



Ronald T. Burkman, MD

LARC Methods—It Makes Sense to Increase Use!

Unintended pregnancy in the United States continues at an unabated rate of almost 50% despite multiple efforts over the past several decades to address this issue. Over one-half of women who experience an unintended pregnancy were using some form of contraception during the month prior to the pregnancy. Of note, about 1

million of such pregnancies occur in oral contraceptive (OC) users. Such data suggest that many women are doing what they can to prevent an unintended pregnancy but do not succeed. Further, the data suggest that use of a method that requires a frequent action such as taking a daily OC is not easy

for many. In a finding that was not gender specific, it was noted that adherence to taking most oral medicines is often poor, not only in contraceptive users, but also in users of medications critical to combating a disease state. The use of long-acting reversible contraceptives (LARCs), which includes intrauterine devices (IUDs) and the contraceptive implant,

something daily or at the time of intercourse to prevent pregnancy.

None of the 3 LARC methods available contains estrogen, although contraceptive implants and one type of IUD release progestins. Thus, the vast majority of women are candidates for these methods. This includes sexually active women of all ages, those who are nulliparous, obese, breastfeeding, who have medical conditions such as hypertension and diabetes, and of course individuals where estrogen use is contraindicated.

The continuation rate in LARC users after 1 year ranges from 78% to 84% compared to about 67% for users of combination OCs. Despite all of these advantages, the use of LARC methods encompasses at best only 6% of individuals using contraception in this country.

So why is use so low? For some women, deciding upon a method brings into play complex social or cultural concerns as well as their knowledge about contraceptive methods. Unfortunately, some of this may be based on misperceptions about LARC methods such as ease of use, effectiveness, side effects, major risks, and concern

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have significant advantages for individuals desiring contraception. The overall failure rate for IUDs and implants falls within a low range of 0.1 to 0.3 pregnancies per year with typical use. The low failure rate is related both to the characteristics of these methods as well as the lack of necessity to do

regarding future fertility when the method is discontinued.

Some of these misperceptions may even be fueled by biases introduced by practitioners who view these methods as more difficult to initiate, more fraught with problems in management and discontinuation, and more concern relative to potential liability. For example, those who have been in the field for a long time may recall the litigation surrounding the Dalkon Shield and the occasional difficulty in removing Norplant implants. However, it is important to recognize that litigation is rare with current LARC methods, and with proper training, they are all rather easy to insert and remove.

Another major barrier has been the financial burden, particularly for patients who have faced substantial upfront co-pays. A clear

benefit of the new health care legislation has been the recent decision that individuals with health insurance will have their contraceptives covered—with only a few exceptions—by August of next year.

In my view, it is imperative that those who provide contraceptive services emphasize the benefits of LARC methods during contraceptive counseling to increase the use of these methods—or at the very least, refer patients to practitioners who provide these services.

Finally, as suggested by Espey and Ogburn,¹ what is needed is a philosophical shift that emphasizes that unintended pregnancy is a public health emergency that requires urgent and vigorous action. Once such a shift occurs, it is likely that appropriate education and increased availability of services relative to LARC methods

will increase their utilization.

For more information about contraceptive options, see this month's article, "Guide to Contraceptive Counseling for Women with Medical Conditions," on page 22.

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Reference

1. Espey E, Ogburn T. Long-acting reversible contraceptives: implants and intrauterine devices. ACOG Practice Bulletin No. 121. American College of Obstetricians and Gynecologists. *Obstet Gynecol.* 2011;117(3):705-719.

Recommended Reading

Long-acting reversible contraception: implants and intrauterine devices. *Obstet Gynecol.* 2011;118(1):184-196.

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