Contraceptive Update

Anita L. Nelson, MD
Harbor-UCLA Medical Center

August 17, 2010

Tools you can use – Feedback Toolbar

Raise Hand
Feedback Results
Yes No
Emoticons

2

Floating Toolbar

- Use the floating toolbar to communicate in today's session.

Participant List
Q&A
You are sharing G202.3_TeenLARC...
Chat

3

Q&A

Type Question
Type your question here. There is a 256 character limit.
Send
Ask: All Panelists
Click Send

4

File Transfer

2 Press Download
Click File 1

5

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Conflict of Interest Disclosure Anita L. Nelson, MD

Grants/ Research	Bayer, Pfizer, Teva
Honoraria/ Speakers Bureau	Bayer, Merck, Pfizer, Teva
Consultant/ Advisory Board	Bayer, Pfizer, Ortho-McNeil, Teva

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Learning Objectives

At the conclusion of this presentation, the participant will be able to:

- Describe all contraceptive methods currently available through Family PACT
- Explain methods in terms of tiers of efficacy
- Describe the contraindications to use of each method in order to help select appropriate women to whom these methods should be offered
- Describe Emergency Contraception (EC) and how to implement EC within provider practice

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Maternal Mortality

- More than 380,000 women worldwide die every year during pregnancy and childbirth
  - Africa and South Asia account for 70% of deaths
- Causes
  - Hemorrhage
  - Obstructed labor
  - Fatal cases of eclampsia
- 80,000 deaths result from the 50,000 women and girls who attempt to perform abortions on themselves each day

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UNICEF Study: Maternal Morbidity

- 15,000,000 pregnancy- and birth-related injuries, infections, and disabilities each year worldwide
  - They most often go untreated
  - 80,000 develop fistula
- 300,000,000 women live with debilitating health problems as a result of pregnancy- and birth-related complications
  - More than 1/4 of adult women in lower-income economies

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PRAMS Survey: Unintended Pregnancy Reasons for Unprotected Intercourse

- 33% thought they could not get pregnant at that time
- 10% thought they or partner were sterile
- 30% ambivalent
- 22% partner did not want to use contraceptives
- 16% side effects
- 10% access problems
- 18% other

Nettleman MD. *Contraception.* **2007**;75(5):361-66

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Timely Refill Rates up to 12 Months

Contraceptive Methods	Number starting	30 days	90 days	360 days
1 Month Methods		%	%	%
Contraceptive Ring	96.598	59.4	51.1	26.0
Contraceptive Patch	433,403	68.4	49.8	25.9
Branded Pills	917,519	72.7	55.2	28.9
Ortho Tri-Cyclen	182,479	69.2	43.2	16.3
Ortho Tri-Cyclen Lo	309,535	74.5	58.6	29.5
Ovcon	103,671	65.9	47.7	20.3
Yasmin	321,834	75.1	61.2	34.5
3 Month Methods				
DMPA	161,226	N/A	52.6	21.0
Seasonale	80,647	N/A	53.4	31.0

Nelson AL, et al. *Obstet Gynecol.* **2008**;112(4):782-7

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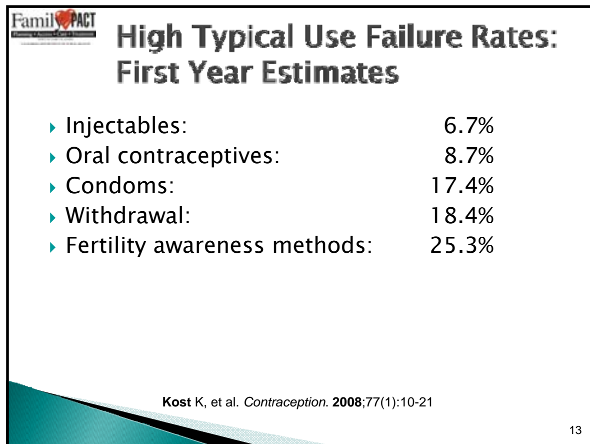
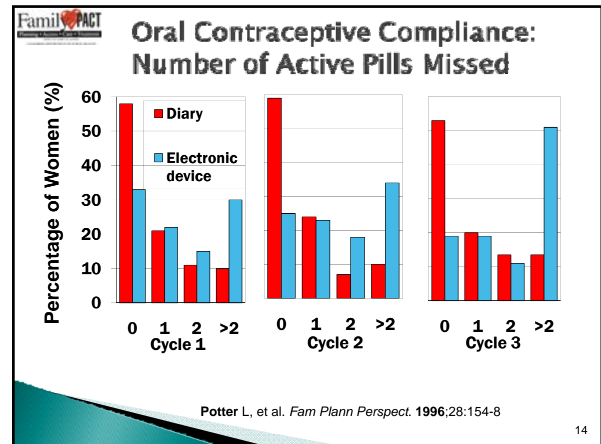
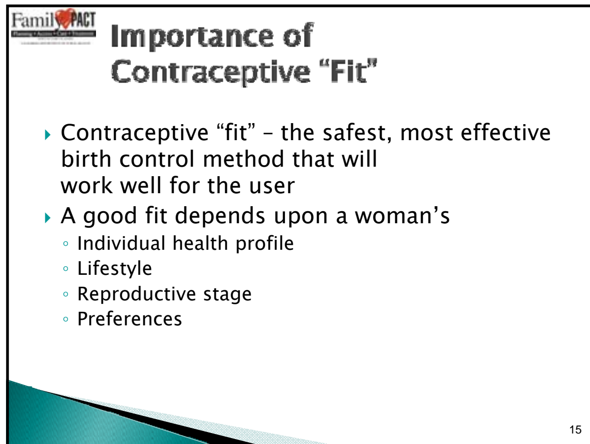

High Typical Use Failure Rates: First Year Estimates
Injectables: 6.7%
Oral contraceptives: 8.7%
Condoms: 17.4%
Withdrawal: 18.4%
Fertility awareness methods: 25.3%
Kost K, et al. Contraception. 2008;77(1):10-21
13


Oral Contraceptive Compliance: Number of Active Pills Missed
Percentage of Women (%)
60
50
40
30
20
10
0
Diary
Electronic device
0 1 2 >2
Cycle 1
0 1 2 >2
Cycle 2
0 1 2 >2
Cycle 3
Potter L, et al. Fam Plann Perspect. 1996;28:154-8
14


Importance of Contraceptive "Fit"
Contraceptive "fit" – the safest, most effective birth control method that will work well for the user
A good fit depends upon a woman's
Individual health profile
Lifestyle
Reproductive stage
Preferences
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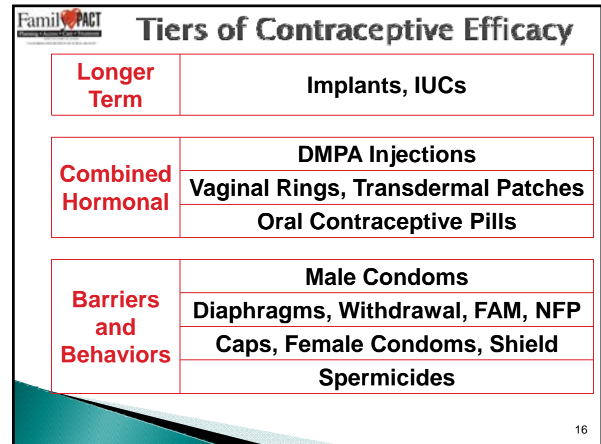
Tiers of Contraceptive Efficacy
Longer Term
Implants, IUCs
Combined Hormonal
DMPA Injections
Vaginal Rings, Transdermal Patches
Oral Contraceptive Pills
Barriers and Behaviors
Male Condoms
Diaphragms, Withdrawal, FAM, NFP
Caps, Female Condoms, Shield
Spermicides
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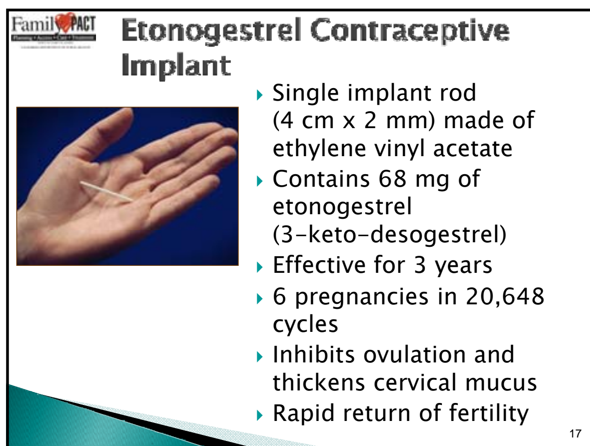
Etonogestrel Contraceptive Implant
Single implant rod (4 cm x 2 mm) made of ethylene vinyl acetate
Contains 68 mg of etonogestrel (3-keto-desogestrel)
Effective for 3 years
6 pregnancies in 20,648 cycles
Inhibits ovulation and thickens cervical mucus
Rapid return of fertility
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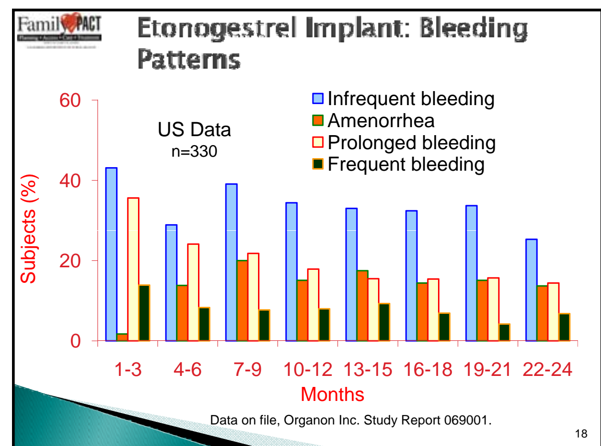
Etonogestrel Implant: Bleeding Patterns
US Data
n=330
Infrequent bleeding
Amenorrhea
Prolonged bleeding
Frequent bleeding
Subjects (%)
60
40
20
0
1-3
4-6
7-9
10-12
13-15
16-18
19-21
22-24
Months
Data on file, Organon Inc. Study Report 069001.
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Copper T 380 IUC

	Net cumulative rates (%) by year					
	1	2	3	4	7	10
Pregnancy	0.7	1.0	1.6	1.8	2.3	2.7
Expulsion	5.7	8.2	9.8	11.0	11.9	14.2
Bleeding/pain	11.9	21.7	28.7	32.2	41.6	50.0
Other medical events	2.5	4.6	6.2	7.9	9.3	10.1

Prescribing Information. 2005

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Candidates for Copper IUC

- Nulliparous women
- Women with untreated vaginitis
  - Unresolved abnormal pap smear not suspicious for carcinoma
  - Increased susceptibility to infection (Diabetes, AIDS, etc)
  - Multiple sexual partners if not at high risk for PID
  - History of ectopic pregnancy
  - History of PID

Note: Immediate IUC placement following first trimester pregnancy loss is safe and effective

Grimes DA, et al. *Contraception.* 2007 Jun;75(6 Suppl):55-9

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Copper Intrauterine Devices Mechanisms of Action

- Interference with sperm transport from cervix to fallopian tube
- Inhibition of sperm capacitation or survival
  - Viable sperm scarce in fallopian tubes of IUC users
- Inhibition of fertilization: no normally dividing fertilized ova in tubes or uterus
- Not an abortifacient

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Condition of Ova Recovered From Fallopian Tubes at Ovulation

Group	Normal Develop-ment	No Develop-ment	Uncertain Or Abnormal Develop-ment
Control	10	3	7
All IUCs	0	9	5
Lippes loop	0	3	1
TCu 200	0	2	3
Progestin IUC	0	4	1

Alvarez F, et al. *Fertil Steril.* **1988**;49(5):768-73

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Estimates of Costs for Various Methods of Birth Control Over a Five-Year Period

Method	Total Cost*
Copper T-IUC	$647
Vasectomy	$713
Male condom	$1,575
Fertility awareness-based method	$1,892
Withdrawal	$2,017
Implant	$2,178
Injectable contraceptive	$2,681
Tubal ligation (sterilization)	$2,978
Vaginal ring	$3,158
Oral contraceptive	$3,381
Transdermal patch	$3,458
No method	$4,739

* Method-related costs, failure costs and side-effect costs

Trussell J, et al. *Contraception.* **2009**;79(1):5-14

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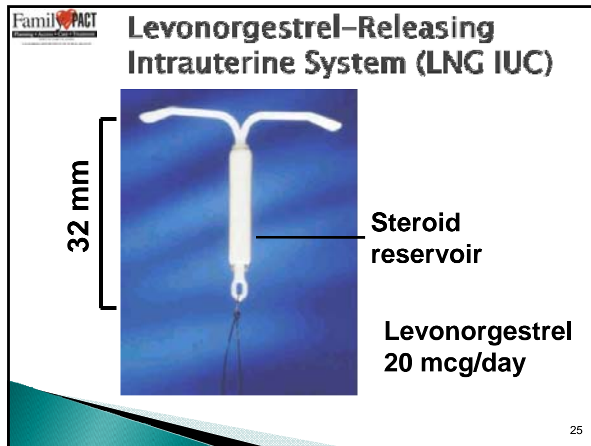

LNG IUC Typical Use Failure Rates (Pearl Index)

- First year 0.14%
- 5-year cumulative 0.71%
- Meta-analysis of comparative clinical trials showed no differences in efficacy compared to copper IUCs with ≥ 250 mm² copper

Anderson K, et al. *Contraception.* **1994**;49:56
Luukkainen T, et al. *Contraception.* **1987**;36:169
French RS, et al. *Br J Obstet Gynecol.* **2000**;107:1218-25

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LNG IUC: Menstrual Cycle Changes

- Months 1-4: increased days of spotting and bleeding (mean 1st month 16-17 days of spotting)
- After 6 months: average 1 day bleeding per month with some residual, unpredictable spotting
- By 12 months: mean bleeding days = 0; 80% had 1-3 days of spotting; 90% reduction in blood loss in women with heavy menstrual bleeding; ↑ hemoglobin 0.4
- Amenorrhea: 20% by 12 months; 30% by 24 months; 60% by 12 years

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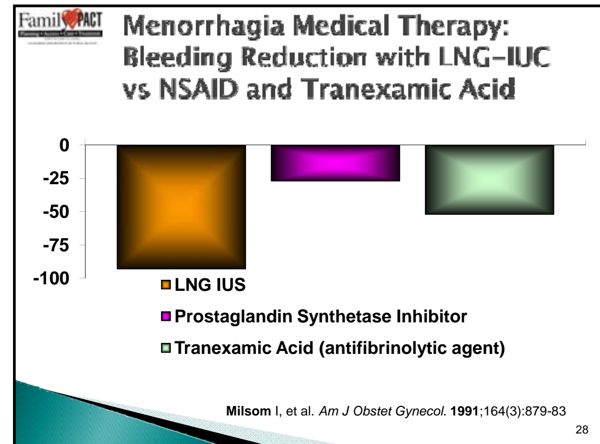
Menorrhagia Medical Therapy: Bleeding Reduction with LNG-IUC vs NSAID and Tranexamic Acid



Milsom I, et al. *Am J Obstet Gynecol.* **1991**;164(3):879-83

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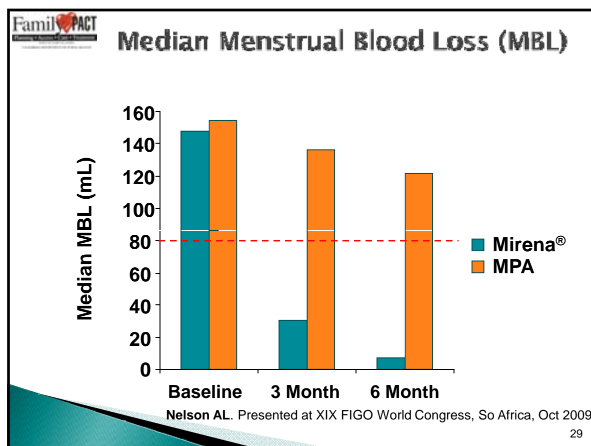
Median Menstrual Blood Loss (MBL)



Nelson AL. Presented at XIX FIGO World Congress, So Africa, Oct 2009

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IUCs Postpartum and During Lactation

- Randomized comparison of LNG-IUC (n=163) vs. CuT380A IUC (n=157)
  - Insertion at 6-8 weeks postpartum
  - Follow-up at 3-month intervals up to 1 year
    - Infant growth and development closely monitored
- Results
  - No pregnancies
  - Continuation at 1 year: 89% (Mirena®) vs. 91% (Cu T380A IUC)

Shaamash, et al. *Contraception.* 2005;72:346.

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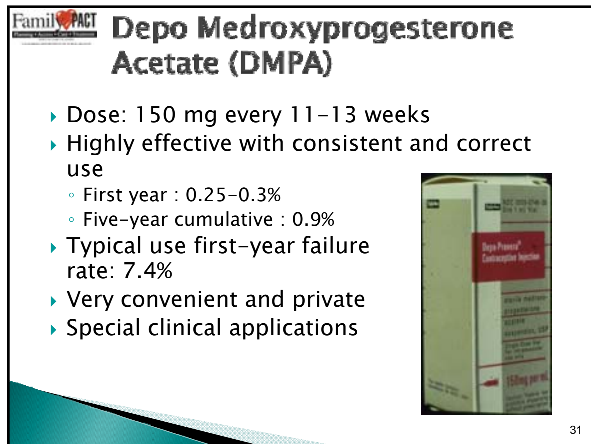

Counseling for Appropriate DMPA Candidates

- Bleeding changes.
  - Unable to tolerate amenorrhea (need to "cleanse" body)
  - Unable to tolerate spotting (sexual or religious taboos and other lifestyle impacts)
- Lay groundwork for follow-up:
  - Advise when to obtain pregnancy test
  - Suggest interventions available for spotting

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DMPA and Bone Density ACOG Committee Study

- "Concerns regarding the effect of DMPA and BMD (bone mineral density) should neither prevent practitioners from prescribing DMPA nor limit its use to 2 consecutive years"[1]
- Bone loss reversed in 2-3 years[2]

1. **ACOG Committee Opinion No. 415,**Sept 2008
2. **Harel Z** et al. *Contraception.* **2010** 81(4):281-91

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DMPA Practice Recommendation to Increase Access and Success

- No pelvic exam or pap smear needed prior to initiation
- Quick Start for initiation and late re-injection[1]
- No pregnancy test needed prior to any injection unless the patient has had unprotected intercourse or has symptoms of pregnancy
- Always provide EC because patients can return late for reinjection
- Reinjection without need of pregnancy testing or back up method may be routinely extended by 2-4 weeks.[2]

1 **Nelson AL,** et al. *Contraception.* **2007** (75(2):84-7
2 **Steiner MJ**, et al. *Contraception.* **2008**;77(6):410-4

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DMPA Administration Flow Sheet

LMP ≤ 5 days? — Yes: Inject DMPA; No: Unprotected IC since LMP?
Unprotected IC since LMP? — Yes: UCG Pregnancy Test; No: Inject DMPA / Advise use of backup method for 7 days
UCG Pregnancy Test — Positive: No DMPA; Negative: Unprotected IC ≤ 5 days?
Unprotected IC ≤ 5 days? — Yes: Offer EC; No: Advise that UCG not conclusive, but DMPA should not affect fetus
Patient desires DMPA now? — Yes: Inject DMPA / Advise use of backup method for 7 days; Repeat UCG in 2-3 weeks if IC < 2 weeks; No: Offer barrier method for 14 days
Menses < 14 days? — Yes: Inject DMPA; No: Repeat UCG
Repeat UCG — Positive: No DMPA; Negative: Inject DMPA

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Oral Contraceptive Pills

- Safe and well-tested -- the gold standard:
  - 50 years of clinical experience in US
  - Best studied medication in history
- Failure rate with consistent and correct use < 1%
- Typical first year failure rate is 8.7%
- Rapidly reversible:
  - Only 2 week average delay in fertility
- Extensive non-contraceptive benefits

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"Birth control pills are not dangerous, but there are dangerous women out there. Find them and keep them away from the pill, and the pill will do its work well."

Paul Brenner, M.D.
Professor, OB-GYN
USC

Pregnancy is hazardous to a woman's health

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Weight Issues and Combination Hormonal Contraception

- Holt found higher failure rates in women > 154 lbs
  - No consistent dose relationship
- Not clear if failure related to obesity or behaviors
- ACOG advises that women over the age of 35 with a BMI ≥ 30 should be prescribed estrogen containing hormonal methods with caution
- British authorities prohibit use of COCs in woman with BMI > 40

1. **Holt** VL, et al. *Obstet Gynecol.* **2005**;105(1):46-52
2. **Holt** VL, et al. *Obstet Gynecol.* **2002**;99(5 Pt 1):820-7
3. *Obstet Gynecol.* **2006**;107(6):1453-72.

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Oral Contraceptive Failure vs Overall Body Mass Index

Data are shown as contraceptive failure rate per 100 women-years of exposure.

BMI = body mass index

Dinger JC et al. *Am J Obstet Gynecol* **2009**; 201(3): 263.36

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Incidence of VTE (events per 100,000 woman-years)

- Estimates of VTE incidence in OC users
- EURAS data[1]
  - OCs with levonorgestrel: 80/100,000
  - OCs with drospirenone: 91/100,000
  - OCs with other progestins: 99/100,000
- INGENIX data[2]
  - OCs with drospirenone: 130/100,000
  - OCs with other progestins: 140/100,000

1. **Dinger JC** et al. *Contraception* **2007**; 75: 344-354.
2. **Seeger JD** et al. *Obstet Gynecol.* **2007**:110:587-593

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YAZ® Package Insert: April 2010 Update…

- EURAS
  - "…risk of thromboembolism (particularly venous thromboembolism) and death in [drospirenone 3 mg/ethinyl estradiol 30 mcg (21/7 regimen)] users to be comparable to that of other oral contraceptive preparations, including those containing levonorgestrel…"
- Ingenix Study
  - "…comparable risk of thromboembolism in [drospirenone 3 mg/ethinyl estradiol 30 mcg (21/7 regimen)] users compared to users of other COCs, including those containing levonorgestrel."
- MEGA Study – Case-Control Study
  - "…the number of [drospirenone 3 mg/ethinyl estradiol 30 mcg (21/7 regimen)] [VTE] cases was very small (1.2% of all cases) making the risk estimates unreliable."
- Danish Cohort Study – Retrospective-Cohort Study
  - "…one-year estimates [of VTE risk] may not be reliable because the analysis may include women of varying risk levels."
  - "Among women who used the product for 1 to 4 years, the relative risk [of VTE] was similar for users of [drospirenone 3 mg/ethinyl estradiol 30 mcg (21/7 regimen]) to that for users of other COC products."

EURAS = European Active Surveillance Study; MEGA = Multiple Environmental and Genetic Assessment (of risk factors for venous thrombosis study); VTE = venous thromboembolism;

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Non-Contraceptive Health Benefits of Oral Contraceptives

Proven Reduction in Risk:

- Ovarian Cancer
- Endometrial Cancer
- Pelvic Inflammatory Disease
- Ectopic Pregnancy
- Benign Breast Disease
- Menorrhagia
- Dysmenorrhea
- Iron Deficiency Anemia
- Low Bone Density

Possible Reduction in Risk:

- Cardiovascular Disease
- Uterine Fibroids
- Endometriosis
- Rheumatoid Arthritis

Adapted from: **Ory** HW. *Fam Plann Perspect.* **1982**;14:182-4

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Incidence of Events Commonly Attributable to OC Use

Data displayed as: N (%)	Triphasic Norgestimate/EE (N=228)	Placebo (N=234)	p-value
Headache	42 (18.4)	48 (20.5)	0.639
Nausea	29 (12.7)	21 (9.0)	0.231
Dysmenorrhea	23 (10.1)	21 (9.0)	0.752
Breast pain	21 (9.2)	11 (4.7)	0.067
Abdominal pain	13 (5.7)	9 (3.9)	0.270
Back pain	13 (5.7)	8 (3.4)	0.597
Vomiting	8 (3.5)	6 (2.6)	0.597
Breast enlargement	6 (2.6)	3 (1.3)	0.333
Emotional lability	6 (2.6)	1 (0.4)	0.065
Weight gain	5 (2.2)	5 (2.1)	1.000

Redmond et al. *Contraception.* **1999**;60:81-5

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Hormone-Withdrawal Symptoms in OC Users

Symptoms	Hormone Treatment % (21 days)	Hormone-Free % (7 days)	p-value
Pelvic pain	21	70	<0.001
Headaches	53	70	<0.001
Breast tenderness	19	58	<0.001
Bloating/swelling	16	38	<0.001
Use of pain medications	43	69	<0.001

Sulak P, et al. *Obstet Gynecol.* **2000**;95:261–6

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Extended OC Applications: Control of Menstrual Cycle Timing For Convenience

- Honeymoons
- Business meetings
- Travel
- Sporting events
- Military campaigns
- Examinations
- Life

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Counseling Points for Women Considering Extended Cycle

- Validate patient's beliefs in need for monthly menses without hormonal contraception
  - Absence could be sign of pregnancy, hormonal imbalances, endocrinopathy or risk for cancer.
- Menses represents reproductive failure. A clean up operation to prepare for better luck next cycle.
- Dispel her concerns proactively
  - Blood not building up
  - Ovaries not swelling
  - Fertility will return (not menopausal)
  - Cancer risk not increased

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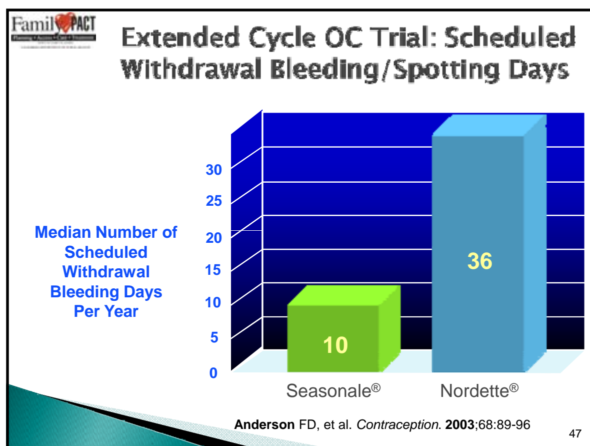
Extended Cycle OC Trial: Scheduled Withdrawal Bleeding/Spotting Days



Anderson FD, et al. *Contraception.* **2003**;68:89-96

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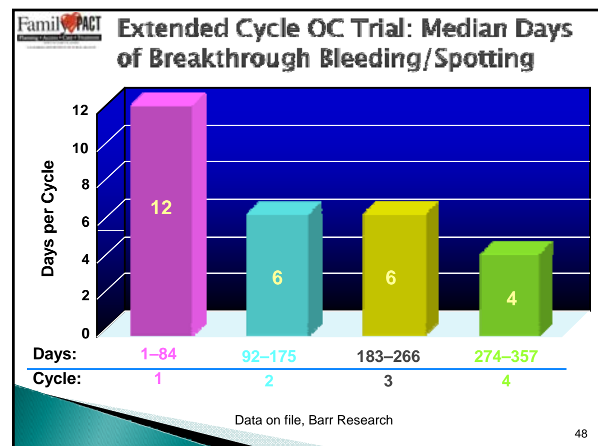
Extended Cycle OC Trial: Median Days of Breakthrough Bleeding/Spotting



Data on file, Barr Research

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Recently Approved Estradiol Not Ethinyl Estradiol

- Estradiol Valerate + Dienogest
  - Sequential formulation a.k.a. "dynamic dosing"
  - Estradiol valerate circulates as estradiol
  - Dienogest:
    - Progestin with potent effects on endometrium and its blood supply

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Oral Contraceptives: Quick Start

- With conventional start of OCs, up to 25% of women do not start their pills due to:
  - Pregnancy
  - Change in method
  - Confusion about pill instructions
  - Fear of possible side effects
- Quick start with OCs protocol
  - Start with first pill in pack
  - Provide backup method for 7 days
  - Provide EC if indicated

Westhoff CW, et al. *Fertil Steril.* **2003**;79:322-9

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Application of Contraceptive Patch on Abdomen

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Contraceptive Patch: Distribution of Pregnancies by Baseline Body Weight Deciles (n=3319 subjects)

Body Weight Decile	Weight Range (kg)	Total Pregnancies
1	<52	1
2	52 - <55	2
3	55 - <58	0
4	58 - <60	0
5	60 - <63	2
6	63 - <66	0
7	66 - <69	1
8	69 - <74	0
9	74 - <80	2
10	≥80	7
	80 - 85	1
	85 - 90	1
	≥90	5

Zieman M, et al. *Fertil Steril.* **2002**; 77 (2 Suppl 2):S13-8

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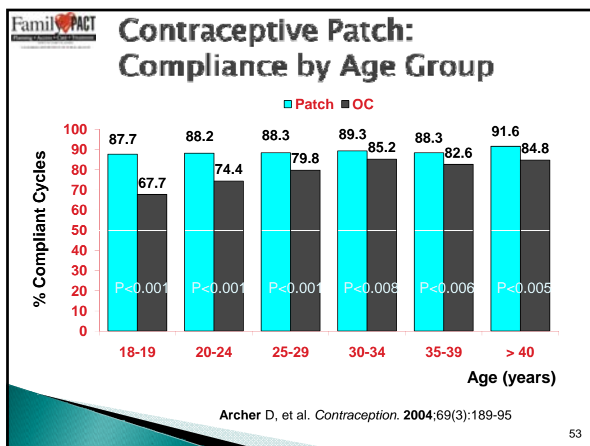
Contraceptive Patch: Compliance by Age Group



Archer D, et al. *Contraception.* **2004**;69(3):189-95

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VTE Risk of Patch vs OCs

Comparator OC	OR (95% CI)
Patch vs NGM/35 EE Pill	0.9 (0.5-1.6)[1]
Patch vs NGM/35 EE Pill	1.1 (0.6-2.1)[2]
Patch vs NGM/35 EE Pill All users New initiators	 2.2 (1.3-3.8)[3] 2.2 (0.8-6.1)[3]
Patch vs NGM/35 EE Pill +24 mo. All users New initiators	 2.0 (1.2-3.3)[4] 1.8 (0.8-3.8)[4]
Patch vs LNG/35 mcg EE	2.0 (0.9-4.1)[5]

VTE = venous thromboembolism; OR = odds ratio
NGM = norgestimate; EE = ethinyl estradiol; LNG = levonorgestrel

1. **Jick** SS, et al. *Contraception.* **2006**;73(3):223-8
2. **Jick** S, et al. *Contraception.* **2007**;76(1):4-7
3. **Cole** JA, et al. *Obstet Gynecol.* **2007**;109(2):339-46
4. **Dore** DD, et al. *Contraception.* **2010**; 85(5):408-13
5. **Jick** SS et al. *Contraception.* **2010**;81(1):16-21

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Contraceptive Vaginal Ring

- Very low dose
  - 120 mcg/day etonogestrel
  - 15 mcg/day ethinyl estradiol
- Flexible
- Transparent
- Outer diameter: 54 mm
- Thickness: 4 mm
- One ring per cycle: 3 weeks ring-in
  1 week ring-free

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Contraceptive Vaginal Ring Advantages

- A monthly method
- Easily placed by the woman
- Discreet
- Lowest EE dose (15 μg/day)
- Constant serum concentrations
- Avoids GI interference with absorption
- Avoids hepatic first-pass metabolism
- Excellent cycle control

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Quick Start Ring vs Pill: Bleeding Patterns

84-day Reference Period	Ring (n = 78)	Pill (n = 78)	Diff.	95% CI
Bleeding-spotting days	14.5	19.2	4.7	2.1,7.3
Bleeding-only days	9.1	11.9	2.8	1.1,4.5
Spotting-only days	5.4	7.3	1.9	0.18,3.7
Bleeding-spotting episodes	2.4	3.0	0.58	0.24,0.92
Bleeding-spotting episode days	6.0	6.5	0.50	-0.28,1.2
Bleeding-spotting-free interval days	21.2	19.0	-2.2	-4.3,-0.03

Westhoff C, et al. *Obstet Gynecol.* **2005**;106(1):89-96

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Contraceptive Vaginal Ring: Extended Use (Off Label)

	Median Days			
	28 d	48 d	91 d	364 d
Total bleeding days				
First 90 days	7	4	4	0
Last 90 days	8	6	2	3.5
Total bleeding/spotting days				
First 90 days	15	9	17	12
Last 90 days	17	11	7	14
Completers	77%	72%	62%	59%

Miller L, et al. *Obstet Gynecol.* **2005**;106:473-82

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Male Condom

- Typical first year failure rate: 17.4%; range 2-20%
- Advantages:
  - Male participation
  - Inexpensive
  - Readily available
  - Protects well against STDs
  - Cervical dysplasia reduced
- Special applications:
  - Premature ejaculation
  - Antisperm antibody
  - Female allergy to sperm

Kost K, et al. *Contraception.* **2008**;77(1):10-21

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Polyurethane Condom

	Polyurethane	Latex
Breakage & slippage, 1997	8.5%	1.6%
Breakage & slippage, 1990	10.5%	1.7%
Breakage	66/1804	7/1882
Slippage	6/1804	1/1882
Uncorrected pregnancy rate	4.6 (2.6)	6.1 (1.0)
Corrected pregnancy rate	5.3 (3.1)	6.5 (1.2)

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Male Condoms: Sizes

- Snug fitting
  - Beyond7, Studded Beyond 7, Exotica Snugger Fit, LifeStyles Snugger Fit, Trojan Ultra Fit
- Larger size—more headroom
  - Trojan Ultra Pleasure, Trojan Very Sensitive, Bareback, Trojan Her Pleasure, Midnight Desire, Pleasure Plus, LifeStyles Xtra Pleasure, Inspiral, Durex Enhanced Pleasure, LifeStyles Natural Feeling
- Larger size—roomy from top to bottom
  - Maxx, Trojan Large, Magnum XL, Magnum, Durex Maximum, LifeStyles Large, Avanti, Crown, Trojan Supra
- Still not enough

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Coitus Interuptus

- Typical failure rate 18.4% – on par with female barrier method failure rates
- Counseling critically important
  - sexual practices
  - pinch techniques
  - what to do about the woman after …

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FemCap

Removal Strap
Bowl
Groove
Rim
Brim
Brim
Dome

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Contraceptive Sponge

- Approved by FDA in 1983, withdrawn in 1994, and reapproved in 2005
- Disposable polyurethane foam disk containing 1 gram N-9
- Single use device moistened and placed high in vault to cover cervix
- Mechanisms of action: spermicide (24 hours) plus device absorbs semen and blocks cervix

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Female Condom – Take 2: FC2

- Made of nitrile (synthetic latex) FDA approved
  - Reduced cost compared to FC1
  - Still more expensive than male condom
  - Comparable to FC1 in breakage, invagination, slippage and misdirection, efficacy, ease of insertion, comfort and overall experience
  - Internationally, other female condoms:
    - The Reddy Condom
    - National Sensation Panty Condom

Schwartz J. *The Female Patient.* **2009 June**;34:26-9

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Cycle Beads

- Color coded string of beads helps women identify days of cycle pregnancy is likely and unlikely

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2-Day Method

- Simplified Billings technique
- Woman checks introital secretions daily and asks herself 2 questions:
  - Was I dry yesterday?
  - Am I dry today?
- Only if the answers to both questions are yes is intercourse allowed
- Failure rates comparable to other FAMs

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"THE EVENING AFTER
THE DAY FOLLOWING
THE MORNING AFTER
THE NIGHT BEFORE
PILL"

EMERGENCY CONTRACEPTION

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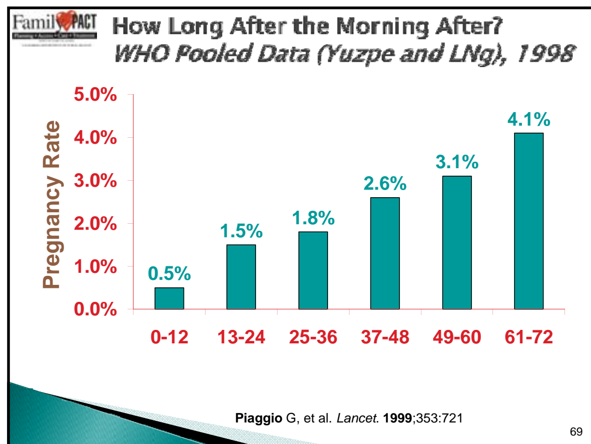

LNG EC Mechanisms of Action

- 99 women
- Ovulation (day 0) calculated from LH, E_2 and P_4 levels obtained just prior to EC ingestion
- Cycle day of IC derived from patient history
- No pregnancies occurred when IC occurred day -5 to day -2 and EC taken before or on day 0
  - 4-5 pregnancies expected, 0 occurred
- All pregnancies occurred when IC was day -1 to day 0 and EC was day +2
  - 3-4 pregnancies expected, 3 occurred

Novikova N, et al. *Contraception* **2007**;75:112-8

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Cycle Phase: Endocrinological vs Patient Estimate

	Women in Cycle Phase		
	Follicular	Periovulatory	Luteal
Number	41	30	20
Percent believing they are in phase			
Follicular	39%	13%	7%
Periovulatory	17%	23%	18%
Luteal	39%	53%	68%
Unknown	5%	11%	17%

Novikova N, et al. *Contraception* **2007**;75:112-8

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Ulipristal Acetate CDB-2914 for Emergency Contraception

- Prevents ovulation and fertilization
  - Works even after the luteinizing hormone surge has begun
- Selective progesterone receptor modulation
  - 50 mg micronized version
  - Works as well as LNG in first 72 hours

Fine P, et al. *Obstet Gynecol* **2010** Feb;115(2 Pt 1):257-63

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Summary of Recommendations

- Find out what she will use
- Make it attractive to her
- Start it now
- Give EC now, and for future use
- Give lots of cycles of contraception
- Give backup method
  - Her back up method becomes primary method if she discontinues her first choice method
- Encourage her to plan and prepare for future pregnancy

NOW and LOTS and MORE

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Questions?

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Evaluation and Other Forms

At the conclusion of session complete:

1. Evaluation Form
2. Sign-in Sheet
3. Continuing Education Forms (if applicable)
   - Post-Test
   - CE Application

Forms can be downloaded at the end of this session by file transfer.

Those without web access can get forms by calling 1-877- FAMPACT

Thank You!

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