

# Guide to Contraceptive Counseling for Women With Medical Comorbidities, Part 2 *Progestin-Only Options*

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**When providing contraceptive counseling to women with medical conditions, clinicians should not only review a patient's medical history but also consider her current medication regimen and its potential to affect contraceptive efficacy. Part 2 of this 2-part series focuses on progestin-only contraceptive options, with special consideration to women with medical comorbidities.**

**A**mong women who have chronic medical conditions, an unintended pregnancy can have serious health consequences. Certain diseases may be exacerbated by pregnancy and/or associated with adverse pregnancy outcomes. Moreover, medications used to treat many chronic medical conditions are teratogenic and/or may interfere with the efficacy of various contraceptive methods. Despite the potential for such complications, women with medical comorbidities may not receive adequate contraceptive counseling.<sup>1,2</sup>

In last month's issue, part 1 of this 2-part series reviewed combined hormonal contraceptive (CHC) options for patients with medical comorbidities. In this issue, part 2 focuses on progestin-only contraceptive choices in this select group of patients.

## Case Example 1: A 31-Year-Old Patient With Seizure Disorder

A 31-year-old patient with a history of a seizure disorder that has been well con-

trolled with phenytoin presents to her clinician to discuss her current use of depot medroxyprogesterone acetate (DMPA) injectable suspension (Depo-Provera®; Pfizer Inc, New York, NY). This patient states that she has been using DMPA for the past 3 years and has found it "works well" for her. She further expresses her preference for not having to take a pill daily and reports having significantly lighter menstrual cycles since initiating DMPA.

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Part 1 of this article



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This patient, however, has concerns regarding continuation of DMPA based on an article she read regarding the effects of DMPA on bone density.

**Depot Medroxyprogesterone Acetate**

DMPA is a progestin-only contraception that is safe for use in women with a history of migraines with aura, thromboem-

use be limited to less than 2 years, unless other methods are inadequate.<sup>8</sup>

In 2006 and 2008, reviews of various studies showed that although there is a clear association between DMPA use and decreased BMD, BMD loss was reversible upon discontinuation of DMPA use.<sup>9,10</sup> Most DMPA users have a low risk for fracture at baseline, and there are scant data linking DMPA use to an increased incidence of fractures.<sup>11</sup>

**FOCUSPOINT** ➤

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bolic disease, cerebrovascular disease, and coronary artery disease.<sup>3</sup> Women with seizure disorder are particularly good candidates for DMPA. Unlike other forms of contraception, DMPA's efficacy is not affected by enzyme-inducing antiseizure drugs.<sup>4</sup> In addition, there is some evidence that DMPA may also decrease seizure frequency, thereby providing additional benefit for this group of patients.<sup>5</sup> Therefore, DMPA is an appropriate contraceptive option for this patient.

**What side effects are associated with DMPA?**

Commonly reported side effects associated with DMPA include menstrual irregularities, weight gain, and mood changes.<sup>6</sup> Eventual amenorrhea is common, which is a desirable side effect for many users.<sup>7</sup>

DMPA reduces serum estradiol levels, which can adversely affect bone health.<sup>3</sup> In 2004, the US Food and Drug Administration (FDA) issued a black box warning to DMPA package labeling, stating that women using DMPA may lose significant bone mineral density (BMD); this warning also recommends duration of DMPA

**Should this patient continue to use DMPA?**

The World Health Organization recommends no restriction on use of DMPA in women aged 18 to 45 years.<sup>12</sup> According to recent consensus guidelines, clinicians should advise patients about the risk for BMD loss as well as inform them of the reversibility of BMD loss upon discontinuation of DMPA.<sup>13</sup> In addition, patients should be informed that calcium and vitamin D supplements are important for maintaining bone health and are not prescribed solely for patients using DMPA. There are currently no recommendations for BMD screening with dual-energy x-ray absorptiometry in patients using DMPA.<sup>13</sup>

In this case example, the clinician should discuss available progestin-only options with this patient, along with the risks and benefits of each option. However, it is reasonable for this patient to continue using DMPA, as it may help control her seizure disorder and does not interact with her current antiseizure medication. The health care provider should review this patient's contraceptive needs and medication regimen on an annual basis.

**Case Example 2: A 33-Year-Old Nulliparous Patient**

A 33-year-old nulliparous patient presents to her clinician to discuss contraceptive options. This patient has a history of endometriosis that required 2 laparoscopies over 10 years ago. She is currently using an extended-cycle oral contraceptive (OC) but continues to experience severe menstrual pain during

the hormone-free interval (HFI). This patient is seeking an alternate contraceptive to reduce dysmenorrhea. She reports having taken DMPA in the past but discontinued use based on personal dislike for regular injections.

### Etonogestrel (ENG) Implant

The ENG implant (Implanon®; NV Organon, Oss, The Netherlands) is a highly effective and long-term progestin-only single-rod, subdermal implant.<sup>14</sup> The rod is implanted in the upper arm and remains active for 3 years. The ENG implant is unique to other progestin-only methods in that the initial decrease in estrogen levels is followed by a gradual rise in estradiol to normal endogenous levels.<sup>15,16</sup>

The ENG implant is placed during a simple office procedure by a trained provider using a preloaded, disposable applicator. Prior to insertion, clinicians

common being infrequent bleeding.<sup>14</sup> At 6 months post-insertion, approximately 30% to 40% of women become amenorrheic, 30% have infrequent bleeding, and the remainder experience frequent or prolonged bleeding.<sup>18</sup> As there is no method to predict individual bleeding response in ENG implant users, health care providers should counsel patients on these side effects—particularly because the highest rate of discontinuation is during the first 8 to 9 months of use and primarily due to frequent bleeding.<sup>18</sup>

In addition to irregular bleeding, the ENG implant has other side effects to consider. In one study, approximately 80% of women with dysmenorrhea at baseline reported a decrease in symptoms.<sup>18</sup> Thus, the ENG implant would be a good contraceptive option for the patient in this case example. Unlike DMPA, weight gain is only rarely associated with the ENG implant.<sup>15</sup> There are no long-term studies assessing BMD or fracture risk post-ENG implant use. However, because the ENG implant does not cause a hypoestrogenic state, it is not considered to have any significant effect on BMD.<sup>15</sup>

The ENG implant is contraindicated in women taking cytochrome P4503A- (CYP3A) inducing (eg, carbamazepine, phenytoin) or CYP3A-inhibiting (eg, ketoconazole, erythromycin) medications.<sup>14</sup>

Active venous thromboembolism (VTE) is a contraindication listed in the packaging information of several progestin-only methods, including the ENG implant; however, use of progestin-only contraceptives has been considered safe in women at increased risk for VTE.<sup>3,19,20</sup> Therefore, despite this listed contraindication, in clinical practice, women's health care providers consider the ENG implant an acceptable contraceptive agent in cases where a combined progestin/estrogen option is contraindicated.<sup>3,15</sup>

may administer a local anesthetic to minimize discomfort or pain. Post-removal, patients experience a quick return to both normal menstrual cycles and fertility; to date, there have been no reports of infertility post-removal.<sup>17</sup>

### What are the common side effects associated with the ENG implant? Are there any contraindications to its use?

Similar to other progestin-only contraceptives, irregular bleeding is the major side effect of the ENG implant, with the most

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### Case Example 3: Uterine Fibroids In A 35-Year-Old Patient

A 35-year-old patient with a medical history of uterine fibroids presents to her cli-

nician for evaluation. For the past 2 years, she has experienced very heavy monthly menses that last for about 7 days and are associated with significant blood clots and cramping. She states she has been taking iron supplements to treat symptomatic anemia for approximately 1 year. She also reports past OC use to reduce menorrhagia but had difficulty remembering to take pills on a daily basis. This patient is not interested in surgical options to treat her fibroids and does not plan on becoming pregnant in the next several years.

### Levonogestrel-Releasing Intrauterine System (LNG-IUS)

The LNG-IUS (Mirena®; Bayer Health-Care Pharmaceuticals Inc, Wayne, NJ) is an intrauterine device (IUD) that releases approximately 20 mcg of LNG daily. The LNG-IUS is a highly effective contraceptive and is considered to be a reversible method of sterilization due to its excellent efficacy in preventing pregnancy and rapid return to fertility post-removal.<sup>21</sup> It is a particularly beneficial and cost-effective option for patients requiring a progestin-only therapy.<sup>3</sup>

Within the first year of use, the LNG-IUS reduces menstrual blood loss by 90%, though in the first 6 months of use, irregular spotting is common.<sup>22</sup> Based on her history of menorrhagia, the patient in this case example may benefit from the LNG-IUS.

Several studies have confirmed the effectiveness of the LNG-IUS for reduction of menstrual blood loss in idiopathic menorrhagia and leiomyoma-associated menorrhagia, as well as amelioration of endometriosis-associated pain.<sup>23,24</sup> The LNG-IUS recently received FDA approval for the indication of menorrhagia and has been shown to decrease menorrhagia in women on anticoagulation therapy.<sup>25,26</sup> Use of the LNG-IUS to manage heavy menstrual bleeding appears to have therapeutic effects comparable to those of endometrial ablation up to 2 years after treatment.<sup>26</sup>

Fibroids rarely distort the uterine cavity to the extent that placing the LNG-IUS be-

comes technically too difficult. Depending on physical examination findings, clinicians may choose to perform a transvaginal ultrasound prior to placement to assess for distortion of the endometrial cavity.

### What are common side effects and contraindications to LNG-IUS use?

The LNG-IUS must be inserted by a trained clinician. At the time of placement, patients may experience cramp-

## FOCUSPOINT

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ing and pain. Uterine-wall rupture is a rare complication of LNG-IUS placement.<sup>21</sup> Though patients will likely develop amenorrhea, they should be counseled about initial irregular bleeding and spotting, and should be advised of the development of ovarian cysts, of which most are asymptomatic.

The LNG-IUS may be used in both nulliparous and multiparous women but should not be placed in women with suspected pregnancy or in those with an active infection, such as acute cervicitis or vaginitis.<sup>21</sup> Although risk of pregnancy is extremely low in IUD users, there is an increased risk of ectopic pregnancy when it does occur.<sup>21</sup> Most data concerning IUD use and ectopic pregnancies are related to the copper IUD. In a 5-year, international study comparing the LNG-IUS and the copper IUD, none of the 6 pregnancies in 1,124 women who had the LNG-IUS were ectopic.<sup>27</sup>

### Conclusion

A comprehensive understanding of available progestin-only contraceptive

**TABLE. Progestin-Only Hormonal Contraception Options**

	<b>DMPA (Depo-Provera®)</b>	<b>ENG implant (Implanon®)</b>	<b>LNG-IUS (Mirena®)</b>
<b>Duration</b>	14 weeks	Up to 3 years	Up to 5 years
<b>Reversibility</b>	May be delayed	Immediate	Immediate
<b>Cost</b>	\$50-\$90/injection ~\$16-\$22/month	\$500-\$750 ~\$15/month	\$400-\$750 ~\$7-\$13/month
<b>Side effects</b>	Irregular bleeding Decrease in BMD	Irregular bleeding	Irregular bleeding
<b>Consider in patients with</b>	Seizure disorder, contraindication to estrogen, hypercoagulable states, dysmenorrhea, long-term contraception, migraine with aura	Contraindication to estrogen, hypercoagulable states, dysmenorrhea, long-term contraception, migraine with aura	Contraindication to estrogen, hypercoagulable states, dysmenorrhea, long-term contraception, migraine with aura

Abbreviations: DMPA, depot medroxyprogesterone acetate; ENG, etonogestrel; LNG-IUS; levonogestrel-releasing intrauterine device; BMD, bone mineral density

options is essential for women's health care providers, particularly those caring for reproductive-aged women with medical comorbidities. Clinicians should carefully review a patient's medical history and current medication regimen to determine if contraindications to any of the progestin-only options exist, as well as consider patient's individual preferences, including acceptable side effects and reversibility.

DMPA is a safe option for use in women with seizure disorders, and associated BMD loss has been shown to be reversible with discontinuation of use.<sup>9,10</sup> The ENG implant offers the unique feature of returning estradiol to normal endogenous levels during use,<sup>15,16</sup> while the high efficacy, reversibility, and low cost of the implant make it an attractive option for many patients. The reduction of menstrual blood loss associated with the LNG-IUS is an excellent option for patients suffering from menorrhagia (Table).

When counseling patients with medical comorbidities on combined estrogen-progestin and progestin-only contraceptive options, health care providers must be knowledgeable of the risks and benefits of each method, con-

sider the patient's personal preferences, and take into account her personal medical history.

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## Coding for Guide to Contraceptive Counseling for Women With Medical Comorbidities, Part 2

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In each case, the choice of the appropriate E & M code level can use time as the determining factor. However, the clinician can also document the review of the patient's comprehensive history as well as the complexity of medical decision making to code the E & M level. For an established patient, a physical examination is not necessary as you need only to document 2 of the 3 components. If time is the determining factor, then be certain to document how much time was spent in counseling as well as what you discussed and recommended to the patient.

If the encounter is to just counsel the patient and provide her with the information necessary to help her make a decision, then choose the E & M level based on time or complexity and the following ICD-9 code:

**V25.09** Family planning advice

The CPT and ICD-9 codes for Case 1 are:

**96372** Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); subcutaneous or intramuscular

**V25.02** Initiation of other contraceptive measures, prescription of foams, creams, or other agents

The CPT and ICD-9 codes for Case 2 are:

**11975** Insertion, implantable contraceptive capsules

**V25.43** Implantable subdermal contraceptive

The CPT and ICD-9 codes for Case 3 are:

**58300** Insertion of intrauterine device (IUD)

**V25.11** Encounter for insertion of intrauterine contraceptive device

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