Contraception Counseling for Adolescents

Samantha Hill, MD, MPH
Adolescent Medicine

Disclosure

- I have no financial disclosures

- Slides taken from:
  - Physicians for Reproductive Health
  - Dr. Robyn Miller's Contraception Grand Rounds 2016

Outline

- Adolescent Consent Laws
- Uses for contraception
- Taking a History
- Methods of Contraception
- Emergency Contraception

Please take a moment to download…

- Make sure you have the following app
- This app can help you figure out what conditions are contraindicated for each type of contraceptive method

CONSENT FOR CONTRACEPTION

At what age can a young person give consent to start contraception without a parent present in the state of Alabama?

A. 11
B. 14
C. 16
D. 18
E. 19

At what age can a young person give consent to start contraception without a parent present in the state of Alabama?

A. 11
B. 14
C. 16
D. 18
E. 19

14yo is brought into clinic by her aunt after sharing with her aunt that she is considering having sex for the first time with her boyfriend. You discuss contraception options with her and she opts to start the patch. She has no contraindications for estrogen and her UPT is negative. Her legal guardians are her parents. Can you start the path today?

Alabama Consent Laws

- Age 14→ can consent to medical care
- Exceptions where those younger than 14 can consent
  - if a child is seeking Title X services, provider has to allow them to consent regardless of state law
  - Graduated high school
  - Married
  - Formerly married, now currently divorced
  - Pregnant
  - Are a parent

TYPE OF SERVICE	ALABAMA STATE LAW	TITLE X LAW (ALWAYS TRUMPS STATE LAW)
Contraceptive Services	Minors 14 years of age and older may consent; minors of any age may consent if they have graduated high school, married, married and divorced, or are a parent.[14]	Adolescents may consent to contraceptive services covered by Title X, regardless of age. This includes the pill, patch, ring, and LARC devices (e.g., implant, IUD).[19]
STD Testing & Treatment (not including HIV)	Minors of any age may consent for STD testing and treatment.[15]	Adolescents may consent to STD testing and treatment covered by Title X, regardless of age.[19]
HIV Testing & Treatment	Minors of any age may consent for HIV testing and treatment.[16]	Adolescents may consent to HIV testing, regardless of age. Title X does not cover HIV treatment.[19]
Emergency Contraception (EC)	Alabama does not currently have any law regarding EC.	Adolescents may consent to contraceptive services covered by Title X (including EC services), regardless of age.[19]
Prenatal Care, Childbirth, and Adoption Services	• Minors of any age may consent to prenatal care and childbirth services.[17] • Minors of any age may consent to medical care for their child.[18]	

Children's of Alabama®

https://www.alabamapublichealth.gov/familyplanning/assets/FINAL.MinorConsent%20compact.4.2019.pdf

USES FOR CONTRACEPTION

An 12yo girl comes into your office for a well child check, during which you discover that her cycles are painful, heavy, and irregular. You discuss options to regulate her period, but her mother does not want to start anything because she says girls who use birth control are fast. She is worried that someone will find out that her daughter uses birth control and think that she is fast.

Children's of Alabama®

Remember…

- Many of the medications used for contraception can also be used for other medical conditions:
  - Dysmenorrhea
  - Menstrual irregularities
  - Premenstrual disorders
  - Acne
  - Mood regulation/stabilization
  - Headaches
  - Reduces risk for endometrial and ovarian cancers, benign breast conditions, PID*
  - Decreases frequency of grand mal seizures**
  - Decreases frequency of sickle cell crises**

CONTRACEPTIVE OPTIONS

A 16yo female with epilepsy well controlled on lamotrigine presents to your office to initiate contraception. She says that her friends suggest she should try the pill and even though she isn't great at remembering to take her seizure medications, she agrees. What would you recommend and why?

Contraceptive Options for Adolescents

Estrogen and Progesterone

- Combined oral contraceptive pills
- The patch
- Intravaginal Ring

Progesterone only

- Injectable progesterone
- Implant
- Intrauterine devices

Non-hormonal Methods

- Copper Intrauterine device
- Condoms/dental dam
- Withdrawal method

EFFECTIVENESS OF FAMILY PLANNING METHODS*

**The percentages indicate the number out of every 100 women who experienced an unintended pregnancy within the first year of typical use of each contraceptive method.*

MOST EFFECTIVE

Less than 1 pregnancy per 100 women in a year

REVERSIBLE

Once in place, little or nothing to do or remember.

Implant — 0.05%

Intrauterine Device (IUD) — 0.2% LNG; 0.8% Copper T

PERMANENT STERILIZATION

After procedure, little or nothing to do or remember.
Use another method for first 3 months (Hysteroscopic, Vasectomy).

Female (Abdominal, Laparoscopic, and Hysteroscopic) — 0.5%

Male (Vasectomy) — 0.15%

6-12 pregnancies per 100 women in a year

REVERSIBLE

Get repeat injections on time.

Injectable — 6%

Take a pill each day.

Pill — 9%

SUN MON TUES WED THUR FRI SAT

Keep in place, change on time.

Patch — 9%

Ring — 9%

Use correctly every time you have sex.

Diaphragm — 12%

18 or more pregnancies per 100 women in a year

REVERSIBLE

Use correctly every time you have sex.

Male Condom — 18%

Female Condom — 21%

Withdrawal — 22%

Sponge — 12% Nulliparous Women; 24% Parous Women

Fertility Awareness-Based Methods — 24%

Abstain or use condoms on fertile days.

JANUARY

1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30	31	1	2	3	4

Spermicide — 28%

Spermicide

Condoms should always be used to reduce the risk of sexually transmitted infections.

LEAST EFFECTIVE

Other Methods of Contraception: (1) **Lactational Amenorrhea Method (LAM):** is a highly effective, temporary method of contraception; and (2) **Emergency Contraception:** emergency contraceptive pills or a copper IUD after unprotected intercourse substantially reduces risk of pregnancy.

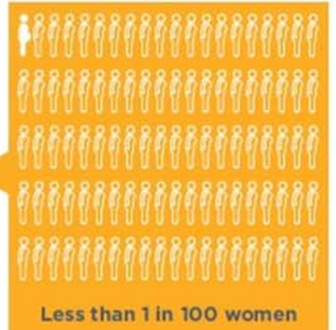
Adapted from World Health Organization (WHO) Department of Reproductive Health and Research, Johns Hopkins Bloomberg School of Public Health/Center for Communication Programs (CCP). Knowledge for health project. Family planning: a global handbook for providers (2011 update). Baltimore, MD; Geneva, Switzerland: CCP and WHO; 2011; and Trussell J. Contraceptive failure in the United States. *Contraception* 2011;83:397–404.

HOW WELL DOES BIRTH CONTROL WORK?

What is your chance of getting pregnant?

Really, really well

	The Implant (Nexplanon)	IUD (Skyla)	IUD (Mirena)	IUD (ParaGard)	Sterilization, for men and women
Works, hassle-free, for up to...	3 years	3 years	5 years	12 years	Forever



Less than 1 in 100 women

Okay

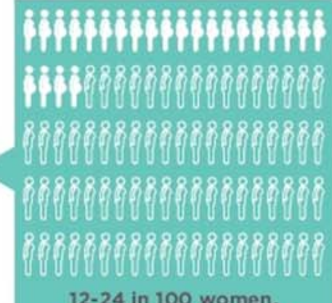
	The Pill	The Patch	The Ring	The Shot (Depo-Provera)
For it to work best, use it...	Every. Single. Day.	Every week	Every month	Every 3 months

6-9 in 100 women, depending on method

Not so well

Withdrawal | Diaphragm | Fertility Awareness | Condoms, for men and women

For each of these methods to work, you or your partner have to use it every single time you have sex.



12-24 in 100 women, depending on method

FYI, without birth control, over 90 in 100 young women get pregnant in a year.

This work by the UCSF School of Medicine Bixby Center and Bedsider is licensed as a Creative Commons Attribution - NonCommercial - NoDeriv 3.0 Unported License.

AAP: LARC and Teens

- "Given the efficacy, safety, and ease of use, LARC methods should be considered first-line contraceptive choices for adolescents."
- "Pediatricians should be able to educate patients about LARC methods…"

American Academy of Pediatrics. Policy Statement. Contraception for Adolescents. 9/29/2014

Which of the following is NOT a contraindication for IUD placement?

A. Current PID
B. History of multiple STIs
C. Suspected pregnancy
D. Anatomically distorted uterine cavity
E. Wilson's disease

Which of the following is NOT a contraindication for IUD placement?

A. Current PID
B. History of multiple STIs
C. Suspected pregnancy
D. Anatomically distorted uterine cavity
E. Wilson's disease

What is the most common side effect of the hormonal implant?

A. Irregular bleeding
B. Cramping
C. Abdominal pain
D. Breast tenderness
E. Acne flair

What is the most common side effect of the hormonal implant?

A. **Irregular bleeding**
B. Cramping
C. Abdominal pain
D. Breast tenderness
E. Acne flair

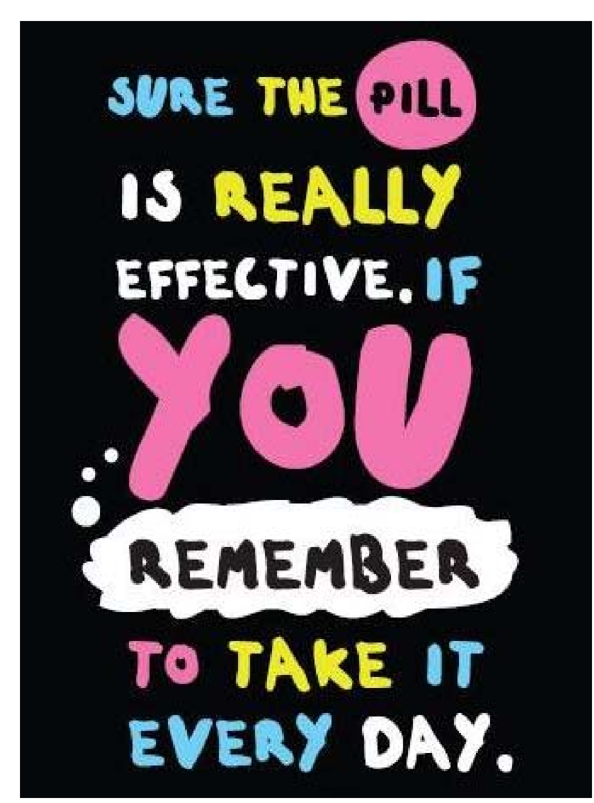
IUDs Have VERY FEW Contraindications

- Current PID
- Current untreated mucopurulent cervicitis, gonorrhea, or chlamydia
- Post abortion/partum infection in past 3 mo.
- Current or suspected pregnancy
- Anatomically distorted uterine cavity
- Wilson’s disease (copper IUD/Paragard)
  - Other: Uncommon issues for teens
    - Known cervical or uterine cancer
    - Known breast cancer (Mirena/levonorgestrel IUD only)
    - Genital bleeding of unknown etiology

CDC US Medical Eligibility Criteria 2010

Long-Acting Reversible Contraception (LARC) = IUDs and Implants

- Most effective methods: >99%
- Safest
  - No estrogen
  - Contraindications rare
- Highest patient satisfaction
  - (80% LARC vs 50% short acting)
- Highest continuation rates
  - (86% LARC vs. 55% short acting)
- Long-term protection—lasts 3-12 years
- Rapid return of fertility
- Most cost effective
- Least likely to be used by teens



PHYSICIANS FOR REPRODUCTIVE HEALTH

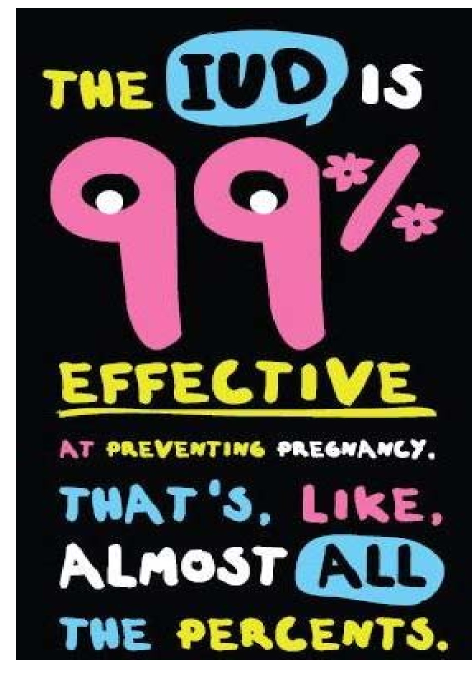
Secura GM. The Contraceptive CHOICE Project. Am J Obstet Gyn. 2011.

Almost ALL TEENS Can Use IUDs

Who Can Use IUDs:

- Teens?
- Never been pregnant?
- Multiple partners?
- History of STD?
- History of PID?
- History of ectopic?

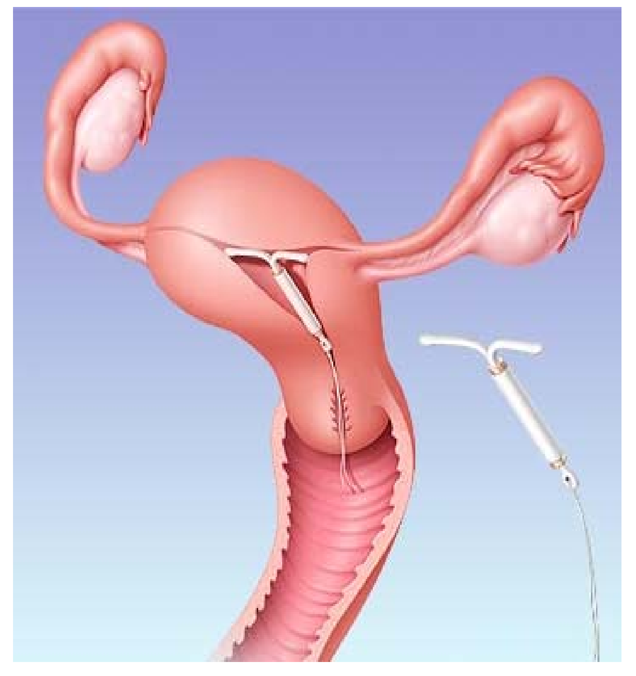
- YES!
- YES!
- YES!
- YES!
- YES!
- YES!



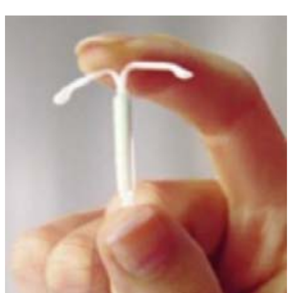
MacIsaac L. Obstet Gynecol Clin N Am. 2007;
Toma A. J Pediatr Adolesc Gynecol. 2006.

Levonorgestrel IUD (Mirena®)

EXTREMELY EFFECTIVE



- 20 mcg levonorgestrel/day
- Progestin-only method
- 5-6 years use
- Cost : $50–$700
- Bleeding pattern:
  - Light spotting initially:
    - 25% at 6 months
    - ~10% at 1 year
  - Amenorrhea in:
    - 44% by 6 months
    - 50% by 12 months



Trussel J. *Contraceptive Technology.* 2007;
Hidalgo M. *Contraception.* 2002.

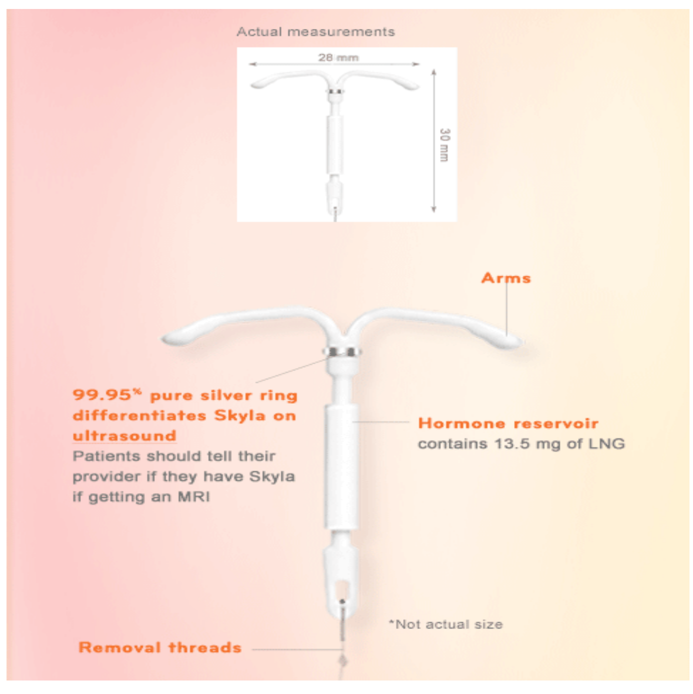
Levonorgestrel IUD: (Liletta®)

LILETTA available for $50 to 340B public health clinics

- FDA approved 2015 for 3 years – anticipate 7 year approval
- 19 mcg levonorgestrel/day – similar to Mirena
- Progestin-only method
- Bleeding pattern:
  - Light spotting initially:
    - 25% at 6 months
    - ~10% at 1 year
  - Amenorrhea in:
    - 44% by 6 months
    - 50% by 12 months

Levonorgestrel IUD (Skyla®)

Extremely Effective



- 14 mcg levonorgestrel/day
- Progestin-only method
- 3 years use
- Cost : ~$300–$650
- Smaller in size than Mirena
  - 1.1 x 1.2 in. (vs. 1.3 x 1.3 in)
  - Inserter tube 0.15 in. (vs. 0.19 in)
- More irregular bleeding than Mirena
  - Only 6% have amenorrhea at 1 yr

Copper-T IUD: (Paragard®)

EXTREMELY EFFECTIVE

- Copper ions
- No hormones
- 12 years of use
- Cost: ~$150-$475
- 99% effective as EC
- Bleeding Pattern:
    - Menses regular
    - May be heavier, longer, stronger cramps for first 6 months

Thonneau, PF. Am J Obstet Gynecol. 2008.
Trussel J. *Contraceptive Technology 2007*

Common Side Effects of IUDs

- Irregular bleeding
- Amenorrhea
- Cramping
- Abdominal/pelvic pain
- Breast tenderness
- Discharge/Vaginitis
- Headache
- Ovarian cysts
- Other possible complications
  - Perforation (1/1000)
  - Expulsion (2-12%)

Which IUD Is the Best Choice?

Copper T IUD	LNG IUD
Want regular periods	OK w/irregular bleeding
Want no hormones	OK w/amenorrhea
No h/o dysmenorrhea	H/O dysmenorrhea
No h/o menorrhagia	H/O menorrhagia

Implant: Nexplanon®

EXTREMELY EFFECTIVE

- Progesterone only (etonogestrel)
- Effective for 3-4 years
- Cost: ~$300–$600
- Mechanism: Inhibits ovulation
- Bleeding pattern:
  - Amenorrhea (22%)
  - Infrequent (34%)
  - 11% stop due to frequent bleeding

Children's of Alabama®

Implanon insert: Diaz S., *Contraception*, 2002: Trussel J, *Contraceptive Technology*, 2007 Croxatto HB, *Contraception*, 1998; Diaz S, *Contraception*, 2002; Funk S, *Contraception*, 2005.

Implant:
Only ONE Contraindication

- Current breast cancer
- Important to know about class labeling of implant with CHC by FDA.

What are the side effects of the Implant?

- Irregular bleeding- MOST COMMON S/E
  - Spotting
  - Breakthrough bleeding
  - Prolonged bleeding
  - Amenorrhea
- Increase appetite
- Possible mood changes
- Acne
- Headache
- Breast pain
- Vaginitis
- Possible ectopic pregnancy
- Very small risk of thromboembolism

Training to Insert Implants

- Training available exclusively through Merck
- Those trained in Implanon® can be trained online to insert and remove Nexplanon®
- www.nexplanon-usa.com/en/hcp/services-and-support/request-training/index.asp

Combined Oral Contraceptive Pills

Very Effective

- Contain estrogen & progestin
- Most newer formulations contain 20 – 35 mcg of ethinyl estradiol
- 1 of 8 available progestins
- Mechanism: Inhibits ovulation

Which of the following is NOT a contraindication for estrogen containing contraceptives

A. Personal history of a bleeding disorder
B. Migraine without aura
C. Hepatoma
D. Family history of a clotting disorder
E. Hypertension

Which of the following is NOT a contraindication for estrogen containing contraceptives

A. Personal history of a bleeding disorder
B. Migraine without aura
C. Hepatoma
D. Family history of a clotting disorder
E. Hypertension

Contraindications

- Migraine with aura
- Hypertension
- Ischemic heart disease, impaired cardiac function
- Personal history of a bleeding or clotting disorder
  - Or individuals who currently have high risk for blood clots
- Current personal history of breast cacner
- Breastfeeding or less than 21 days post partum
- Specific hepatobiliary disease
  - Cirrhosis
- Solid organ transplant

****Antiepileptics may also interact with estrogens**

Side Effects

- Estrogen
  - Nausea
  - Abdominal pain
  - Weight fluctuations
  - Rare blood clots
- Progesterone
  - Abdominal bloating
  - Anxiety
  - Irritability
  - Depression
  - Myalgia
  - Menstrual irregularities
  - edema

VTE Risk in Context

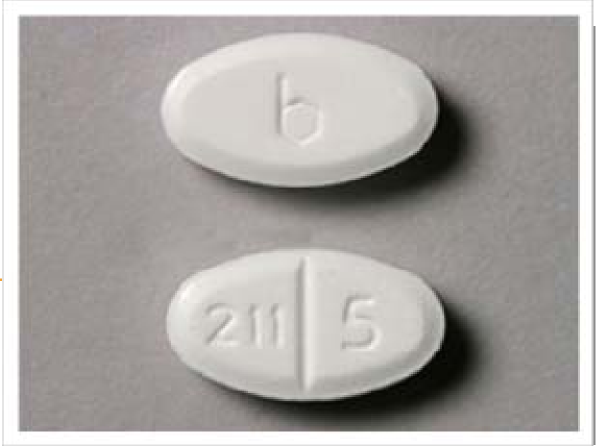
Risk in General Population	Risk in COC Users	Pregnancy and Postpartum Period
0.8 per 10,000 women per year	3-4 per 10,000 women per year	6-12 per 10,000 women per year

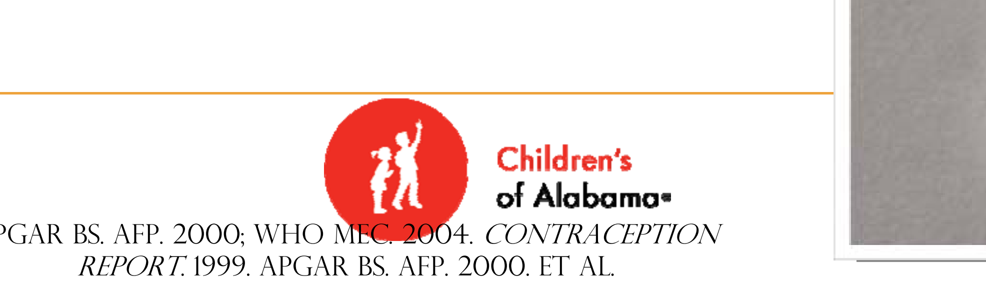
Extended Cycling

- Decrease hormonal shifts and number of menses
- Convenience, treat dysmenorrhea, other cyclic symptoms
  - Seasonale®—levonorgestrel, 30 mcg EE for 84 days, 7 placebos
  - Seasonique®—added 10 mcg EE to placebos
  - LoSeasonique®—20 mcg EE for 84 days
  - Lybrel™—28 days 20 mcg EE, no placebos
- Do NOT need branded extended-cycling product!

Progestin-Only Oral Contraceptives

- Called the “mini-pill”
- Two formulations: norethindrone and norgestrel
- No placebo week
- Mechanism of action: thickens cervical mucous
- **Timing crucial – ideally SAME TIME EVERY DAY**
  - If >3h late – backup contraception for 48h





APGAR BS. AFP. 2000; WHO MEC. 2004. *CONTRACEPTION REPORT.* 1999. APGAR BS. AFP. 2000. ET AL.

Transdermal Patch: Ortho Evra®

- Estrogen and progestin
- Beige-colored patch changed once per week
- 3 weeks on/1 week off
- 9 days of medication in each patch
- Mechanism: Inhibits ovulation

Counseling Issues and Facilitating Use

Application

- Place on clean, dry skin on arm, torso, buttocks, or stomach, NOT the breast
- Must stick directly to skin

Reapplication

- No patch during the fourth week
- Apply a new patch after day 7 even if still bleeding

Missed or Late Patch

Use back-up method when:

- On for >9 days
- Off for >7 days
- Falls off >24 hrs

Side Effects

- May not be as effective in women 198lbs or greater
- Low risk for blood clot
- Hyperpigmentation/skin irritation

Vaginal Ring

- Estrogen and progestin
- Flexible, unfitted ring placed in vagina
- In 3 weeks; out 1 week
- 4 weeks of medication in ring
- Continuous use: change first of each month
- Mechanism: inhibits ovulation

Counseling Issues and Facilitating Use

Insertion	Reinsertion	If Ring Falls Out
• Provider can place the ring in patient's vagina in the office/clinic and have patient remove it and practice	• Advise patients to reinsert ring on the same day every month to increase compliance	• During week 1 and 2, reinsert ring • During week 3, insert NEW ring OR have withdrawal bleed and insert NEW ring after 7 days • In all cases, use back-up method for 7 days

Ring can be removed safely for up to 3 hrs/day

Side Effects

- Similar side effects as OCPs
- Increased vaginal discharge
- Increased likelihood partner may feel it

An 18yo female with sickle cell is presenting for a discussion of her birth control options. She reports that her cycles are heavy, irregular and painful. She has also had 3 sickle cell crises this year. She states that she is not interested in hearing about injectable medroxyprogesterone acetate because all of her friends said they gained 15 pounds on it. What options do you discuss with her and why?

Children's of Alabama®

Very Effective

Injectable: Depo-Provera® (DMPA)

- Progestin only
- IM or SQ injection every 3 months (14 weeks)
- Mechanism: Inhibits ovulation

Trussel J. Contraceptive Technology. 2007. Cromer BA. Am J Obstet Gynecol. 2005. Trussel J. Contraception. 2004.; Westhoff C. Contraception. 2003. et al.

Side Effects

- Bone Loss
  - Greatest during years 1-2 and then stabilizes
  - Has not been associated with increased risk of fractures
  - Temporary and reversible once medication is discontinued
  - No current recommendations to monitor bone mineral density
- Weight Gain
  - Not all users gain weight (only 25%)

How can you reasonably determine that a patient is not pregnant?

A. Start of period was less than/equal to 10 days ago
B. Has not had sex since the start of last period
C. Has prior history of contraception use
D. Has had an abortion less than/equal to 10 days ago
E. Is 8 weeks postpartum or less
F. Is breastfeeding for >50% of feeds
G. Patient has amenorrhea

How can you reasonably determine that a patient is not pregnant?

A. Start of period was less than/equal to 10 days ago
B. Has not had sex since the start of last period
C. Has prior history of contraception use
D. Has had an abortion less than/equal to 10 days ago
E. Is 8 weeks postpartum or less
F. Is breastfeeding for >50% of feeds
G. Patient has amenorrhea

Improving Contraception Initiation with Quick Start for Hormonal Methods

- Start the method THE DAY they fill the prescription for OCP, Ring, Patch, DMPA, Implant

- Ensure that:
  - Negative pregnancy test that day
  - Use condoms for first week
  - Understands risks and benefits of method and when protected
  - Discussion of EC

Children's of Alabama

WESTOFF C, KERNS J, MORRONI C, ET AL. *CONTRACEPTION.* 2002;66:141–5.

How to be Reasonably Certain that Your Patient is Not Pregnant (CDC SPR 2016)

- If they have no symptoms or signs of pregnancy and meet any one of the following criteria:
  - is ≤7 days after the start of normal menses
  - has not had sexual intercourse since the start of 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 the vast majority [≥85%] of feeds are breastfeeds), amenorrheic, and <6 months postpartum

EMERGENCY CONTRACEPTION

A 16yo female presents to your office for a sick visit. She wishes to start birth control. After taking a through menstrual and sexual history, you learn that she had unprotected sex 3 days ago. Her last menstrual period was 3 weeks ago. What do you do for her?

Figure 2

Use of Emergency Contraception Pills, by Age and Race/ Ethnicity

Share of Women Who Reported Ever Using EC Pills, 2011-2013:

Age Group

15-24 29%

25-34 21%

35-44 8%

Race/ Ethnicity

Hispanic 22%

White 17%

Black 17%

Other 15%

NOTE: Among women who ever had sex, ages 15-44
SOURCE: Kaiser Family Foundation analysis of 2011-2013 National Survey of Family Growth

General Contraindications to Emergency Contraception

- Known or suspected pregnancy

Levonorgestrel (Plan B/ NextChoice)

- FDA approved in 1999/2009
- 1.5mg in 1 dose or 0.75mg in 2 doses every 12 to 24 hours
- Mechanism: blockade and/or delay of ovulation via suppression of the luteinizing hormone (LH) peak
- Effective up to 72 hours after intercourse
- Efficacy: 81-90% effective
- $50 over the counter
- Side Effects: nausea, vomiting, dizziness, and fatigue

Additional Names for Plan B

- Next Choice One Dose®
- Levonorgestrel tablet 1.5mg®
- Fallback Solo®
- Aftero®
- AfterPill®
- Econtra EZ®
- My Way®
- Take Action®

Yuzpe Method

- FDA Approved in 1998
- 100ug ethinyl estradiol and 0.5mg levonorgestrel- 2x, 12 hours apart
- Mechanism: inhibits and delays ovulation by an unknown mechanism
- Effective up to 120 hours after intercourse
- Efficacy: 75% reduced risk
- Cost: free* (but need a prescription)
- Side Effects: nausea, vomiting, fatigue, breast tenderness, dizziness, headaches, abdominal pain
- ***There is NO contraindication of this method for those who may otherwise have contraindications to estrogen!

Oral Contraceptive Options Covered by Medicaid

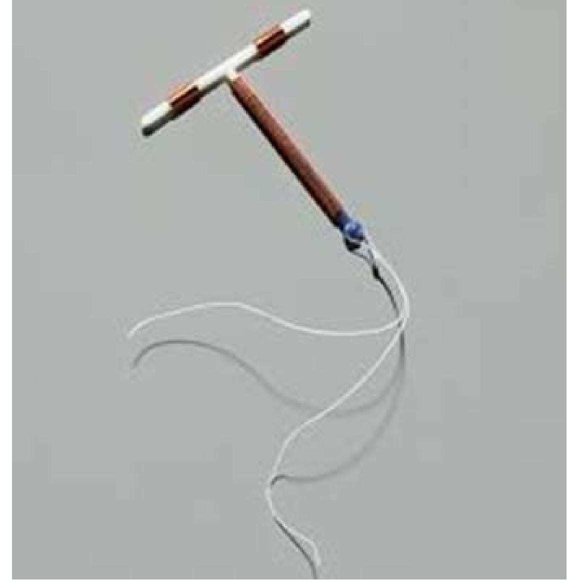
Name of pill	Number of pills with 1st dose	Number of pills with 2nd dose
Ovral	2 white pills	2 white pills
Lo/ovral	4 white pills	4 white pills
Levlen	4 light-orange pills	4 light-orange pills
Nordette	4 light-orange pills	4 light-orange pills
Tri-levlen	4 yellow pills	4 yellow pills
Triphasil	4 yellow pills	4 yellow pills
Alesse	5 pink pills	5 pink pills

Copper IUD (Paraguard)

- FDA approved 1988
- Dose-N/A
- Mechanism- prevents implantation (in theory) and sperm from reaching egg
- Effective up to 120 hours following intercourse
- Efficacy: 99%
- Cost: $500-$1000 (need a clinical visit)
- Side effects: bleeding and pain
- ***Also is a LARC and prevents pregnancy for up to 10 years

Specific Contraindications

- PID
- Current STI (that hasn't been treated)
- Abnormally shaped uterine cavity
- Endometrial/cervical neoplasm
- Wilson's disease



Ulipristal Acetate (Ella)

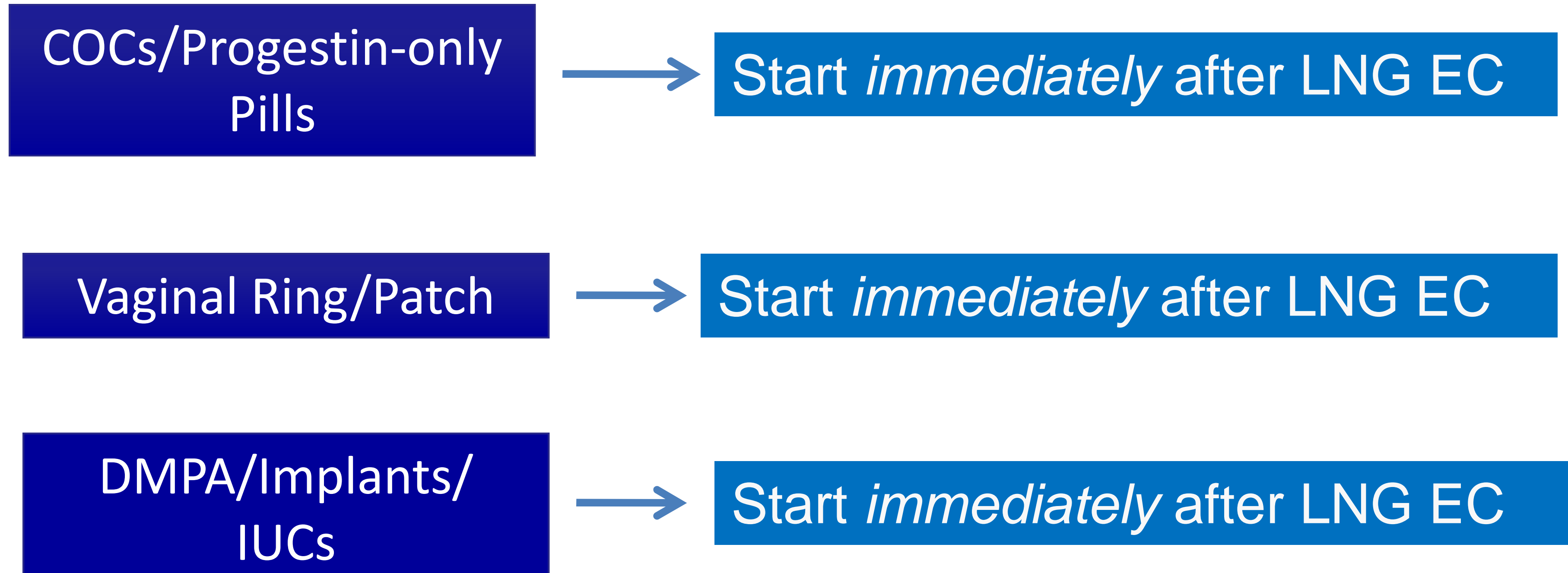
- FDA approved in 2010
- Synthetic selective progesterone receptor modulator (30mg)
- Mechanism: prevents follicle rupture
- Effective up to 120 hours after intercour

- Efficacy: 2.1% failure rate
- Cost: $50+ (requires prescription)
- Side effects: headache, nausea, abdominal pain, dysmenorrhea, tiredness, dizziness
  - May not be as effective in individuals with BMIs over 35

Barriers to Access

- Patient awareness of access
- Provider awareness of options
- Misunderstanding of the difference between Emergency Contraception and Abortion
- Cost/ Insurance Coverage
- Available providers to place Copper IUD
- Access for adolescents
- Improving access in Emergency Rooms to victims of rape

Starting Contraception After LNG EC



***With ALL methods: abstain/use back-up protection for first 7 days**

Starting Contraception After UPA EC – U.S. Selected Practice Recommendations for Contraceptive Use, 2016

- Start or resume hormonal contraception NO SOONER than 5 days after use of UPA
- Any non-hormonal contraceptive method can be started immediately after the use of UPA.
- For methods requiring a visit to a health care provider, such as Depo, implants, and IUDs, starting the method at the time of UPA use may be considered; the risk that the regular contraceptive method might decrease the effectiveness of UPA must be weighed against the risk of not starting a regular hormonal contraceptive method.

- Advise a pregnancy test if she does not have a withdrawal bleed within 3 weeks.

***With hormonal methods: abstain/use back-up protection for <u>7 days</u> after restarting contraception**

When to Refer to a Specialist

- Please consider referring to one of the following specialists if:
  - There is a bleeding/clotting disorder (Hematology)
  - Placement of LARC, if needed (Adolescent Medicine, Pediatric and Adolescent Gynecology)
  - Patient is transitioning genders (Adolescent Medicine, Pediatric and Adolescent Gynecology, Endocrinology)
  - Failure of multiple types of options
  - Patients with complex medical histories (i.e. multiple medications with interactions, individuals with special needs) (Adolescent Medicine, Pediatric Adolescent Gynecology)

Some Additional Resources

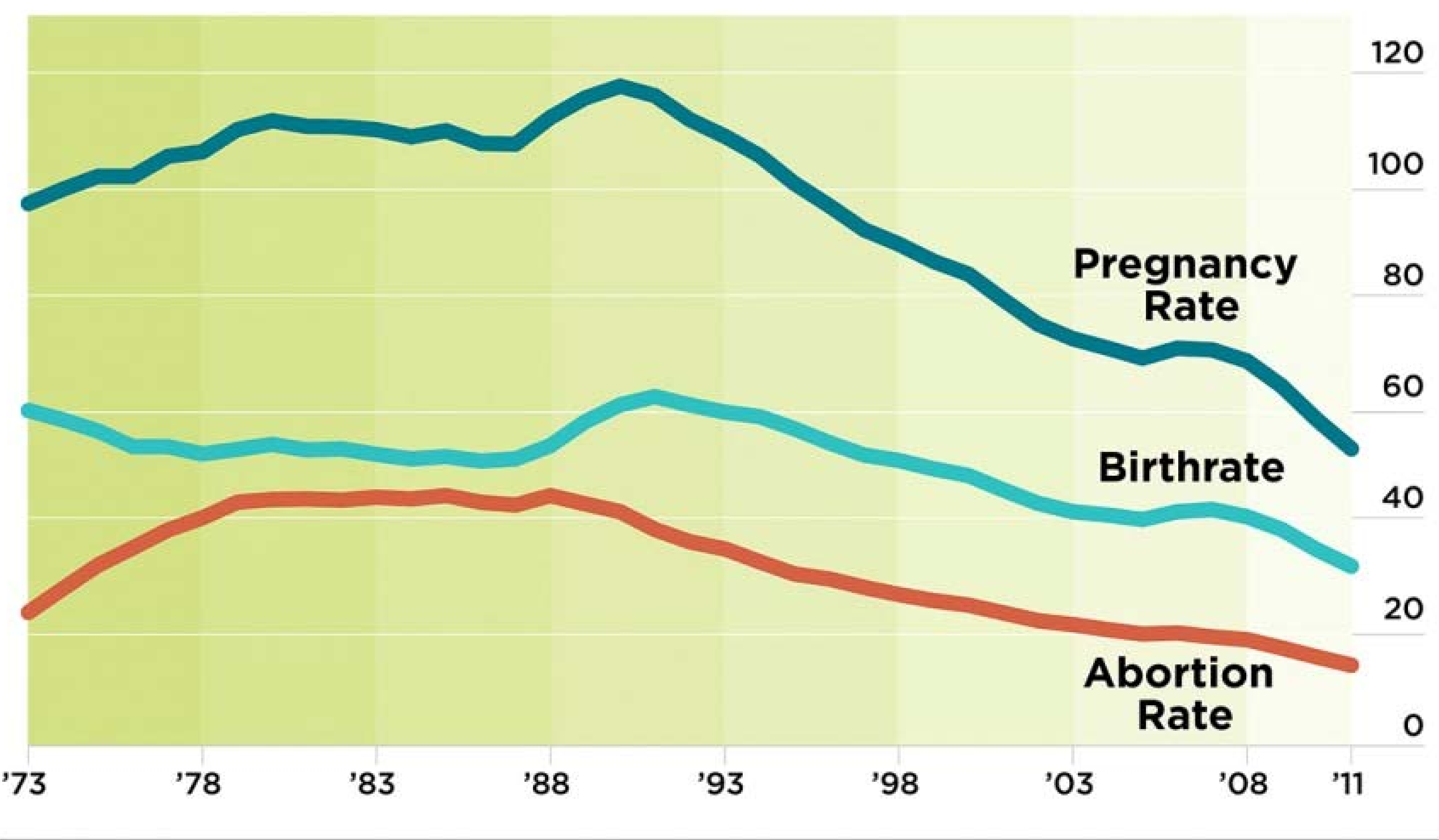
- American Academy of Pediatrics
  - www.aap.org
  - Policy Statement: Contraception for Adolescents (2014). Pediatrics
- The Society for Adolescent Health and Medicine
  - www.adolescenthealth.org
- The North American Society for Pediatric and Adolescent Gynecology
  - www.naspag.org
- The American College of Obstetrics and Gynecologists
  - www.acog.org
- Youngwomenshealth.org
- Bedsider.org
- Alabama Child Health Improvement Alliance (ACHIA)
  - Module 8- LARC for the General Pediatrician
    - https://www.achia.org/cme/staywell-an-adolescent-well-visit-learning-collaborative/8-larc-for-the-general-pediatrician
  - Module 3- Confidentiality and Consent: The Teen's Role in His/Her Care
    - https://www.achia.org/cme/staywell-an-adolescent-well-visit-learning-collaborative/3-confidentiality-and-consent-the-teen-s-role-in-his-her-care-require-for-moc
- Minor Consent and Confidentiality in Alabama
  - https://www.alabamapublichealth.gov/familyplanning/assets/FINAL.MinorConsent%20compact.4.2019.pdf

Children's of Alabama

Extras

U.S. teen pregnancy, birth and abortion rates reached historic lows in 2011

Rates per 1,000 women aged 15–19



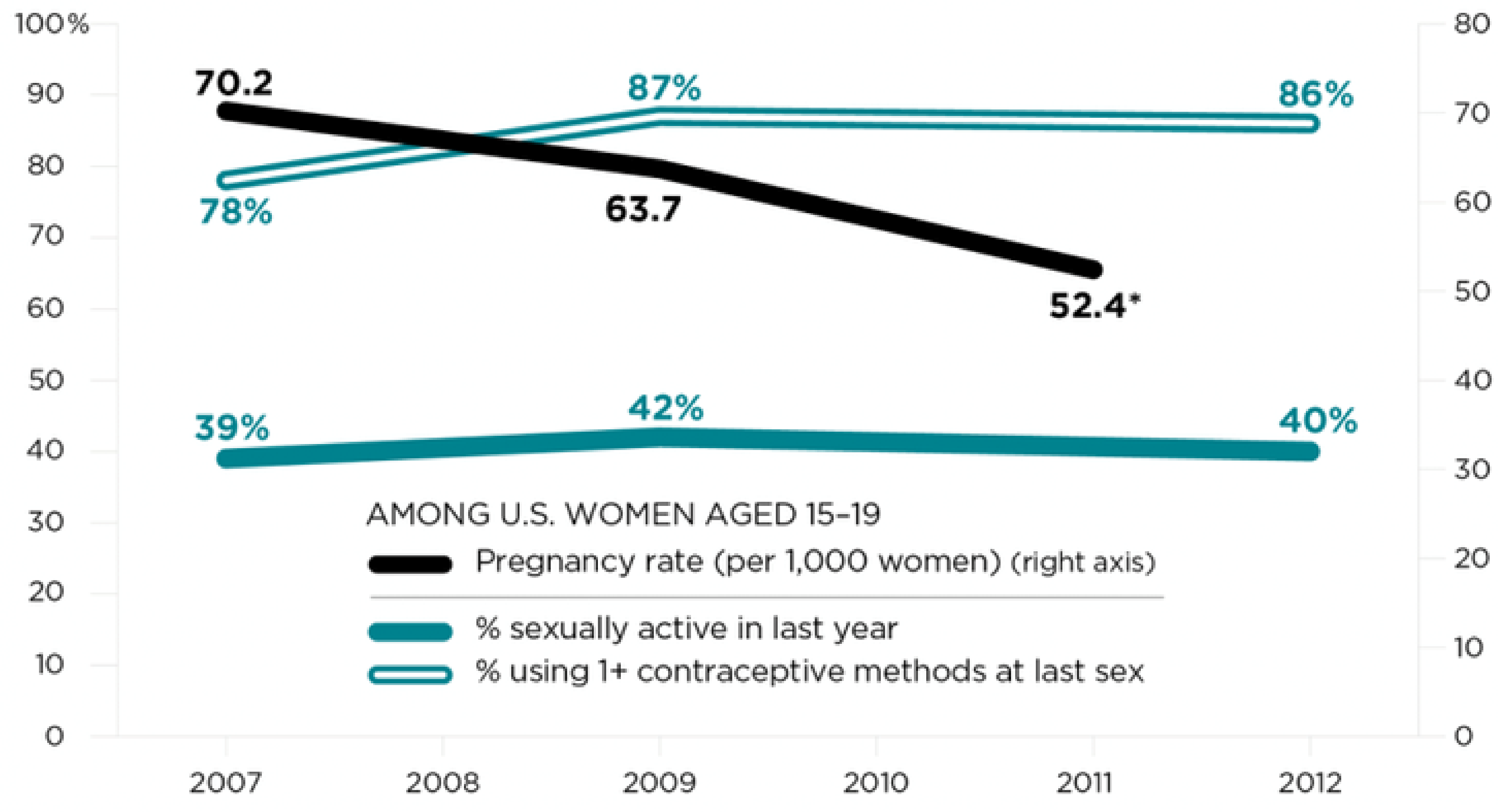
©2016

https://guttmacher.org/media/nr/2014/05/05/index.html

GUTTMACHER INSTITUTE

Contraception is Key

Teen sexual activity remains steady, while improved contraceptive use is likely driving declines in teen pregnancy



*2011 is the most recent year available for teen pregnancy rate

gu.tt/PRI2016 ©2016

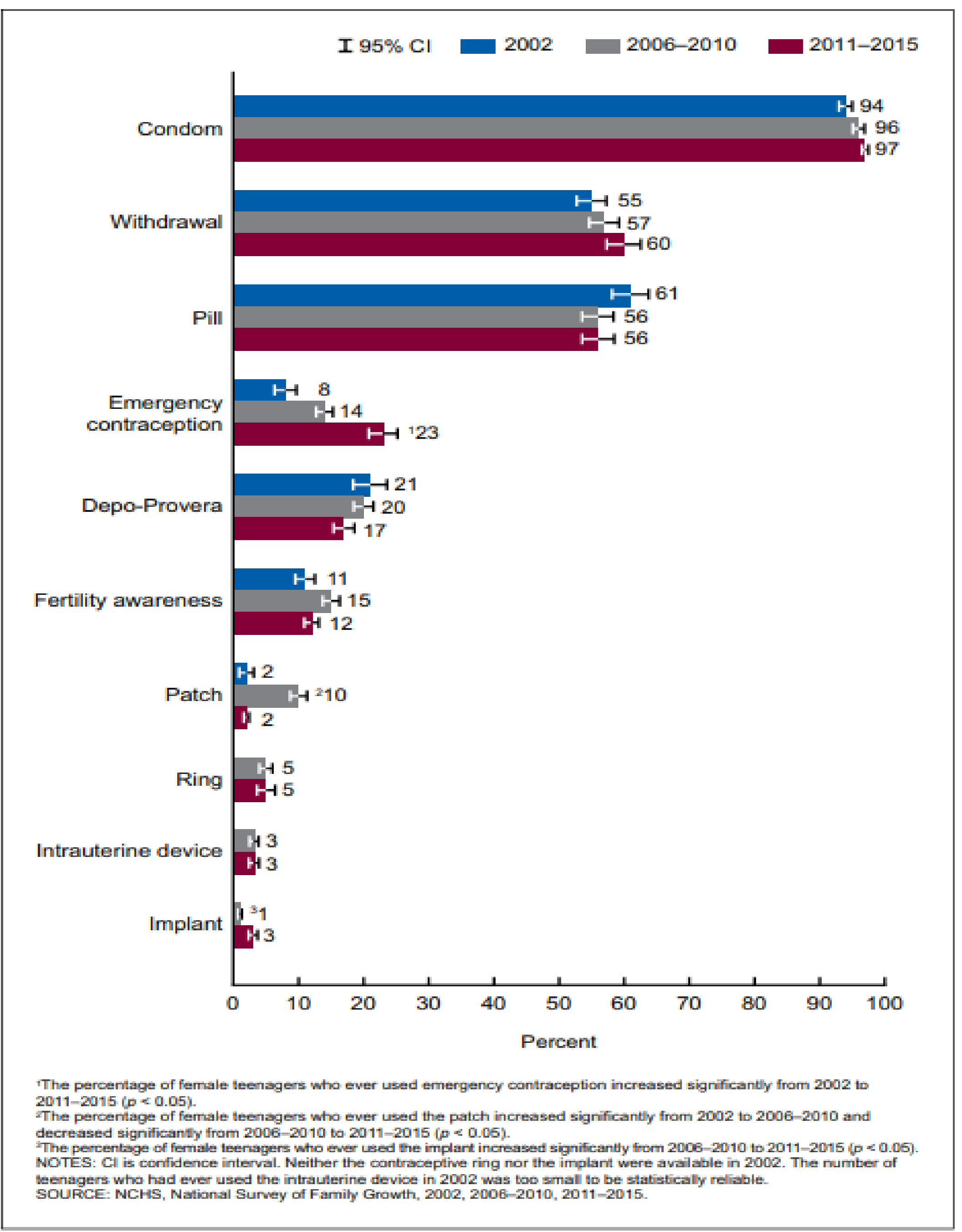


Figure 3. Methods of contraception ever used among females aged 15–19 who had ever had sexual intercourse: United States, 2002, 2006–2010, and 2011–2015

95% CI

Just friends or just met

Going out once in a while, going steady, cohabiting, engaged, or married

Percent

100
80
60
40
20
0

	Just friends or just met	Going out once in a while, going steady, cohabiting, engaged, or married
Female	74	83
Male	[1]76	88

[1]The percentage of male teenagers who used a method of contraception at first sex was significantly lower for those whose first partner was someone they had just met or were just friends with compared with those whose first partner was someone they were going out with once in a while, going steady with, cohabiting with, or engaged or married to ($p < 0.05$).

NOTE: CI is confidence interval.

SOURCE: NCHS, National Survey of Family Growth, 2011–2015.

Figure 5. Use of contraception at first sex among males and females aged 15–19 who had ever had sexual intercourse, by relationship with first sexual partner: United States, 2011–2015

TAKING AN APPROPRIATE HISTORY

Adolescent Development

- 3 stages
  - Early adolescence
    - Ages 10-14 years
    - Grades 5-9
  - Middle Adolescence
    - Ages 15-17 years
    - Grades 9-12
  - Late Adolescence/Young Adulthood
    - Ages 18 -24 years
    - Post high school

Beginning Questions

- When was menarche?
- Last menstrual period
- Regularity of cycles: including presence of clots, cramps
- Is there a PMH of bleeding or clotting disorders, hypertension, hepatobiliary disease or migraines with aura?
- Is there a family history of bleeding or clotting disorders
- Is there a personal or family history of uterine/cervical/breast/ovarian cancer
- Personal history of epilepsy or sickle cell disorder

Additional Questions

- 5 P's
  - Partners
    - Gender(s), Number (three months, lifetime)
  - Prevention of pregnancy
    - Contraception, Emergency Contraception use
  - Protection from STIs
    - Condom use
  - Practices
    - Types of sex: anal, vaginal , oral
  - Past History of STIs

***Please remember these questions should always be asked in private** in order to reassure accuracy of responses and help the teen develop.

Why is it Important to ask about…?

- Menarche
  - You need to make sure the patient is progressing normally prior to start of contraception
  - If you feel that they are not→
    - Initiate workup yourself
    - Refer to a specialist
- Regularity of cycles
  - May help you identify a pre-existing menstrual problem
  - Helps you give appropriate recommendations regarding contraceptive options

Children's of Alabama®

More Questions

- What are her goals (current, after high school etc.)?
- Does she plan on getting pregnant while in high school?
- How is she with taking a medication daily?

Don't forget your MOTIVATIONAL INTERVIEWING training!

Take Away Points

- Yes you are a doctor but:
  - Ask age appropriate questions
  - Avoid using medical terminology
  - Avoid assumptions
    - Gender
    - Sexuality
    - Sexual practices
    - Cultural norms
  - If you don't know a term, ASK!
  - You have to be able to think on your feet
    - Take advantage of educational opportunities as they present
  - Remember to be empathetic (or sympathetic)
- Always try to leave your patients feeling EMPOWERED!