the same. Thank you. It was meningioma and not the glioblastoma. So again, it's not a significantly increased risk for Depo-Provera and the meningioma. It was in an observational study, and so by and large, we're not recommending across the board people change their practice patterns for the birth controls that inhibit ovulation. Is there anything that shows that it would potentially delay the onset of menopause with long-term use of 10 years? So apparently, no, it hasn't impacted or significantly changed the age of menopause, even with long-term use. And while we're on the subject, you can allow people to, if they're still hoping to avoid pregnancy, you can allow them to safely use contraceptive methods up until the point of menopause, as long as they don't develop any contraindications to the use of such. Going back to the How does contraception work slide, would you include the pH-modulating vaginal gel in the incapacitate sperm section or the block sperm or egg section? That's a good question because yes, I didn't put that

Laura Ellerbe:

So that's a good question.

Carrie Cwiak:

I guess it could be both because certainly is incapacitating sperm and it's working in the vagina. And so, if the sperm is being incapacitated such that less actually get into the cervix and the uterus, then you are doing the work to block them from getting in. But really, the intention is from the pH modulation to incapacitate them so that they're not effective. Good question. How likely is a 60-pound weight gain due to Depo-Provera with six months of initial use since 17 years old? So, across the board, in population studies, this is not a likely outcome. We have seen weight gain associated, again with certain populations, potentially those that are already at higher risk for weight gain. Like for instance, postpartum adolescents or, as I mentioned, people who gain weight with a first injection. To have a 60 pound weight gain be only about Depo-Provera is not as likely. That kind of weight gain would lead me to be curious about what is happening with the patient throughout their life. What's their nutrition, what's their physical activity? Can I help them with any of those lifestyle changes? But if they feel like the Depo-Provera is causing weight gain, or certainly if it's hijacking their attempts at losing the weight that they've gained, then we talk about using a different method.

Carrie Cwiak:

Okay, next question. Again, brain tumors. Everybody's interested in that long-term use of Depo, long-term use. So, long-term benefits, again, the decreases in cancer risk are greater with increases with longer years of Depo-Provera. In terms of the decreased mineral density, bone mineral density that we

see with Depo-Provera, it has a plateau effect where it plateaus at about two years of use. And so instead of going progressively lower and lower and lower, it tends to stop around that two years of use and it's easily reversible. Depo-Provera users, injectable users were included in that study about long-term mortality.

Carrie Cwiak:

Maybe not the same one that I cited, but it has been a included in long-term studies. And so without knowing other specifics, I hope I touched the main highlights. So certainly in terms of a cutoff for Depo-Provera use, you don't have to stop at a certain amount of time. If they acquire other reasons for decreased bone mineral density like chronic steroid use, then you may want to consider talking to them about using a different method. And then of course, I talked to some of my patients and I mentioned this possibility to them, and they decide that in fact, with everything else going on in their life, that it still is best for them to be amenorrheic, and so they decide to use the Depo-Provera. But the point is, is that we have a conversation, we talk about factual information, they understand what the risks are compared to the benefits, and they make the decision that works best for them based on what their priorities are.

Carrie Cwiak:

One of the concerns in the FQHCs is from in health centers, revolves around immigrant refugee reproductive health. Yeah. So do you have recommendations for patient provider interactions about contraception where the patient has a very low or very different level type of health literacy? Really good question. We have a high number of immigrants in Atlanta, and so we're interacting with them frequently in our family planning clinic. The pictorial resources are really helpful. The chart that shows the pictures rather than numbers or text is really helpful. So important to use a translator when necessary. Sometimes it takes time and sometimes you need to focus on things that are most bothering them, what their priorities are, key concepts for every visit so that you can again, focus on the things that most important to them. I think actually it just comes back to the same points about person-centered contraceptive care for everyone. Find out what their concerns are, find out what their priorities are, give them factual information, let them make that decision for themselves and be there to answer their questions and change their method if they change their mind.

Carrie Cwiak:

Oh, okay. So this says, has there been sufficient or any research on the other side effects such as blood clot and bone density due to long-term contraceptive uses? So I mentioned already the bone mineral density. The one method that has this effect is Depo-Provera, and we don't see that with the other methods, certainly not with the combined methods that have estrogen might be a little bit protective. We're also not seeing it with the low dose progestin only methods. Even the systemic method like the implant with blood clot, actually the risk of blood clot, your risk of blood clot is highest in your first few months of contraceptive use. And perhaps that's just because if you are going to have an event, a complication from provoked by estrogen, perhaps it's going to happen right when people start using it. And so that's the phenomenon that we see that VTE is actually more common in the early months of use.

Carrie Cwiak:

It's the same with hormonal replacement for menopausal patients. And so instead of seeing an increase in blood clots over time, we see related to hormonal contraception related to estrogen-related or containing contraception, we actually see a decrease over time. And again, if someone is a successful user, less likely to have a complication and so they continue the method, perhaps we're seeing a healthier, less risky population that continues the method as they go. It's also probably why when you look at the typical use failure rates, the typical use pregnancy rates, you'll see that in contraceptive technology. We utilize the same method that we have for decades where we look at the first year of pregnancy rates because every year after that the pregnancy rates decrease because if you've been a successful use that first year, you're more likely to be a successful user of that second year and have a lower pregnancy rate the year after that, the year after that.

Carrie Cwiak:

And so in general, we tend to see for people who stay on the same method, they tend to have overall for that population of users lower pregnancy rates and so don't see an increase over time. Now the one thing that I would think about with that is that someone's baseline risk may be changing over time. So are they naturally gaining weight on their own because we all gain weight over the years. Are they developing hyperlipidemia that didn't have before? Are they now older? And so thinking about age over 35, you have to put all that into perspective and combine the age with it. And so you always need to think about readdressing the baseline risk of your patients and if they're developing risks as they go. That's why even if you may not need an annual visit, certainly not an annual pap, it's important to have regular check-ins. And for some people that's still an annual check-in where you review their history and maybe go over important counseling that they need at that time. How do you go about choosing a combined hormonal contraceptive pill for patients? Do you have a preference for some over the others? So you all might know Dr. Hatcher, the senior, the father of contraceptive technology, he was my teacher way back when.

Carrie Cwiak:

And if you can determine, I just remember him saying this and it's still the same. If you can determine that someone can use estrogen, they can use any pill, they really can, and then it's just a matter of choosing which one is more accessible to them. Do they prefer one that they've used before and they want to go back to the same one? Do you have someone who had estrogen related side effects and they want to use the lowest dose possible? Do you have someone who's looking for a newer estrogen so that they can possibly decrease their risk even more? And is it accessible to them and affordable? Do you have someone who wants a better bleeding profile than what they've had in the past? And so you're looking for a more longer acting progestin like Sperone or norethindrone. But for the majority of people, again, because the majority of them don't have significant side effects or issues with any of these methods, they really could use anything.

Carrie Cwiak:

I like to prioritize access. And so I think about what do we have available in our Title 10 clinic that we can provide patients because if we can provide them the packages in hand, that's just all the better. If they have the access, I go for a low dose method, so I like to look at the 20 microgram range and 24.4 is certainly a nicer regimen than 21.7. There are a lot of benefits of the newer methods. The regimens with the shorter withdrawal bleed, again, if that is available to them if you can have a withdrawal bleed for

only four days instead of seven days, all the better. More importantly, you have less chance of escaping ovulation during that time. And so they're actually more effective, but sometimes not always available for a person's insurance or at your clinic on your formulary. Do non-hormonal birth control methods have side effects as well? If so, what are they? So there have been some effects like increased rate of UTI or vaginitis with the older diaphragms. Now we have that newer one-size-fits-most caya diaphragm that seems to be more vagina-friendly shape. So I don't know if it had to do with the older diaphragm itself or if it has to do with irritation from the spermicide. We know that Nonoxynol-9 can cause significant vaginal irritation for people. And so that's why it's still advised that we use those with caution in people who are at increased risk for HIV Transmission.

Carrie Cwiak:

Aside from that, I suppose if they have a latex allergy, allergy is probably not as likely. It's more likely that they're reacting to some additive on the condom or like a spermicide if it's added. Oh, when starting oral contraception, when do you recommend directing them to start? So I am a disciple of the selected practice recommendations. I'm really big on evidence-informed guidelines. In fact, we were involved with Dr. West Hoff's Quickstart trial when she originally did it. Everybody could quick start everybody right away. So no matter what we use, we allow them to use it right away. The question is I want to determine if I can be reasonably certain they're not pregnant, right? If they've had recent unprotected intercourse, can I offer them emergency contraception? If they're outside of that window of emergency contraception and within 14 days my urine test still isn't going to pick it up, do I then recommend that they repeat a pregnancy test to find out sooner rather than later if they're pregnant?

Carrie Cwiak:

But they can start any method right away. And in fact, we know that the copper IUD is the most effective emergency contraceptive and the levonorgestrel IUD the full size, the standard size is either just as effective emergency contraceptive is the copper IUD or it just so happens that it's really low chance at the time that someone comes in if they have a negative pregnancy test that they're going to be pregnant at that time. So it can actually be inserted right away as well. For the IUDs, we do talk about the possibility that it could impact a pregnancy if that pregnancy is already in the uterus when you're placing the IUD because I don't know if potentially could happen, but more importantly, if they come back pregnant with the IUD, it's important to pull the IUD. So that's what I talked to patients about because I want them to be aware of the possible pitfalls of having an IUD inserted right away. But if they want it right away, we do it right away.

Carrie Cwiak:

And I often have patients ask me which method is best for those who struggle with weight gain. Good question. How do you answer this question? So I tell them specifically, I talk about Depo-Provera and I say for some people, Depo-Provera is definitely associated with weight gain, and so that might be something that's best to avoid, but by and large across the board, the other ones are not. And so there's no reason why a person needs to stay away from the other methods. If a person uses birth control for less time, would it mean their body's ability to get pregnant would be quicker than a person who used it for more time? It doesn't seem to be impacted by the length like the return to fertility is still quick, and so it doesn't seem to be impacted by the length of time they're on birth control beforehand. It's just I'm quickly reversible luckily.

Carrie Cwiak:

And I think that when the question here, this is again about meningioma with Depo-Provera with limited evidence, are we required to include this during counseling risks? What you need to do is think about how you need to provide your patients with a reasonable amount of information, and we can't talk about everything. We just don't have time. Plus people typically remember three major messages as they leave your office or your clinic. And so thinking about that, don't overload them with information that obscures their own priorities, what they came there for, what questions they have. Certainly, if they're asking about that, then you want to focus on that.

Carrie Cwiak:

So I would focus on the most important risks and benefits for them and the most important concerns and priorities they have. I find that with using person-centered counseling techniques, I can better get to what are your priorities? I find that some people have, again, as I alluded to, some people have priorities that say I don't want to have any bleeding. Other people say my top priority is effectiveness. Other people say my top priority is not to use hormones. So you find out what's important to them and what's their priority. And you can tailor your counseling based on that. And that really means that it's not one size fits all for all patients because you really need to have a conversation based on the biggest risks and benefits for them. And especially if you're talking to patients with complex medical conditions, there are going to be specific risks that they have that you want to help them avoid. So again, do you have someone with significant anemia and heavy menstrual bleeding? And so you want to help them with that specific concern that they have and that specific health risk that they have. And so I would focus on that benefit for them.

Carrie Cwiak:

So I cannot speak to specifically what's in your protocol about the limit for Depo-Provera. The black box, I believe still says two years of use, but I don't pay attention to the black box. I pay attention to the evidence. And so that guides me to know that again, it's not a progressive loss of bone mineral density over time. In fact, if they stop use at two years, I'm not preventing further bone mineral density I, I'm just stopping them using their Depo-Provera at those two years. Now, if they decide that they want to use something different, then that's a good opportunity for them to use something different. But the bone loss that we see, again, plateaus at two years is reversible, is very similar to the bone mineral density. I shouldn't say bone loss, bone mineral density because it's really a marker. The bone mineral density loss, it's very similar to what we see when breastfeed very similar, very similar curves.

Carrie Cwiak:

So let's see. Oh, is a break needed from taking birth control? You're right. So this is a very common question and people say, I need a break. I just need a break. I need to go back to my normal period. Maybe if I didn't have it before and I just need a break. I need to see what my period is doing now, if that's important to them and if they want to do that, they can certainly do that. And we talk about that and I say, there's nothing wrong with that. On the other hand, there's nothing wrong with continuing. You're not gaining a health benefit. You're not avoiding a health risk just by stopping your birth control and taking a break. In fact, if you're remaining sexually active and you don't want to be pregnant, you're potentially putting yourself at risk for unintended pregnancy and the risks that are associated.

Carrie Cwiak:

And so again, you try to find out the reason for wanting to take a break. Do they want to see what their periods are doing? Are they thinking maybe that they want to get pregnant later on in the year? Do they just want to take a break from all medications? That's okay. That's okay, but you want to make sure they're doing it based on factual information and taking a break from birth control. There's just not any noted benefit. In fact, as I showed you from the long-term studies, the longer a patient was on birth control, the less likely they were to have or the lower risk they had of mortality overall for all cause mortality. What contraception is best for PCOS? This is a great question. Okay, so once again, it comes down to prioritizing with the patient. What are they concerned about? So is acne or herm, the androgen related symptoms, their biggest concern, then the most effective method for them is going to be a combined method.

Carrie Cwiak:

But what if they don't want to use that? They could use another medication to control those things because obviously contraception is not the first line for treatment of acne or treatment of herm. If they want to control their irregular bleeding, then they can decide if they want to do it and just decrease it but not go to regular periods because a lot of them don't have regular periods to begin with. So some of them feel comfortable with that, but some people want to have a regular menstrual period and so you help them with that. This is where I'll give them the information that it's really important. With chronic anovulation, with PCOS, it's important that we protect their uterus over time. And so at a minimum, what they need to think about is a progestin that protects their uterus from unopposed estrogen from chronic anovulation because we do see higher rates of endometrial hyperplasia and endometrial cancer even in young patients after years of anovulation due to PCOS or other related conditions.

Carrie Cwiak:

And so it's just important to find out what their priorities are and then you can determine what they need based on that. But also if they said, I want to use copper ID and that's because they want to use it because their priority is effective contraception and it is not going to impact their PCOS at all, that's okay because that's what they want to use for contraception. And so think about how you protect them from the other methods. Although ironically, the copper IUD also protects you from, maybe it's not ironic, but it also protects you from uterine cancer.

Carrie Cwiak:

Let's see. So it's important to note our language when we talk about Depo-Provera. Depo-Provera causes decreased bone mineral density. It doesn't actually cause osteoporosis, and it doesn't increase osteoporosis-related fractures even when people enter menopause. So you're not stopping it at two years to reverse osteoporosis or to prevent osteoporosis. What has been shown in the studies is a decrease in bone mineral density. And it's true, we need to make sure that that doesn't develop and get worse and lead to osteoporosis for other reasons. But again, you don't have to stop them at two years of use. Why do providers have to wear face shields and gowns when administering depo? We don't talk about wearing gowns, but because it's an injection, you potentially could get a splash of blood or the medication, and so perhaps that's why it's been requested that you wear a face shield at the minimum wear gloves, but I'm not quite sure about the gown.

Carrie Cwiak:

Okay, so the question is can you further explain the note? Mood changes, decreased libido, other side effects are not increased in hormonal contraceptive users. Overall, how do you settle patients' minds with mood changes such as anxiety or depression or anger? So I think it's important to recognize what we're looking at with these studies. Can you look at studies that compare the contraceptive user to a placebo or to using a noncontraceptive, I mean a non-hormonal contraceptive? So you have a combined oral contraceptive compared to a copper IUD, and then you can determine what's the effect in actuality from the progestin or the estrogen itself or again, compare it to a placebo so that you could determine what's the true effect of taking the medication itself rather than just something that just develops commonly over time. And so when you look at comparative studies across the board, there is no evidence that there's no consistent evidence that there is that we're seeing those risks associated to a large extent with contraceptives in the general population.

Carrie Cwiak:

However, that doesn't mean that your individual patient may not is absolutely immune from experiencing that side effect. When I talk to patients who have a concern about these changes, then I talk about using a short-term method, potentially using a lower dose. So for instance, if they want to use a combined hormonal method, then the patch that I have available for most of my patients, unfortunately I still have just the traditional patch rather than the newer lower dose patch that's available in for most of my patients. So we'll talk about that. Maybe that higher dose of the patch is not the best one. Thinking about a lower dose, maybe going for a long-term method that would be harder for them to come back and has removed that they can't just stop on their own a short-term method might be better doing a long-term method Depo-Provera harder to reverse the impacts of might not be ideal for them.

Carrie Cwiak:

And so again, oftentimes we talk about a short-term method, and then they determine if they like the impact than switching to a longer-term method if that's their desire. But it's just when you look at comparative studies, it's just not increased in these populations. One of the reasons why we might see individual variability is that there's a lot of individual variability in how people metabolize progesterone. And so just like progesterone is the major component that provides us the contraceptive effect, even our combined methods are progesterone dominant. And so it could be that the way a person metabolizes progesterone differently leads them to these side effects, but by and large, it's not something that you should expect to a great extent that you should be warning people about. And then again, thinking about the potential for some of those effects to happen in the first few months as people get used to the method that they're taking, while LARCs have become more available to underserved populations, comfort measures have not, these is a really good question.

Carrie Cwiak:

Sedation is rarely approved for IUD insertion. Do you have recommendations on this front? What can we do to ensure patient comfort and autonomy? That's a great question. So think about things that you can utilize. There have been some studies that have looked at the lidocaine spray, like the hurricane spray, some of them that looked at the gel. It doesn't seem to be as effective or takes a little longer with the gel. They insert it themselves vaginally. I still prefer to use the paracervical block for people who want it, but we do have the hurricane spray if people don't want to block. So those are things you could

potentially have in your clinic for your patients if you can provide oral sedation. Oftentimes, if you can't do IV sedation where you're at many places, in many places you could do oral sedation because oral sedation doesn't require typically extra monitoring.

Carrie Cwiak:

They don't have to stay longer. The only thing that we tell people is if they're naive to the Xanax or the Valium that they need to have somebody drive or escort them home. One of the other things that we consider is relaxation techniques. We suggest they bring their phone with their headphones so that they can distract themselves or listen to that. We have great clinic staff that talk to them to keep them distracted while replacing the IUD. And so I think some of those things can be helpful, but I think the paracervical block and the minimal sedation is really quite popular and relatively feasible. And sometimes when I bring it up, people say that they don't want to use it and that's fine, but I've given them that choice to do that. We've also worked with some of our outpatient independent abortion providers who have ORs and are used to providing very cost-effective care even undersedation. And so oftentimes, we pair with them to provide affordable sedation for people who can't tolerate an exam or an IUD insertion and can't afford it or their insurance doesn't cover having it done in the OR.

Carrie Cwiak:

But great question, what can cause IUDs to dislodge and what are the negative implications if this happens? So expulsion with IUDs if they're put in not related to postpartum. So if we consider interval insertion, the range of expulsion is about five to 10%. That increases with fibroids that impinge on the cavity or are large enough to cause heavy menstrual bleeding. Also, actually, people with heavy menstrual bleeding across the board and multiparous patients have shown an increase in expulsion in some studies, but not a significant amount. If there's an unrecognized anomaly that distorts the cavity, let's say there's a septum there, that might be why you have an IUD dislodged. It is not likely to happen.

Carrie Cwiak:

The risk is certainly decreased if you use careful technique when you're placing the IUD because it's important that we're gentle when we're inserting in the cervix that we know if the uterus is verted or retroverted, that we use a tenaculum to make sure that we're straightening out the cervical uterine ankle. And so those things can be helpful. We even talk to patients about if they have an IUD expulsion that they're at increased risk of having another one. And so for that reason, some of them choose not to try it again, but for others they're highly motivated to try it again. And so sometimes in those situations we put 'em in under ultrasound guidance if there's been a complication in the past. If it is in the uterus still, then it's probably in some way in some manner it's likely still effective while they're using it.

Carrie Cwiak:

But we actually, because of either the leave adjust oil that it's releasing or the copper ions that it's releasing locally, but we don't recommend people rely on that if we're unsure, like if we have missing strings or if it looks like it's dislodged on ultrasound, and we're planning to remove it and reinsert another one. We usually recommend that they use something else for contraception. In the meantime. If you think about it, they're typically those people that are highly motivated at the time and you don't want them to get pregnant. Even if they're thinking about getting pregnant, you don't want them to get pregnant with a dislodged IUD in place. And then of course, the implication, the obvious implication is

that you have to remove it if it's not in the right place and not being effective. And so sometimes that takes extra equipment. Sometimes that's when you need a pair of cervical block, have a dilator, have an OS finder to have a flexible dilator. You need it. Maybe you need an alligator forceps. Those are the ones that are very thin and then open up at the end. Those can be effective if you have an ultrasound in your office or your clinic to provide ultrasound guidance that can also be quite effective to avoid having them to have to go to the OR.

Carrie Cwiak:

How do you prescribe Depo-Provera if the patient wants it indefinitely? She doesn't want any other birth control with a smile If they don't have any contraindications. I don't put any time limit on Depo-Provera. I check on their history to make sure that they're not developing any new risk factors. And if so, we talk about it. I check with them at the next visits if they like their bleeding pattern. I don't assume that they like it. If they're having amenia, I ask them if they're concerned by that. Just like I would ask them if they're concerned about prolonged bleeding and I remind them that they can come to me if they ever have any questions about it or send me a MyChart message. How do you best explain the increased bleeding that can occur with Nexplanon? I want to properly explain to my clients without swaying them from it as an option.

Carrie Cwiak:

So the majority of people with Nexplanon, if you look at the clinical studies, the majority of people had less menstrual flow, so less amount of bleeding and less frequent episodes. But there were some patients that had prolonged bleeding episodes during the clinical trials. And of course, we have heard of patients that talk about that their bleeding is either still heavy or heavier, and so we just need to respond to that when it happens. And think about how you can manage that. You can either do that with a short course of NSAIDs with a short course of estrogen if it's easier if you're, again, in a Title 10 funded location; we often provide them with a pack of estrogen-containing pills that they can add if they don't have a contraindication is taking estrogen. So they can certainly use all of those methods to improve their bleeding.

Carrie Cwiak:

But when you are talking to patients about Nexplanon, I would say that when I talk about the progestin-only methods, I say these methods tend to decrease your bleeding, but when you do get bleeding, even though it may be lighter, it's going to be unpredictable in timing. We do know that some people do bleed regularly on these progestin only methods, but by and large it's typically unpredictable in timing. So I prepare them for that. But in general, it tends to be lighter. And then of course, like I said, we react accordingly as we need to when they find that it's not lighter, that it's heavier than they want to be. How do you recommend new providers to get hands-on training and IUD and Nexplanon insertion and removals? The Nexplanon specifically, you can reach out to the pharmaceutical company, the IUD, actually; you also might be able to do that, or you might be able to look at local conferences in your area to see if they also provide hands-on training and IUD insertion.

Carrie Cwiak:

Another possibility is to get together with a group of people in your city or your region that is all looking for the same type of training and think about inviting somebody to provide that training. So there's

some options for you. And the pharmaceutical companies actually will provide models for training. This is for both IUD and removals and I see that in the chat. They're putting up the resources available for training. So that's wonderful. How effective is implants in reducing heavy periods compared with the IUD? The IUD tends to be a little more effective locally acting, I'm looking at the time, but they both have about the same rate of amenorrhea, about 20%. So overall in studies, although I've heard a lot of people talk about more progressive amenorrhea over time with use of the IUD compared to use of the implants. And so anything with progestin is going to decrease heavy menstrual bleeding. And so I think you can offer both of those instances an option. You could talk about the potential for maybe further improving in time with the leave in adjust IUD, especially since it has been studied more for that and it has that indication, but you really could offer them anything with hormones in it.

Nicole Nguyen:

Alright. No, thank you so much. Wow, that was a marathon of questions and I know we didn't even get to go through all of them, but oh my gosh, Carrie, thank you. Thank you. Thank you so much for answering those questions. I know our audience was super engaged and asked all these awesome questions, so I want to say thank you to you. Thank you to our audience. So that pretty much concludes our webinar. So please fill out the survey that will appear at the end once this webinar ends, and give us your feedback and see what kind of content you want to see for the next webinars and other trainings. And then again, we'll also send out the link to the CME certificate, the recording with all these great Q&A and the slides in a follow-up, you in a follow-up email. So give us about three or four weeks for that. And then lastly, I just want to say thank you so much, Carrie, for being here and answering these questions and giving that wonderful presentation. We hope you all enjoyed it and thank you all for tuning in. Until next time then, thank you so much. Thank you.