Contraception Update
Pelin Batur, MD, FACP, NCMP, CCD

Education Director,
Primary Care Women’s Health

Deputy Editor,
Cleveland Clinic Journal of Medicine

No Financial Disclosures or Conflicts of Interest
Why do I care?

- GYNs might need our help
- Help find answers to ‘annoying’ questions
- You are using the most teratogenic meds
- Might need info in your personal life!
Some fun facts...

- 50% of pregnancies unintended
  - 4/10 of these lead to abortion
    - 54% of those who had abortions had used a contraceptive that month
- 1/3 US servicewomen can’t access before deployment
  - Most effective methods discouraged or unavailable
  - 41% hard time getting refills

Finer et al. Contraception 2011; 84:478–485
Grindlay et al. Contraception 2013; 87:162-169
Conditions that may make unintended pregnancy an unacceptable health risk

- Breast cancer
- Complicated valvular heart disease
- Diabetes with vascular complications
- Endometrial or ovarian cancer
- Epilepsy
- Bariatric surgery within 2 years
- HIV/AIDS
- Ischemic heart disease
- Malignant liver tumors
- Peripartum cardiomyopathy
- Schistosomiasis with liver fibrosis
- Severe cirrhosis
- Sickle cell disease
- Solid organ transplant within 2 years
- Stroke
- SLE
- Thrombogenic mutations
- Tuberculosis
Female
Condom
Sponge
Diaphragm
Cervical cap
Long Acting Reversible Contraceptives (LARCs)

- The contraceptive CHOICE project
- Prospective study: *what happens if cost is not an issue?*
  - LARCs chosen by 75% of women
  - LARCs 20x more effective than CHC
  - 2008-2013 pregnancy and birth rate 1/5 the national rate
    - Abortion rates less than ¼ national rate

Peipert JF et al. Obs Gynecol Oct 2012
Winner B, et al. NEJM May 2012
Secura GM et al. NEJM Oct 2 2014
"Ashley wanted to play doctor, but I'm trying to stay out of the health care debate."
Does it save us money?

- **Cost of unintended pregnancy in the US = $4.6 billion/yr**

- Including LARCs:
  - If 10% of women age 20-29 changed to LARCs, savings $288 million/year

- Extending coverage to low income Americans for 5 yrs
  - 72 prevented pregnancies per 1000 women
  - Saves $489 per woman enrolled

  - Doesn’t include cost of
    - Decreased productivity
    - Ob complications
    - Health of children
    - Undocumented immigrants

Trussel et al. Contraception 2013; 87:154
Burlone et al. Contraception 2013; 87:143
Intrauterine Contraception: IUD

Copper
- 10 yrs
- No hormones

LNG IUS
- 5 yrs
- 3 yrs
- Both with local progestin

Amenorrhea 20-80% at 1 yr
Similar to endometrial ablation

Marjoribanks et al. Cochrane Database Syst Rev. 2006
What’s new with **Implanon Nexplanon**

- Lasts 3 yrs
- 99+ % effective
- 30-40% amenorrhea at 1 yr
  - ↑ bleeding often occurs in first year
Arm pain and numbness in an implant user

Intrauterine Permanent Contraception: **Essure**

- Local anesthesia, 10 minutes
- Back-up method needed for first 3 months
MRI Safety

- **MR Safe**
  - Mirena
  - Nexplanon

- **MR Conditional**
  - Safe if scanner <3 T
    - Essure
    - Copper IUD
    - Skyla

- **MR Unsafe**
"WE'RE ALMOST THERE, HAPPY ANNIVERSARY, DEAR!"
Effectiveness of Family Planning Methods

How to make your method most effective
- After procedure, little or nothing to do or remember.
- Vasectomy and hysteroscopic sterilization: Use another method for first 3 months.

Injectable: Get repeat injections on time.
Pills: Take a pill each day.
Patch, Ring: Keep in place, change on time.
Diaphragm: Use correctly every time you have sex.

Condoms, sponge, withdrawal, spermicides: Use correctly every time you have sex.
Fertility awareness-based methods: Abstain or use condoms on fertile days. Newest methods (Standard Days Method and TwoDay Method) may be the easiest to use and consequently more effective.

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.

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

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

U.S. Medical Eligibility Criteria for Contraceptive Use, 2010
Adapted from the World Health Organization Medical Eligibility Criteria for Contraceptive Use, 4th edition

U.S. Selected Practice Recommendations for Contraceptive Use, 2013
Adapted from the World Health Organization Selected Practice Recommendations for Contraceptive Use, 2nd Edition
CDC 2010 “MEC” Guidelines: Contraception for diabetics

Summary Chart of U.S. Medical Eligibility Criteria for Contraceptive Use, 2010

<table>
<thead>
<tr>
<th>Condition</th>
<th>Sub-condition</th>
<th>Combined pill, patch, ring</th>
<th>Progestin-only pill</th>
<th>Injection</th>
<th>Implant</th>
<th>LNG–IUD</th>
<th>Copper–IUD</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>I</td>
<td>C</td>
<td>I</td>
<td>C</td>
<td>I</td>
<td>C</td>
</tr>
<tr>
<td>DM (cont.)</td>
<td>b) Non-vascular disease</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>(i) non-insulin dependent</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>(ii) insulin dependent†</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>c) Nephropathy/retinopathy/ neuropathy†</td>
<td>3/4*</td>
<td>2</td>
<td>3</td>
<td>2</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>d) Other vascular disease or diabetes of &gt;20 years’ duration†</td>
<td>3/4*</td>
<td>2</td>
<td>3</td>
<td>2</td>
<td>2</td>
<td>1</td>
</tr>
</tbody>
</table>
CDC MEC mobile app

**Appendix B: Classifications for Combined Hormonal Contraceptives**

**Condition: BREAST DISEASE - Clarification**

**Category:**

- a. Undiagnosed mass - 2 (advantages generally outweigh risks)
- b. Benign breast disease - 1 (no restriction)
- c. Family history of cancer - 1 (no restriction)
- d. Breast cancer -
  - i. Current - 4 (unacceptable risk)
  - ii. Past and no evidence of current disease for 5 yrs - 3 (risks usually outweigh advantages)

**Clarification (undiagnosed mass):** The woman should be evaluated as early as possible.

**Evidence (family history of cancer):** Women with breast cancer susceptibility genes (such as BRCA1 and BRCA2) have a higher baseline risk for breast cancer than do women without these genes. The baseline risk for breast cancer is also higher among women with a family history of breast cancer than among those who do not have such a history. However, current evidence does not suggest that the increased risk for breast cancer among women with either a family history of breast cancer or breast cancer susceptibility genes is modified by the use of COCs.

**Comment (breast cancer, current):** Breast cancer is a hormonally sensitive tumor, and the prognosis for women with
BOX 1. How To Be Reasonably Certain that a Woman Is Not Pregnant

A health-care provider can be reasonably certain that a woman is not pregnant if she has no symptoms or signs of pregnancy and meets 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

# CDC 2013 “SPR” Guidelines: Highlights

## TABLE. Examinations and tests needed before initiation of contraceptive methods

<table>
<thead>
<tr>
<th>Examination or test</th>
<th>Cu-IUD and LNG-IUD</th>
<th>Implant</th>
<th>Injectable</th>
<th>CHC</th>
<th>POP</th>
<th>Condom</th>
<th>Diaphragm or cervical cap</th>
<th>Spermicide</th>
</tr>
</thead>
<tbody>
<tr>
<td>Examination</td>
<td>C</td>
<td>C</td>
<td>C</td>
<td>A*</td>
<td>C</td>
<td>C</td>
<td>C</td>
<td>C</td>
</tr>
<tr>
<td>Blood pressure</td>
<td>C</td>
<td>C</td>
<td>C</td>
<td>C</td>
<td>C</td>
<td>C</td>
<td>C</td>
<td>C</td>
</tr>
<tr>
<td>Weight (BMI) (weight [kg]/height [m]^2)</td>
<td>_†</td>
<td>_†</td>
<td>_†</td>
<td>_†</td>
<td>_†</td>
<td>C</td>
<td>C</td>
<td>C</td>
</tr>
<tr>
<td>Clinical breast examination</td>
<td>C</td>
<td>C</td>
<td>C</td>
<td>C</td>
<td>C</td>
<td>C</td>
<td>C</td>
<td>C</td>
</tr>
<tr>
<td>Bimanual examination and cervical inspection</td>
<td>A</td>
<td>C</td>
<td>C</td>
<td>C</td>
<td>C</td>
<td>C</td>
<td>C</td>
<td>A§</td>
</tr>
<tr>
<td>Laboratory test</td>
<td>Glucose</td>
<td>C</td>
<td>C</td>
<td>C</td>
<td>C</td>
<td>C</td>
<td>C</td>
<td>C</td>
</tr>
<tr>
<td></td>
<td>Lipids</td>
<td>C</td>
<td>C</td>
<td>C</td>
<td>C</td>
<td>C</td>
<td>C</td>
<td>C</td>
</tr>
<tr>
<td></td>
<td>Liver enzymes</td>
<td>C</td>
<td>C</td>
<td>C</td>
<td>C</td>
<td>C</td>
<td>C</td>
<td>C</td>
</tr>
<tr>
<td></td>
<td>Hemoglobin</td>
<td>C</td>
<td>C</td>
<td>C</td>
<td>C</td>
<td>C</td>
<td>C</td>
<td>C</td>
</tr>
<tr>
<td></td>
<td>Thrombogenic mutations</td>
<td>C</td>
<td>C</td>
<td>C</td>
<td>C</td>
<td>C</td>
<td>C</td>
<td>C</td>
</tr>
<tr>
<td></td>
<td>Cervical cytology</td>
<td>(Papanicolaou smear)</td>
<td>C</td>
<td>C</td>
<td>C</td>
<td>C</td>
<td>C</td>
<td></td>
</tr>
<tr>
<td></td>
<td>STD screening with laboratory tests</td>
<td>_†</td>
<td>C</td>
<td>C</td>
<td>C</td>
<td>C</td>
<td>C</td>
<td>C</td>
</tr>
<tr>
<td>HIV screening with laboratory tests</td>
<td>C</td>
<td>C</td>
<td>C</td>
<td>C</td>
<td>C</td>
<td>C</td>
<td>C</td>
<td>C</td>
</tr>
</tbody>
</table>
What’s new with Depo Provera

- Failure rate ‘0.0–0.7%’ 6%
- Side Effects:
  - Weight gain (1-3 kg)
  - Hypoestrogenic
  - Higher insulin and FBS
  - ↓ HDL
- Uncontrolled HTN/Vascular Dz
  - Progestin only pill and Implant: category 2
  - Depo: category 3
Bone Health: Depo-Provera

- **Black box warning: Osteopenia**
  - Studies on BMD mixed
  - BMD ↓ at 5 yrs vs controls
    - -5.38% in LS (-3.13% 2 yrs after dc)
    - -5.16% in TH (-1.34%)
    - -6.12% in FN (-5.38%)
  - Decline is more pronounced in first 2 yrs

- **ACOG & WHO: Advantages of DMPA > risks**
  - Can continue for decades!

Batur P, Joy S. Clinical Reviews of Bone and Mineral Metabolism; 3(2): 103-113, 2005
Bone Health: Depo-Provera

- Use of DMPA and incidence of bone fracture
  - 312,395 women in UK, retrospectively followed 5 yrs
  - Fx incidence in 1000 women: 9.1 (Depo) vs 7.3 (non-Depo)
    - Incidence RR 1.23 (95% CI 1.16-1.130)

- Overall “message”: no significant increase
  - DMPA cohort higher risk of fx at baseline
  - Risk did not increase further after DMPA initiated
  - Longer term users had lower fx risk than short term
  - No excess risk of axial fx (hip, pelvis, vertebral)

Bone Health: Depo-Provera

Take home points

- Use it if patient needs it
- Consider LARC method instead
- Perimenopausal women have less time to recover BMD after discontinuation
- DXA scan not needed to monitor
Progestin only pill "mini-pill"

- For those who cannot tolerate estrogen
  - CAD, VTE, stroke
  - Migraine w/ aura
  - DM w/ vascular complication
  - <6 wks postpartum
  - Uncontrolled hypertension

- Main use in lactating women
  - Higher rates of breakthrough bleeding
  - Lower contraceptive efficacy
  - Back up method for 2 days if > 3hrs late w/ dose
Combined Hormonal Contraceptives (CHC)

- Have been used ~ 50 years in the US
- Most popular contraceptive choice along with sterilization

- Combined Oral Contraceptives (the pill, COC)
- NuvaRing (vaginal ring)
- Ortho Evra (skin patch)
Combined Oral Contraceptives: 

**Progestin Formulations**

- **1st Generation**: (cycle control problems)
  - norethindrone
  - ethynodiol diacetate

- **2nd Generation**: (androgenic problems)
  - norgestrel
  - levonorgestrel

- **3rd Generation**: (RR VTE 1.7-6x)
  - desogestrel
  - etonogestrel
  - norgestimate
  - norelgestromin
  - gestodene (RR VTE 1-3x)

- **4th Generation**: (RR VTE 0.9-3x)
  - drospirenone
  - dienogest
Combined Oral Contraceptives:

*Progestin Formulations*

• **1st Generation**: (cycle control problems)
  – *norethindrone*
  – *ethynodiol diacetate*

• **2nd Generation**: (androgenic problems)
  – *norgestrel*
  – *levonorgestrel*

• **3rd Generation**: (RR VTE 1.7-6x)
  – *desogestrel*
  – *etonogestrel*
  – *norgestimate*
  – *norelgestromin*
  – *gestodene* (RR VTE 1-3x)

• **4th Generation**: (RR VTE 0.9-3x)
  – *drosiprenone*
  – *dienogest*
Why are they so mean to Yasmin/Yaz?
The aftermath...

• $1.575 billion settlements in the U.S.\(^1\)
  – 7,660 claimants (mostly VTE)
  – average claim per case = $212,000

• Bayer agreed to settle ~ 8800 gallbladder injuries = $24 million

What does the data really show?

# Summary of VTE: absolute risks

<table>
<thead>
<tr>
<th>Condition</th>
<th>Rate of VTE (per 10,000 women per year)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reproductive Aged (baseline-no pill)</td>
<td>1-5</td>
</tr>
<tr>
<td>Pill users</td>
<td>3-10</td>
</tr>
<tr>
<td></td>
<td>(*rates vary by progestins)</td>
</tr>
<tr>
<td>Pregnancy</td>
<td>10-29</td>
</tr>
<tr>
<td>Postpartum</td>
<td>65-400</td>
</tr>
</tbody>
</table>

What’s new with CHC Risks?

- Breast cancer
- Stroke
- Coronary artery disease
- VTE
What’s new with CHC Risks?

- **Breast cancer**
- Stroke
- Coronary artery disease
- VTE

No ↑ risk
- Contraception 2012; 85: p342
- NEJM 1986; 315:p405
- JAMA 2000;284: p1791
- NEJM 2002; 346: p2025

↑ risk
- Br J Cancer 2003;88: p50
- Can Epid Prev 2010; 19: p2496
What’s new with CHC **BENEFITS**?

- **Breast cancer**

  **BRCA carriers:**
  - ↓ ovarian cancer RR 0.50 (CI 0.33-0.75)
  - No association with breast cancer
  - Only old formulations used before 1975 ↑ risk: RR 1.47 (1.06-2.04)

**Ovarian Cancer Prevention**
- NNT 185 x 5 yrs
- Longer use is better
- Protection attenuates after d/c
- Consider using in 40s

*Eur J Cancer 2010;46(12): 2275*

*Obstet Gynecol July 2013; 122(1):139*
What’s new with CHC Risks?

- Breast cancer
- **Stroke**
- Coronary artery disease
- VTE
What’s new with CHC Risks?

- Breast cancer
- **Stroke**
- Coronary artery disease
- VTE

Obstet Gynecol Aug 2013; 122(2):380
OR Ischemic stroke = 1.90 (95% CI 1.24-2.91)
Very few with EE <35mcg dose
Insufficient data to stratify by progestin

NEJM 2012; 366:2257
30-40 mcg EE RR ↑ 1.5-2.2
20 mcg EE RR ↑ 0.9-1.7
Ortho Evra ↑ 3.2 [CI 0.8-2.6]
NuvaRing ↑ 2.5 [CI 1.4-4.4]

Obstet Gynecol Oct 2013; 122(4): 800
NuvaRing not increased compared to COC
What’s new with CHC Risks?

- Breast cancer
  - Obstet Gynecol Aug 2013; 122:380
  - OR= 1.34 (CI 0.87-2.08)
  - Insufficient data to stratify by EE dose

- Stroke

- MI
  - NEJM 2012; 366:2257
  - 30-40 mcg EE RR ↑ 1.3-2.3
  - 20 mcg EE RR ↑ 0.0-1.6
  - Ortho Evra  RR 0.0
  - NuvaRing ↑ 2.1 [CI 0.7-6.5]

- VTE
  - Obstet Gynecol Oct 2013; 122(4): 800
  - NuvaRing not increased compared to COC
Does the type of progestin used affect the arterial risk?  **No**

<table>
<thead>
<tr>
<th>Type of Progestin/ Hormonal Contraception</th>
<th>CVA</th>
<th>MI</th>
</tr>
</thead>
<tbody>
<tr>
<td>### of events/ 100,000 person-years</td>
<td>Adjusted RR (30 mcg EE dose)</td>
<td># of events/ 100,000 person-years</td>
</tr>
<tr>
<td>Norethindrone</td>
<td>22.1</td>
<td>1.17 (1.49-3.15)</td>
</tr>
<tr>
<td>Levonorgestrel</td>
<td>31.3</td>
<td>1.65 (1.39-1.95)</td>
</tr>
<tr>
<td>Norgestimate</td>
<td>17.2</td>
<td>1.52 (1.21-1.91)</td>
</tr>
<tr>
<td>Desogestrel*</td>
<td>31.6</td>
<td>2.20 (1.79-2.69)</td>
</tr>
<tr>
<td>Gestodene*</td>
<td>21.6</td>
<td>1.80 (1.58-2.04)</td>
</tr>
<tr>
<td>Drospirenone*</td>
<td>18.1</td>
<td>1.64 (1.24-2.18)</td>
</tr>
<tr>
<td>Patch</td>
<td>42.1</td>
<td>3.15 (0.79-12.60)</td>
</tr>
<tr>
<td>Vaginal ring</td>
<td>31.4</td>
<td>2.49 (1.41-4.41)</td>
</tr>
</tbody>
</table>

What’s new with COC Risks?

- Breast cancer
- Stroke
- Coronary artery disease
- VTE
### Does the VTE risk vary based on the progestin formulation?  *Probably yes*

<table>
<thead>
<tr>
<th></th>
<th>Non-use</th>
<th>First</th>
<th>Second</th>
<th>Third</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-use</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>First generation</td>
<td>3.2 (2.0-5.1)</td>
<td>1</td>
<td>0.9 (0.6-1.4)</td>
<td>1.3 (1.0-1.8)</td>
</tr>
<tr>
<td>Second generation</td>
<td>2.8 (2.0-4.1)</td>
<td>1.2 (0.8-1.9)</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Third generation</td>
<td>3.8 (2.7-5.4)</td>
<td></td>
<td></td>
<td>1</td>
</tr>
</tbody>
</table>

Medical Considerations: Bariatric Surgery

- **Gastric bypass**
  - Oral pills are category 3
  - All other methods category 1

- **Restrictive (lap band)**
  - All category 1
### Medical Considerations: Headache

<table>
<thead>
<tr>
<th>Condition</th>
<th>Sub-condition</th>
<th>Combined pill, patch, ring</th>
<th>Progestin-only pill</th>
<th>Injection</th>
<th>Implant</th>
<th>LNG–IUD</th>
<th>Copper–IUD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Headaches</td>
<td>a) Non-migrainous</td>
<td>1*</td>
<td>2*</td>
<td>1*</td>
<td>1*</td>
<td>1*</td>
<td>1*</td>
</tr>
<tr>
<td></td>
<td>b) Migraine</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>i) without aura, age &lt;35</td>
<td>2*</td>
<td>3*</td>
<td>1*</td>
<td>2*</td>
<td>2*</td>
<td>2*</td>
</tr>
<tr>
<td></td>
<td>ii) without aura, age ≥35</td>
<td>3*</td>
<td>4*</td>
<td>1*</td>
<td>2*</td>
<td>2*</td>
<td>2*</td>
</tr>
<tr>
<td></td>
<td>iii) with aura, any age</td>
<td>4*</td>
<td>4*</td>
<td>2*</td>
<td>3*</td>
<td>2*</td>
<td>3*</td>
</tr>
</tbody>
</table>


Seizure Disorder

- Decreased contraceptive efficacy, consider IUD

- Use estrogen doses >50 mcg EE with:
  - Barbiturates, carbamazepine, oxcarbazepine, felbamate, topiramate levels reduced
    - Levetiracetam, valproic acid ok

- lamotrigine levels ↓ 50% with COC pills
  - May need higher doses of lamotrigine to control seizure
  - Can get toxic levels in placebo week
    - Use continuous regimen if COC must be used
Medical Considerations: Organ Transplant

- Amenorrhea/infertility common with hepato-renal disease
  - 1/20 transplant patients of childbearing get pregnant

- National transplantation pregnancy registry:
  - Live birth rate 50-86%

- Medicare:
  - Live birth rate 55%
  - Post transplant pregnancy 33/1000 women

- Estimates don’t include abortions
Organ Transplant

- Pregnancy risks post transplant:
  - Graft rejection
  - Pregnancy complications
  - Most antirejection agents are pregnancy class D

- Contraception should be discussed prior to transplant
  - Women should wait 18-24 months before pregnancy
  - IUD, hormonal options are category 2
    - Unless graft failure, rejection, allograft vasculopathy
      - COC category 4
      - IUD category 3
      - Depo, POP category 2
Medical Considerations:
Systemic Lupus Erythematosus

- Low likelihood of significant flare w/COC*
  - Thrombosis risk not increased
  - Excluded those with mod-high ab levels

- Caution w/ drospirenone, DMPA
- Severe thrombocytopenia: avoid ParaGard & DMPA
- Use of immunosuppressants does not affect choice

Medical Considerations: Rheumatoid arthritis

- COC has no negative outcomes on RA
  - COC use > 5 yrs, RR of severe dz 0.1 (95% CI 0.01-0.6)
- DMARDs: methotrexate & leflunomide are pregnancy category X
  - Stop MTX 3 months & leflunomide 2 yrs prior to conception

J of Rheumatology. Vol 31: Supplement 69, March 2004
What’s new with:
Emergency contraception

Pregnancies per 1000 Women after Unprotected Intercourse

ParaGard, ella, Plan B/Next Choice, Yuzpe, Nothing

ECPs “Over-the-Counter” in the US

- Plan B® One-Step
  - Over the counter for all ages
- Next Choice One Dose™
  - Behind counter for ≥ 17 years
  - Rx needed if < 17 years
- Levonorgestrel
- My Way™

$35-60 $24-42 $19-30 $24-42
Example of “easy access OTC”
# Emergency Contraception

<table>
<thead>
<tr>
<th>Method</th>
<th>Dose</th>
<th>Efficacy</th>
</tr>
</thead>
<tbody>
<tr>
<td>high dose estrogen</td>
<td>5 mg EE qd x 5</td>
<td>75-80%</td>
</tr>
<tr>
<td>estrogen + progestin</td>
<td>100 ug EE + 0.5 mg levonorgestrel po q12 hr x 2</td>
<td>56-89 %</td>
</tr>
<tr>
<td>levonorgestrel</td>
<td>(Plan B) 0.75 mg q12 x 2 (Plan B One-Step) 1.5 mg x1</td>
<td>60-94 %</td>
</tr>
<tr>
<td>ulipristal (<em>ella™</em>)</td>
<td>30 mg</td>
<td>~98.6%</td>
</tr>
<tr>
<td>copper IUD</td>
<td>Insert within 5 days</td>
<td>99%</td>
</tr>
</tbody>
</table>
# Emergency Contraception

<table>
<thead>
<tr>
<th>Method</th>
<th>Dose</th>
<th>Efficacy</th>
</tr>
</thead>
<tbody>
<tr>
<td>levonorgestrel (Plan B)</td>
<td>(Plan B) 0.75 mg q12 x 2 (Plan B One-Step) 1.5 mg x1</td>
<td>60-94 %</td>
</tr>
<tr>
<td>ulipristal (ella™)</td>
<td>30 mg</td>
<td>~98.6 %</td>
</tr>
</tbody>
</table>
# Emergency Contraception

<table>
<thead>
<tr>
<th>Method</th>
<th>Dose</th>
<th>Efficacy</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>EC Hotline:</strong></td>
<td><strong>1-888-NOT-2-LATE</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Thank you!

baturp@ccf.org