Practice Guidelines

CDC UPDATED RECOMMENDATIONS FOR CONTRACEPTIVE USE

Almost one-half of pregnancies are unintentional, with one-half of these in women not using a contraceptive method when conception occurred. Adolescents and young women, those who are racial or ethnic minorities, and those with lower levels of education and income are more likely to become pregnant unintentionally. Guiding women and their partners in selecting an appropriate contraceptive method and ensuring its correct and consistent use can help with prevention.

The Centers for Disease Control and Prevention (CDC) first published the *U.S. Selected Practice Recommendations for Contraceptive Use* (U.S. SPR) in 2013 to provide direction for safe and effective use of contraceptive methods. These guidelines update the 2013 report.

Using the Guidelines

The guidelines are arranged by contraceptive method and discussed in order from highest to lowest effectiveness. It should be noted that recommendations do not comment on every aspect of use, but instead provide the best evidence available for issues that commonly occur. In general, initiation, follow-up, and management of problems are discussed for each method, with the recommendations listed first, followed by comments and evidence summaries.

The *U.S. Medical Eligibility Criteria for Contraceptive Use*, which can be found at http://www.cdc.gov/reproductivehealth/contraception/usmec.htm, contains recommendations for women who require additional contraceptive guidance for medical reasons. Charts and algorithms that summarize the recommendations can be found in the appendix of the original CDC guidelines. The U.S. SPR website provides more helpful tools at http://www.cdc.gov/reproductivehealth/contraception/usspr.htm.

Updates

The 2016 guidelines updated recommendations about starting or resuming regular contraception after using ulipristal emergency contraceptive pills and added new recommendations regarding medications to help with inserting intrauterine devices (IUDs).

Physicians should counsel women to wait at least five days after taking ulipristal before starting or continuing their hormonal contraception. However, if using a method that is nonhormonal, it can be started or resumed immediately after taking ulipristal. If needed, a regular contraceptive method should be prescribed. If a woman opts for a method that would require an appointment with a physician (e.g., depot medroxyprogesterone, implants, IUDs), starting it at the same time as ulipristal is an option. Although this could make ulipristal less effective, it is a risk that should be balanced with the risk of not initiating regular contraception. Sexual intercourse should be avoided or barrier contraception used in the first week of starting or restarting regular contraception or until menses occurs. If there is no withdrawal bleeding in three weeks, a pregnancy test is recommended.

When performing IUD insertion, routine administration of misoprostol is not recommended, but its use may be beneficial in some women, including those in whom insertion has recently failed. To decrease pain associated with insertion, a paracervical block with lidocaine may be helpful.

Confirming a Woman is not Pregnant

Most of the guidance indicates that a contraceptive method can be started anytime during a woman's menstrual cycle, assuming she is not pregnant. Physicians can be reasonably certain that a woman is not pregnant by using the following criteria, which have a high accuracy. If there are no signs or symptoms of pregnancy and at least one criterion is met, it can be assumed with reasonable certainty that the woman is not pregnant; however, a urine test can still be warranted based on the physician's clinical judgment. If criteria are not met, then pregnancy cannot be ruled out with reasonable certainty. This is true even if there are negative results on a pregnancy test.

Criteria include that she has started her normal menses or had a spontaneous or induced abortion no more than seven days ago; has not participated in sexual intercourse since the start of her last normal menses; is

Source: Adapted from Am Fam Physician. 2017;95(2):125-126.

correctly and consistently using a reliable contraceptive method; is four weeks or less postpartum; or is fully or almost fully breastfeeding, has amenorrhea, and is less than six months postpartum.

Procedures

Recommendations regarding the examinations and tests to perform before starting each contraceptive method in women presumed to be healthy are provided in the guidelines. The CDC has chosen to use a classification system created by the World Health Organization to determine their applicability. Class A indicates that the tests are essential and mandatory in all circumstances. Class B indicates that they contribute substantially to safe and effective contraceptive use, but their application can be considered within the public health context, service context, or both. Risks associated with not performing Class B tests should be weighed against the benefits of making the contraceptive method available. Class C tests do not contribute considerably to safe and effective use.

Class A

Before copper or levonorgestrel-releasing IUD insertion, bimanual examination and cervical inspection should be performed to determine uterine size and position, as well as to identify cervical or uterine abnormalities that could be a sign of infection or that could prevent IUD insertion. No examinations or tests are needed before using an implant, or initiating depot medroxyprogesterone or progestin-only pills. However, before starting combined hormonal contraceptives, blood pressure should be measured. Additionally, measuring baseline weight and body mass index could be useful to monitor women using all of these contraceptive methods.

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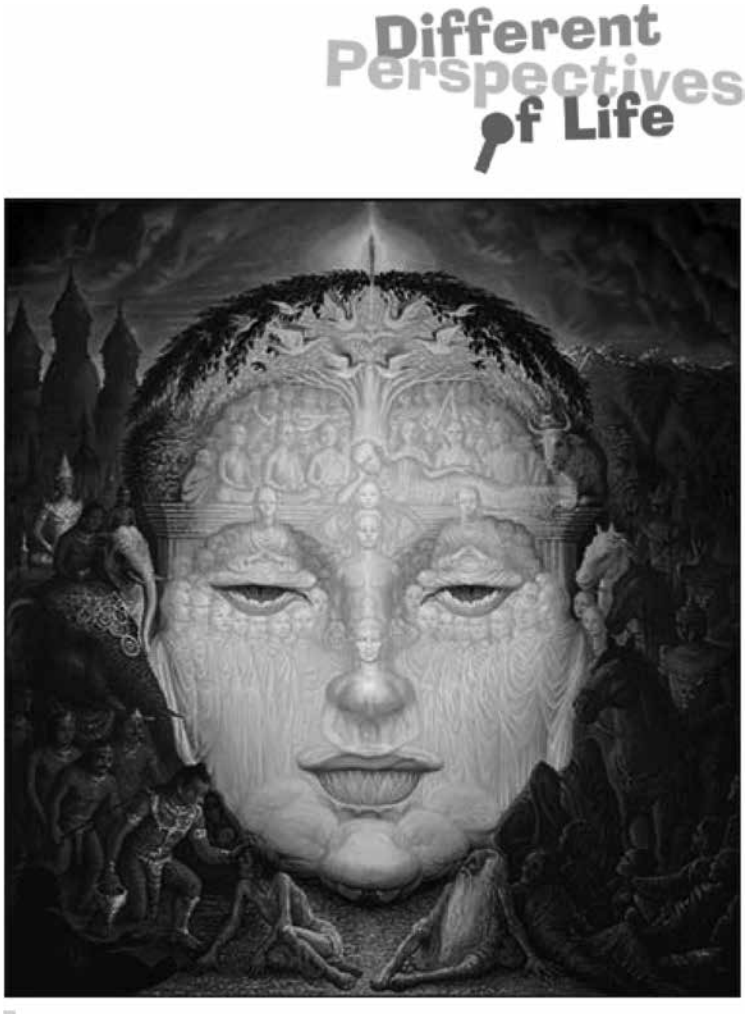

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