Ask The Doctor

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Goals and Objectives

- **Apply USMEC guidelines** to contraceptive counseling in patients with complex medical and psychosocial comorbidities.
- **Compare efficacy and safety profiles** of contraceptive methods using Pearl Index data, long-term cohort outcomes, and emerging evidence.
- **Formulate individualized counseling strategies** for adolescents and adults, integrating mental health, cancer risk, and metabolic considerations.
- **Recognize and manage common side effects and complications** of contraceptive methods (e.g., bleeding with implants, bone health with DMPA, VTE risk with CHCs).

Scenario 1:

A 49-year-old perimenopausal woman has used depot medroxyprogesterone acetate (DMPA) for 15 years. She values amenorrhea and privacy and wants to continue. How should we counsel her about duration, menopause, and new safety evidence?

Scenario 1: Patient Demographics

- Age: 49
- PMH: Controlled hypertension, migraine without aura
- PSH: None
- Meds: Hydrochlorothiazide, DMPA every 13 weeks
- Allergies: NKDA
- Social: Nonsmoker, occasional alcohol
- Exam: BP at goal, BMI 28, no focal neurologic symptoms
- Goal: Continue reliable contraception and amenorrhea

Scenario 1: Counselling Pearls

- Start with her preference and pregnancy goal

Age alone does not require stopping DMPA

- Reassess bone and fracture risk

Explain the meningioma signal and warning symptoms

- Review breast and cardiometabolic context

Make a menopause-transition plan

Scenario 1: Contraception Options

- Continue DMPA: informed preference, annual reassessment
- 52-mg LNG-IUD: contraception, bleeding control, future endometrial protection
- Implant or progestin-only pill: estrogen-free; bleeding may be less predictable
- Copper IUD or barrier method: avoids hormone exposure
- Combined hormonal methods: generally avoid with her hypertension and age

Scenario 1: Options/USMEC

- DMPA: age >45 = 2; controlled hypertension = 2
- LNG-IUD, copper IUD, implant: age >45 = 1
- Migraine without aura: progestin-only methods and IUDs = 1
- CHC: age ≥40 = 2; controlled hypertension = 3
- No CDC or ACOG two-year stop rule
- At age 50: actively revisit switching off DMPA

Scenario 2:

A 28-year-old G4P4 woman delivered a baby girl and does not want any more children . She is 8 months postpartum and desires long term birth control. She is breastfeeding and is uninsured.

Scenario 2: Patient Demographics

- Age: 28
- PMH: overweight
- PSH: None
- Meds: Prenatal vitamins
- Allergies: NKDA
- Social: Nonsmoker, does not drink alcohol, works part-time at hotel as a housekeeper
- Exam: Stable vitals, well-appearing, cervix was closed.

Scenario 2: Contraception Options

- Birth control pills
- Depo provera®
- Nexplanon
- LNG-IUD
- Copper IUD

- Contraindication: nuva ring, Xulane patch (patient is breastfeeding)

Scenario 2: Counselling Pearls

- Depot medroxyprogesterone acetate (DMPA): Category 1 for breastfeeding women
- LNG-IUD: Category 1.
- Copper IUD: Category 1.
- Combined hormonal contraception: Category 4

Scenario 2: Treatment Options

- Under title X program:
  - Birth control pills are provided in the office under a sliding fee scale.
  - Depo provera every 3 months
  - Nexplanon provided under sliding fee scale
  - IUD < $100 (based on sliding fee scale)
  - IUD paraguard – client pays the full cost $450

Scenario 3:

A 24-year-old G0 comes to your office concerned because she has experienced light bleeding and spotting for 3 weeks. She had an etonogestrel implant placed 5 months ago.

Scenario: Patient Demographics

- Age: 24
- PMH: migraine without aura; no VTE, liver disease, or bleeding disorder
- PSH: appendectomy
- Meds: sertraline 50 mg daily; implant
- Social/Sexual: Non smoker, occasional alcohol. New sexual partner x 2 months
  Condom use inconsistent. No pelvic pain, fever, dizziness, or heavy bleeding
- Exam: Vitals normal; well appearing. Abdomen soft/nontender. Pelvic exam: scant dark blood, cervix without lesion or friability, no CMT/adnexal tenderness. Pregnancy test negative. Obtain GC/CT testing based on risk. Consider CBC only if bleeding is heavy/prolonged or anemia suspected.

First question: Is it really the contraception?

- Rule out pregnancy when clinically indicated.
- Ask about adherence, method timing, interacting medications, smoking, and emergency contraception.
- Consider STI/cervicitis based on sexual history and exam.
- Consider thyroid disease or new uterine pathology (polyps/fibroids) when the pattern or context suggests it.
- Red flags: hemodynamic symptoms, very heavy bleeding, significant pain, fever, postcoital bleeding/cervical lesion, or anemia.
- **Bleeding changes usually do NOT mean the contraceptive has stopped working.**

Match the strategy to the method + the patient's goal

Implant

If evaluation is reassuring:

- Reassure / observe
- NSAID 5–7 days
- 20–30 µg EE COC or estrogen if medically eligible
- Tranexamic acid 5 days may be considered
- Tamoxifen 7–10 days may be considered

Bleeding may recur after some short-term therapies.

Match the strategy to the method + the patient's goal

DMPA/IUD

- DMPA:
  - NSAID 5–7 days
  - For heavy/prolonged bleeding: low-dose COC or estrogen 10–20 days if eligible

  Copper IUD:
  - NSAID 5–7 days during bleeding

  LNG-IUD:
  - Reassurance is often central; exclude other causes when indicated.

Match the strategy to the method + the patient's goal

Pill/ring/patch

- Check missed doses and drug interactions.

  For continuous CHC users with bothersome spotting, a short hormone-free interval can sometimes help, provided method-specific guidance is followed.

  If persistent: consider formulation/regimen change or another method based on patient preference.

Back to our patient

Her pregnancy test is negative; exam is reassuring; STI testing is sent.

- Shared decision-making

She wants to KEEP the implant because she values its effectiveness and convenience.

Offer reassurance that irregular spotting is common and generally not harmful.

If she wants treatment and has no contraindication: discuss a short course option such as an NSAID; estrogen-containing treatment is another option for medically eligible patients.

Back to our patient

Her pregnancy test is negative; exam is reassuring; STI testing is sent.

- What I would say
- "The bleeding is frustrating, but it does not automatically mean anything is wrong or that your implant is failing. We'll make sure there isn't another cause, and if you want to keep the implant, we have options to try to improve the bleeding."

Patient Autonomy: If she wants the implant removed, remove it — bothersome bleeding is a valid reason to change methods.

Clinical pearls: the 60-second takeaway

- Counsel BEFORE starting contraception: expected bleeding patterns reduce surprise and may improve continuation.
- Breakthrough bleeding is usually a side effect, not a sign of contraceptive failure.
- Do not reflexively blame the method: pregnancy, STI, medication interactions, thyroid disease, polyps/fibroids may matter.
- Ask what the patient wants: reassurance, treatment while continuing, or a different method.
- Treat the person — not just the bleeding pattern. A medically benign side effect can still be unacceptable to the patient.

Scenario 4:

A 34-year-old woman with obesity uses a combined oral contraceptive reliably and is starting tirzepatide for weight management. She plans dose escalation and does not want pregnancy. What changes today?

Scenario 4: Patient Demographics

- Age: 34
- PMH: Obesity; no diabetes or vascular disease
- PSH: None
- Meds: Ethinyl estradiol/levonorgestrel pill; starting tirzepatide
- Allergies: NKDA
- Social: Nonsmoker, sexually active
- Exam: BP normal, BMI 38
- Goal: Avoid pregnancy for at least 2 years

Scenario 4: Counselling Pearls

- Act before the first tirzepatide dose

Use backup or non-oral contraception for 4 weeks

- Repeat after every dose escalation

Apply missed-pill rules for vomiting or severe diarrhea

- Plan pregnancy only after stopping tirzepatide

Discuss emergency contraception before it is needed

Scenario 4: Contraception Options

- LNG-IUD, copper IUD, implant: unaffected by gastric emptying
- Injection: unaffected; discuss usual DMPA tradeoffs
- Vaginal ring: non-oral; assess estrogen eligibility
- Keep the pill: add condoms for each 4-week risk window
- Patch: non-oral, but product-specific BMI/weight limits matter

Scenario 4: Options/USMEC

- No tirzepatide-specific U.S. MEC category
- FDA: non-oral method or barrier for 4 weeks after start and each escalation
- Obesity alone: IUDs, implant, DMPA, POP = 1
- Obesity alone: CHC = 2
- Pregnancy: stop tirzepatide; plan a 1-month washout
- EC: copper IUD avoids oral-absorption uncertainty

Scenario 5:

A 26-year-old woman with BMI 21 seeks medical care to discuss side effects of depo provera ®. She has been having irregular menses/bleeding between periods for the past eight months. Patient is planning a wedding and would like to ensure that she is not bleeding on her wedding day or honeymoon.

Scenario 5: Patient Demographics

- Age: 26
- PMH: anemia, hypothyroidism
- PSH: levothyroxine
- Meds: depo provera® every 3 months
- Allergies: NKDA
- Social: Non-smoker, drinks socially, works full time
- Exam: BMI 21

Counselling Pearls

- Acknowledge her concerns and priorities

Scenario 5: Contraception Options

Best options

- Combination birth control pills – e.g. Junel Fe, Sprintec - high efficacy
- The patch
- The ring

- IUD
- Nexplanon

Scenario 5: Options/Side effect profile

- CHC (pill, patch, ring): Category 1
- Nexplanon implant: Category 1 regardless of BMI. Side effects include acne, menstrual changes, headache, breast pain or tenderness
- IUD: irregular menstrual bleeding, light bleeding between periods, amenorrhea, cramping

Contraception on the Internet: Myth vs Fact

MYTH	FACT
"Birth control makes you infertile."	Reversible contraception does not cause long-term infertility. Fertility returns after stopping most methods; return after DMPA can be delayed.
"An IUD is only for someone who has already had a baby."	IUDs can be appropriate for adolescents and for people who have never given birth.
"Hormonal birth control causes everyone to gain weight."	Weight effects vary. DMPA is associated with weight gain in some users; evidence does not support a universal causal weight-gain effect for all hormonal methods.
"Emergency contraception is an abortion pill."	Emergency contraception prevents pregnancy; it does not terminate an established pregnancy.

Contraception on the Internet: Myth vs Fact

MYTH	FACT
"You need to take a break from the pill to 'cleanse' your body."	There is no medical need for routine contraceptive "breaks." Stopping creates pregnancy risk if another method is not used.
"No period on hormonal contraception means blood is building up inside."	Hormonal methods can thin the endometrium. Amenorrhea on many methods is expected and is not retained menstrual blood.
"The implant/IUD moves all over your body."	Migration or perforation is uncommon. Devices do not routinely travel freely through the body.
"Natural = safer."	A method being 'natural' does not automatically make it safer or more effective. Counseling should compare effectiveness, risks, benefits, and patient preferences.

Three Things I Want Patients To Hear

- Unexpected bleeding is COMMON with several contraceptive methods — and usually manageable.
- A viral story is not the same as population-level evidence. Side effects are real; universal claims usually are not.
- The best contraceptive method is one that is medically appropriate AND acceptable to the person using it.

Reassure. Rule out. Treat. Respect the patient's goal.

Questions?

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