CME CREDIT *EDUCATIONAL OBJECTIVE:* Readers will not set up unnecessary barriers to women obtaining contraception

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ONE MINUTE CONSULT

BRIEF ANSWERS TO SPECIFIC CLINICAL QUESTIONS

Q: Are breast and pelvic exams necessary when prescribing hormonal contraception?

A: No. According to 2013 guidelines of the US Centers for Disease Control and Prevention (CDC),[1] there is little evidence of benefit for many of the tests commonly mandated by healthcare providers before prescribing hormonal contraception (pill, ring, patch). These tests include breast and pelvic examinations, screening for cervical and sexually transmitted infections, laboratory testing, and mammography.

Only a medical history and blood pressure measurement are needed before prescribing estrogen-containing contraceptives. Patients who have elevated blood pressure but have not been previously diagnosed with hypertension should be preferentially offered other forms of contraception to avoid an additional risk of stroke or myocardial infarction, such as progestin-only products and intrauterine devices (IUDs). Women with blood pressures between 140/90 and 160/100 mm Hg may use estrogen-containing contraceptives only if other options are not appropriate. The CDC guidelines further state that if a patient is unable to come to the office for blood pressure assessment, then a community reading reported by the patient may be used to guide decision-making.

IS A PELVIC EXAMINATION NEEDED?

A pelvic examination (cervical inspection and bimanual examination) will not affect decisions related to prescribing contraceptives, except when prescribing female barrier methods (diaphragm, cervical cap) or IUDs.

Based on a systematic review of the literature between 1946 and 2014, the American College of Physicians now recommends against a screening pelvic examination in asymptomatic, nonpregnant, adult women when a Papanicolaou test is not otherwise indicated.[2]

The American College of Obstetricians and Gynecologists (ACOG) acknowledges that no current scientific evidence supports or refutes the need for an annual pelvic examination for an asymptomatic, low-risk patient. But ACOG supports pelvic examinations as a way to establish open communication with patients about sexual health and reproduction.[3] ACOG also recommends an annual health visit for all women. Whether or not a pelvic examination is performed, women should be counseled annually about birth control and offered contraception.

Patients should also be encouraged to keep their preventive care up-to-date, including cervical cancer screening with a Papanicolaou test or a human papillomavirus test (or both) at appropriate intervals, especially if the patient has cervical abnormalities requiring follow-up. However, falling behind on preventive care should not be a barrier to obtaining contraception.

IMPROVING ADHERENCE, DECREASING UNINTENDED PREGNANCY

One goal of the CDC's 2013 guidelines was to remove unnecessary barriers to women's access to contraceptives. In the United States, half of all pregnancies are unintended, and almost half of unintended pregnancies lead to abortion.[4] Only half of women who have had an abortion used any contraceptive method within the last month.[5] This suggests high levels of unprotected and underprotected sex.

For most patients, several national societies now recommend long-acting reversible contraceptive (LARC) methods, which include IUDs and progestin-only arm implants,

It is usually safe to begin hormonal contraception after a detailed history with no office visits, examinations, or screening tests

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TABLE 1

How to be reasonably certain a woman is not pregnant

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

Is ≤ 7 days after the start of normal menses

Has not had sexual intercourse since the start of her last normal menses

Has been correctly and consistently using a reliable method of contraception

Is ≤ 7 days after spontaneous or induced abortion

Is within 4 weeks postpartum

Is fully or nearly fully breastfeeding (exclusively breastfeeding or ≥ 85% of feeds are breastfeeds), amenorrheic, and < 6 months postpartum

Information adapted from reference 1.

because they have lower failure rates in a real-world setting.[1,6,7] LARC methods offer the advantage of the patient's not having to remember to take, apply, or insert the contraceptive (ie, they are worry-free), and of not having to rely on a yearly appointment for refills.

Emergency contraception taken orally should be offered without an office visit

The Contraceptive CHOICE Project[8] was a large prospective cohort study that assessed the impact of offering contraception free of charge in St. Louis, Missouri. Most of the 9,256 women who participated selected a LARC method.[8] Those taking combined hormonal contraceptives (ie, birth control pill, patch, or ring) had a higher contraceptive failure rate than those using LARC methods (4.55 vs 0.27 per 100 participant-years; hazard ratio after adjustment for age, education, and unintended pregnancy history, 21.8; 95% confidence interval 13.7–34.9). The rate of unintended pregnancy in those under age 21 using combined hormonal contraceptives was almost twice as high as in older participants. Subsequent analyses showed that the abortion rates in the St. Louis region decreased to less than a quarter of the national average after the start of this project.[9]

Given that the failure rate with combined hormonal contraceptives averages 9% per year,[1] it is of the utmost importance that providers not limit access to patients' prescriptions by requesting unnecessary visits and tests. If oral contraception is selected, women who are dispensed a full year's supply of pill packs are more likely to continue with their contraceptive in the long term.[10]

THE PATIENT WITH A COMPLEX MEDICAL HISTORY

Limiting a woman's contraceptive choices can increase her odds of experiencing an unintended pregnancy, which is associated with a far greater risk of adverse events than any contraceptive.[11] Thus, the CDC developed separate guidelines in 2010 to help determine all available options for the patient with medical comorbidities and with a concerning family history (ie, breast cancer, venous thromboembolism).[12] It can be helpful to consult the 2010 CDC medical eligibility criteria before offering contraception to these patients. Compared with the 2013 guidelines, which provide practical advice on how to use each contraceptive, the 2010 guidelines give guidance on when it is appropriate to prescribe each contraceptive—eg, which contraceptives are preferred based on a patient's risk factors, medical history, and medication use. In addition to a two-page color summary chart of the 2010 medical eligibility criteria on the CDC website (www.cdc.gov/reproductivehealth/UnintendedPregnancy/PDF/Legal_Summary%20Chart_English_Final_TAG508.pdf), a free mobile app is also available to guide decision-making.[13]

Pregnancy should be ruled out before initiating any contraceptive. This can be done through a detailed history. The six-item checklist in **Table 1** has a 99.8% negative predictive value, so healthcare providers may be confident that a woman is not pregnant if pregnancy is excluded based on this history.[14] A pregnancy test is needed in those who test positive on the checklist if they wish to start a LARC method such as an IUD or a progestin-only arm implant. However, because the test has a high false-positive rate, initiation of shorter-acting methods such as combined hormonal contraceptives should not be delayed on the basis of a positive checklist screen alone.[1]

Emergency contraception taken orally should be offered without an office visit, as its short duration of use allows women with traditional contraindications to hormonal contraceptives to safely use this birth control method.[1,12] Because all emergency contraceptives must be used within 5 days of intercourse (the earlier the better), unnecessary office visits delay access and effectiveness.

Although a levonorgestrel-based emergency contraceptive is available over the counter, ulipristal acetate is more effective, especially in women who are overweight.[15] A copper IUD placed within 5 days of intercourse is the most effective form of emergency contraception[15] but requires an office visit. This method is an option for most women but should be strongly considered for women at highest risk of pregnancy (previous unintended pregnancy, intercourse at midcycle, obesity).

In summary, most women may safely begin their hormonal contraceptive with a detailed medical history alone, without additional office visits, examinations, or screening tests. ■

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