What's New in the 2024 US Medical Eligibility Criteria for Contraceptive Use, U.S. MEC, Selected Practice Recommendations for Contraceptive Use, U.S. SPR, and Quality Family Planning Guidelines Webinar Transcripts, June 24, 2025

Nicole Nguyen:

Hi everyone. Welcome. Thank you so much for joining us today for our webinar, What's New in the 2024 US Medical Eligibility Criteria for Contraceptive Use U.S. MEC, Selected Practice Recommendations for Contraceptive Use U.S. SPR and Quality Family Planning Guidelines. We hope you are all doing well and staying safe. My name is Nicole Nguyen, program manager of the Family Planning Program at the California Prevention Training Center, the CAPTC, under contract with the California Department of Healthcare Services Office of Family Planning, is sponsoring today's event. So welcome. And before we get started, I'd just like to go over some quick housekeeping slides. So, for our new updated dashboard. So, the first, the top right ribbon on your screen, is the control panel, and then you'll see the question icon. This is where it controls where you can submit comments and questions. There is a little paper clip icons that controls where you can access any handouts that will be attached for this presentation. There's also a setting icon. This controls your audio connection preference, and then the three dots are how you can switch to full-screen mode. And then also to check your audio, please click on the settings icon. And from there you can check to your desire setting to join either through your computer or to call in through your phone. And if your internet connection is a bit shaky, we highly recommend that you call in through the phone for the best possible sound.

Nicole Nguyen:

And then please use the questions icon to submit any questions and comments for the presenters throughout this webinar. This webinar will be about 90 minutes and include time at the end for the presenters to answer all your questions. So continue to send them in throughout the presentation and our speakers will address as many of them as possible. At the very end, this webinar will be recorded and we will send out a follow-up email with the recording and the slide deck. There is an evaluation at the end, so please make sure you take the time to fill that out because your feedback is really important and really help guides us in developing our future content. And then before I introduce our presenters, I want to acknowledge that we are working with the University of Nevada Reno School of Medicine to provide CMEs for this event. This webinar qualifies for 1.5 CME credits and only available to those who watched the entire webinar live today.

Nicole Nguyen:

Those who watched the recording afterward will not be eligible for any CME credits, and the link to access your CME certificate will be included in the follow-up email to those who attended today. Along with the recording, the slides and the evaluation. And then of course for transparency, we want to state that all presenters, planners, or anyone in the position to control the content of this continuing medical education activity have indicated that neither they nor their spouse or legally recognize domestic partner has any financial relationship with commercial interest related to the content of this activity. Okay, so now I get to introduce our awesome presenters. We have two joining us today. So first we have Dr. Michael Policar, who is Professor Emeritus of Obstetrics, Gynecology, and Reproductive Sciences at

the University of California, San Francisco School of Medicine, and he's the owner of Policar Lectures, a reproductive health policy consultant company in San Rafael, California. Since 2015, he has been a clinical fellow for the National Family Planning and Reproductive Health Association, NFPRHA, in which he advises staff regarding clinical and health policy issues regarding Title 10, the Federal Family Planning Program. He is also a senior medical advisor to the California State Office of Family Planning through a contract with the California Prevention Training Center in San Francisco, California. He is a widely known speaker with an interest in the health delivery system and women's health issues, including family planning, cervical cancer screening, and management of pre-cancerous health screening, menopause, female genital tract infections, and general skin conditions. And he's the senior author of the textbook Contraceptive Technology. The most recent edition is the 22nd revised edition that came out in 2024, and the chapter author is for screening for cervical, ovarian, and breast cancer. He has served on multiple expert advisory panels for the Centers for Disease Control that resulted in the publication of the US MEC for contraceptive use in 2012, 2016, and 2024 and the Selected Practice Recommendations for contraceptive use and providing quality family planning services, recommendations of CDC and the U.S. Office of Population Affairs in 2014. And we're so happy to have them present with us today.

Nicole Nguyen:

And then our second amazing presenter is Dr. Jennifer Karlin. She is an associate professor in the Department of Family and Community Medicine at the University of California, San Francisco, with fellowship training in family planning and clinical medical ethics and a PhD in Anthropology and History of Medicine. Dr. Karlin is a researcher and full-scope family physician who sees patients in urgent care and Planned Parenthood. Jennifer serves in an advisor role as the new medical consultant for the California Prevention Training Center and the Family PACT program, a role that was previously held by Mike, and now she has taken that on. So we're super excited to introduce her as our new medical consultant. She is also an associate editor for the Annals of Family Planning and sits on the grantee Clinical Leadership Advisory Council for the Clinical Training Center for Sexual and Reproductive Health. Thank you so much for joining us today. And with that, the floor is yours, Mike.

Michael Policar:

There we go. And Nicole, be sure to allow me to be able to advance the slides.

Nicole Nguyen:

Yes, go ahead. You should be good to go now.

Michael Policar:

There we go. Take the remote control. I'll be able to do that, I hope. Okay, great. Well, thank you all so much for joining us. We've been working on this for months and months to get it ready to go. And before we jump in and start talking about these guidelines, what I want to do is tell you a little bit about why so important in Family PACT. And that is since the beginning of the Family PACT program in 1996. Of course, this program goes back even earlier, when we were state-only family planning, but since 1996, a really high priority of the California Office of Family Planning has been this expectation of providing high-quality, evidence-based care to Family PACT clients. And one of the ways that we do that is we've integrated into the Family PACT standards, the expectations that clinicians seeing Family PACT clients are going to be following a couple of National Benchmark Clinical Practice guidelines.

Michael Policar:

Now, two of those are the ones that we're talking about today, the Medical Eligibility Criteria and the Selected Practice Recommendations. There's also a reference to the Quality Family Planning guidelines, which we will also discuss today, and a number of other guidelines, for example, the 2021 CDC STD treatment guidelines. So there is an expectation that, as you see, Family PACT patients, and of course, this would apply to your other patients as well, that you are going to use these evidence-based tools as you provide care to your clients. And just one other thing to mention very quickly is that Family PACT also offers lots of other guidance that comes from these guidelines. For example, our Clinical Practice Alerts, of which now I think we're up to 15 or 18 of them, the whole library of webinars that we put together, and we'll be referencing a few of those today as well.

Michael Policar:

That information, which is in the PPBI, the policies, procedures, and billing Instructions for Family PACT. And there are also lots of links to other national guidelines. So it's not only what we talk about right now, but all of the other resources that are available to you on familypact.org. So with that, I am going to try to, oh, there we go. I'm looking into how to advance here. Okay, good. So you know about us, we've already done our introductions and our disclosures. Okay, and here is our agenda. Now we're going to talk about the updated sections of the 2024 Quality Family Planning Guidelines. That's one that you may not know as much about in comparison to the MEC and the SPR. Then, for those of you who are kind of new to this particular topic, we'll talk about some of the conventions used with the safety categorization system, which is used in the Medical Eligibility Criteria, various categories that actually originated with the World Health Organization and are now used in the Medical Eligibility Criteria.

Michael Policar:

There's a whole suite of resources that are available for implementing the Medical Eligibility Criteria and Selected Practice Recommendations from the CDC. I'll tell you a little bit about what they are and how to get them. And then Jen is going to cover specifically what the updates and modifications are in the 2024 version of the MEC and the SPR, the new conditions that are covered, particularly chronic kidney disease and sickle cell disease, but also how some of the safety classifications actually changed with numbers going up or numbers going down in this version of the MEC. Then we'll wrap it up and take your questions after that.

Michael Policar:

Okay, so now just a quick review about the National Family Planning guidelines that we all should be using. And I love this graphic because it looks at a whole suite of family planning recommendations that are available mainly from the Centers for Disease Control, but from other sources as well. First off, if you look over at nine o'clock where it says Contraception Guidelines, that includes the two guidelines that we're going to be talking about this afternoon, the Medical Eligibility Criteria and the Selected Practice Recommendations down at six o'clock. You see other guidelines that are recommended by the Office of Family Planning, and that is the CDC STI treatment guidelines. And by the way, that badge is a little old since 2015. Of course, we now work with the 2021 C-D-C-S-T-I treatment guidelines. And the red ribbon of course refers to the HIV guidelines, which come from the CDC over three o'clock are what used to be called the preconception guidelines.

Michael Policar:

Nowadays, they're called the pre-pregnancy guidelines that also come from the CDC. And up at the top at 12 o'clock are the guidelines for number one, helping people to achieve pregnancy when they want to, and then also information about how to do infertility evaluations for both females and males. The CDC doesn't have guidelines on that, but instead, we use the guidelines from the ASRM, which stands for the American Society for Reproductive Medicine. But basically, all of these are an integrated suite of guidelines that really cover virtually everything that we do in the world of family planning. Oops. Now I need to try to go back, Nicole. I don't know if you can do that. Oh, hang on a second. Maybe I can go back just a second. Okay, so here we are with QFP. So the Quality Family Planning Guidelines were first published in 2014, and they were a collaboration of the Office of Population Affairs, which runs the Title 10 program nationally, and the Centers for Disease Control.

Michael Policar:

And the purpose of the QFP guidelines was basically to fill gaps that existed on a number of topics that were not covered in the MEC or the SPR. So in that version 1.0 of the QFP, it included contraceptive counseling, client-centered reproductive goals counseling, which used to be called back then Reproductive Life Plan. Now we have a much better term for it, which is called Reproductive Goals counseling. It also had recommendations regarding pregnancy testing and options counseling, achieving pregnancy, basic infertility services, pre-pregnancy health, and then preventive screening for both women and men. And it was a really wonderful document that was fairly widely used in the family planning community after it was published, but it was time to have that updated. And so the Office of Population Affairs had a task force that was empaneled about two years ago, and then they finally published the updated Quality Family Planning guidelines, what we refer to as QFP 2.0, and a number of resources that are available for using them.

Michael Policar:

The new sections that are in the second version of the QFP include performance measures to track and improve quality of care. They were very briefly mentioned in version one point out now they're in much more detail in this version and also a very wonderful chapter on person-centered contraceptive care strategies. That is to say how to do contraceptive counseling and pregnancy intention counsel. And in fact, Family PACT did a webinar on that very topic in October of 2022, done by Patty Cason and another speaker, and I've included the link for you there if you want to go back and have a look at that webinar that has to do with contraceptive counseling strategies. Really well done. And all of what is in that webinar is now reflected in the updated QFP guidelines.

Michael Policar:

Okay, I'm trying to get to the next slide. Oh, there we go. I got to go back one. Okay, we're jumping all over the place. Sorry about that. Lemme see if I can go backwards. I'm getting really close, I promise. Okay, here we are. Alright, so this is the link to the actual publication of the Quality Family Planning Guidelines. It was published in the American Journal of Preventive Medicine in December of 2024. Note that this was not part of a collaboration with the CDC, this was done entirely with the Office of Population Affairs, but with this link you'll be able to get the full article. Now, one of the things that's very helpful is an online QFP guide, and I've included the link for you: QFPguide.org. This lists all of the different topics that are covered in the Quality Family Planning Guidelines. And you can click on these 10 different domains.

Michael Policar:

It will go into much more detail about what's in the QFP. So for example, fundamental issues of sexual and reproductive health care in that first box, determining that an individual's need and desire for services, person-centered contraceptive care, STI and HIV care, pregnancy testing and counseling, early pregnancy management, which is a new section, performance measures and so on. So this as a job aid is just incredibly helpful because of the fact that it will give you lots of recommendations at your fingertips in terms of these quality family planning services. By the way, that was actually down for a short period of time, but that was up and available. So let's go to what you really came for, which was to hear more about what's new in the MEC, the Medical Eligibility Criteria and the Selected Practice Recommendation. So fundamentally, the difference between these two documents is the fact that the Medical Eligibility Criteria focuses on safety for contraceptive users, while the SPR focuses much more on efficacy on how to use methods correctly in order to both maximize effectiveness and minimize side effects, for example.

Michael Policar:

So this is the cover from the updated version of the Medical Eligibility Criteria published in Morbidity and Mortality Week reports. Lots of different ways for you to actually get that. Oops. The second one that went by very quickly was the cover that had to do in that same issue of MMWR for the Selected Practice Recommendations. Now this is the template which is used for being able to look at the safety of various methods of contraception in people who have underlying medical problems. Again, originally that came from the World Health Organization and we use it more or less the same way in the U.S. CDC Medical Eligibility Criteria. Remember those four categories are category one, which means that the method is considered to be safe for a person who has a particular condition and they can use the method. Category two means that there may be some small problems associated with using that method for a given individual that are either proven or theoretical, but it's still reasonable for the person to use the method.

Michael Policar:

However, the recommendation is that person may need a little bit more follow-up. And a good example of that might be a person who has type two diabetes maybe is using metformin or insulin that decides to use a hormonal method of contraception. One of the things we might have to do is to follow up that person a little more closely to make sure that the progestin part of their method is not having a negative impact on their blood sugar levels, but still perfectly reasonable for them to use the method. Now, what a three means is that now we're starting to get into this very close balance between benefits of the method and the risks of the method. Anything that is considered to be, I mean, a category three is still safer for that individual than actually becoming pregnant, but there could be significant problems of using the method, but they're usually outweighed by the benefits.

Michael Policar:

So there are two different subsets of category three. One is when there's information about the benefits and risks of that particular method, and they're explained in the Medical Eligibility Criteria; there are other circumstances where there just aren't very many published studies. And so instead the CDC had to rely on expert opinion in deciding which particular category this should be in. But in general, we'd rather see people use category one or category two methods, but if they don't work or that's not acceptable to the client, then it's fine to use a category three method with appropriate follow-up. And then finally, the

category four methods are one where the harms or the risks are substantially more than the benefits in a person shouldn't use the method in her particular circumstance. An example of that might be a person diagnosed with breast cancer treated for that within the last year or two, and we try to stay away from hormonal methods so that it wouldn't have an effect on recurrences, for example.

Michael Policar:

Okay, trying to get to the next one. There we go. Now, one of the things that's kind of underappreciated as it relates to the MEC is the fact that remember the way that it works basically is that they look at various underlying medical conditions as well as various categories of contraceptives. That's where those numbers come in. But one of the things that's contained in the document and in the app by the way, is what is called clarifications, evidence and comments. And I think that oftentimes clinicians don't look at that and we really need to. So why there a necessary element is that it gives you a lot more explanation when the numbers are just not enough. And I can tell you, having been on that expert panel, the three times that we've worked on these, we really spend a lot of time on the comments just because of the fact that sometimes there are nuances, they're just not picked up in that number system. So it clarifies the numeric category. If the number doesn't actually capture what the recommendation is, it summarizes the evidence for the recommendation if it exists.

Michael Policar:

And as I said, when there's no evidence available, then we use expert opinion either from the WHO or from the U.S. expert meetings. The comments provide additional rationale for the recommendation and oftentimes references additional detail that can be used during counseling and referrals. So I'm going to give you an example of how that works. So this is an updated version of what the U.S. MEC says about headaches. So the first line is people who have headaches that are not migraines. So that might be tension headaches, cluster headaches and so on. And you can see that every single method is considered to be MEC one. The next two lines refer to people who have migraines without aura and with aura. And you can see that for everything except for the last column, which is combined hormonal contraception, oral contraceptives, patch, and ring, they're also considered to be one.

Michael Policar:

But for people who have migraine without aura, that's a two migraine with aura, that's a four. So they shouldn't use the method, but you'll notice the asterisk. The asterisk refers to what's contained in the clarification, evidence and comment. And what that says for headaches is the classification depends on an accurate diagnosis of what kind of headache it is. So it gives you references, particularly in this case the International Headache Societies classification of headache disorders, to help you as a clinician figure out is this a migraine without aura, a migraine with aura, attention, headache, a cluster headache, a post-traumatic headache. And then the clarification goes on to say that if a person has new headaches or changes in their headaches, once they start a method, you need to evaluate that and that the classification system of the ones, twos and fours is for people who don't have stroke risk factors. And if they do have stroke risk factors, then you're going to use different judgment in making the decision about whether or not to use a hormonal method. So please pay attention to the comments just because they may change your mind in terms of whether or not you're going to recommend a particular method to a patient. Now let's talk more generically about what some of the changes that occurred in the Medical Eligibility Criteria and Selected Practice Recommendations this time around. And then that is that there's a real emphasis on person-centered counseling and method provision emphasizing reproductive autonomy, people making their own decisions, how to go about the process of shared

decision making, and a real wonderful definition and explanation of what patient-centered approaches are to contraceptive decision making. And by the way, the QFP 2.0 goes into even more detail on that particular topic. The language is much more gender inclusive.

Michael Policar:

And then the third point is they, they really made a point of trying to tie into definitions that are used in, let's say, internal medicine, for example, for various kinds of conditions to make sure that they were doing the same thing. So when it comes to clotting disorders like thrombophilia or hematologic conditions or various subcategories of liver disease like cirrhosis or solid organ transplantation, those definitions were updated to make sure that they match the rest of the medical literature. Now again, a real emphasis is on a person-centered approach to contraceptive counseling and decision-making, and that prioritizes what the patient's preferences are in terms of what they need in a method of contraception. And it really sort of explains the fact that not everyone is thinking about using the most effective method. We as clinicians tend to focus on efficacy, but many of our clients, that's not their priority.

Michael Policar:

They're thinking about other things. Will my partner find out what about side effects? How convenient is it, what's the cost? All those kinds of things might go into their decision about the method. How would they deal with the reality of the method didn't work, then they had an unintended pregnancy. So with this approach, it expects the individual as being the main decision maker, not the clinician, and points out the fact that we have to respect the decision that a client might have about discontinuing a method like I want my IUD or my implant out, or the decision not to use contraception at all and just to be open to pregnancy, for example. Okay, so much more of that in this version. Now the next thing that I want to mention before I hand things over to Jen is some of the resources that are available to us. And these are all available for free, developed by the Centers for Disease Control. So one is just going straight to the CDC website that has to do with the Medical Eligibility Criteria and the Selected Practice Recommendations. The URL is below, and not only can you get the documents of the MEC and the SPR, but quite a number of others as well.

Michael Policar:

Okay. Oops, I'm going to go back one because I missed something that I really want you to see. And unfortunately our ability to share these slides is a little bit sluggish, but I'm getting there. Okay, one more. Alright, good. That's what I wanted. That is I wanted to show you the picture of the app. So I know that most of you who are with us today have already downloaded the MEC SPR app. Maybe in its earlier version, hopefully you've also downloaded the new version as well. So you can see that over on the left side that when you bring this up on your cell phone, for example, whether it's an Android phone, an iPhone, or a tablet and so on, you can see that you can look up the Medical Eligibility Criteria, classification by condition, in other words, high blood pressure, heart disease, history of deep vein thrombosis being postpartum and breastfeeding and so on.

Michael Policar:

The second is by method. So you could look at what all the recommendations are for pills, patches, and rings for progestin only methods and so on. Then there's a link to the Selected Practice Recommendations. And then that bottom box is if you've saved any information, then the middle

column will give you an example of the kinds of medical conditions for which the MEC has made recommendations based on age anatomical abnormalities, which are primarily of the uterus, things like fibroids, people who are on anti-convulsant therapy and so on down the line. And then you'll see over on the right side the fact that the app also covers the topics that are covered in the Selected Practice Recommendations. So you can do that by chapters that have to do with specific methods. Copper IUDs levonorgestrel IUDs, the ones that circled is a new chapter that has to do with testosterone use for gender diverse people.

Michael Policar:

And all of that is available on the app. So if you haven't downloaded it yet, it's available for free, please do that. Just type in contraception in the app store and you'll be, in fact better yet, CDC contraception. And then you'll be able to download it after that. You've already seen this other provider tools which are on the CDC website or MEC summary tables. I'll show you that in just a second. And then a whole bunch of new algorithms that are included. So when to start contraceptive methods, what to do if you're late in starting your method or you miss pills. Management of people who have PID when they use an intrauterine device management of bleeding irregularities while using contraception. All of those tables have been updated and are available both on the website and on the app. This is an example of the two page summary charts that are available.

Michael Policar:

And I love how they've done this because of the fact that they are color coded. So if it's dark green, it's a one. If it's light green, it's a two. If it's sort of that light rose color, it's a three. If it's a darker red, it's a four. And this is page one of that summary of the MEC. And then there's a second page as well that includes all of the conditions that are covered in the Medical Eligibility Criteria. So again, the way that a lot of people use that is to download it printed on a color printer, put it in a binder, or literally put it on bulletin boards in each exam room so that it's available to people. But if not, clinicians are very used to able to use the app for the purpose of looking at those numbers.

Michael Policar:

And one other thing to say, and I think Jen was actually responsible for getting this done, but now on the familypact.org website, you can also have access to the same resources from the CDC, the MEC, the SPR, the summary chart, and so on. If you have trouble getting into the CDC website, you're going to be able to access all of those on the familypact.org website as well. So with that, I'm going to stop for a little while, hand the microphone over to Jen, who is going to explain specifically what the updates were in the Medical Eligibility Criteria and the SPR. And then after that, we're going to do a couple of cases.

Jennifer Karlin:

Great, thank you so much, Mike. So thank you for giving us that great history and overview of where we get all these guidelines from and where we can find all the provider tools. I'm going to jump in and do a little bit more of a deep dive into what are the changes that were made between the last version of the MEC and SPR and the new 2024 version. So I'm going to, there we go, advance the slide. So one of the major changes is that there were new disease categories that were added to the me. So one of those new disease categories was chronic kidney disease, and that includes a breakdown of specific situations that people could be in with chronic kidney disease, like having nephrotic syndrome or being on hemo or peritoneal dialysis, which is now included in the current version of the MEC that wasn't there before.

Jennifer Karlin:

And then the inclusion of new contraceptive methods since 2016. And so these new contraceptive methods include new formulations of combined pills or patches or vaginal rings, new formulation of our progestin only pills, all four of the levonorgestrel IUDs and the vaginal pH modulator. And I wanted to make a note so that everybody on this webinar remembers that Twirla, Annovera, all four levonorgestrel IUDs and Phexxi are all FPACT benefits. So all of your clients can access these with their benefit package. So there's also been some changes in the way that the MEC is laid out. And so before the MEC used to be laid out where all of the diseases and different contraceptive methods would fall into a specific category, either one or two or three or four. And now we have some combined categories. So a MEC category one slash two, and that really speaks to the considerations that Mike had brought up a little bit earlier.

Jennifer Karlin:

So an example is MEC, category one slash two, it's now considered for chronic kidney disease for the contraceptive methods of the copper IUD, the levonorgestrel IUD, the implant, the barrier, norgestrel and norethindrone, progestin only pills. And then for the category three and four, you'll see our combined hormonal contraceptives, depo hydroxyprogesterone acetate, and then our sperone progestin only pill with known hyperkalemia. And so if known hyperkalemia and you're worried about worsening where it really becomes a MEC four, they've done a really good job to have you think about what are the specific conditions that would push somebody to a four rather than a three when that category is there. So again, the importance of looking at those asterisks and those nuances when you're looking at the MEC, it also speaks to the more person-centered approach that was taken in this version because this really gives more decision-making ability and shared decision-making between the guidelines, the provider, and the client. Who's the most important decision maker in the end?

Jennifer Karlin:

Alright, there were also a few updated recommendations that were just tiny tweaks up and down, and they include everything on this list. For example, postpartum or post-abortion, including medication, abortion, cirrhosis, liver tumors, and solid organ transplant. I want you to take a second to just look at this list. And the most important thing about this list is to remember to take a look at your new guidelines before you think that you might know what category some of the contraceptive methods fall into. This is the importance of really downloading the new updated version on your phone because in our heads we might remember, oh, that's a one and now actually it's a two and maybe we just want to talk to our client about that a little bit more. And so I just want you to have this list to remember that there were small tweaks to categories, although nothing really large changed in these categories. So just to keep in mind, take a look before you prescribe something, make sure that your memory is the same as where the guidelines are until we all get used to using all of the new guidelines.

Jennifer Karlin:

Okay, so there were also some, I wanted to point out some of the updated recommendations where there was less concern about safety or more concern about safety. So again, just getting these sort of in the back of your head, we're not going to remember all of these immediately, but just have it in the back of your head. So you could say, oh, I remember Dr. Karlin said something about depo hydroxy progesterone acetate. I can't remember if it was more concern or less concern. I'm going to look it up real quick. It's more concern, but we'll show you how and when right now. Okay, so less concern about

safety. These are some of the disease categories that moved down in safety. So they were a three or a four. So they were those categories that we really wanted to stop and talk to our clients about. If they were a three, really explaining to them that we had some concerns about risk and if they were a four, not using them with patients who had those disease categories and they have moved to a one or two. So really less concern about safety. And those include our solid organ transplant and graft failure for IUD initiation. So any IUD initiation copper or levonorgestrel IUDs, our systemic lupus positive or unknown antibodies for levonorgestrel IUD, our implants and our progestin only pills have moved down to a one or two decompensated cirrhosis has also moved down for levonorgestrel IUDs implants and progestin-only pills. And then our hepatocellular adenoma has also moved down for those three categories of methods choices.

Jennifer Karlin:

This is not such a big change because it just moved from a two to a one, but our high risk for HIV IUDs moved down to a one. So no concern. Solid organ transplant, no graft failure, IUDs down to a one and then major surgery with prolonged immobilization levonorgestrel IUDs implants and progestin only pills have moved down also to a one. And all of this is based on new evidence and research that has really come out to support these moves. And then lastly, a previous DVT or PE and on anticoagulation therapy at a therapeutic dose for combined hormonal contraception has moved down from absolutely not to a let's have a serious discussion with our client from a four to a three. So those are all the areas that we have less concern about safety. Now on the right, I'm going to talk a little bit about some areas that have more concern about safety.

Jennifer Karlin:

So as I gave you a little bit of a foregrounding about our depo hydroxy progesterone acetate has increased in risk from a one or two to a three or four for people with venous thromboembolism. So a previous one, our sickle cell disease for combined hormonal contraceptives and also for depo hydroxy progesterone acetate. And then peripartum cardiomyopathy and impaired cardiac function has also moved from one to two, to three to four. So really try to keep that in the back of your head for those categories. That's a big change where you really want to talk to someone before initiating those. And then a one to a two, a little bit more concern about safety, but still in the one to two range is our conditions with increased risk of VTE. So your depo hydroxy progesterone acetate, and then your postpartum less than 10 minutes after delivery for IUDs and post-abortion, first trimester medication abortion with mifepristone for use for the abortion initiation for depo hydroxy progesterone acetate. So not for a misoprostol only post-abortion, but a post-abortion with mifepristone and misoprostol has moved from a one to a two. So again, really thinking about those first lines, the three to four to the one to two, and the one to two to three to four is a little switch in her brain that needs to go off with these changes. Oh, I'm having the same problems as Mike here. Hold on. Sorry. Okay, there we go. Okay,

Jennifer Karlin:

So the next larger change, like I mentioned before and this now our previous slide and was thinking about different disease categories, this is more about the method. So really here what we're seeing is there's been a lot of data that's come out talking about increased risk of clotting with depo hydroxy progesterone acetate. And so that is really why you're seeing all of these changes in these disease categories moving from a one to two to a three. It's really about the data that's come out about depo-methoxyprogesterone acetate. And so when we're thinking about increased risk of clotting, we're thinking about people with a history of DVT and pulmonary embolus. We're thinking about people with

thrombophilia, we're thinking about people with sickle cell disease, and then those other postpartum cardiomyopathies that I mentioned earlier, and then again, postpartum, we're thinking about people who are postpartum. So at increased risks of clotting because of still the increase estrogen in interaction with the depo medroxyprogesterone acetate makes them at a higher risk of clotting disorder. So again, in your head you just think, okay, I remember Dr. Karlin saying something about there being a higher risk. We think about clotting with depo methoxyprogesterone acetate. I'm going to just take a look in the MEC, but that was one of the big changes that came out in the MEC and now I'm going to move on to the SPR and tell you about some of the changes.

Jennifer Karlin:

There. Alright, so the SPR was updated as Mike was giving us a little bit of background about in alignment with one another because it's part of this compendium of resources that we have. And so the changes that were in the SPR really align with our changes in the MEC. And then there were some new recommendations. So testosterone, one of those new recommendations is that testosterone risk use and risk of pregnancy among transgender gender diverse and non-binary persons with uterus is discussed in the SPR. In addition, the self-administration of depo hydroxy progesterone acetate is discussed in the new SPR and that aligns again with the MEC and all of the recommendations in it. Also, there have been updated recommendations on how to manage bleeding irregularities during implant use and then also pain management for IUD placement is a big change. That was included in the SPR. And we actually have already had a detailed Family PACT webinar on this topic on September 17th. So you can find that on our webinar section of the Family PACT website about pain management for IUD placement. We will also be talking about paracervical blocks and pain management for IUD placements at our IUD placement workshop in October in Sacramento. So you could come meet us there and get a hands-on experience with that if that's what you're looking for. So just a heads up about that. Alright, so the new SPR 2024 recommendations for testosterone use and risk of pregnancy is that for people who are using testosterone, we really need to be thinking about counseling that it may not prevent pregnancy and then offer contraceptive counseling to those who are still at risk of pregnancy. So that's the main update included in the SPR about testosterone use. And then the main update about subcutaneous injectable contraception with our depo hydroxy progesterone acetate subcutaneous version, which is 104 milligrams, is that it should be available for self-administration along with the intramuscular version to everybody who is coming in to hear about contraception. And I wanted to note that again, currently the subcutaneous injection is only available by prescription from pharmacies. So you would need to write the prescription. The client could pick up the subcutaneous depo and they could either inject it themselves or they could come back to learn how to inject with you in your office.

Jennifer Karlin:

Sorry about the delay of this cursor, it's just taking, okay here we go. And then like I mentioned, the medications for IUD placement and the paracervical block has been covered in previous Family PACT webinars. And the main update to the SPR is that we should be talking about clients' pain that they may experience during IUD placement and then ways of managing it that work for them. So different clients have various ways of already coping with pain and discomfort themselves. So finding out what those are and utilizing those and then offering the tools that we have in our toolbox for helping with pain management in the clinic setting. This jumped, just need to go back one. There we go. Alright. And then it just needs to go back, Nicole. I'm not sure if you can control the back. I can't seem to get back.

Nicole Nguyen:

Yes. Let me do that for you right now.

Jennifer Karlin:

Thank you.

Nicole Nguyen:

Lemme know when to stop

Jennifer Karlin:

Back. One back one. Okay, perfect. Oh, okay. We did that and then forward about testosterone and then forward and subcutaneous depo covered by FPACT. Okay, next one. Next slide. We were in the right place. Okay, here we go. So also the SPR included two different types of progesterone only pills, so the better known as the O Pill and Slynd in their SPR about when to start a specific contraceptive method. So that was another breakout and change is by including both of those options and talking about the additional contraceptive or backup that's needed because those are different for the O pill insulin. So, make sure when you're prescribing your progestin-only pills, take a look at that provider, the provider tools to find when to start a specific contraceptive method. So now we're going to just

Michael Policar:

Really quick comment before you go on. And the reason that those are highlighted is number one, because those methods were not available in the 2016 version. In other words, Slynd came out after the 2016 O Pill, of course, is the norgestrel progestin-only pill, which is available over the counter. And you can get that in a pharmacy in a grocery store, it's available on Amazon, you can buy O Pill now without a prescription. And the questions come up is O Pill covered by Family PACT and by Medi-Cal? The answer to that is yes, it's a little sort of convoluted in terms of how to actually access it, but they are covered. Slynd, the drospirenone progestin only pill, is not either a Family PACT benefit or a Medi-Cal benefit. It has to do with the way that contracts are done with the drug company that makes Verone Progestin pills or Slynd and how they work with the Medi-Cal pharmacy branch. So that was not a decision that was made by the Office of Family Planning not to cover Slynd. It has to do with how the pharmacy branch and their partner healthcare services work. Okay, Jen, back to you.

Jennifer Karlin:

Great. So now we're going to see how much Mike was actually paying attention. And I'm going to pose a case to you, Mike, and if you could tell me a little bit about what you know about, you could just advance the slide, Nicole, about chronic kidney disease. Great. So, Mike, your case is we have a 28-year-old G2P2 with chronic kidney disease due to diabetic nephropathy here and about to require hemodialysis. So they're here to see you, they want to initiate a contraceptive method and they're trying to decide between an IUD or another hormonal method. So out of the copper IUD, the levonorgestrel IUD, the implant deoxy, progesterone acetate, the progestin only pill, or any of our combined hormonal contraceptives. How would you go about talking to this client and answering this question? Next slide.

Michael Policar:

Okay, there we go. So as Jen mentioned, chronic kidney disease is one of the new disease states, which is included in the 2024 version of the MEC. It was not in earlier versions. The reason why, by the way, was because there weren't very many studies about the use of hormonal contraceptives in people with chronic kidney disease. But since 2016, there have been enough studies published to be able to come up with these recommendations. That's why it's brand new. Now, chronic kidney disease is not common in people of reproductive age, but it's not rare either. About 14% of adults have chronic kidney disease. It's somewhat more common in females than it is in males. And there is an increasing prevalence of chronic kidney disease with age. And that is to say about a third of people who are 65 or older, about 12% of adults between 45 and 64, which is kind of on the edge of the older age group for contraception. But 6% of adults between 18 and 44 have chronic kidney disease. Unfortunately, I'm not going to be able to advance. So Nicole, next slide or next? Just hit it once. There we go. Oh yeah, take remote control. Go ahead Mike.

Nicole Nguyen:

Go ahead Mike. You can advance the slides now.

Michael Policar:

All right, good. Okay. Hopefully flake. Oh, there we go. Okay. So the prevalence of chronic kidney disease among people who are reproductive age females is not entirely known, but the global estimate is somewhere from one in a thousand all the way up to 6%. About a hundred thousand women aged 18 to 54 in the US have end-stage kidney disease, of which about 13,000 were diagnosed in 2019. So again, it goes along with what I mentioned a moment ago. It's not common, but on the other hand, it's not rare for us to have to deal with this. Now, one of the things that we do know a fair amount about is problems related to pregnancy in people who have chronic kidney disease. And this is a study that was published in 2019 that looks at a variety of different obstetrical outcomes in people who have higher stages of chronic kidney disease, stage three, four, and five being much worse versions of chronic kidney disease. So you can see rather that when people have the higher stages of chronic kidney disease, they're more likely to have progression of their kidney disease, which leads to a need for them to use dialysis. They're more likely to develop hypertension or preeclampsia when they're pregnant. And near term average birth weights are lower in people who have higher grades of chronic kidney disease and they're substantially more likely to have preterm delivery. Look at those bottom two lines. And you can see that for people who have stage three or stage four or five chronic kidney disease, that quite a lot of 'em, not quite a majority, but almost are at risk of having a delivery at under 34 weeks. So there are certainly risks of being pregnant going to term with chronic kidney disease. And for people who don't want to take those pregnancy risks risk, we need to be clear about what their contraceptive options are. Okay, there we go. Alright. Now one of the things that the CDC really focused on is the fact that when people have chronic kidney disease, they're at an increased risk of clotting problems, both on the venous side and the arterial side. So this looks at the increased risk particularly of venous thrombosis in people with severe chronic kidney disease. Those who use dialysis, people who have a diagnosis of nephrotic syndrome, often overlap with each other. We know in addition to that risk of both venous and arterial thrombosis, there's an increased risk of bone fractures in people who have severe chronic kidney disease and if they use dialysis, we really don't have a whole lot of studies looking at hormonal contraceptive use in people who have a variety of those kidney conditions which lead to chronic kidney disease. But we know that among people who have chronic kidney disease, that our concern is that using combined hormonal contraceptives with estrogen, that is to say pill, patch and ring might increase

their thrombosis risk on top of the already increased risk they have because of their kidney disease. And now there's concern that Depo-Provera might do the same thing, not to the degree that the estrogen-containing methods do, but Depo can do that, okay? Not only increase the risk of deep vein thrombosis and pulmonary embolism, but we also know that because depo reduces endogenous estrogen levels, some people will lose some amount of bone mineral density as a result of using depo. That's already happening in people with chronic kidney disease. So the concern is that that bone loss might be even worse in people who have chronic kidney disease and who use depo. Okay, we went too far. Let me see if I can go back. If not, Danielle. Now we're still going too far. So here we go. Lemme go back to now three. I'm sorry. This is how, okay, there we go. That's what I was looking for. So now we have to go forward and what this rather busy table is telling us basically is the effect of various progestins on clotting disorders, particularly the likelihood of venous thromboembolic events on the venous side. And this looks at a whole variety of case control and other comparative studies, which basically refer to where those risks of clotting disorders, deep vein thrombosis, and pulmonary embolism are the highest. So people who use the DMPA injectable diphenyl hydroxy progesterone acetate, any TA is hydroxy acetate. That's where the risks are. The highest NPA is oral Provera. And then the three at the bottom are people who use levonorgestrel, use contraceptive implants, neuro syndrome by itself and the levonorgestrel IUD.

Michael Policar:

And you can see with the three at the bottom, particularly with implants and with Levo Inge IUDs, there is no increased risk of venous clotting in the way that we see that occurring with people who use depo. And it's studies like these that led to all these upgrades of the classification in using Depo-Provera because historically we've said using Depo-Provera doesn't increase the likelihood of clotting disorders, but now we realize that there is some contribution, although it's not nearly as great as it is with estrogen. Now we know that in people who use combined hormonal contraceptives, that there clearly is increased risk of thrombotic events that happens with increasing age, particularly in the late forties and into the fifties. People who are obese who are smokers, particularly heavy smokers, people who have hypertension thrombogenic mutations like factor five, lain defect, lupus and diabetes. So we already know from those studies coming out over, geez, the last 30 years or longer, people who use pill patching have an increased risk of venous thrombotic events. We don't know much about other thrombotic conditions and we really don't have a lot of evidence on patch or ring some, but not a whole lot. And so we rely more so on the combined oral contraceptive data.

Michael Policar:

Okay, too far again, let me see if I can go back one. Okay. Alright. So that's what happens with combined hormonal methods. The next part has to do with progestin only contraception. Okay? And that is to say we know with depo that there's an increased risk of venous thromboembolic events when people use depo postpartum or if they're diabetics for other progestin early contraceptives. There's limited evidence. And here we're talking about levonorgestrel IUDs, for example, or implants. That limited evidence shows that there's no increased risk of DVP pulmonary embolism and we just don't have evidence on most other thrombogenic conditions.

Michael Policar:

Okay, now there we go. Alright, so here's some examples of medical conditions that are related to chronic kidney disease, not the same but related. And the reason I showed this is that the top panel is for people who have diabetes. The bottom panel is for people with hypertension. You can see all the

way over on the right side that for combined hormonal contraception for people who have more severe manifestations of disease, for example, diabetics with nephropathy retinopathy, nervous system problems like neuropathy, people who have had diabetes for over 20 years that combine hormonal contraceptives because of this risk of both arterial and venous thrombosis or either a three or a four. And by the way, whether it is a three or a four depends on their severity of disease. Some people have less severe disease, other people have much more advanced disease. The more advanced disease, the more likely it's to be a four.

Michael Policar:

And by the way, I want to just mention one other thing we haven't talked about, and that's the difference between the I'S and the c's. So one column for the I refers to initiating the method, the C part of the column refers to continuing the method. So if a person's already using method and the developed diabetes or the developed hypertension, that's how it relates. So we know with other medical conditions like diabetes, like hypertension, that there is an increased risk of thrombotic events. Now what's new is in the DMPA call because now you can see with there are more advanced conditions with either diabetes or with hypertension, that now those are threes and they used to be tubes in people who use DMPA.

Michael Policar:

All right, so that in a moment we'll get us to the last slide that has to do with chronic kidney disease. There we go. Now this is really taking a while. I may have to have Nicole advance that one for me. Okay, there we go. And so this is a summary of the 2024 MEC recommendations about chronic kidney disease. So basically what it's telling us is that for people who have nephrotic syndrome who are on hemodialysis copper IUDs are ones believe or levonorgestrel IUDs and implants are twos. DMPAs are threes because of the contribution to clogging effects. Progestin-only pills are mostly twos with the exception of Sperone pills. That is to say S slim in a person who has known high potassium levels. And then in any of those kidney conditions, either starting or continuing the use of pill, patch, or ring is considered to be a four.

Michael Policar:

Okay. So just to finish up then on the case study that we're doing is what methods can she use given the fact that she's not on dialysis yet, but may need that at some point? Nicole, just advance it one more please. And it'll have the answers to our case study. There we go. And that is for a 28-year-old G2P2 with chronic kidney disease, what's considered to be perfectly acceptable methods, including copper IUDs, levonorgestrel, IUD implants, and most progestin-only pills. Depo is considered to be a three; drospirenone, known in a person who has high potassium levels, is a four. Patch, ring are also considered to be forced. So that's that case. Now I am going to read a case that Jen is going to answer and it's about a person who has sickle cell disease. If we can get this going. All right,

Nicole Nguyen:

Jen, you should be able to control it.

Michael Policar:

Okay. Yeah, she's going to bring us the case, which I'll read Nicole, I mean then Jen is going to answer. There we go. So our case is a 35-year-old G3P1 with sickle cell disease and she's homozygous, so she's SS sickle cell disease, not sickle trait with a history of hospitalization for painful sickle crises. And she'd like to initiate a contraceptive method and is considering either an IUD or a hormonal method. So in a person with sickle cell disease who has a recent history of painful crises, which methods can be used. And here again, our alternatives are either type of IUD, implant, Sperone, progestin-only pills, or combined hormonal contraceptives. So what would you say again about methods for this 35-year-old patient?

Jennifer Karlin:

Great, thank you, Mike. So when I'm thinking about this, I'm really thinking about both the pain crises and whether there are methods that will help or will hurt the previous pain crises. And then also the likelihood for someone with sickle cell to have more risk of stroke and clotting disorders. And so really those are the two things that are in the back of my mind when I'm thinking about someone with sickle cell. And then the other issue is their anemia. How are any of these methods going to affect their underlying low hemoglobin levels and anemia? And so the first thing I think about is, okay, old MEC, which hasn't really changed on this, is that our copper IUD is a two. Now with the two again, you really need to think about what the person's baseline anemia is, because what a copper IUD will cause is a higher likelihood for increased blood loss in someone who is already anemic.

Jennifer Karlin:

And so it really matters how bad that symptom is for that particular individual when you're thinking about using a copper IUD. So that's the first thing that we will think about. And then just for some background on sickle cell disease, as you mentioned, this is somebody with sickle cell disease. So they have actually two recessive traits as opposed to sickle cell trait where you would only have one and it is a disorder of the beta globulin mutation. So it causes sickling of the red blood cells, and that sickling, that change in the shape of the red blood cells, is what leads to venous stasis, blood being more hyper-viscous, and those Vaso-occlusive situations. In addition to tissue infarction and anemia, I already mentioned there's two different, there's homozygous sickle cell disease and then there's the trait and the prevalence in the United States is about a hundred thousand people, but it occurs differently in people with different origins, which oftentimes we name as black or of African origin. So it's one in every 365 black or African-American births, and then one in every 16,300 Hispanic births. So it's just a little background.

Jennifer Karlin:

And as I mentioned earlier, individuals with sickle cell disease are at an increased risk for both arterial and venous thrombosis. So a quarter of them will have a stroke by 45, which is quite impressive. And then 11% incidences of a venous thromboembolism by the age of 40, and that was from a single institution cohort study. So we need to be very concerned about venous thromboembolism in our patients who present. Okay. The other thing that we know from a few meta-analyses is that the concern for a baseline risk of A VTE is actually higher in people with sickle cell disease than a pulmonary embolus.

Jennifer Karlin:

And both of those more than a deep venous thrombosis. All right? And there's a higher concern for recurrent vte. So if one of your clients has had a previous VTE and has sickle cell disease, that means they're at an even higher risk for a recurrent VTE. So here you see the odds ratio in pregnant and postpartum people for a venous thromboembolus of 33, and then of a DVT in pregnant people of 30. So again, we're talking about a third of people with sickle cell disease. So really important for us to keep that in mind.

Jennifer Karlin:

There's been a lot of evidence from meta-analyses about contraception in people with sickle cell disease. And so this is a summary slide of that. This is really great to look back on. So when we're thinking about stroke, there was a secondary analysis of a large prospective cohort of both occlusive and non-occlusive strokes, and there's an increased absolute risk of stroke for people with sickle cell disease for venous thrombosis. There are two studies that we pulled from that show that there is a low prevalence of thrombosis among hormonal contraceptive users with sickle cell disease, but no relative risk was examined. So really just looking at the overall prevalence and then to note for pain, we talked about this in this case, this particular case showing that the person had had previous pain crises. So what do we know about contraception and pain crises? Well, we do know that combined oral contraception and progestin-only contraception did not increase the frequency of pain. And in fact, depo medroxyprogesterone acetate may decrease risk of pain crises. I dunno why this, sorry,

Jennifer Karlin:

Moved ahead. Okay. May decrease risk of pain crises and also dysmenorrhea DMPA does decrease dysmenorrhea in other populations of people, not just with sickle cell disease. Again, this really points to the fact as we've talked about, DMPA increases our risk of venous thrombo embolus, but it may decrease the risk of pain crises. So really talking to your client about what is it you're worried about, what is the likelihood of your disease course and what may happen to you when you're thinking about contraceptives. And then osteopenia, there were two small studies that generally showed no increased risk of lower bone mineral density or osteopenia among those of hormonal contraceptive users. Alright, so the next slide, there we go. So with that evidence at hand, how did that get incorporated into the 2024 MEC updates? So what you will see here is that the combined hormonal contraception went from a two to a four for sickle cell disease.

Jennifer Karlin:

So really higher concern about those VTE and DVT risks. And then your DMPA also went from a one to a two or three again indicating, and that superscript of the B is really moving towards A three if somebody has a higher risk of venous thrombo embolus. So that would be someone who has had a previous VTE, as I mentioned, because the recurrent VTEs make you more likely to have more VTEs. And then you'll see, like I mentioned at the beginning, that the copper IUD and the concern for anemia and causing higher rates of blood loss with a copper IUD did not change. So that's still at a two.

Jennifer Karlin:

All right, so that in summary for this patient, you would really want to think about the levonorgestrel IUD, the implant, your progestin-only pills, and your copper IUD. If you had someone who really was

concerned about their pain crises and they wanted to decrease the likelihood of that, I would talk to them about DMPA and risk and balance those two side effects with them. Then, really, staying away from some of our estrogen-containing contraception is the update. So I'm going to summarize everything that we've talked about and give you some take home points. So the CDC's U.S. MEC and SPR are really excellent resources. They are available on our Family PACT website. They will stay available on our Family PACT website. They have been off and on available on the federal website. So if you are looking for these materials, go to your Family PACT website and you'll be able to find them there and we will keep them updated. Most people can safely use most methods. We really want to tailor our contraceptive counseling to be non-coercive, respect autonomy, and understand that different people have different goals and aims with their contraceptive, and it might not always align with ours as a provider. Most of the MEC category updates were related to the effect of DMPA on increasing risk for venous and arterial complications.

Jennifer Karlin:

The new disease categories that are included in the MEC were CKD, and most methods can be used in people with chronic kidney disease, except again, those that increase the risk of Veno thrombolysis and arterial complications. So that's your depo hydroxy progesterone acetate at a three and your combined hormonal contraceptives at a four because of the estrogen component, which can increase potassium levels. So our Sperone progestin only pills with hyperkalemia is now a MEC four for our sickle cell disease. Another new disease category. Most methods can be used in people except those that increase the risk of thromboembolism. If there's anything that you learned from this, that is the take home from this talk today. Again, depo hydroxy progesterone acetate, added two or three, and then your combined hormonal contraception at a MEC four. And then we really want to think about talking to all of our clients about pain reduction in IUD placement, but also with all of our contraceptive methods if we're doing any other GYN procedures or just talking to people about the side effects of any of their contraception, we really want to preemptively talk to people so we could help them work with strategies that will work for 'em.

Jennifer Karlin:

And then the other big announcement I wanted to say is that the Reproductive Health Hotline is a new service that is going to be offered out of UCSF. It is funded by the state of California, and it's a free, confidential, and nationwide on-demand hotline that can answer your questions in the moment when you're seeing all of your clients in the clinic. You could pick up the phone and phone a friend. Experts in sexual and reproductive health will be picking up the calls live, and they'll be able to answer any of your questions about the MEC and SPR, vaginitis, or any other questions that you have. Miscarriage management, abortion, where legal, you can call 1 8 4 4 Repro. We are live as of Monday. You can review our terms of service@reprohh.ucsf.edu and learn more about us. And you could also connect to us and get our materials by scanning this QR code. So I just wanted to let you know about this. It is sustainably funded for the next five years, so please give us a call, ask us. There's no dumb questions and there's no question too complex. So please call us about anything that you have questions about regarding sexual and reproductive health and we look forward to talking to you there.

Michael Policar:

Jen, one quick question about the hotline and that is, can you type in a question, or does it have to be by telephone?

Jennifer Karlin:

It has to be by telephone. And the other thing to note is we've taken a lot of care for this to be confidential and anonymous. So we do not collect a lot of data. If you are in the state of California, we will ask if you want to provide your information so we could keep you updated. But other than that, we will not be collecting any information. And that's also the reason why we don't accept texts at this time because we wanted to provide a service that was comfortable for everybody to call in. We may at some point be able to do text, but right now it's just by phone. Great question. Alright, and then I'll move on also, I had a few thanks, Mike before I finish, to some of our CDC colleagues who are previously in the division of reproductive health who created, did all the research and the systematic reviews to create these incredible provider guidelines for us and to give us so much evidence in such an easy way to understand with these tables and spreadsheets. So I just wanted to give a shout-out to Antoinette Nguyen and Kate Curtis. And then of course, here's Mike's and my contact information for anyone to contact us. We are always happy to answer questions and be in touch. And then, now we will go to questions from our participants. Thank you so much.

Michael Policar:

Okay. So, Jen, one of the things I wanted to say about is that probably a third of the questions have to do with the very topic you discovered, and that is, what about the division of reproductive health at the CDC, and are they going to be able to continue to update the MEC and the SPR? And what about additional job aids coming from them? So, for example, some of the comments.

Nicole Nguyen:

I'm sorry to interrupt, to share. Sorry, Mike, I just wanted to share. I know we're almost at time, at one 30, but I just want to let everyone know that both Mike and Jen are staying on for an extra 15 minutes to 1:45. So continue to send your questions in through the question box and they'll try to get to as many of them as possible. And remember, this is also recorded, so if you yet to leave at one 30, still get your question in and you can watch the answer at a later time and you'll still get full CME credits. Thank you. Go ahead.

Michael Policar:

Okay, thank you. And Jen can also help me with this as need be, but many of the questions have to do with, I had trouble downloading the app because of the fact that it says that the guidelines are being updated, changed, hang on, we'll get you the app sooner or later. Also, a couple of questions about the CDC in the past have come up with a wheel product that we could actually use with patients as a way of explaining to them about the various safety categories of the MEC, for example. Regrettably, it really is a moving target at this point. What we kind of hear the best case scenario is, is that what's going on with the CDC, with the MEC and SPR app now is that the CDC is changing some of the language to be consistent with executive orders from the president, mostly have to do with gender and inclusiveness and so on. And that once that process is done with, then these job aids will be reposted that they'll come back up again. We have no idea what they're going to look like. I don't think we have any sort of insight information about how much information is going to be deleted or how it's going to be changed. But at least what we've heard from the CDC is they recognize the importance of this work and that once it goes through this scrubbing process that it will be reposted. But one of the most important things that Jen just pointed out is it's not as if this is a complete blackout. You can get the original documents from the familypact.org website. The Society for Family Planning has these documents on their website,

acog.org. Mayor College of OB GYN has them available without a password on their website. So there are a number of different places that you can go to be able to download these at least in their original version while we're waiting for the updates to happen. Okay, I wish I could tell you more of it. That's about as much as we know about all the turmoil that's happening in the CDC about making sure that these guidelines are widely available to all of us. Jen, I've seen a couple of questions about Depo. You're the big Depo expert; you shouldn't say you, you're the Depo expert. So I'm going to ask you a couple of questions. Okay? Sure. So one is Depo SubQ given every three months. My one correction to that would be every 12 or 13 weeks. We think about it in weeks rather than months. So you might answer that in terms of what the interval is that is recommended for Depo SubQ in comparison to Depo.

Jennifer Karlin:

Yeah, it's the same so every 12 weeks, but you have a grace period of two weeks. So like Mike said, ideally we counsel just because simple to set your calendar to provide a subcutaneous injection every 12 weeks. But if somebody misses their injection by one or two weeks, they don't need to use a backup method. They just give themselves an injection as soon as they remember and then restart the clock All. The other thing to note about subcutaneous depo is that the people who are candidates for subcutaneous depo are the same as IM candidates. The formulation itself doesn't change the contraindications or the side effects or who the good, suitable candidates are. So of course when you're talking to your patients, it has to do with whether or not they're interested in giving themselves an injection and all the other person centered sort of benefits that come along with either a self-administered option or there are some clients who like to come to our clinics and receive the injection for various reasons and don't want to give themselves an injection. So, really tailoring the way that they're receiving the injection is what is most important, as opposed to what the formulations themselves do. Although there is less contraceptive liquid, so there's less liquid and the needle is smaller in the subcutaneous formulation.

Michael Policar:

Right. So let me ask you one other question about Depo and I'll paraphrase a little bit of it, but read most of it. So given what we've been talking about relative to the increased risk of deep vein thrombosis, pulmonary embolism from Depo, if a blood pressure check isn't required of someone who's going to start Depo, what if they have hypertension that they don't know about? And the question is, what if their blood pressure is really one 60 over a hundred and they don't know that given the new findings, basically, is there any difference in terms of how you would expect blood pressure screening and follow up to be done in someone who's using either Depo IM or Depo SubQ?

Jennifer Karlin:

No, because the pathophysiology for the clotting is not due to blood pressure or increased blood pressure. So those things are not related. You really think about blood pressure with estrogen with the estrogen component.

Michael Policar:

Right. Okay. Another one came in about Depo SubQ, and

Jennifer Karlin:

You're getting all of these, I don't see them.

Michael Policar:

Are there any guidelines for patients giving themselves Depo SubQ at home?

Jennifer Karlin:

So there's no national guidelines, but the CTC, we could try to put this in the chat. The Clinician Training Center for Sexual and Reproductive Health has a toolkit, which I worked with a team to develop that is guidelines about how to talk about it with clients and has a ton of both provider tools and patient tools to be able to provide subcutaneous depo. So that is my go-to place because it links all the evidence and it links all of the great materials that are out there, which include videos to share with clients that are both in English and Spanish, and then written materials in all sorts of languages to share with your clients.

Michael Policar:

We have so many depo questions. So let me ask you another one. Although this is one that came up a lot at the Contraceptive Technology Conference in San Francisco a couple of months ago, and that is, do you have any information about how to counsel patients on the study that says that DMPA leads to benign brain tumor? So just a quick background on that. There was a study done in Europe, I think it was in the Netherlands. It was a case control study, a fairly large study, but remember that case control studies are not great from an epidemiologic point of view, which said that DMPA was associated with the development of a particular type of brain tumor, CNS tumor, which is called a meningioma. Now, the thing about meningiomas is that they don't actually happen in the parenchyma of the brain itself. It happens in the meninges, which are the covering of the brain, and they are benign. When that study came out, there was a lot of criticism of it, both for its methodology, which was not great, and the fact that in this subgroup of people who were using Depo, the numbers weren't very high in making this epidemiologic association between meningiomas and Depo. So most of us have sort of discounted that relationship. Why you're seeing a lot about it on places like Facebook and on social media is because plaintiff's warriors are trying to find people who may have had that problem and then they'll do product liability lawsuits about, but at least in the medical community, we weren't very impressed by it.

Jennifer Karlin:

I would agree. Yeah, I would agree with that. Mike. And I would also point out, someone asked this in the questions earlier, and I wrote a little response that was shorter, but similar to what you just said, but also to note that if somebody has, the association was again, a higher risk of having meningioma with prolonged use at DMPA. And there also was no suggestions about what to do if somebody had meningioma and already and then starting DMPA and there was no clinical association with the meningiomas getting larger, but they also didn't have the power to even look at that. So the CDC, so someone had asked earlier, is there any CDC guidance on this? And there just isn't enough of an evidence base to suggest that it should be a higher risk category. So generally this question has come up a bunch, and again, usually I share this information with the clients and then allow them to make a decision about the benefits that they're going to gain from DMPA and then the risks that they feel from a benign meningioma.

Michael Policar:

Great. Okay. Let's see. Let me see if I can find one.

Jennifer Karlin:

I have one over here. That's okay, please. So this is recalling the information question, Mike. So for someone who has a thrombotic risk, does it matter if the patient is taking one of the antithrombotic medications? What were the recommendations in the MEC about this?

Michael Policar:

Yeah, well that was one of the things you mentioned. So presumably what's being referred to is a person who is on anticoagulant medication. So that could be heparin or one of the many, of course, newer ones like low molecular weight heparin and a variety of other medications which are intended to prevent either A DVT or a pulmonary embolism on the venous side or a heart attack or stroke on the arterial side. And one of the things that was addressed in the updated Medical Eligibility Criteria is that if a person uses anticoagulant medications and they are in the therapeutic range, then you can use hormonal methods including pill, patch, or ring in that person because of the fact that they're taking anticoagulant medications, which presumably given the fact that you've been following their laboratory studies and they seem to be effective as anticoagulants, that by adding estrogen to that equation, you're not going to now reinstate increased risk of deeping thrombosis, pulmonary embolism or a stroke. So that's why I think, can't remember, we just talked about it, but if it's a two or a three, but basically what it's saying is that as long as someone is in the therapeutic range of their anticoagulation, that they can use any of the hormonal methods. Jen, I'm going to ask you a question. I know you're looking something up and you

Jennifer Karlin:

Oh no, I'm just answering that qualify

Michael Policar:

To answer this one as a family medicine doctor, rather than for me, because I've never prescribed these medications. And this, by the way, I'll tell you in advance, was not addressed at all in the M-E-C or S-P-R, but can you speak to the contraceptive efficacy of the GLP one drugs like Ozempic, Wegovy, and so on? Do they have any effect on the efficacy of hormonal contraceptives? What do we tell people who are using those medications, let's say for weight loss or for type 2 diabetes? Do we know about any interactions with hormonal contraceptives?

Jennifer Karlin:

So yes, and there is a chart that has the different GLP one. I'm trying to look up the chart really quickly. I believe it was by wrap. I will try to find it before the webinar ends and it just tells you which ones you may want to be concerned about if somebody is on 'em. But I don't always remember the different medications off the top of my head. And which ones have a little bit of an interaction.

Michael Policar:

And do you remember, is that based primarily on theoretical concerns about compromising contraceptive efficacy or are there actually any studies that look at failure rates?

Jennifer Karlin:

I think it's due to, I think some of the issues were due to delayed gastric emptying and the theoretical way that that would affect.

Michael Policar:

Yeah, that totally makes sense. Yeah,

Jennifer Karlin:

And I think it's also different, honestly, between the injectables and then the pills. So I can't answer it off the top of my head, but if you call the reproductive health hotline, I will be able to answer that for you, not in the middle of a webinar.

Michael Policar:

That's great. And then I think that Nicole Garcia put into the chat, oh yeah, there it is. So Nicole, yeah, that 1:35, Nicole actually put in the link to reproductiveaccess.org about drug interactions with GLP one.

Jennifer Karlin:

That was the one I was looking for, Nicole. Thank you. That was exactly, so that's my go-to chart that I've used. They summarized the evidence for us.

Michael Policar:

Yeah. Alright, well there's one that I'll take, although of course Jen's more than welcome to comment as well. Is Avera still considered to be a lark? A long-acting reversible contra? It was actually never considered to be a lark. The company that makes it sort of promoted it as being a long-acting reversible method, and given the fact that it's a one year contraceptive, you can see why some people might actually consider to look. But the original definition of long-acting reversible contraceptives, that is to say IUDs and implants had to do with, and I love this term that they are forgettable contraceptives. Once you've had your implant placed, once you've had the IUD placed, basically you can kind of forget about contraception unless you're having side effects until it's expired and you need to have it changed. That is absolutely not the case with Avera because of the fact that it is removable, people can remove it, in fact, should remove it to take it out and wash it every now and then. Some people actually take it out before they have intercourse because it kind of gets in the way and then after intercourse is over, then they wash it and put it back in, which you're supposed to do within a couple of hours. So yes, it's a one year contraceptive. Yes, it's a family pack benefit. Yes, it works really well as long as you use it according to instructions, but it's really not a forgettable contraceptive in the way that an IUD or an implant is a forgettable contraceptive. Jen, are you looking at questions? Anything you want to ask?

Jennifer Karlin:

Well, so I can't see all the questions. All the questions on my side have been answered. So I think that that Nicole is sending you different questions than me, but oh, okay.

Michael Policar:

Alright.

Jennifer Karlin:

I don't know if I can see yours somewhere. So if you have other questions that haven't been answered on my side, all of them we've either answered out loud or I've answered via the chat.

Michael Policar:

Okay. Alright. I'm looking at one that says, should I then treat all obese patients with A BMI above 30 the same regardless if they are morbidly obese? Well, weight issues are one of the categories that are listed as a chronic medical condition in the Medical Eligibility Criteria. I don't think that they really changed very much. If anything, they might've changed a tiny bit for depo, maybe to go up one notch. But the way I think about this is with something that was published in an ACOG practice alert, a practice bulletin on the topic maybe, I don't know, five or six years ago, and it was evidence-based to have a really good way of remembering things. They basically said that if a person has a BMI of 35 or more, which is really being on the obese side because technically obesity is a BMI of 30 or more. They said if a person has a BMI of 35 or more and their age is 35 or older, that combination in and of itself increases the risk of DVT pulmonary embolism substantially. So just being of that weight and being 38 or 40 or 42 already increases your risk of DVT pulmonary embolism. Then if you add the estrogen of pill, patch, ring, on top of that, that would magnify the risk even more. So at least what that ACOG guideline says, and by the way, the same numbers are not used in the MEC, but I thought it was well documented in the ACOG guideline. That's a circumstance that you would at least consider a three if not a four, the combination of both older age and a BMI of well over 35. And then if you add on top of that cigarette smoking or diabetes or other sorts of things which increase the risk of cardiovascular problems, particularly on the arterial side, you would be that much less likely to be willing to use an estrogen-containing method in that circumstance. And on the other hand, the flip side is that either the IUDs or implants are really good choices for people who are in that high DMI category, because we know that for people who are in a very high DMI category, implants seem to work as well, and Depo seems to work as well. So in those circumstances, we certainly have other alternatives rather than having to rely on an estrogen-containing methyl. All right. I'm just trying to see if there's anything else that we haven't covered. I think that actually does cover most of it. Plus, I think we're just about out of time anyway; we only have a few minutes left. So that being the case, I'm going to go back to Nicole and ask if you want to say any comments to wrap things up.

Nicole Nguyen:

Yes. No, thank you so much. That was such an amazing webinar. Thank you. And thank you for going through all the questions. I know we have a lot more that we couldn't answer, but there were such good questions and those scenarios. So again, that will our webinars and please fill out the survey that will appear at the end when this webinar ends. Your feedback is extremely important and really helps guide the content and the type of webinar topics that we present. And again, the link to access your CME

certificate, the recording and the slide will be sent out in a follow-up email. So again, I want to thank you, Mike and Jen, the amazing tag team duo that did these presentations, and I hope you enjoyed it. And thank you for joining us and we hope you enjoyed the rest of your week. Thank you so much. Take care.