HOT TOPICS IN REPRODUCTIVE HEALTH FOR 2026

EVIDENCE FOR EVERYDAY PRACTICE

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VICE CHAIR – OPERATIONS, WOMEN'S HEALTH

HENRY FORD HEALTH

LEARNING OBJECTIVES

- DISCUSS IMPORTANT CONTRACEPTION CHANGES
- MANAGE ABNORMAL BLEEDING, PAIN, AND MEDICATION-INTERACTION QUESTIONS
- INTEGRATE CONTRACEPTION WITH COMMON PREVENTIVE AND MIDLIFE CARE NEEDS
- REVIEW UPDATED CERVICAL CANCER SCREENING CHANGES

A 42-YEAR-OLD TAKING TIRZEPATIDE PRESENTS FOR HEAVY, IRREGULAR BLEEDING, CONTRACEPTION, CERVICAL SCREENING AND CONCERN ABOUT IUD PAIN. WHAT CAN WE ACCOMPLISH TODAY?

D. 85%

- Pregnancy risk and contraceptive goals
- Medication interactions
- Heavy bleeding
- Perimenopause
- IUD counseling and pain control
- Cervical cancer screening

TIERED EFFICACY

Longer Term	Implants, IUDs
Combined Hormonal	DMPA Injections
	Vaginal Rings, Transdermal Patches
	Oral Contraceptive Pills
Barriers and Behaviors	External (Male) Condoms
	Diaphragms, Withdrawal, FAM, NFP
	Cervical Cap, Internal (Female) Condom,
	Spermicides

USMEC

Maya, age 38, wants the pill

- Smokes about 10 cigarettes per day
- Blood pressure: 128/78
- No migraine, VTE, or cardiovascular history
- Prefers predictable bleeding and asks for a combined pill

For accessible version, please see the summary of classifications at https://www.cdc.gov/contraception/hcp/usmec/.

Summary Chart of U.S. Medical Eligibility Criteria for Contraceptive Use (U.S. MEC)

Updated in 2024. This summary sheet only contains a subset of the recommendations from the U.S. MEC. For complete guidance, see: https://www.cdc.gov/contraception/hcp/usmec/. Most contraceptive methods do not protect against STIs. Consistent and correct use of the external (male) latex condom reduces the risk of STIs and HIV.
Please see NIH guidelines for up to date recommendations on hormonal contraception and ARVs: https://clinicalinfo.hiv.gov/en/guidelines/perinatal/pregregnancy-counseling-childbearing-age-overview?view=fulltable-3 and https://clinicalinfo.hiv.gov/en/guidelines/hiv-clinical-guidelines-adult-and-adolescent-arv/drug-interactions-overview?view=full.

KEY: 1 = No restriction (method can be used) | 2 = Advantages generally outweigh theoretical or proven risks | 3 = Theoretical or proven risks usually outweigh the advantages | 4 = Unacceptable health risk (method not to be used)

Condition	Sub-Condition	Cu-IUD I	Cu-IUD C	LNG-IUD I	LNG-IUD C	Implant I	Implant C	DMPA I	DMPA C	POP I	POP C	CHC I	CHC C
Age													
		Menarche to <20 yrs:2		Menarche to <20 yrs:2		Menarche to <18 yrs:1		Menarche to <18 yrs:1		Menarche to <18 yrs:1		Menarche to <40 yrs:1	
		≥20 yrs:1		≥20 yrs:1		18–45 yrs:1		18–45 yrs:1		18–45 yrs:1		≥40 yrs:2	
						>45 yrs:1		>45 yrs:2		>45 yrs:1			
Anatomical abnormalities	a. Distorted uterine cavity	4		4									
	b. Other abnormalities	2		2									
Anemia, iron-deficiency		2		1		1		1		1		1	
Benign ovarian tumors	(including cysts)	1		1		1		1		1		1	
Breast disease	a. Undiagnosed mass	1		2*		2*		2*		2*		2*	
	b. Benign breast disease	1		1		1		1		1		1	
	c. Family history of cancer	1		1		1		1		1		1	
	d. Breast cancer[1]												
	i. Current	1		4		4		4		4		4	
	ii. Past and no evidence of current disease for 5 years	1		3		3		3		3		3	
	b. 21 to <30 days postpartum					2*		2*		2*		4*	
	i. With other risk factors for VTE					2*		2*		2*		3*	
	ii. Without other risk factors for VTE					2*		2*		2*		3*	
	c. 30-42 days postpartum												
	i. With other risk factors for VTE					1*		2*		1*		3*	
	ii. Without other risk factors for VTE					1*		1*		1*		2*	
	d. >42 days postpartum					1*		1*		1*		2*	
Cervical cancer	Awaiting treatment	4	2	4	2	2		2		1		2	
Cervical ectropion		1		1		1		1		1		1	
Cervical intraepithelial neoplasia		1		2		2		2		1		2	
Chronic kidney disease[2]	a. Current nephrotic syndrome	1	1	2	2	2		3		2/4*		4	
	b. Hemodialysis	1	1	2	2	2		3		2/4*		4	
	c. Peritoneal dialysis	2	1	2	2	2		3		2/4*		4	
Cirrhosis	a. Compensated (normal liver function)	1		1		1		1		1		1	
	b. Decompensated[3] (impaired liver function)	1		2		2		3		2		4	
Cystic fibrosis[2]		1*		1*		1*		2*		1*		1*	
Deep venous thrombosis (DVT)/Pulmonary embolism (PE)[2]	a. Current or history of DVT/PE, receiving anticoagulant therapy (therapeutic dose)	2*		2*		2*		2*		2*		3*	
	b. History of DVT/PE, receiving anticoagulant therapy (prophylactic dose)												
	i. Higher risk for recurrent DVT/PE	2*		2*		2*		3*		2*		4*	
	ii. Lower risk for recurrent DVT/PE	2*		2*		2*		2*		2*		3*	
	c. History of DVT/PE, not receiving anticoagulant therapy												
	i. Higher risk for recurrent DVT/PE	1		2		2		3		2		4	
	ii. Lower risk for recurrent DVT/PE	1		2		2		2		2		3	
	d. Family history (first-degree relatives)	1		1		1		1		1		2	
Depressive disorders		1*		1*		1*		1*		1*		1*	

Condition	Sub-Condition	Cu-IUD I	Cu-IUD C	LNG-IUD I	LNG-IUD C	Implant I	Implant C	DMPA I	DMPA C	POP I	POP C	CHC I	CHC C
Diabetes	a. History of gestational disease	1		1		1		1		1		1	
	b. Nonvascular disease												
	i. Non-insulin dependent	1		2		2		2		2		2	
	ii. Insulin dependent[2]	1		2		2		2		2		2	
	c. Nephropathy, retinopathy, or neuropathy[2]	1		2		2		3		2		3/4*	
	d. Other vascular disease or diabetes of >20 years' duration[2]	1		2		2		3		2		3/4*	
Dysmenorrhea	Severe	2		1		1		1		1		1	
Endometrial cancer[2]		4	2	4	2	1		1		1		1	
Endometrial hyperplasia		1		1		1		1		1		1	
Endometriosis		2		1		1		1		1		1	
Epilepsy[2]	(see also Drug Interactions)	1		1		1*		1*		1*		1*	
Gallbladder disease	a. Asymptomatic	1		2		2		2		2		2	
	b. Symptomatic												
	i. Current	1		2		2		2		2		3	
	ii. Treated by cholecystectomy	1		2		2		2		2		2	
	iii. Medically treated	1		2		2		2		2		3	
Gestational trophoblastic disease (GTD)[2]	a. Suspected GTD (immediate postevacuation)												
	i. Uterine size first trimester	1*		1*		1*		1*		1*		1*	
	ii. Uterine size second trimester	2*		2*		1*		1*		1*		1*	
	b. Confirmed GTD												
	i. Undetectable or non-pregnant β-hCG levels	1*	1*	1*	1*	1*		1*		1*		1*	
	ii. Decreasing β-hCG levels	2*	1*	2*	1*	1*		1*		1*		1*	
	iii. Persistently elevated β-hCG levels or malignant disease, with no evidence or suspicion of intrauterine disease	2*	1*	2*	1*	1*		1*		1*		1*	
	iv. Persistently elevated β-hCG levels or malignant disease, with evidence or suspicion of intrauterine disease	4*	2*	4*	2*	1*		1*		1*		1*	
Headaches	a. Nonmigraine (mild or severe)	1		1		1		1		1		1*	
	b. Migraine												
	i. Without aura (includes menstrual migraine)	1		1		1		1		1		2*	
	ii. With aura	1		1		1		1		1		4*	
History of bariatric surgery[2]	a. Restrictive procedures	1		1		1		1		1		1	
	b. Malabsorptive procedures	1		1		1		1		3		COCs: 3 P/R: 1	
History of cholestasis	a. Pregnancy related	1		1		1		1		1		2	
	b. Past COC related	1		2		2		2		2		3	
History of high blood pressure during pregnancy		1		1		1		1		1		2	
History of pelvic surgery	(see also Postpartum (including cesarean delivery))	1		1		1		1		1		1	
HIV	a. High risk for HIV	1*	1*	1*	1*	1		1		1		1	
	b. HIV infection							1*	1*	1*		1*	
	i. Clinically well receiving ARV therapy	1	1	1	1	If on ARV, see also Drug Interactions.							
	ii. Not clinically well or not receiving ARV therapy[4]	2	1	2	1	If on ARV, see also Drug Interactions.							

Abbreviations: ARV = antiretroviral; C = continuation of contraceptive method; CHC = combined hormonal contraceptive (pill, patch, and ring); COC = combined oral contraceptive; Cu-IUD = copper intrauterine device; DMPA = depot medroxyprogesterone acetate; I = initiation of contraceptive method; LNG-IUD = levonorgestrel intrauterine device; NA = not applicable; POP = progestin-only pill; P/R = patch/ring; SSRI = selective serotonin reuptake inhibitor; STI = sexually transmitted infection; VTE = venous thromboembolism. [1]Condition associated with increased risk as a result of pregnancy. *Please see the complete guidance for a clarification to this classification: https://www.cdc.gov/contraception/hcp/usmec/.

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Condition	Sub-Condition	Cu-IUD I	Cu-IUD C	LNG-IUD I	LNG-IUD C	Implant I	Implant C	DMPA I	DMPA C	POP I	POP C	CHC I	CHC C
Hypertension	a. Adequately controlled hypertension	1*		1*		1*		2*		1*		3*	
	b. Elevated blood pressure levels (properly taken measurements)												
	i. Systolic 140-159 or diastolic 90-99	1*		1*		1*		2*		1*		3*	
	ii. Systolic ≥160 or diastolic ≥100	1*		2*		2*		3*		2*		4*	
	c. Vascular disease	1*		2*		2*		3*		2*		4*	
Inflammatory bowel disease	(ulcerative colitis or Crohn's disease)	1		1		1		2		2		2/3*	
Ischemic heart disease[2]	Current and history of	1	2	3	2	3		3	2	3		4	
Liver tumors	a. Benign												
	i. Focal nodular hyperplasia	1		2		2		2		2		3	
	ii. Hepatocellular adenoma[2]	1		2		2		3		2		4	
	b. Malignant[2] (hepatocellular carcinoma)	1		3		3		3		3		4	
Malaria		1		1		1		1		1		1	
Multiple risk factors for atherosclerotic cardiovascular disease	(e.g., older age, smoking, diabetes, hypertension, low HDL, high LDL, or high triglyceride levels)	1		2		2*		3*		2*		3/4*	
Multiple sclerosis	a. Without prolonged immobility	1		1		1		2		1		1	
	b. With prolonged immobility	1		1		1		2		1		3	
Obesity	a. Body mass index (BMI) ≥30 kg/m²	1		1		1		1		1		2*	
	b. Menarche to <18 years and BMI ≥30 kg/m²	1		1		1		2		1		2*	
Ovarian cancer[2]		1		1		1		1		1		1	
Parity	a. Nulliparous	2		2		1		1		1		1	
	b. Parous	1		1		1		1		1		1	
Past ectopic pregnancy		1		1		1		1		2		1	
Pelvic inflammatory disease	a. Current	4	2*	4	2*	1		1		1		1	
	b. Past												
	i. With subsequent pregnancy	1	1	1	1	1		1		1		1	
	ii. Without subsequent pregnancy	2	2	2	2	1		1		1		1	
Peripartum cardiomyopathy[2]	a. Normal or mildly impaired cardiac function												
	i. <6 months	2		2		1		2		1		4	
	ii. ≥6 months	2		2		1		2		1		3	
	b. Moderately or severely impaired cardiac function	2		2		2		3		2		4	
Postabortion (spontaneous or induced)	a. First trimester abortion												
	i. Procedural (surgical)	1*		1*		1*		1*		1*		1*	
	ii. Medication	1*		1*		1*		1/2*		1*		1*	
	iii. Spontaneous abortion with no intervention	1*		1*		1*		1*		1*		1*	
	b. Second trimester abortion												
	i. Procedural (surgical)	2*		2*		1*		1*		1*		1*	
	ii. Medication	2*		2*		1*		1*		1*		1*	
	iii. Spontaneous abortion with no intervention	2*		2*		1*		1*		1*		1*	
	c. Immediate postseptic abortion	4		4		1*		1*		1*		1*	
Postpartum (nonbreastfeeding)	a. <21 days					1		2		1		4	
	b. 21 days to 42 days												
	i. With other risk factors for VTE					1		2		1		3*	
	ii. Without other risk factors for VTE					1		1		1		2	
	c. >42 days					1		1		1		1	
Postpartum (including cesarean delivery, breastfeeding, or nonbreastfeeding)	a. <10 minutes after delivery of the placenta	2*		2*									
	b. 10 minutes after delivery of the placenta to <4 weeks	2*		2*									
	c. ≥4 weeks	1*		1*									
	d. Postpartum sepsis	4		4									
Pregnancy		4*		4*		NA*		NA*		NA*		NA*	

Condition	Sub-Condition	Cu-IUD I	Cu-IUD C	LNG-IUD I	LNG-IUD C	Implant I	Implant C	DMPA I	DMPA C	POP I	POP C	CHC I	CHC C
Rheumatoid arthritis	a. Not on immunosuppressive therapy	1		1		1		2		1		2	
	b. On immunosuppressive therapy	2	1	2	1	1		2/3*		1		2	
Schistosomiasis	a. Uncomplicated	1		1		1		1		1		1	
	b. Fibrosis of the liver[2] (if severe, see also Cirrhosis)	1		1		1		1		1		1	
Sexually transmitted infections (STIs)	a. Current purulent cervicitis or chlamydial infection or gonococcal infection	4	2*	4	2*	1		1		1		1	
	b. Vaginitis (including trichomoniasis, vaginitis due to bacterial vaginosis)	2	2	2	2	1		2		1		1	
	c. Other factors related to STIs	2*	2	2*	2	1		1		1		1	
Sickle cell disease[2]		2		1		1		2/3*		1		4	
Smoking	a. Age <35	1		1		1		1		1		2	
	b. Age ≥35, <15 cigarettes/day	1		1		1		1		1		3	
	c. Age ≥35, ≥15 cigarettes/day	1		1		1		1		1		4	
Solid-organ transplantation[2]	a. No graft failure	1	1	1	1	2		2/3*		2		4*	
	b. Graft failure	2	1	2	1	2		2/3*		2		4	
Stroke[2]	History of cerebrovascular accident	1		2	2	3		3	2	3		4	
Superficial venous disorders	a. Varicose veins	1		1		1		1		1		1	
	b. Superficial venous thrombosis (acute or history)	1		1		1		2		1		3*	
Surgery	a. Minor surgery without immobilization	1		1		1		1		1		1	
	b. Major surgery												
	i. Without prolonged immobilization	1		1		1		1		1		2	
	ii. With prolonged immobilization	1		1		1		2		1		4	
Systemic lupus erythematosus[2]	a. Positive (or unknown) antiphospholipid antibodies	1*	1*	2*		2*	3*	3*	2*			4*	
	b. Severe thrombocytopenia	3*	2*	2*		2*	3*	2*	2*			2*	
	c. Immunosuppressive therapy	2*	1*	2*		2*	2*	2*	2*			2*	
	d. None of the above	1*	1*	2*		2*	2*	2*	2*			2*	
Thalassemia		2		1		1		1		1		1	
Thrombophilia[2]		1*		2*		2*		3*		2*		4*	
Thyroid disorders	Simple goiter, hyperthyroid, or hypothyroid	1		1		1		1		1		1	
Tuberculosis[2] (see also Drug Interactions)	a. Nonpelvic	1	1	1	1	1*		1*		1*		1*	
	b. Pelvic	4	3	4	3	1*		1*		1*		1*	
Unexplained vaginal bleeding	(suspicious for serious condition) before evaluation	4*	2*	4*	2*	3*		3*		2*		2*	
Uterine fibroids		2		2		1		1		1		1	
Valvular heart disease	a. Uncomplicated	1		1		1		1		1		2	
	b. Complicated[2]	1		1		1		2		1		4	
Vaginal bleeding patterns	a. Irregular pattern without heavy bleeding	1		1	1	2		2		2		1	
	b. Heavy or prolonged bleeding	2*		1*	2*	2*		2*		2*		1*	
Viral hepatitis	a. Acute or flare	1		1		1		1		1		3/4*	2
	b. Chronic	1		1		1		1		1		1	1
Drug Interactions													
Antiretrovirals (ARVs) used for prevention (PrEP) or treatment of HIV[4]	Fosamprenavir (FPV)	1/2*	1*	1/2*	1*	2*		2*		2*		3*	
	All other ARVs are 1 or 2 for all methods												
Anticonvulsant therapy	a. Certain anticonvulsants (phenytoin, carbamazepine, barbiturates, primidone, topiramate, oxcarbazepine)	1		1		2*		1*		3*		3*	
	b. Lamotrigine	1		1		1		1		1		3*	
Antimicrobial therapy	a. Broad-spectrum antibiotics	1		1		1		1		1		1	
	b. Antifungals	1		1		1		1		1		1	
	c. Antiparasitics	1		1		1		1		1		1	
	d. Rifampin or rifabutin therapy	1		1		2*		1*		3*		3*	
SSRIs		1		1		1		1		1		1	
St. John's wort		1		1		2		1		2		2	

U.S. SPR 2024: REMOVE THE BARRIERS

*Most contraception can be started **TODAY***

BEFORE INITIATION:

- **IUD:** Bimanual exam + cervical inspection
- **CHC:** Blood pressure
- **Implant, DMPA, POP:** No routine exam or test required
- **Pap, STI testing, labs:** Do NOT delay contraception when otherwise indicated

IF REASONABLY CERTAIN THE PATIENT IS NOT PREGNANT → QUICK START



DON'T MAKE THE PATIENT COME BACK JUST TO START CONTRACEPTION.

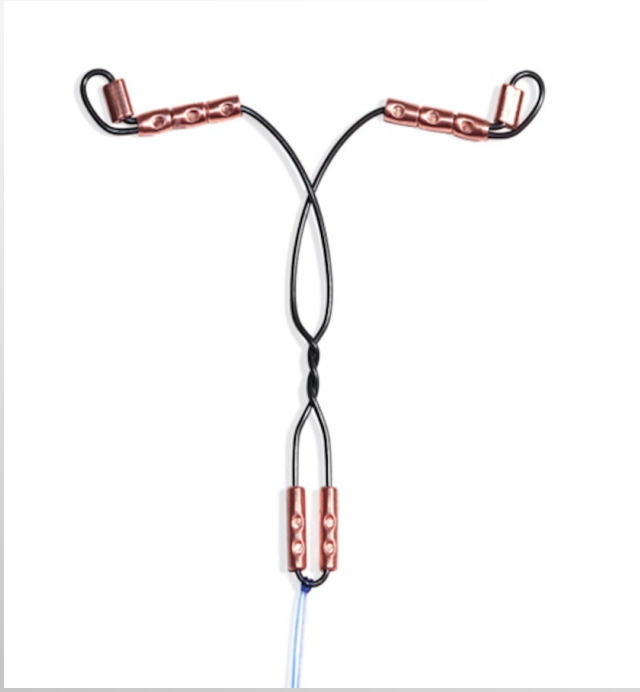
Remove unnecessary steps. Use the encounter. **Improve her health.**

CONTRACEPTIVE UPDATES

ETONOGESTREL SUBDERMAL IMPLANT

- EXTENDED DURATION OF USE
  - PREGNANCY PREVENTION FOR UP TO **5 YEARS**
  - PEARL INDEX 0.0 IN YEAR 4 AND 5
- LARGER BMI
- ADOLESCENTS INCLUDED IN STUDY
- REMS IN PLACE
  - PROVIDERS MUST BE CERTIFIED TO REMOVE AND REPLACE
  - INSERTION AND REMOVAL RELATED EVENTS MUST BE REPORTED

NEW COPPER IUD



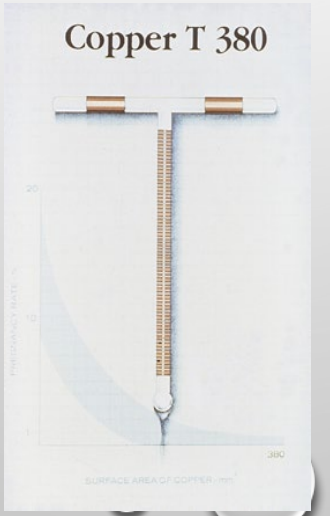
- Less copper
  - Less bleeding?
- Nitinol frame“less”
- 3 years of use
- 0.25 inch shorter and more flexible
  - Less cramping?
- Cannot be used as emergency contraception
- Also has a REMS



IUD CHOICE STARTS WITH PATIENT PRIORITIES

- Hormone-free: TCu380A—longest duration; established EC evidence
- Hormone-free: Frameless
  - Flexible, lower-copper frame; 3 years
- Lighter bleeding: 52-mg LNG-IUD—greatest bleeding benefit
- Lower-dose LNG-IUDs—smaller devices; 3–5 years







TWO COPPER OPTIONS OFFER DIFFERENT TRADEOFFS

TCU380A

FDA-LABELED FOR 10 YEARS

ESTABLISHED EMERGENCY CONTRACEPTION EVIDENCE

TRADITIONAL T-FRAME; 380 MM² COPPER

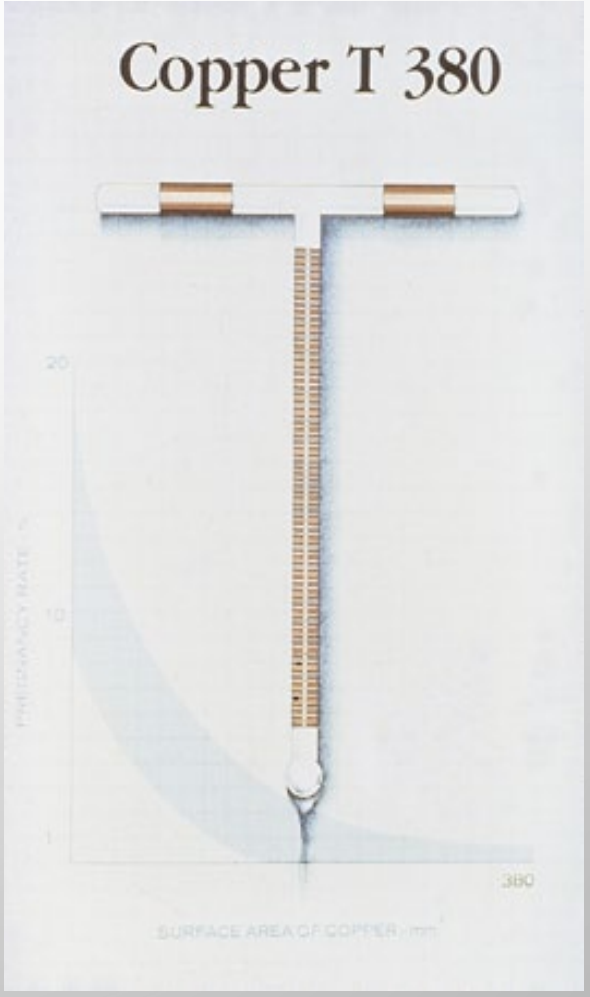
MIUDELLA

FDA-APPROVED IN 2025 FOR 3 YEARS

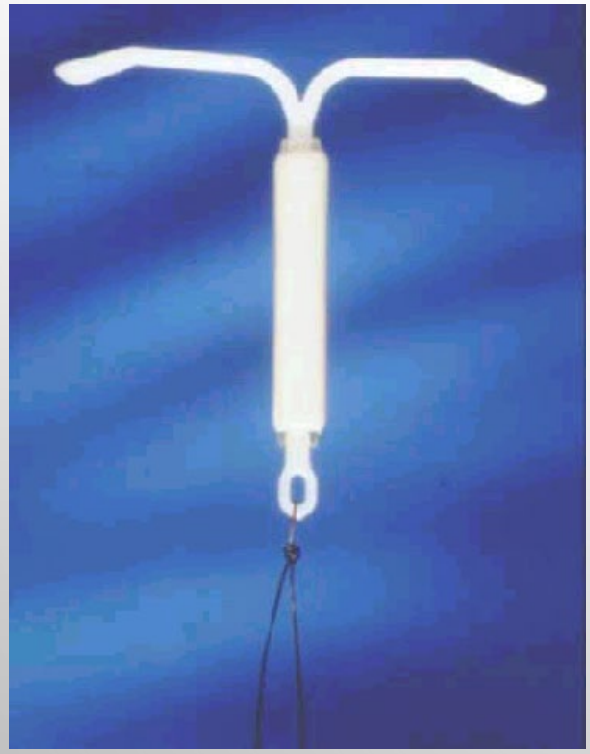
FLEXIBLE NITINOL FRAME; 175 MM² COPPER

SMALLER, HORMONE-FREE OPTION

MIUDELLA EXPANDS CHOICE—IT DOES NOT REPLACE THE TCU380A.



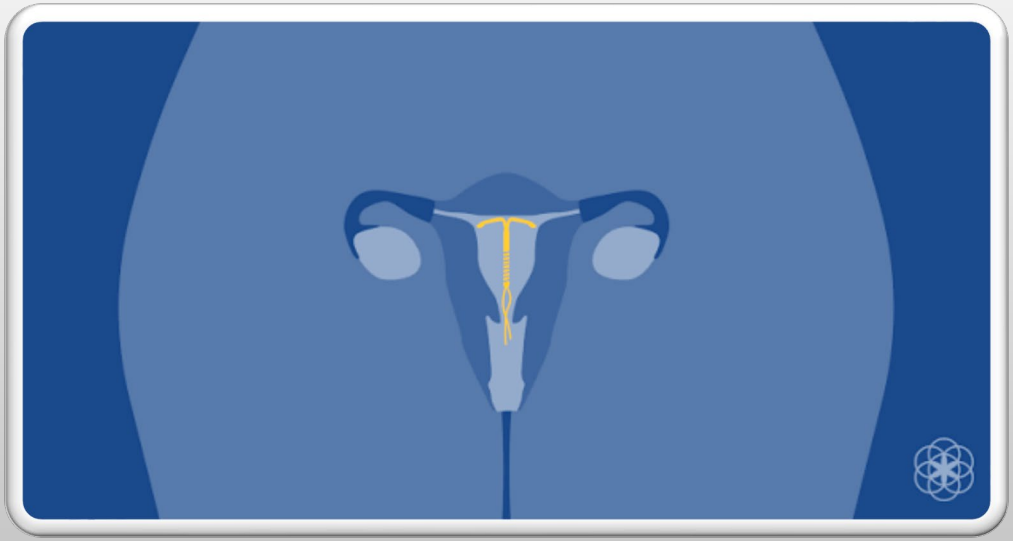
LNG DOSE SHAPES DURATION AND BLEEDING BENEFIT



- 52-mg LNG-IUD: 8 years; greatest amenorrhea; HMB treatment
- 19.5-mg LNG-IUD: 5 years; smaller; less amenorrhea
- 13.5-mg LNG-IUD: 3 years; smaller; less amenorrhea
- Ask: Would lighter or absent periods be a benefit?

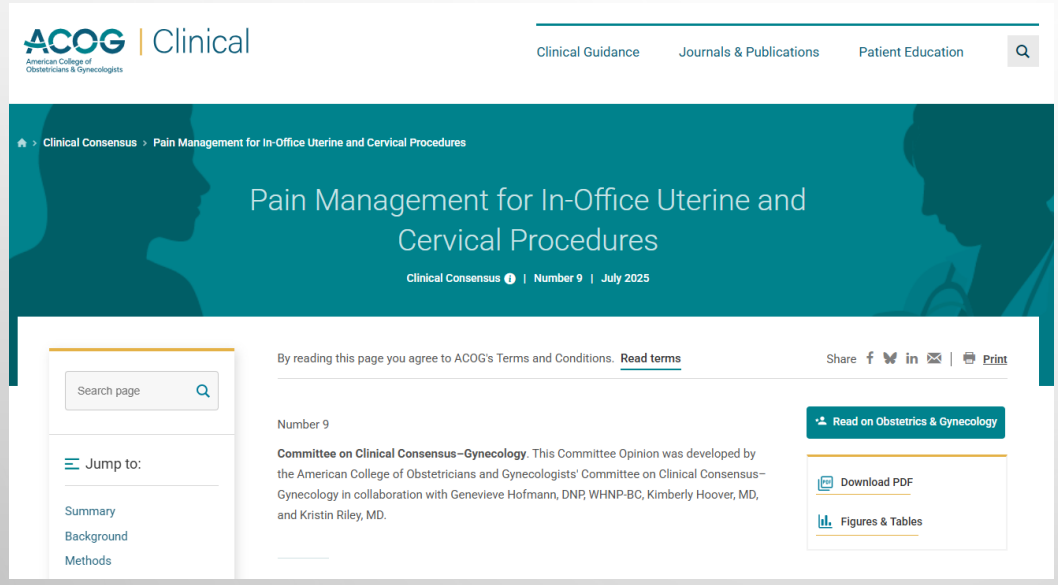
CDC U.S. SPR 2024; current FDA product labeling

MATCH THE IUD TO THE GOAL



- NO HORMONES + LONGEST DURATION → TCU380A
- HEAVY PERIODS → 52-MG LNG-IUD
  - STRONGEST BLEEDING BENEFIT
- NO HORMONES + SMALLER FLEXIBLE FRAME → FRAMELESS
- SMALLER DEVICE + LIGHTER—NOT ABSENT—PERIODS → LOWER-DOSE LNG-IUD

PAIN MANAGEMENT FOR IUD INSERTIONS



Not every patient will experience pain

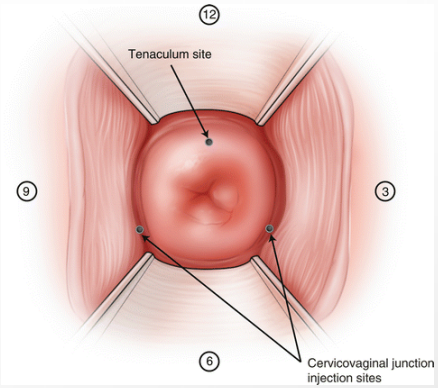
BUT

There are no reliable predictive factors to gauge potential for pain

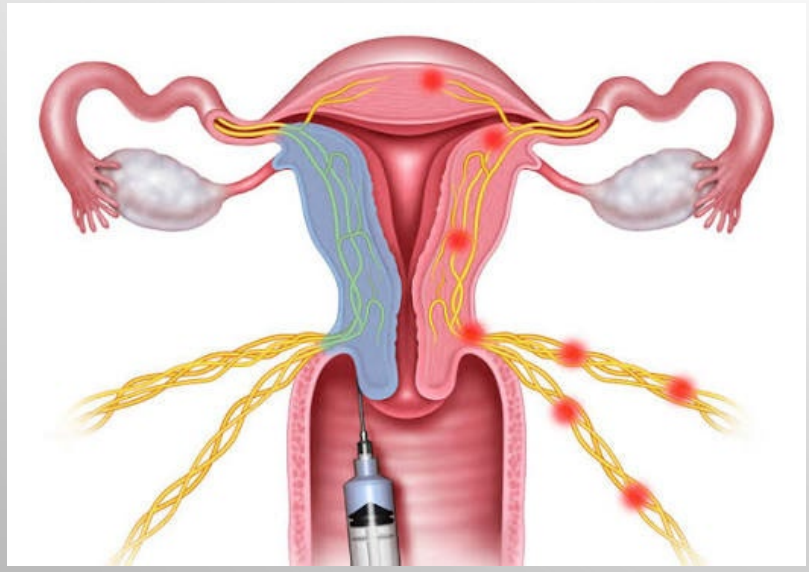
DEFINITELY DO

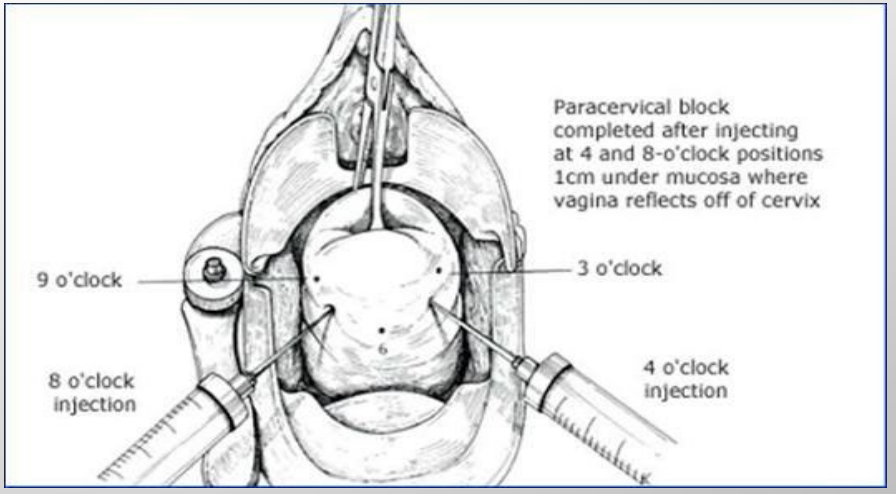
- OFFER OPTIONS!
  - LIDOCAINE MUCOSAL GEL
  - LIDOCAINE TOPICAL SPRAY
  - PARACERVICAL INJECTION
  - NSAIDS

PARACERVICAL BLOCK



- TARGET IS UTEROSACRAL LIGAMENTS CONTAINING NERVES INNERVATING CERVIX AND UTERUS



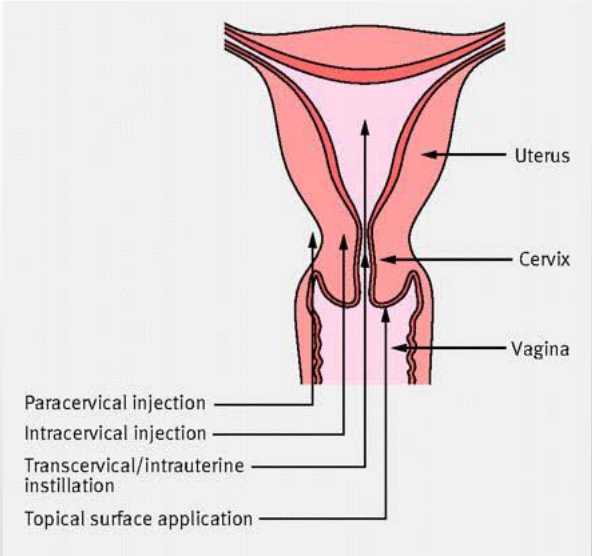


MAYBE DO?

- OPIOIDS/ANXIOLYTICS

PROBABLY DON'T DO

- INTRACERVICAL LIDOCAINE 2% BLOCK
- INTRAUTERINE INSTILLATION OF LIDOCAINE
- ANALGESICS
- SMOOTH MUSCLE RELAXANTS



DEFINITELY DON'T DO

- ROUTINE PRE-PROCEDURE MISOPROSTOL

COPPER IUD FOR EC

- 8400 POSTCOITAL COPPER IUD PLACEMENTS
  - PREGNANCY RATE 0.1% TO 0.7%
- PROSPECTIVE TRIAL: 1963 CUT380A PLACEMENTS WITHIN 120 HOURS
  - NO PREGNANCIES; NO PID
  - 94.3% PAROUS WOMEN CONTINUED AT 12 MONTHS
  - 88.2% NULLIPAROUS WOMEN CONTINUED FOR 1 YEAR
- CHINESE TRIAL: 1933 WOMEN WITHIN 120 HOURS
  - PREGNANCY RATE: 0.13%

LNG IUD VS CU-IUD FOR EMERGENCY CONTRACEPTION

- 317 LNG-IUD : 321 CU 380A IUD
- FOLLOW-UP AT ONE-MONTH:
  - 290/317; 91.5% LNG
  - 300/321; 93.5% CU
- PREGNANCY RATE: 1/290 LNG- IUS
  - 0/321 COPPER IUD
- LNG-IUS WAS NON-INFERIOR TO COPPER IUD FOR EMERGENCY CONTRACEPTION. SMALL STUDY SIZE

INJECTABLE CONTRACEPTION

DMPA: What You Need to Know

Two formulations. One 13-week rhythm.

IM — **150 mg**
intramuscular

SC — **104 mg / 0.65 mL**
subcutaneous • can be self-administered



~4 pregnancies per 100 users in year 1 with typical use

Repeat every 13 ± 2 weeks

Sources: CDC U.S. SPR 2024; source slide 'DMPA Injectable Contraceptive Formulations.' Image: AI-generated.

2024 U.S. SPR IN PRACTICE

DMPA: Remove Avoidable Barriers

START TODAY

If reasonably certain the patient is not pregnant
No pelvic exam or Pap prerequisite

13 weeks	Routine reinjection • early is acceptable
≤15 weeks	Inject • no backup needed
>15 weeks	**Inject if reasonably certain not pregnant + 7 days backup**

Offer self-administered DMPA-SC

CDC recommends • FDA labeling remains off-label



Source: CDC U.S. Selected Practice Recommendations for Contraceptive Use, 2024. Image: AI-generated.

SET EXPECTATIONS BEFORE SIDE EFFECTS HAPPEN

DMPA: Counsel Before You Inject

BLEEDING

Irregular bleeding is common early; amenorrhea increases with time

FERTILITY

Median ~10 months from last injection among those who conceive

BONE

BMD loss is usually reversible; boxed warning—individualize continued use beyond 2 years

MENINGIOMA

2025 FDA warning after repeated, mainly long-term exposure; discontinue if diagnosed



Sources: CDC U.S. SPR 2024; FDA Depo-Provera CI Prescribing Information (2025). Image: AI-generated.

THREE POPS—DIFFERENT ACCESS AND MISSED-PILL RULES

- NORETHINDRONE OR NORGESTREL: >3 HOURS LATE = MISSED
  - TAKE ASAP + USE BACKUP FOR 2 DAYS
  - NORGESTREL 0.075 MG IS AVAILABLE OTC
- DROSPIRENONE: ONE LATE/MISSED PILL <48 HOURS NEEDS NO BACKUP
- IF ≥2 ACTIVE DRSP PILLS ARE MISSED: BACKUP FOR 7 DAYS
- TYPICAL-USE PREGNANCY: APPROXIMATELY 7 PER 100 USERS/YEAR



CHCS: BENEFITS, SAFETY, AND ACCESS

BEEN AROUND FOR OVER 65 YEARS

WHAT ARE HER GOALS:

- CONTRACEPTION
- SYMPTOM CONTROL

NO PELVIC OR PAP NEEDED

SAME DAY START

PROVIDE UP TO 13 MONTHS



PATCH AND RING REDUCE DAILY ADHERENCE WORK

PATCH: CHANGED WEEKLY

RING: USER INSERTED

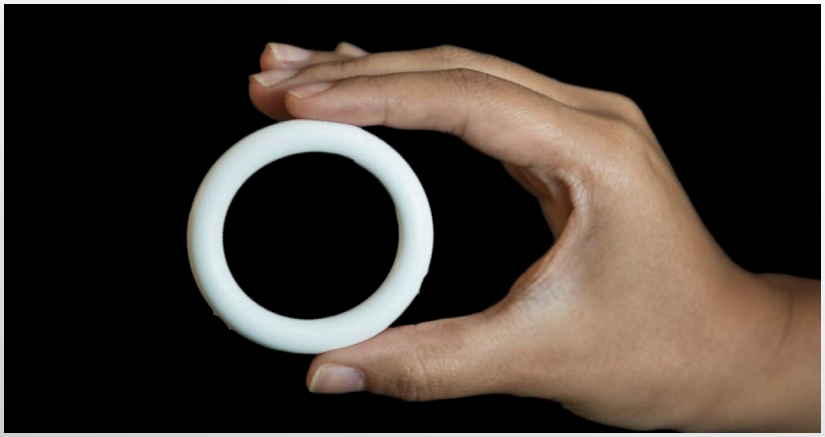
CAN BE DISPOSABLE OR REUSABLE

TYPICAL USE EFFECTIVENESS IS COMPARABLE TO CHCS

USE THE SAME ESTROGEN ELLIGIBILITY CRITERIA AS OTHER CHCS



SEGESTERONE ACETATE + EE VAGINAL RING



- NO NEED TO REFRIGERATE, LESS WASTE
- **0.15MG/0.013MG DAILY** VS ETONORGESTREL/ETHINYL ESTRADIOL 0.12MG/0.015MG DAILY
- *PATENT EXPIRATION JUNE 2039*



LNG + EE <u>WEEKLY</u> PATCH



- **40MCG LNG/10MCG EE DAILY*** VS NORELGESTROMIN/EE 150 MCG/35MCG
- *PATENT EXPIRATION AUGUST 2028*

VAGINAL PH MODULATOR, NON-SPERMICIDAL





- **lactic acid, citric acid, and potassium bitartrate** vs nonoxyl-9
- Shelf-life 48 months
- *Patent expiration 2033*

TIRZEPATIDE CHANGES ORAL-CONTRACEPTIVE COUNSELING

NOT A CLASS WARNING FOR ALL GLP-1 MEDICATIONS

- GLP-1 THERAPY OFTEN INCREASES FERTILITY RATHER THAN DECREASES IT.

ONLY TIRZEPATIDE HAS A CLINICALLY MEANINGFUL INTERACTION WITH ORAL

- ROUTINE BACKUP CONTRACEPTION AFTER INITIATION OR DOSE ESCALATION.
- NON-ORAL CONTRACEPTION OR BARRIER FOR 4 WEEKS AT INITIATION AND AT EVERY DOSE CHANGE

COUNSEL ABOUT BACKUP CONTRACEPTION WITH VOMITING OR SEVERE DIARRHEA REGARDLESS OF GLP-1 AGENT.

LARC METHODS COMPLETELY AVOID CONCERNS ABOUT GASTROINTESTINAL ABSORPTION.

DISCUSS PREGNANCY INTENTIONS BEFORE PRESCRIBING GLP-1 THERAPY AND DISCONTINUE THE MEDICATION BEFORE PLANNED CONCEPTION



ABNORMAL UTERINE BLEEDING

WHAT IS **NORMAL** UTERINE BLEEDING?

Menarche: 12.43 years
Menopause: 51.4 years



AGE



DURATION

Cycle: 28 days ± 7
Variation: ≤ 7 days
Duration: ≤ 7 days

< 80 mL blood loss/day
Average: 35 mL



VOLUME



PERCEPTION

No impact
on physical, social, emotional wellbeing, QOL

WHEN IS ABNORMAL BLEEDING NORMAL?

- Extremes of age: adolescence and peri-menopausal
- Lactation
- Pregnancy

TERMINOLOGY



Heavy menstrual bleeding (HMB)



Intermenstrual bleeding (IMB)



Post-coital bleeding



Breakthrough bleeding

TABLE Potential causes of abnormal uterine bleeding according to the PALM-COEIN classification[5]

Polyp **A**denomyosis **L**eiomyoma **M**alignancy & hyperplasia	Structural pathology measurable through imaging or histopathology
Coagulopathy **O**vulatory disorders **E**ndometrial dysfunction **I**atrogenic	Bleeding unrelated to structural abnormalities
Not otherwise classified	

AUB EVALUATION STARTS WITH STABILITY, PREGNANCY, AND PALM–COEIN

- STABILITY:
  - QUANTIFY BLEEDING
  - ASSESS ANEMIA
  - EXCLUDE PREGNANCY

- USE IMAGING AND PALM-COEIN TO SEPARATE STRUCTURAL FROM NON-STRUCTURAL CAUSES

- ENDOMETRIAL SAMPLING IS INDICATED IN WOMEN AGE >45 OR YOUNGER DEPENDING ON RISK FACTORS

MATCH AUB TREATMENT TO THE CAUSE—AND THE PATIENT'S GOALS

- 52MG LNG-IUD: FDA APPROVED FOR HEAVY BLEEDING + HIGHLY EFFECTIVE CONTRACEPTION
- CHC OR ORAL PROGESTIN: CYCLE CONTROL OR SUPPRESSION
- TXA OR NSAIDS: GOOD NON-CONTRACEPTIVE OPTIONS FOR SELECTED PATIENTS
- ESCALATE FOR STRUCTURAL DISEASE, SUSPECTED MALIGNANCY, REFRACTORY BLEEDING OR INSTABILITY

WHAT ABOUT **MENOPAUSE?**

PERIMENOPAUSE DOES NOT MEAN CONTRACEPTION IS NO LONGER NEEDED

- Pregnancy is uncommon after 44 – but it still occurs!!!
- Can safely continue contraception until age 55
- Amenorrhea on hormones does not prove menopause

CDC U.S. SPR, 2024: When Contraception Is No Longer Needed

CHOOSE CONTRACEPTION AROUND SYMPTOMS AND CARDIOMETABOLIC RISK

52-mg LNG-IUD: contraception + major reduction in heavy bleeding

CHC: contraception + cycle control; may help vasomotor symptoms if eligible

Progestin-only or copper IUD: options when estrogen is not appropriate

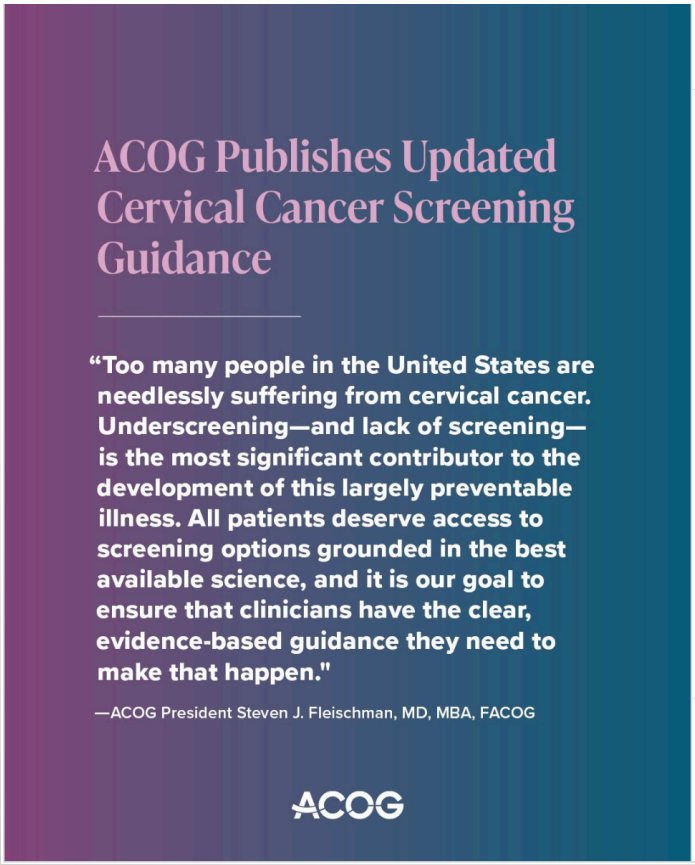
Recheck BP, smoking, migraine aura, VTE/CVD risk, breast disease, and medications

CONTRACEPTION AND MENOPAUSAL HORMONE THERAPY ARE NOT INTERCHANGEABLE

- MENOPAUSAL HORMONE THERAPY TREATS SYMPTOMS – IT IS NOT CONTRACEPTION
- WITH A UTERUS, SYSTEMIC ESTROGEN NEEDS PROTECTION: AN LNG-IUD MAY BE AN OPTION
- PLAN THE TRANSITION AROUND PREGNANCY PREVENTION, SYMPTOMS, BLEEDING AND MEDICAL RISK

ACOG: Hormone Therapy for Menopause; CDC U.S. SPR, 2024

UPDATED GUIDELINES AND OPTIONS FOR CERVICAL CANCER SCREENING



acog_org • Follow

acog_org 5w

Screening is an important step in the early detection and prevention of cervical cancer—but many patients face barriers that make getting screened difficult or even impossible. ACOG is working to make this process more accessible.

Today, we released updated guidance that now includes the option for patients to collect their own samples for high-risk human papillomavirus (hrHPV) testing. Now, patients who are 30 to 65 years old and of average risk may be eligible to collect their own samples for hrHPV primary screening every three years.

While having your clinician collect samples is still the preferred option, self-collection can offer flexibility and increased accessibility under the right

1.6K 17

April 23

Log in to like or comment.

Overview: ACOG announced updated recommendations for cervical cancer screening on April 23rd, 2026

- Update is geared toward women of "average risk"
- Does not apply to patients with:
    - HIV
    - Immunocompromised without HIV
    - Patients with in-utero DES exposure
- No change in recommendations for patients 21-29 or older that 65 and those who have undergone hysterectomy with removal of cervix

PROVIDER EDUCATION

Table 1. Summary of Recommendations for Cervical Cancer Screening for Patients at Average Risk

Age Group (y)	Recommendation
21–29	Cervical cytology every 3 years
30–65	Clinician-collected primary hrHPV every 5 y If primary clinician-collected hrHPV is not available: • Co-testing with hrHPV testing with cervical cytology every 5 y • Patient-collected primary hrHPV screening every 3 y* If primary hrHPV (clinician- or patient-collected) and co-testing are not available: • Cervical cytology alone every 3 y†
Older than 65	Routine screening not clinically indicated with adequate prior screening‡

hrHPV, high-risk human papillomavirus.

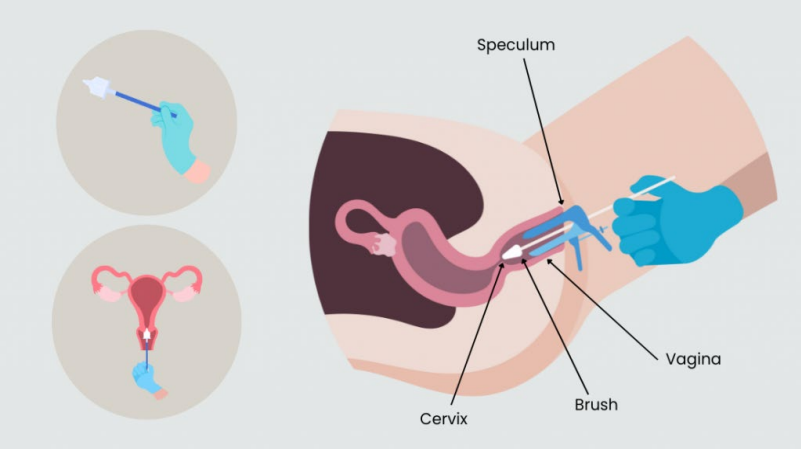
*Using clinician-ordered, U.S. Food and Drug Administration–approved testing kits.

†Only in settings in which hrHPV primary testing or co-testing is not available or, if after counseling, the patient chooses cervical cytology alone and systems for appropriate follow-up are in place.

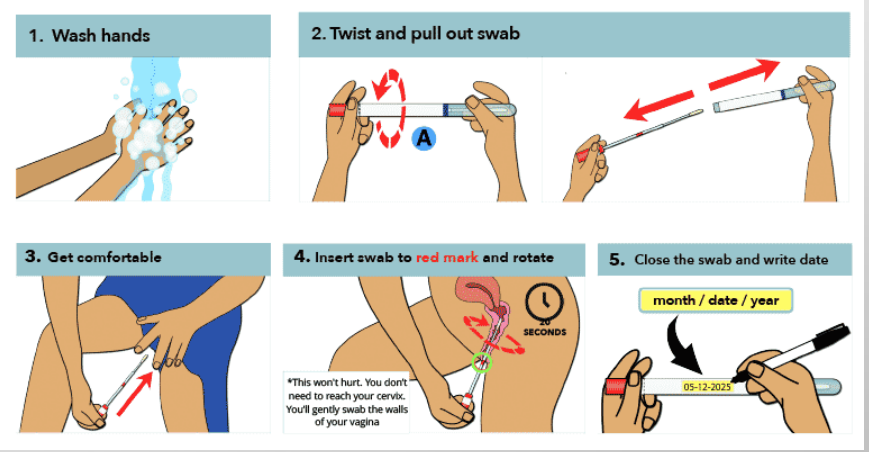
‡Defined as three consecutive negative cytology results or two consecutive negative co-testing results within 10 years before stopping screening, with the most recent test occurring within 3 years for cytology alone or 5 years for co-testing.

COLLECTION OPTIONS

PROVIDER COLLECT



SELF COLLECT



PRIMARY HRHPV SCREENING

Manage risk—not the result in isolation

PRIMARY hrHPV RESULT

hrHPV negative

Routine screening interval*

HPV 16 or 18 positive

Reflex cytology + colposcopy even when cytology is NILM

Other hrHPV positive

Reflex cytology from the same specimen

Use current result + prior history

- NILM or minor abnormality → often 1-year surveillance
- Higher-risk cytology → colposcopy or treatment pathway
- Confirm the action in the ASCCP app

The same cytology result can lead to different management when the patient's prior HPV history changes the CIN 3+ risk.

*Clinician-collected primary hrHPV: 5 years. Patient-collected primary hrHPV: 3 years for eligible average-risk patients ages 30–65.

Sources: ACOG Committee Statement 28 (2026); ASCCP risk-based management guidelines.

A 42-YEAR-OLD TAKING TIRZEPATIDE PRESENTS FOR HEAVY, IRREGULAR BLEEDING, CONTRACEPTION, CERVICAL SCREENING AND CONCERN ABOUT IUD PAIN. WHAT CAN WE ACCOMPLISH TODAY?

- ✓ **Clarify pregnancy goals** — and offer contraception that fits her priorities
- ✓ **Account for tirzepatide** — when counseling about oral contraception
- ✓ **Evaluate heavy, irregular bleeding** — without dismissing it as “just perimenopause”
- ✓ **Recognize the perimenopausal transition** — while remembering pregnancy is still possible
- ✓ **Offer an IUD if desired** — with anticipatory counseling and evidence-based pain control
- ✓ **Update cervical screening** — using current risk-based recommendations

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The goal is not to do everything today. It is to avoid postponing what we can do today.







QUESTIONS?