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Expanding Contraceptive Choices Beyond Long-Acting Reversible Methods

Announcer:

Welcome to CME on ReachMD. This activity, entitled “Expanding Contraceptive Choices Beyond Long-Acting Reversible Methods” is provided by Omnia Education and is supported by an independent educational grant from Agile Pharmaceutical.

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Dr. Shulman:

Each year, 43 million women, or nearly 70% of all reproductive-age women in the United States, are at risk for unplanned pregnancy. All of these women are candidates for contraceptive counseling and services. The availability of a broad range of contraceptive options is integral to the health and well-being of women of childbearing age. New methods are emerging that are not long-acting reversible contraceptives, or LARCs. A detailed knowledge of these contraceptive methods and their appropriateness for each patient is needed by all medical professionals who provide contraceptive services to women in their reproductive years.

This is CME on ReachMD, and I'm Dr. Lee Shulman.

Dr. Nelson:

And I'm Dr. Anita Nelson.

Dr. Shulman:

So, Dr. Nelson, to start us off, please identify the patient considerations that clinicians need to address. What factors do we need to take into account when helping women decide on a contraceptive method that will provide the greatest opportunity for successful use?

Dr. Nelson:

Well, I think you've just put your finger on the important theme, and that is: What is going to be appropriate for her so she can be successful at controlling her fertility, for planning and preparing for pregnancy and not having unintended pregnancies? So, at the heart today of our approach is a patient-centered approach to contraceptives, so clearly what you want to do is query her. What is she interested in? What is she interested in for her future fertility? What are her lifetime reproductive plans? When does she plan to have another pregnancy? What are her preferences? What are her concerns about any of the methods? And I think our goal here is to make sure that she has the information she needs to have to make informed choices. So, what methods is she eligible for on the basis of her medical eligibility? And how does that fit against her preferences? And so, verifying she knows not only efficacy but side effects, all of those types of things, and what are the noncontraceptive benefits that are important to her.

Clearly, one of the things you can start with is: Does she want to have a monthly period? And, of course, very important these days also is: What is the cost to her? Does she have any barriers that are there that might influence it? Again, we want to make sure we find out where she's coming from and that we give her enough information about all of her choices so that she can make a choice, choose the method that will work best for her in her current situation.

Dr. Shulman:

We need to help women find a method that they're going to use consistently and correctly, and the items that you just listed are just so critical for the modern clinician who is caring for this reproductive-age woman to make sure that that clinician is finding out what methods are going to be suitable for the patient, not what methods that clinician feels are best for her.

In April 2020, the Guttmacher Institute update on contraceptive use in the United States noted that just under 15% of women on contraception chose a LARC method, such as IUDs or implants. The pill, patch, injection, and ring, which are non-LARC methods, are still very much viable options for women looking to use contraception. What are some of the misconceptions women may hold regarding non-LARC methods? And then please also briefly discuss what non-LARC options are available to women today.

Dr. Nelson:

Oh my goodness, that's such flipping the question, isn't it, for sure? I think one of the big things for the second tier of methods that we have as misconceptions is that people are still afraid of hormones. They are afraid that somehow or another that they are unnatural, that they change their periods, they are accumulating in their bodies, all of these types of things. So I think the common misconceptions are about safety. What does a side effect mean? Is it saying if you're spotting that it's not working? All of those types of questions that we've heard for the last several decades may still be here, and we want to make sure that women understand that there are no long-term adverse effects from using it, that we have so many choices for them to choose from until we get that perfect match within these areas.

So, what are the current options? Well, certainly what we're all excited about are the contraceptive patches. Certainly, the patch overcomes the daily administration issue, and what we have today is a new candidate to help provide—meet that niche, one that doesn't have high levels of estrogen or maybe a prothrombotic progestin. Twirla is a once-a-week, low-dose patch. It does have ethinyl estradiol in combination with a very well-established, well-researched progestin, levonorgestrel, which has, as you know, a history of less thrombosis when put into combination with an estrogen. And of course we still have oral contraceptives that can be used on a daily basis, either combination with estrogen or the new progestin-only birth control pill with better cycle control and better efficacy and better forgiving, and we have vaginal rings, the once-a-month and the once-a-year, yearlong. It's actually once a month, but it has a year's worth of hormones in it. And today, barrier methods, we have condoms that are more fun to use, and we still have all the spermicidal agents, the sponge, not too much in way of diaphragms or cervical caps, and a new spermicide that's actually not technically a spermicide. It's a vaginal pH modulator.

And where we've seen a lot of creativity is around fertility awareness, new apps, new products that come out as standalone software applications, or they can be combined with other methods to enhance the couple's ability to detect fertility and avoid conception by avoiding coitus at the same time.

Dr. Shulman:

You know, Dr. Nelson, I think what I'm most impressed with with some of the newer methods is the attention to physiologic detail. What I see now, everything from newer patches, newer progestin-only pills, even the apps, is an attention to detail, to physiology, instead of just looking at almost like a 10-, 20,000-foot view, looking at the physiologic changes that lead to fertility and being able to interact with those physiologic changes to provide effective contraception and at the same time for each particular woman an acceptable side effect profile.

Recently, we've seen the introduction of several new contraceptive methods like the patch and the vaginal pH modulator. These options have pregnancy rates that are somewhat higher than older contraceptives because they are based on clinical trials that used updated FDA guidance on factors like patient populations and the inclusion or exclusion of certain data. James Trussell coined this the "Creeping Pearl Index." How does this "Creeping Pearl Index" come into play with non-LARC options, more specifically the patch?

Dr. Nelson:

That's such a great question. As you mentioned, there are changes in the way clinical trials are done now, and that very same pill in a clinical trial that was done 10, 15 years later, oh my goodness, it has over a 2% failure rate, and one that was done 10 years after that now has a 4% pregnancy rate. And what's going on here, as you suggested, part of it may be the women who were entering into clinical trials. It may be the sensitivity of the pregnancy tests that we're using and we're sending them home with a patient so she can have that very faint positive that gets counted as a pregnancy test, positive pregnancy in the clinical trial, and we've been a lot more selective. So we all expect this, we've seen it, and it's just delightful to be able to say, you know, it's not because lower doses are associated with higher pregnancies. The rules of the game changed—clearly that plus, perhaps, the impact that increased BMI is having on women and their ability to take these short-term methods correctly or are they working as well for them.

Dr. Shulman:

Anita, I think you've really focused on this concept of "Creeping Pearl Index." I think one of the issues was the Pearl Index was provided as a number for all women when now we know that that number doesn't necessarily apply to all women, and henceforth, that's why counseling is just such a critical issue for these newer contraceptives. I think using this new patch Twirla is a great example of this. We

know that in women who have a BMI under 25 who are normal weight, it is an incredibly effective contraceptive when used properly. We also know that in women over 30 that it has not been shown to be as effective. And for women who have a BMI between 25 and 30, it's sort of a gray area. Clearly it's effective but may not be as effective as in women in normal weight, so this is really where counseling provides such critically important information so that we can help women to not just identify methods that are going to be best for them but which methods are going to provide the best contraception for them if used properly.

Well, keeping all of this in mind, can you walk us through a typical counseling session where your goal is to help a woman select the contraceptive method that will work best for her? And how can this approach be applied specifically to patients considering the use of the patch?

Dr. Nelson:

Well, I think we've already outlined how it is you want to relate to her, right? You want to connect to her. She has to know that you're listening to her priorities and her concerns. Then the issue will be to find out what it is she knows about the methods or what she's concerned about. And particularly, since we're talking about the patch, maybe she heard that the other patch had higher hormone levels, or maybe certainly it was all over the news about a concern for higher venous thrombosis issues. Does it fit into her life? Does it come off her skin? Does it stick?—all those really concrete types of questions, and you really want to find out what she's worried about. Is she in a situation where she has to conceal her method? So maybe a patch, the benefits that we talk about for a patch being visible so you know, "Oh goodness, it's working for me." There's not that question: Did I forget my pill this morning? Right? She can verify. And then the real significant difference, the convenience of the patch, not only the visibility but it's a once-a-week type of a decision or an action that has to be taken as opposed to a daily, and how that translates for her also. She gets into a steady state, so not only does she not have to take a pill every day, but there are not the swings of hormones, that her experience with hormones in the steady state may be different than it was with a daily pill.

If she's interested in educational materials, we certainly want to give them relative to her education, her understanding, her literacy levels. Do we have anything online, anything that might be helpful in having her learn about it? And then we want to get down to the nitty-gritty. Once she is interested in the convenience of the patch, then we really want to talk to her about when you start it, how you put it on, where you put the patch. Right? What do you do if it does dislodge? And it's kind of interesting. How do you remove it?

And, of course, if she's at risk for sexually transmitted infections, including HIV, we always want to remind women to consistently use condoms along with what other patch or other methods that they are choosing. Although I've taken up a fair amount of time here, we really always want to spend more time listening than talking. We want to make sure that she has time to ask all the questions that she needs to have answers to so she can be successful.

Dr. Shulman:

Well, this has certainly been a valuable and enjoyable conversation. And before we wrap up, Dr. Nelson, can you share with our audience the one take-home message that you want them to remember from our discussion?

Dr. Nelson:

I think a thing for our folks to remember is this is really not your mother's patch. It has lower ethinyl estradiol levels, area under the curve. It has a long-acting, low VTE progestin, and it has a cover to it that really resists decoration, so people aren't going to put decals or draw on it and mess up the kinetics and the absorption of it. I think this will open up a new chapter for contraceptive patches in this country.

Dr. Shulman:

Well, I sure hope so. That's great, Dr. Nelson. And from my vantage point, I think also the biggest takeaways here are, the better studies that are done to evaluate methods, the better contraception we get by knowing more about the methods, how well they work, what are their side effects, and what patient, what woman is going to do best with that particular method.

So, with those important messages, I want to thank all of you, our audience, for your participation and thank you, Dr. Nelson, for joining me and sharing all of your valuable insights. It was great speaking with you today.

Dr. Nelson:

Thank you so much.

Announcer:

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