IN THE KNOW:
UPDATE ON PAPS, CONTRACEPTIVES AND STI



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OBJECTIVES

- *Present the 2019 Pap smear management criteria per the ASCCP*
- *Review US Medical Eligibility Criteria for contraceptives last update*
- *Clarification on CDC Guidelines: Clinical Management f STDs*





ASCCP 2019 Updated Consensus Guidelines for the Management of Abnormal Cervical Cancer Screening Tests and Cancer[1]



ESSENTIAL CHANGES FROM PRIOR MANAGEMENT GUIDELINES[2]

- *1) Recommendations are based on risk, not results.*
- *2) Colposcopy can be deferred for certain patients.*
- *3) Guidance for expedited treatment is expanded*
- *4) Excisional treatment is preferred to ablative treatment for histologic HSIL (CIN 2 or CIN 3).*
- *5) Observation is preferred to treatment for CIN 1.*
- *6) Histopathology reports based on Lower Anogenital Squamous Terminology (LAST)/ (WHO) recommendations for reporting histologic HSIL should include CIN 2 or CIN 3 qualifiers, i.e., HSIL(CIN 2) and HSIL (CIN 3)*
- *7) All positive HPV tests, regardless of genotype, should have additional reflex triage testing performed from the same laboratory specimen (e.g., reflex cytology).*

2019 GUIDELINES[1,2]

are designed to maximize cervical cancer prevention and minimize harms from over-testing and overtreating by managing patients according to their current and future risks of CIN 3+.

High-risk patients require *closer* follow-up to maximize detection of CIN 3+, whereas low-risk patients require fewer tests and procedures.

2019 NEW PRINCIPLES[2]

- *1. HPV–based testing is the basis for risk estimation*
- *2.Personalized risk-based management is possible with knowledge of current results and past history.*
- **3.***Guidelines must allow updates to incorporate new test methods as they are validated, and to adjust for decreasing CIN3+ risks as more patients who received HPV vaccination reach screening age.*
- **4.***Colposcopy practice must follow guidance detailed in the ASCCP Colposcopy Standards.*
- *Women at any age should NOT be screened annually by any screening method; rather, recommended screening intervals for women are based on age and clinical history.*

2012 PRINCIPLES CARRIED FORWARD[2]

The primary goal of screening and management is cancer prevention through detection and treatment of cervical precancer.

Guidelines apply to women and transgender men with a cervix, including individuals who have undergone supracervical hysterectomy.

Equal management for equal risk. History and current test results are used to calculate a patient's current and future risk of CIN 3+.

Balancing benefits and harms. Providing the best care means balancing cancer prevention with overtesting and overtreatment.

Patients with symptoms such as abnormal uterine or vaginal bleeding or a visibly abnormal-appearing cervix require appropriate diagnostic testing as this may be a sign of cancer

Table 1. Screening Methods for Cervical Cancer: Joint Recommendations of the American Cancer Society, the American Society for Colposcopy and Cervical Pathology, and the American Society for Clinical Pathology

Population	Recommended Screening Method	Comment
Women younger than 21 years	No screening	
Women aged 21–29 years	Cytology alone every 3 years	
Women aged 30–65 years	Human papillomavirus and cytology co-testing (preferred) every 5 years Cytology alone (acceptable) every 3 years	Screening by HPV testing alone is not recommended
Women older than 65 years	No screening is necessary after adequate negative prior screening results	Women with a history of CIN 2, CIN 3 or adenocarcinoma in situ should continue routine age-based screening for at least 20 years
Women who underwent total hysterectomy	No screening is necessary	Applies to women without a cervix and without a history of CIN 2, CIN 3, adenocarcinoma in situ, or cancer in the past 20 years
Women vaccinated against HPV	Follow age-specific recommendations (same as unvaccinated women)	

Abbreviations: CIN indicates cervical intraepithelial neoplasia; HPV, human papillomavirus.

Modified from Saslow D, Solomon D, Lawson HW, Killackey M, Kulasingam SL, Cain J, et al. American Cancer Society, American Society for Colposcopy and Cervical Pathology, and American Society for Clinical Pathology screening guidelines for the prevention and early detection of cervical cancer.

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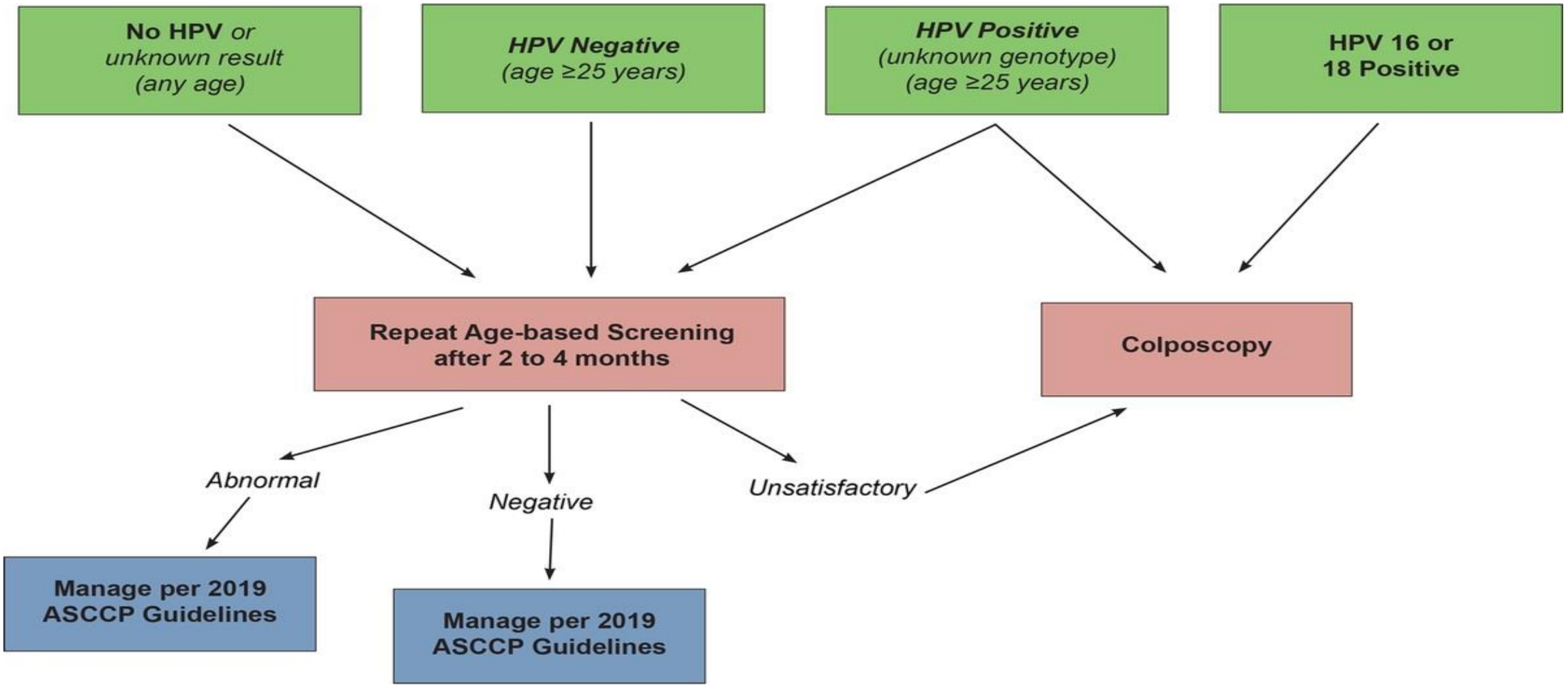


UNSATISFACTORY PAP

- *be rendered unsatisfactory by obscuring blood, inflammation, or lubricant*
- *arise largely from insufficient squamous cells*
- *unsatisfactory cytology result and no/unknown/or a negative HPV test result, repeat cytology in 2-4 months is recommended*
- *30 years and older (co-test) with unsatisfactory cytology and a positive HPV test, repeat cytology in 2-4 months or colposcopy is acceptable.*
- *Colposcopy is recommended for women with two consecutive unsatisfactory cytology tests*



CLINICAL MANAGEMENT OF *UNSATISFACTORY* CYTOLOGY[2]



WITH NEGATIVE CYTOLOGY AND ABSENT/INSUFFICIENT EC/TZ

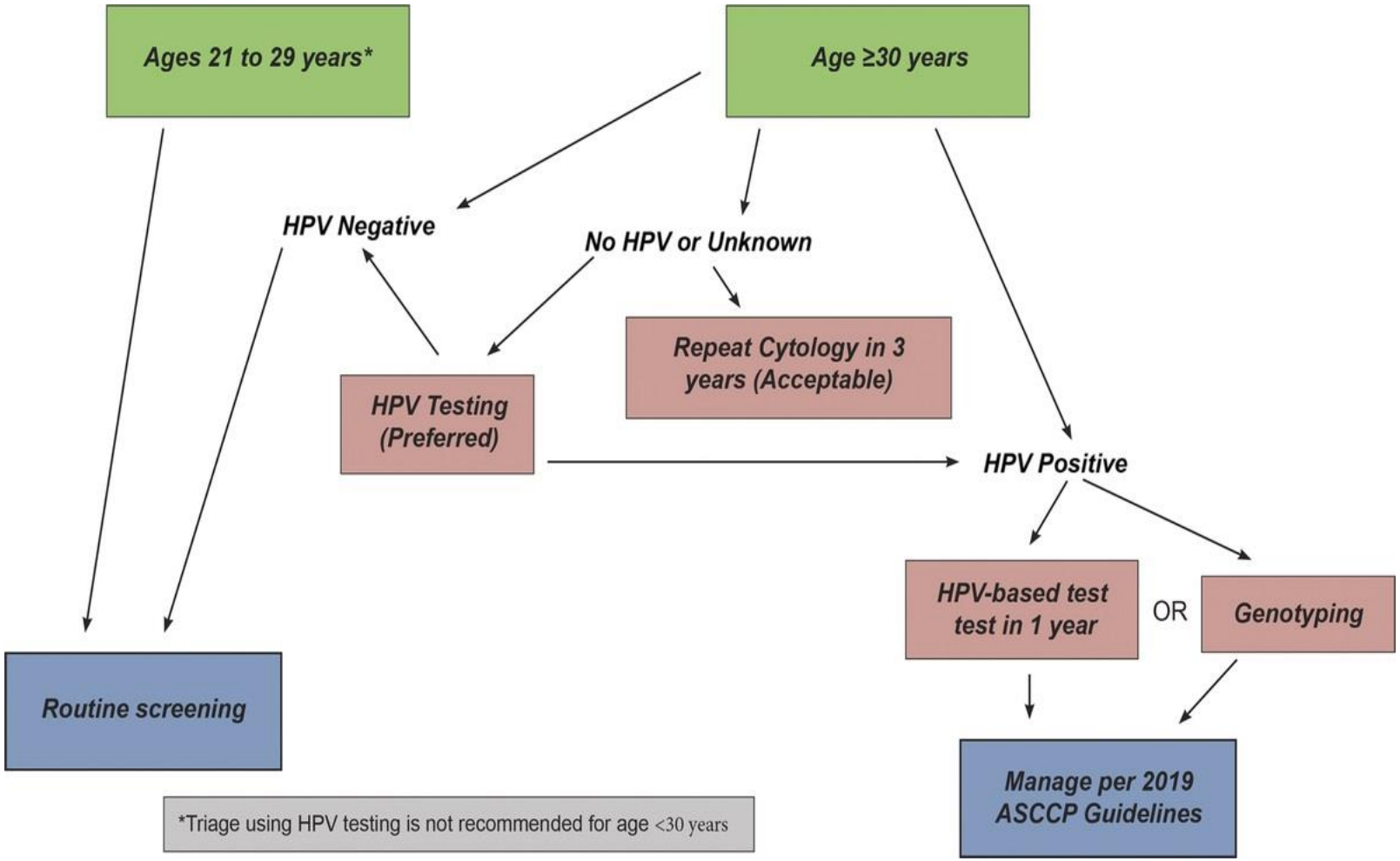
- 21–29 years of age

routine screening is recommended.

- ≥30 years of age,

- *in whom co-testing is preferred, the HPV result guides management:*
- *If the HPV test is done and is negative, return to routine screening*
- *if HPV type 16 or 18 is present, colposcopy.*
- *If HPV type 16 &18 are absent, repeat co-testing in 12 >months is recommended*

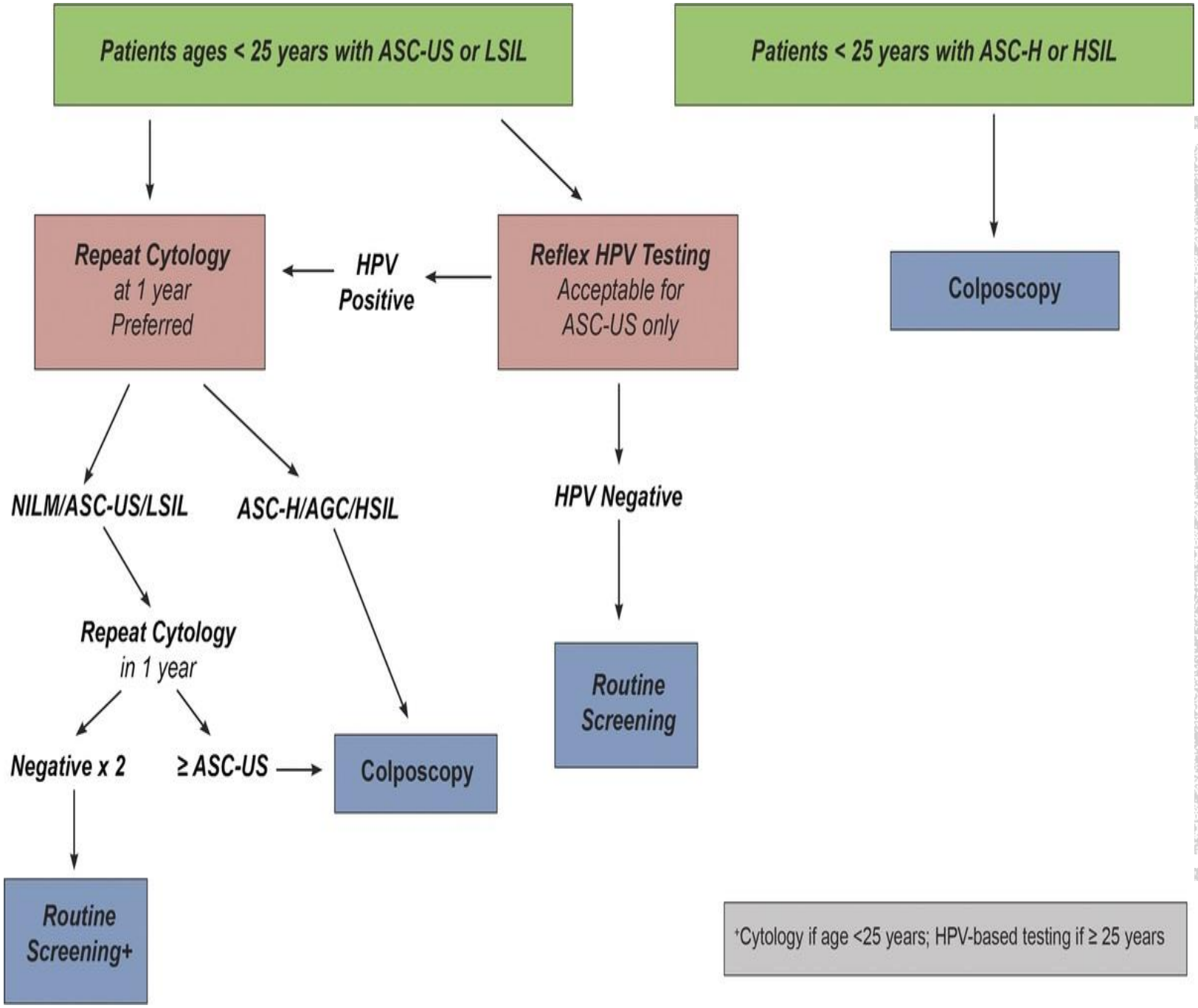




NILM/ *ABSENT TRANSFORMATION ZONE OR ENDOCERVICAL CELLS*[2]

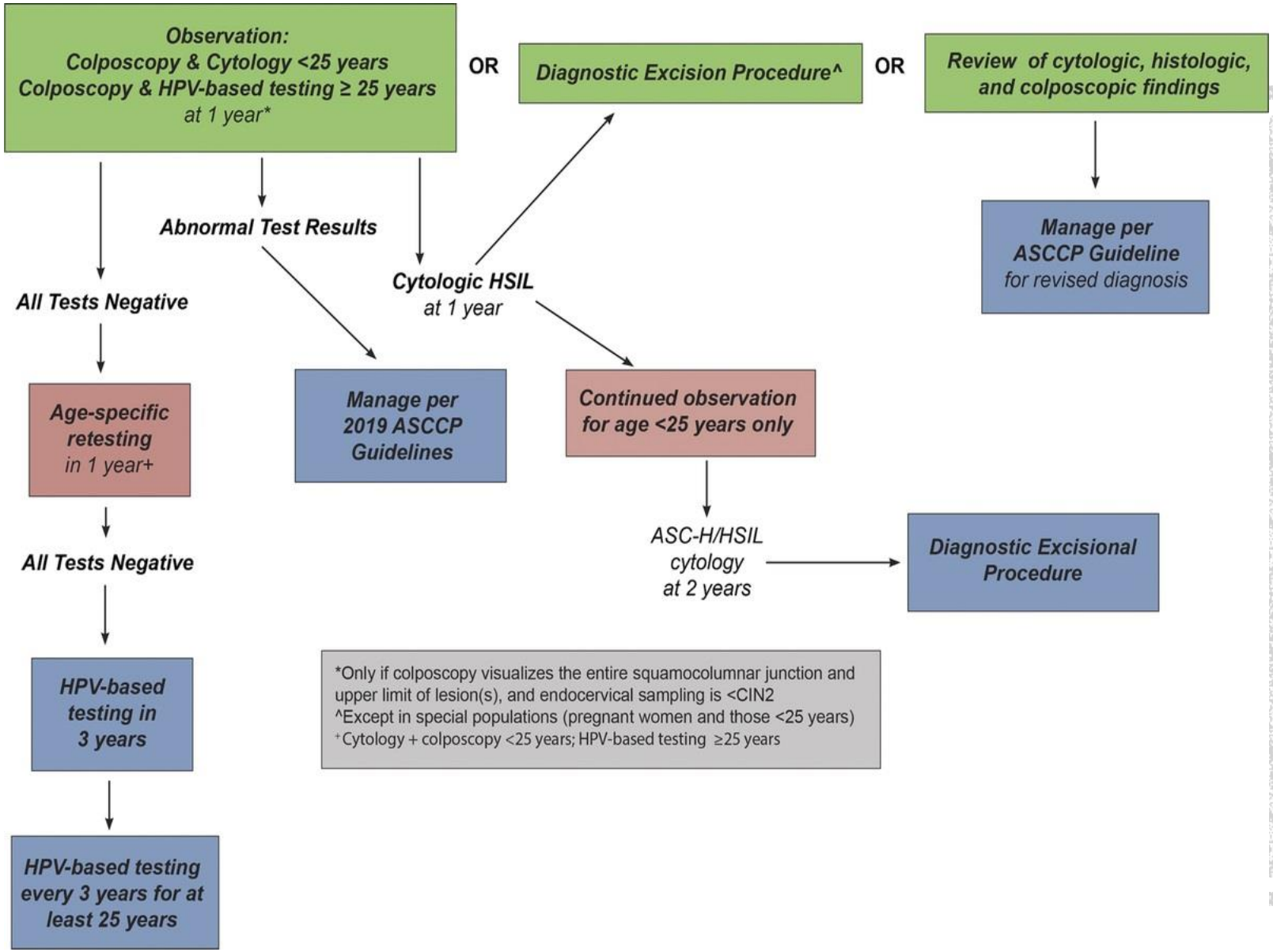

ABNORMAL PAP

MANAGEMENT OF CYTOLOGIC ABNORMALITIES IN PATIENTS YOUNGER THAN 25 YEARS[2,3]

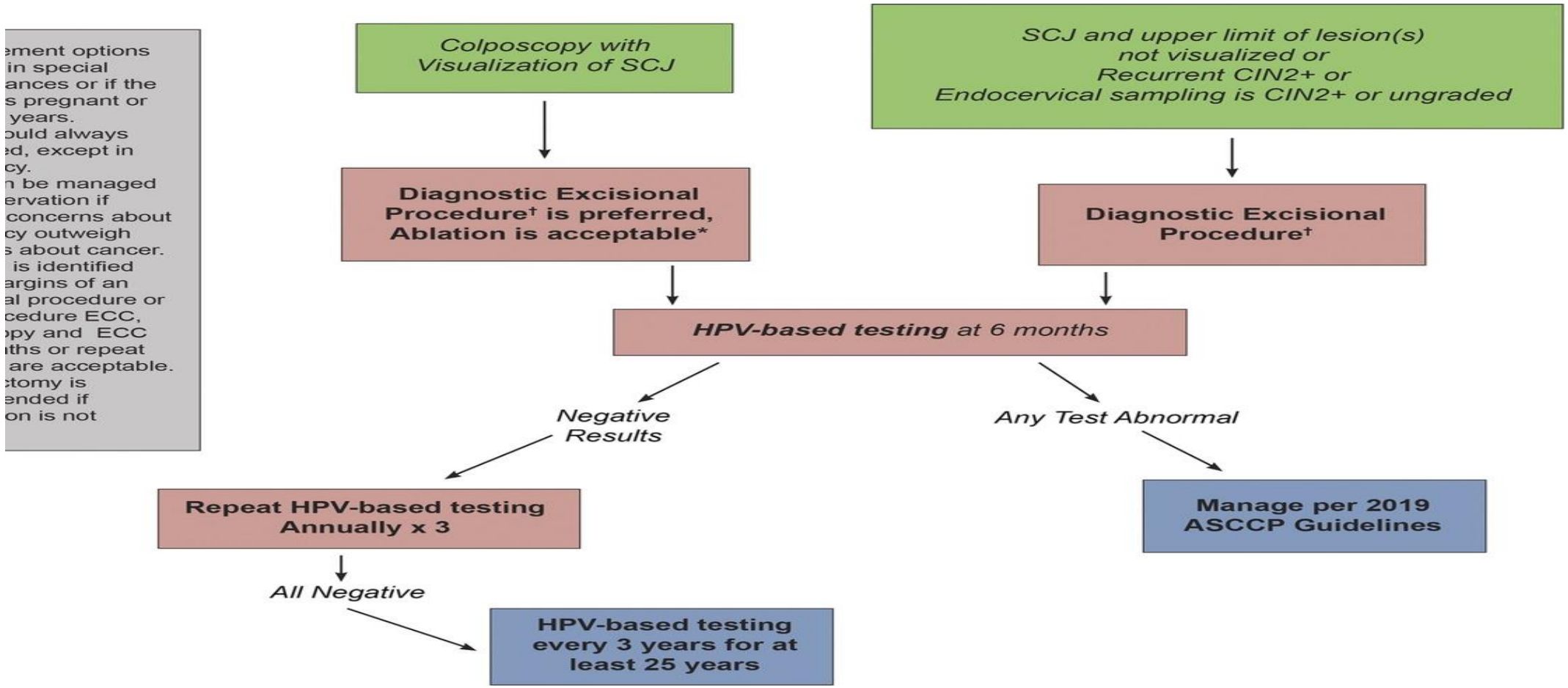


*Cytology if age <25 years; HPV-based testing if ≥ 25 years

MANAGEMENT OF HISTOLOGIC LSIL (CIN 1) PRECEDED BY HSIL CYTOLOGY[2]



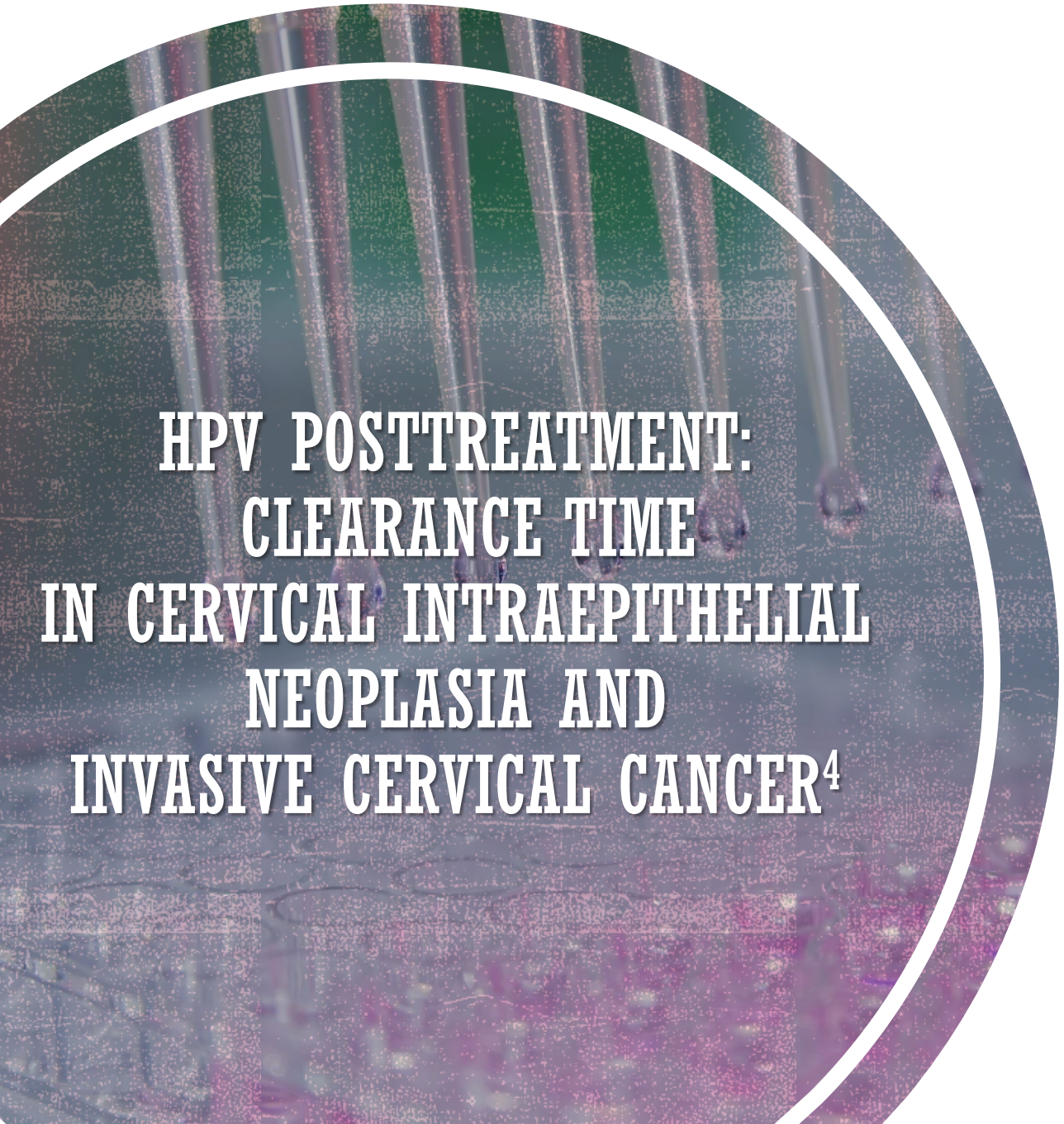
MANAGEMENT OF HISTOLOGIC HSIL[2,3]



ANYTHING ABOVE LSIL: COLPO

- *Women with HPV-/HSIL or HPV-/ASC-H are at high risk of high grade precancer and need colposcopy.*
- *After ASC-H or HSIL cytology, colposcopy is recommended, but immediate treatment (see-and-treat LEEP) is unacceptable.*
- *Women with HPV-/AGC are at high risk and need colposcopy, often with endometrial sampling.*
- *Women with no CIN2,3 at colposcopy should be observed with colposcopy and cytology every 6 months for up to two years, until 2 consecutive negative Pap tests are reported and no high-grade colposcopic abnormality is observed.*
- *Repeat biopsies are indicated if ASC-H/HSIL fail to regress after one year, and diagnostic excision is recommended if HSIL cytology persists for 2 years.*





HPV POSTTREATMENT: CLEARANCE TIME IN CERVICAL INTRAEPITHELIAL NEOPLASIA AND INVASIVE CERVICAL CANCER[4]

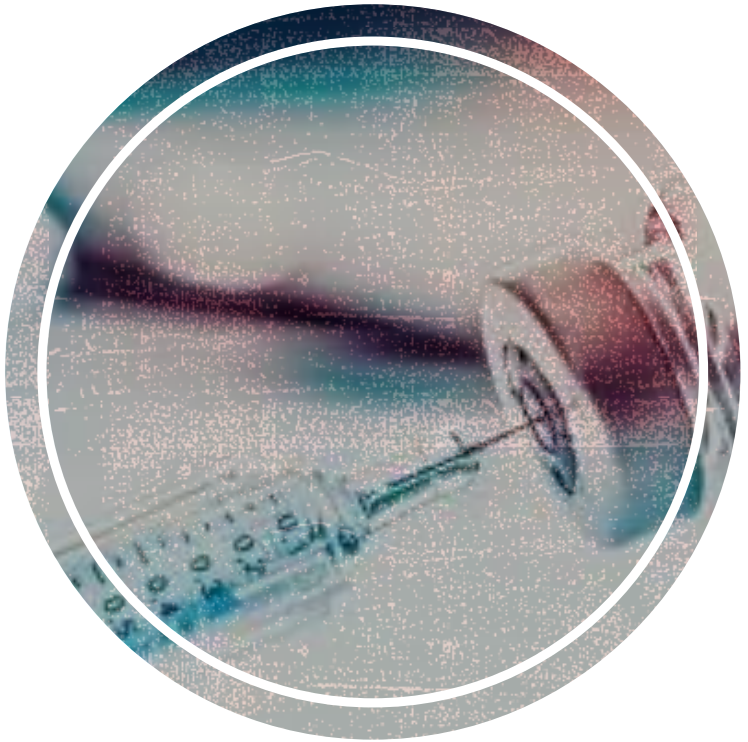
- *the median clearance time of HPV was 10.4 months*
- *The median clearance time was longer in HSIL patients than in early invasive CC patients ($p < .05$).*
- *delaying first posttreatment follow-up time to 9 months in patients at high risk of noncompliance could potentially reduce burden of cost and repeated clinical visits without significantly compromising patient's safety.*
- *This follow-up approach could be consistently applied to all women regardless of age, severity, and extent of disease.*



HPV VACCINE

HPV VACCINE RECOMMENDATIONS[4,5]

- *HPV vaccine is recommended for routine vaccination at age 11 or 12 years. (Vaccination can be started at age 9.)*
- *ACIP also recommends vaccination for everyone through age 26 years if not adequately vaccinated previously. HPV vaccination is given as a series of either two or three doses, depending on age at initial vaccination.*
- *Vaccination is not recommended for everyone ^26 years old. However, some ages 27 - 45 years may decide to get the HPV vaccines-based clinician discussions. Vaccination of people in this age provides less benefit, for several reasons, including that more people in this age range have already been exposed to HPV.*
- *Adults ages 27 - 45 years, clinicians can consider discussing HPV vaccination with people who are most likely to benefit. HPV vaccination does not need to be discussed with most adults over age 26 years.*



HPV VACCINE: DOSING SCHEDULES[4,5]

- *Two doses are recommended for most persons starting the series before their 15th birthday.*
  - *The second dose of HPV vaccine should be given 6 to 12 months after the first dose.*
  - *Adolescents who receive two doses less than 5 months apart will require a third dose of HPV vaccine.*

- *Three doses of HPV vaccine are recommended for teens and young adults who start the series at ages 15 through 26 years, and for immunocompromised persons.*
  - *The recommended three-dose schedule is 0, 1–2 and 6 months.*

- *Three doses are recommended for immunocompromised persons (including those with HIV infection) aged 9 through 26 years*

US PREVENTATIVE SERVICE TASK FORCE GUIDELINES (USPSTF)

- Colorectal Cancer: in all adults aged 50 to 75 years and may start as early as age 45.(May 18, 2021)

- Screening for hypertension in adults 18 years or older with office blood pressure measurement (OBPM). The USPSTF recommends obtaining blood pressure measurements outside of the clinical setting for diagnostic confirmation before starting treatment.

- Breast Cancer: An Update for This Topic is In Progress (April 2021)

- Cervical Cancer: every 3 years with cervical cytology alone in women aged 21 to 29 years. For women aged 30 to 65 years, the USPSTF recommends screening every 3 years with cervical cytology alone, every 5 years with high-risk human papillomavirus (hrHPV) testing alone, or every 5 years with HPV testing in combination with cytology (co-testing).

THE PAP APP

Available on the Android App Store

amazon apps Available at amazon

Download on the App Store

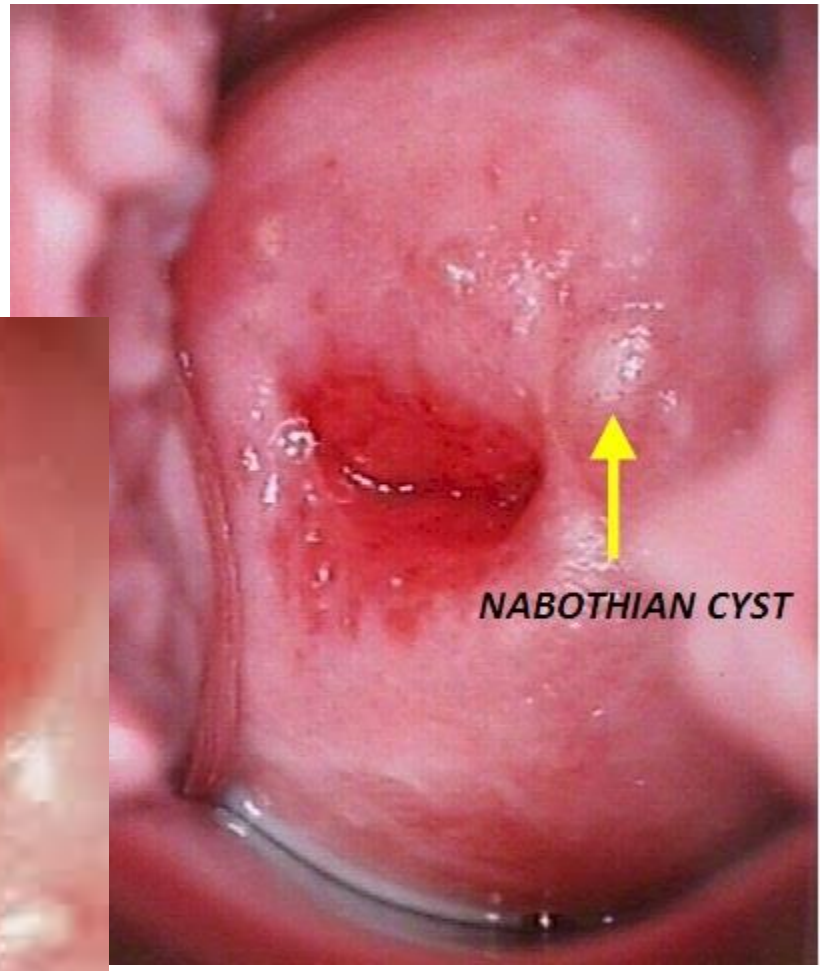


NABOTHIAN CYST





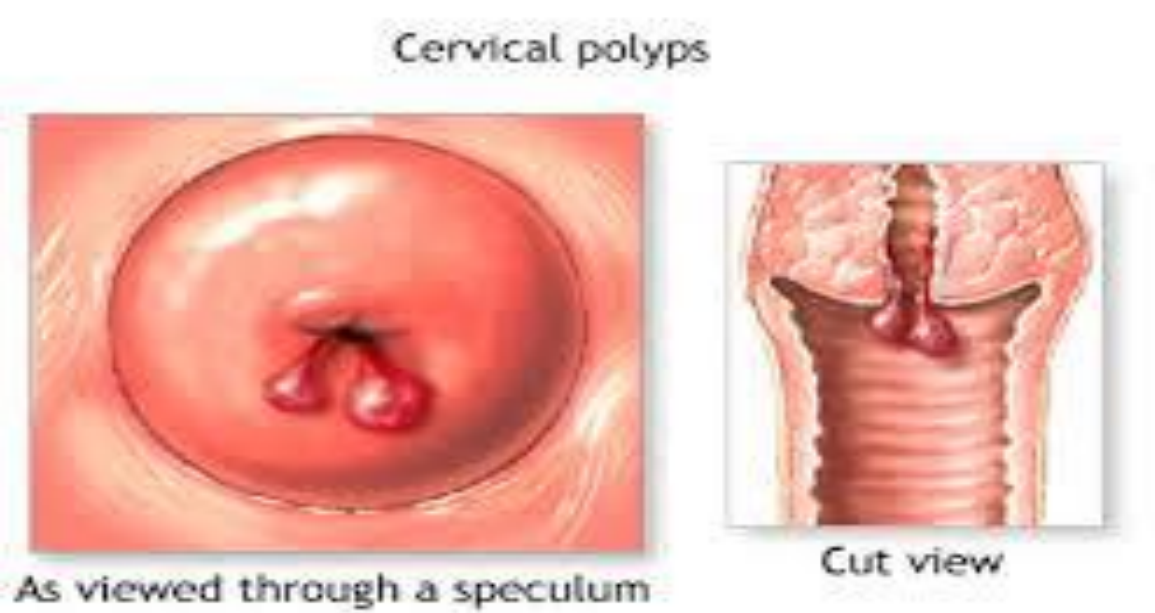
FIGURE 2.3:
VIA negative. The nabothian cysts appear as pinhole- or button-like areas after the application of acetic acid.



CERVICAL POLYPS











CONTRACEPTIVES[10]

HOW WELL DOES BIRTH CONTROL WORK?

What is your chance of getting pregnant?

Really, really well



	The Implant (Nexplanon)	IUD (Skyla)	IUD (Mirena)	IUD (ParaGard)	Sterilization, for men and women
Works, hassle-free, for up to...	3 years	3 years	5 years	12 years	Forever

Less than 1 in 100 women

Okay



	The Pill	The Patch	The Ring	The Shot (Depo-Provera)
For it to work best, use it...	Every. Single. Day.	Every week	Every month	Every 3 months

6-9 in 100 women, depending on method

Not so well



	Withdrawal	Diaphragm	Fertility Awareness	Condoms, for men and women

For each of these methods to work, you or your partner have to use it every single time you have sex.

12-24 in 100 women, depending on method

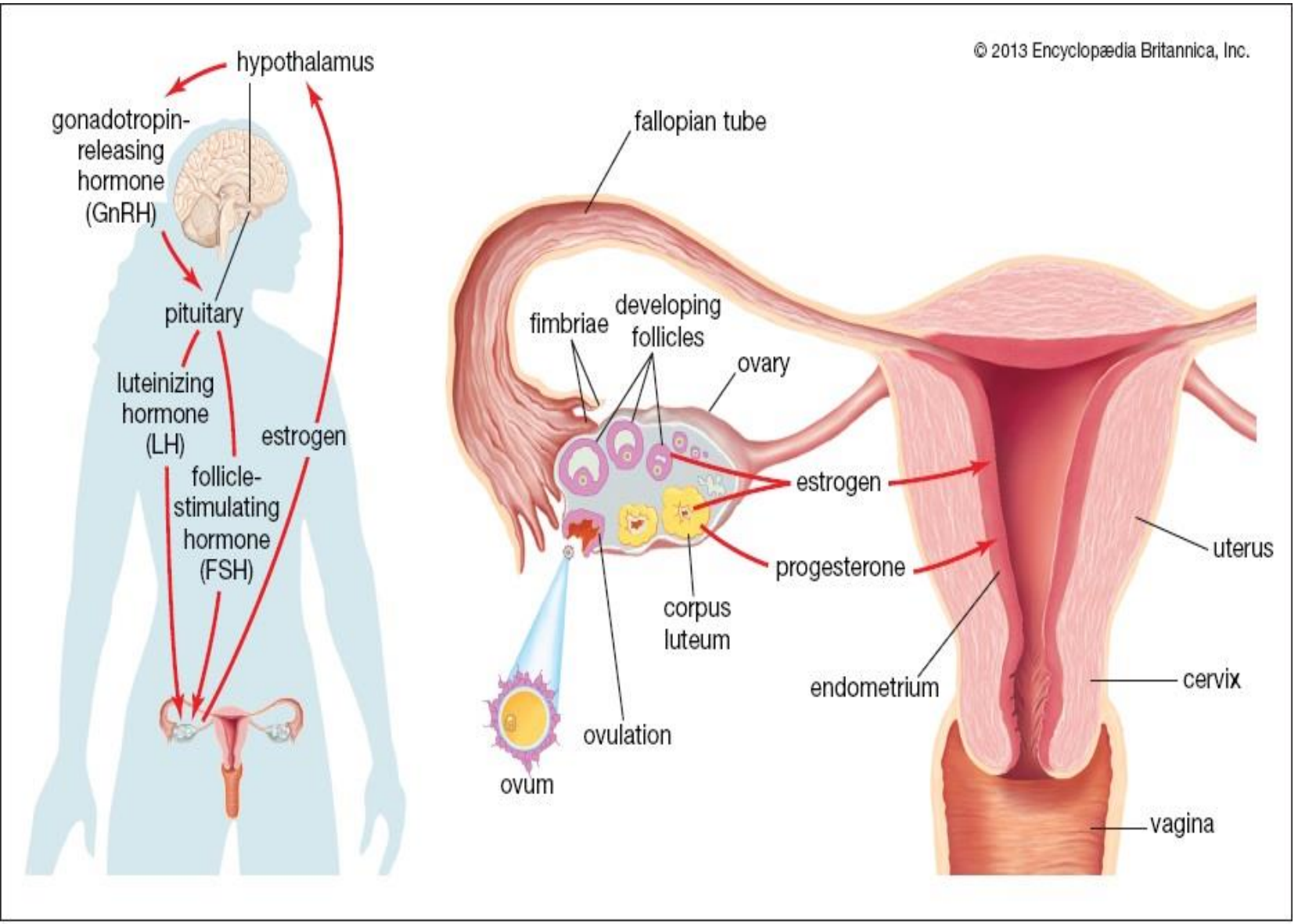
FYI, without birth control, over 90 in 100 young women get pregnant in a year.

BEDSIDER Bedsider.org

Bixby Center for Global Reproductive Health

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HORMONAL BIRTH CONTROL: HOW IT WORKS[5]



At left: the hypothalamus secretes gonadotropin-releasing hormone (GnRH), which stimulates the pituitary gland to secrete the gonadotropins luteinizing hormone (LH) and follicle-stimulating hormone (FSH). LH and FSH stimulate the growth and maturation of the ovarian follicles. The mature follicle secretes estrogen, inhibiting the hypothalamus from further GnRH production (until the next reproductive cycle). At right: after ovulation, blood levels of LH and FSH fall, and the ruptured follicle, now a corpus luteum, secretes estrogen and progesterone to prepare the uterine lining for fertilization and implantation. Adapted with permission from Encyclopædia Britannica, © 2013 by Encyclopædia Britannica, Inc.

- *Both progestins and estrogen inhibit the hypothalamic–pituitary–ovarian axis, which controls the reproductive cycle*
- **Progestins** *prevent pregnancy by inhibiting the luteinizing hormone (LH) surge, thus suppressing ovulation, thickening the cervical mucus, lowering fallopian tube motility, and causing the endometrium to become atrophic.*
- **Estrogens** *prevent pregnancy by suppressing follicle-stimulating hormone (FSH) production, which prevents the development of a dominant follicle.*
- *Progestin is responsible for the majority of both contraceptive action and side effects; the addition of estrogen helps prevent irregular or unscheduled bleeding.*

WOMEN ONLY

Combined hormones

- *OCPs , daily*
- *Patches:*
  - *Xulane: etonogestrol + EE*
  - *Twirla: segesterone acetate + EE*
- *Ring:*
  - *Nuva Ring (monthly),*
  - *Annovera (annually)*

Non Hormonal

- *Gel (Phexxi) lactic, citric acid, potassium bitartrate*

Progestin Only

- *POPs: same time every day, no off days*
  - *Micronor: norethinrone*
  - *Slynd: drospirenone*
- *Injection: 3 months, monthly*
- *Implant: 3 years (Nexplanon)*
- *IUD:*

SPECIFICATIONS[1,3-5]

	LILETTA®	Mirena®	Kyleena®	Skyla®
Levonorgestrel Dose (mg)	52	52	19.5	13.5
Overall Size (mm)	32 x 32	32 x 32	28 x 30	28 x 30
Approved Duration				

EFFICACY: PREGNANCIES PER 100 WOMEN IN A YEAR

Under 1 per year

- *Implant: .05*
- *Vasectomy: 0.15*
- *Hormonal IUD: 0.2*
- *Bilateral Tubal ligation: 0.5*
- *Copper IUD: 0.8*

ABOVE one a year

- *MPA injection: 8.0*
- *Pill , Patch, and Ring: 9.0*
- *Diaphragm: 12.0*
- *Condoms: Male: 18 Female:21*
- *Withdraw: 22*
- *Family planning/Sponge: 24*
- *Spermicide: 28*



WHATS NEW

FOR MEN ONLY

Non-Hormonal

- **Epididymal Protease Inhibitor (Eppin), Gendarussa:** *works by binding to the protein on the sperm's surface—preventing sperm from swimming towards the egg.*
- **Triptonide**, *a purified from a Chinese herb (Tripterygium Wilfordii Hook F,)*
  - *Daily oral doses of triptonide altered sperm having minimal or no forward motility with close to 100% penetrance and consequently male infertility in 3-4 and 5-6 weeks. Once the treatment is stopped, the males become fertile again in ~4-6 weeks, and can produce healthy offspring*
- **RISUG** *(Vasalgel), which stands for Reversible Inhibition of Sperm Under Guidance, is non-hormonal, minimally invasive, reversible, and is effective for up to 10 years*
  - *polymer gel that's injected into the vas deferens. This positively charged gel attaches to the inner walls of the vas deferens. When (-) sperm flow through the vas deferens, the gel damages their heads and tails, rendering them infertile. Completely reversible with injection of bicarb into the vas deferens.*

Hormonal

- **Dimethandrolone undecanoate (DMAU)** *is a once-daily pill, combining synthetic anabolic steroids (AAS) like testosterone with progestin that suppresses two types of male hormones – follicle-stimulating hormone (FSH) and luteinizing hormone (LH) – to simultaneously decrease production of testosterone and sperm without causing symptoms of low-testosterone (low-T).*
- *weekly testosterone injections: anywhere from 3-4 months to become effective.*
- *implant (Nexplanon) plus injectable testosterone decanoate every 4-6 weeks*
- **Clean Sheets Pill:** *This is a fast-acting male birth control method currently in the early stages of development in London. This contraceptive allows a man to orgasm without ejaculating. Taken 2-3 hours prior to sex and lasts for 16-24 hours*

US MEC

US Medical Eligibility Criteria for Contraceptive Use, 2016

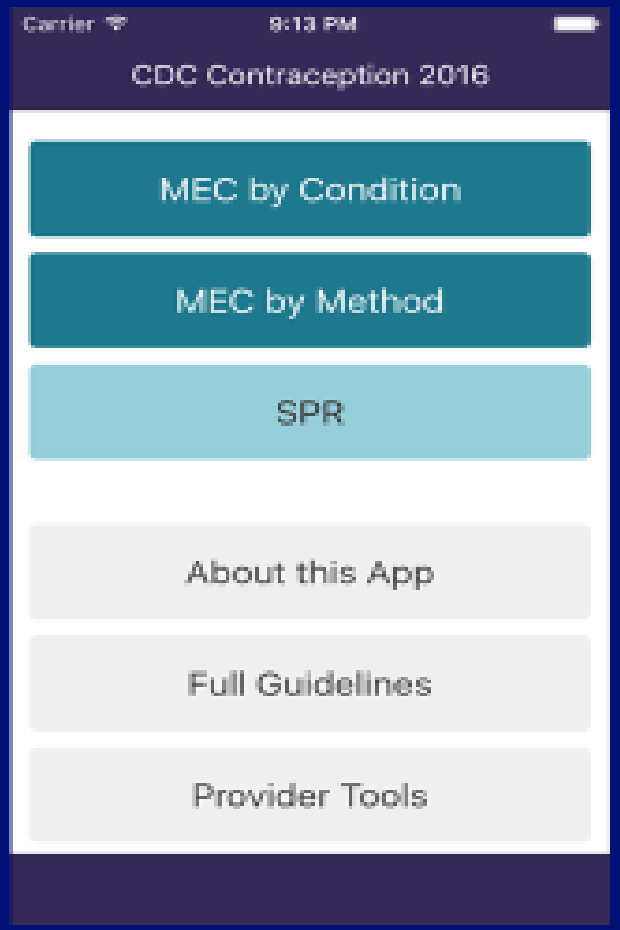
INTRO

Approximately 45% of all pregnancies that occur in the United States are unintended with associated increased risks for adverse maternal and infant health outcomes and increased health care costs

Women, men, and couples have increasing numbers of safe and effective choices for contraceptive methods, including LARCs methods such as intrauterine devices (IUDs) and implants, to reduce the risk for an unintended pregnancy. health care costs.

2016 U.S. MEC and SPR App

US MEC
US SPR
CDC







CONTRACEPTIVE METHODS IN US MEC

- Intrauterine devices
- Progestin-only contraceptives
- Combined hormonal contraceptives
- Emergency contraceptive pills
- Barrier contraceptive methods
- Fertility Awareness-Based Methods
- Lactational Amenorrhea Method
- Coitus Interruptus
- Female and Male Sterilization



U.S. MEC: Categories

1	No restriction for the use of the contraceptive method for a woman with that condition
2	Advantages of using the method generally outweigh the theoretical or proven risks
3	Theoretical or proven risks of the method usually outweigh the advantages – not usually recommended unless more appropriate methods are not available or acceptable
4	Unacceptable health risk if the contraceptive method is used by a woman with that condition



- *A smoker aged <35 years generally can use CHCs (Category 2).For a smoker 35 years or older who smokes <15 cigarettes per day, however, the use of CHCs is usually not recommended unless other methods are not available or acceptable to her (Category 3).*

- *For smokers 35 years or older who smoke 15 or more cigarettes, the use of CHCs poses unacceptable health risks, primarily, the risk for myocardial infarction and stroke (Category 4).*

Example: Smoking and Contraceptive Use

Condition	Cu-IUD	LNG-IUD	Implants	DMPA	POPs	CHCs
Smoking						
a. Age <35	1	1	1	1	1	2
b. Age≥35						
i. <15 cigarettes/day	1	1	1	1	1	3
II.≥15 cigarettes/day	1	1	1	1	1	4

Cu IUD: Copper IUD;
LNG-IUD: Levonorgestrel IUD;
DMPA: Depo-Medroxyprogesterone Acetate;
POPs: Progestin-only pills;
CHCs: Combined hormonal contraceptives including pills, patch, and ring

Headaches

Condition	Cu-IUD	LNG IUD	Implants	DMPA	POP	CHCs
Non-migraine	1	1	1	1	1	1*
Migraine						
Without aura (including menstrual migraine)	1	1	1	1	1	2*
With aura	1	1	1	1	1	4*

* These recommendations rely upon accurate diagnosis of headache as migraine with or without aura. They are intended for women without other risk factors for stroke. Consult full guidance for additional clarification.

Diabetes

Condition	Cu-IUD	LNG-IUD	Implant	DMPA	POP	CHC
History of gestational disease	1	1	1	1	1	1
Nonvascular disease						
Noninsulin-dependent	1	2	2	2	2	2
Insulin-dependent§	1	2	2	2	2	2
Nephropathy/retinopathy/ neuropathy§	1	2	2	3	2	3/4†
Other vascular disease or diabetes of >20 yrs' duration§	1	2	2	3	2	3/4†

§ This condition is associated with increased risk for adverse health events as a result of pregnancy

† This category should be assessed according to the severity of the condition

HEADACHES AND DIABETES

- *Recommendations for headache rely on proper classification of headache, particularly with regard to auras.*
- *This is important because migraine with aura is associated with an increased risk of stroke while migraine without aura is generally not.*
- *According to the International Headache Society Classification System,* **menstrual associated migraines are considered migraine without aura.**

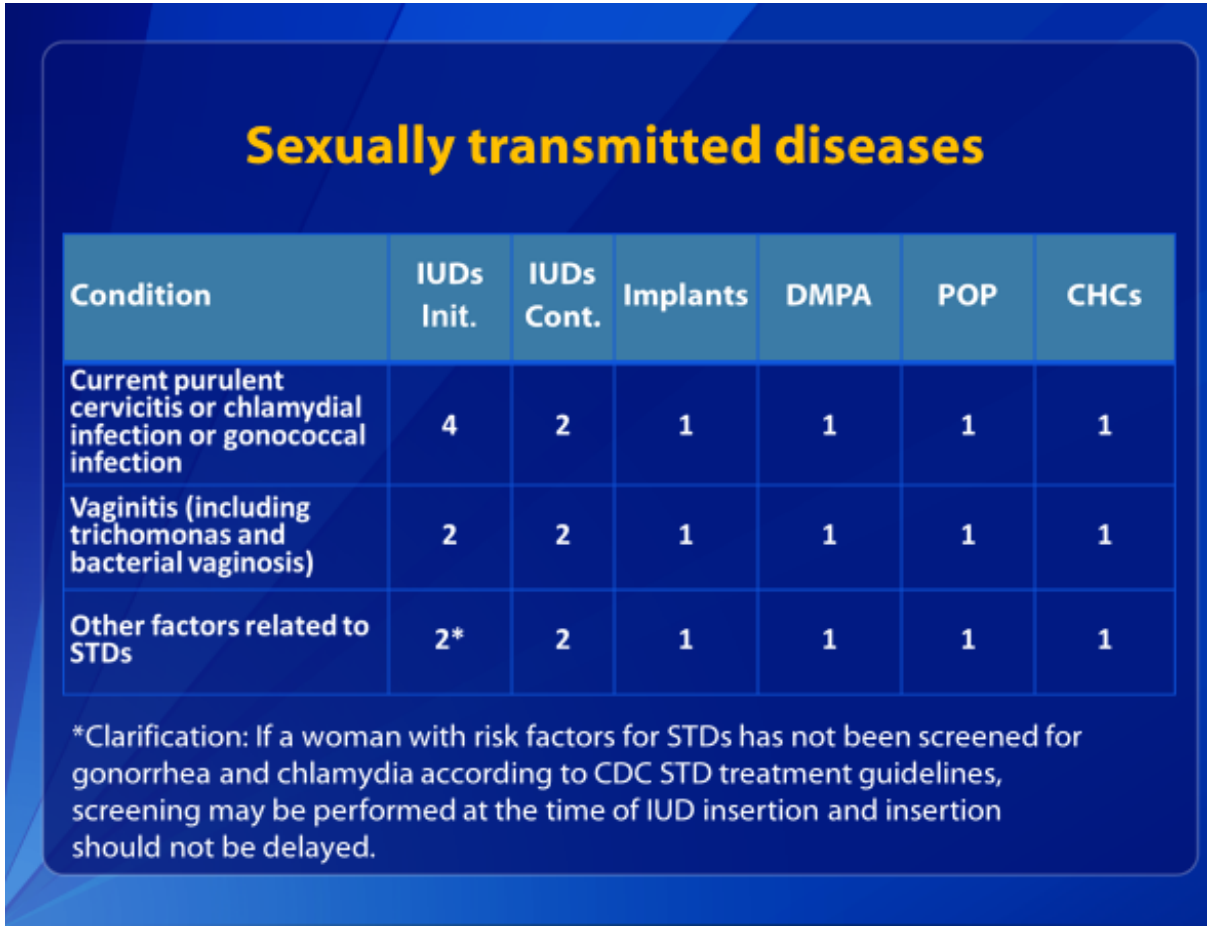
Why is postpartum contraception important?

- *Avoid unintended pregnancy and short pregnancy interval*
- *Avoid repeat adolescent pregnancy (20% repeat)*
- *May be ideal time to provide contraception:*
  - *Motivation*
  - *Access to healthcare services, especially during delivery hospitalization*

Postpartum IUD insertion

Postpartum (including cesarean delivery)	LNG-IUD	Cu-IUD
<10 min after delivery of placenta		
Breastfeeding	2	1
Non-breastfeeding	1	1
10 min to <4 weeks	2	2
≥4 weeks	1	1
Postpartum sepsis	4	4

STD CATEGORIES HAVE BEEN STREAMLINED TO INCLUDE THE FOLLOWING:



Sexually transmitted diseases

Condition	IUDs Init.	IUDs Cont.	Implants	DMPA	POP	CHCs
Current purulent cervicitis or chlamydial infection or gonococcal infection	4	2	1	1	1	1
Vaginitis (including trichomonas and bacterial vaginosis)	2	2	1	1	1	1
Other factors related to STDs	2*	2	1	1	1	1

*Clarification: If a woman with risk factors for STDs has not been screened for gonorrhea and chlamydia according to CDC STD treatment guidelines, screening may be performed at the time of IUD insertion and insertion should not be delayed.

- *(1) current purulent cervicitis or chlamydial or gonococcal infection,*
- *(2) vaginitis including trichomonas vaginalis and bacterial vaginosis, and*
- *(3) other factors related to STDs.*
- *All methods other than IUDs are category 1 for all STD categories.*
- *IUD insertion is category 2 for all STDs except for current purulent cervicitis or known chlamydial/gonococcal infection, which is category 4 (contraindicated).*

Psychotropic drugs

Condition	Cu-IUD	LNG-IUD	Implants	DMPA	POP	CHCs
SSRIs	1	1	1	1	1	1
St. John's Wort	1	1	2	1	2	2

- *No evidence for reduced effect of the contraceptive, the SSRI, or for increased side effects from either drug. Therefore, all methods are category 1 with SSRIs*
- *St John's wort affected breakthrough bleeding, predictors of ovulation, and pharmacokinetics of estrogen and progestins. Though no studies looked directly at pregnancy outcomes, these findings suggest that St. John's wort may have the potential to reduce the effectiveness of hormonal contraceptives. Therefore, St. John's wort is a category 2 for oral contraceptive pills and progestin implants. .*

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

Centers for Disease Control and Prevention
National Center for Chronic Disease Prevention and Health Promotion

Condition	Sub-Condition	Cu-IUD		LNG-IUD		Implant		DMPA		POP		CHC	
		I	C	I	C	I	C	I	C	I	C	I	C
Age		Menarche to <20 yrs: 2		Menarche to <20 yrs: 2		Menarche to <18 yrs: 1		Menarche to <18 yrs: 2		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									
Anemias	a) Thalassemia	2		1		1		1		1		1	
	b) Sickle cell disease‡	2		1		1		1		1		2	
	c) Iron-deficiency anemia	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‡												
	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	
Breastfeeding	a) <21 days postpartum					2*		2*		2*		4*	
	b) 21 to <30 days postpartum												
	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*		1*		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	
Cirrhosis	a) Mild (*compensated*)	1		1		1		1		1		1	
	b) Severe‡ (*decompensated*)	1		3		3		3		3		4	
Cystic fibrosis‡		1*		1*		1*		2*		1*		1*	
Deep venous thrombosis (DVT)/Pulmonary embolism (PE)	a) History of DVT/PE, not receiving anticoagulant therapy												
	i) Higher risk for recurrent DVT/PE	1		2		2		2		2		4	
	ii) Lower risk for recurrent DVT/PE	1		2		2		2		2		3	
	b) Acute DVT/PE	2		2		2		2		2		4	
	c) DVT/PE and established anticoagulant therapy for at least 3 months												
	i) Higher risk for recurrent DVT/PE	2		2		2		2		2		4*	
	ii) Lower risk for recurrent DVT/PE	2		2		2		2		2		3*	
	d) Family history (*first-degree relatives*)	1		1		1		1		1		2	
	e) Major surgery												
	i) With prolonged immobilization	1		2		2		2		2		4	
	ii) Without prolonged immobilization	1		1		1		1		1		2	
	f) Minor surgery without immobilization	1		1		1		1		1		1	
Depressive disorders		1*		1*		1*		1*		1*		1*	

Condition	Sub-Condition	Cu-IUD		LNG-IUD		Implant		DMPA		POP		CHC	
		I	C	I	C	I	C	I	C	I	C	I	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	1		2		2		2		2		2	
	c) Nephropathy/retinopathy/neuropathy‡	1		2		2		3		2		3/4*	
	d) Other vascular disease or diabetes of >20 years' duration‡	1		2		2		3		2		3/4*	
Dysmenorrhea	Severe	2		1		1		1		1		1	
Endometrial cancer‡		4	2	4	2	1		1		1		1	
Endometrial hyperplasia		1		1		1		1		1		1	
Endometriosis		2		1		1		1		1		1	
Epilepsy‡	(*see also Drug Interactions*)	1		1		1*		1*		1*		1*	
Gallbladder disease	a) Symptomatic												
	i) Treated by cholecystectomy	1		2		2		2		2		2	
	ii) Medically treated	1		2		2		2		2		3	
	iii) Current	1		2		2		2		2		3	
	b) Asymptomatic	1		2		2		2		2		2	
Gestational trophoblastic disease‡	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/non-pregnant ß-hCG levels	1*	1*	1*	1*	1*		1*		1*		1*	
	ii) Decreasing ß-hCG levels	2*	1*	2*	1*	1*		1*		1*		1*	
	iii) Persistently elevated ß-hCG levels or malignant disease, with no evidence or suspicion of intrauterine disease	2*	1*	2*	1*	1*		1*		1*		1*	
	iv) Persistently elevated ß-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‡	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		1		1		1		1		1		1	
HIV	a) High risk for HIV	2	2	2	2	1		2*		1		1	
	b) HIV infection					1*		1*		1*		1*	
	i) Clinically well receiving ARV therapy	1	1	1	1	If on treatment, see Drug Interactions							
	ii) Not clinically well or not receiving ARV therapy‡	2	1	2	1	If on treatment, see Drug Interactions							

	Category			
	Cu -IUD	UPA	LNG	COC
Pregnancy	4	NA	NA	NA
Breastfeeding	1	1	1	1
Ectopic	1	1	1	1
Severe CVD	1	2	2	2
RA w/wo immune	2/1	1	1	1
IBS	1	1	1	1
Migraines	1	1	1	2
Liver Dx	1	2	2	2
Obesity	1	2	2	2
Sex Assault	2	1	1	1
CYP3A4 inducers	1	2	2	2



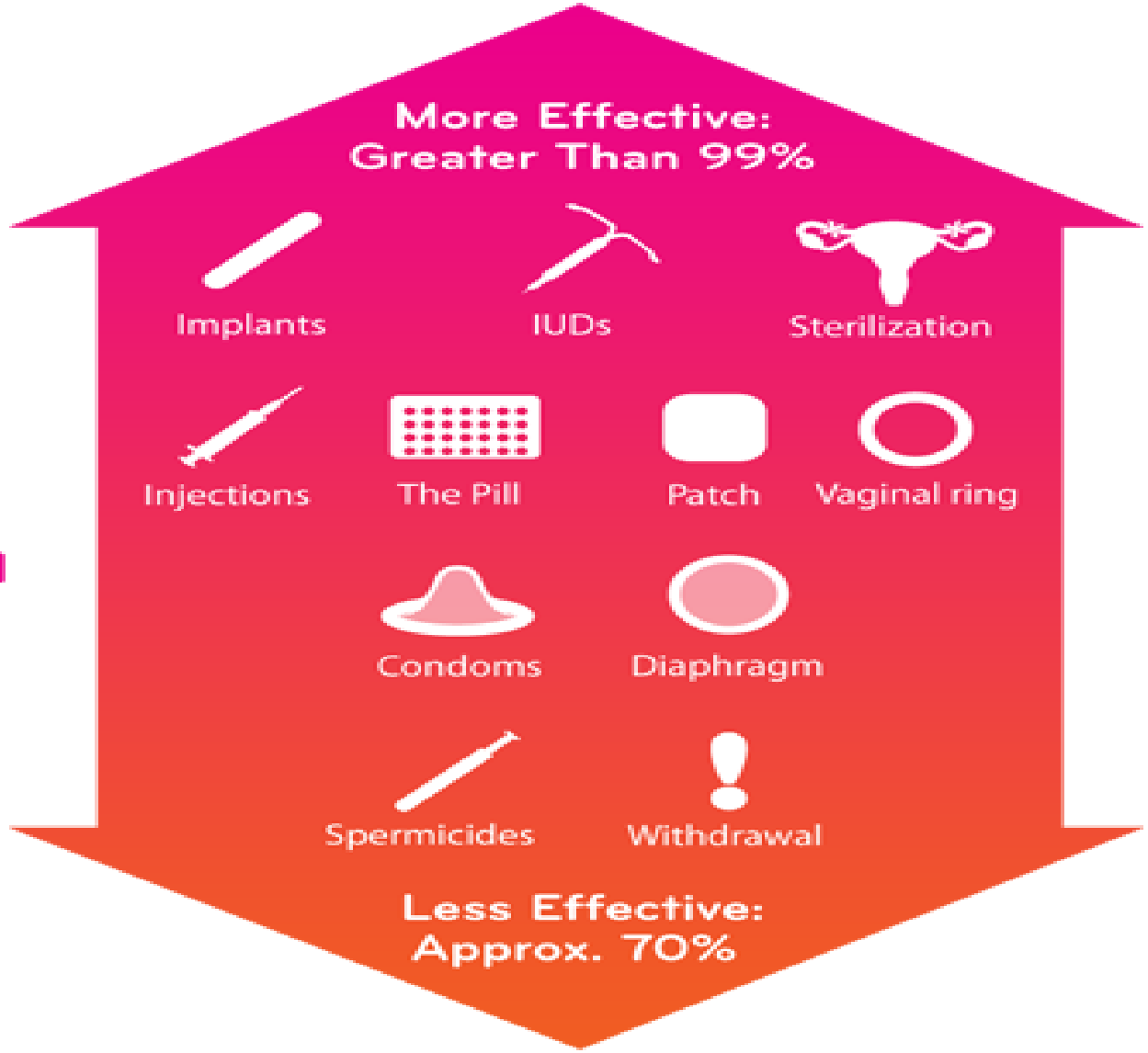
- *with increased risk for adverse health events as a result of pregnancy*
- *a. Restrictive procedures: decrease storage capacity of the stomach (vertical banded gastroplasty, laparoscopic adjustable gastric band, or laparoscopic sleeve gastrectomy)*
  - *Category*

Cu-IUD	UPA	LNG	COC
1	1	1	1

- *b. Malabsorptive procedures: decrease absorption of nutrients and calories by shortening the functional length of the small intestine (Roux-en-Y gastric bypass or biliopancreatic diversion)*

Cu-IUD	UPA	LNG	COC
1	1	1	1

Generally the less you have to do, the more effective the birth control method tends to be.



Recommended Actions After Late or Missed Combined Oral Contraceptives

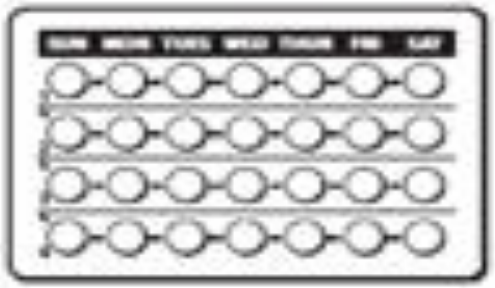
If one hormonal pill is late: (<24 hours since a pill should have been taken)

If one hormonal pill has been missed: (24 to <48 hours since a pill should have been taken)

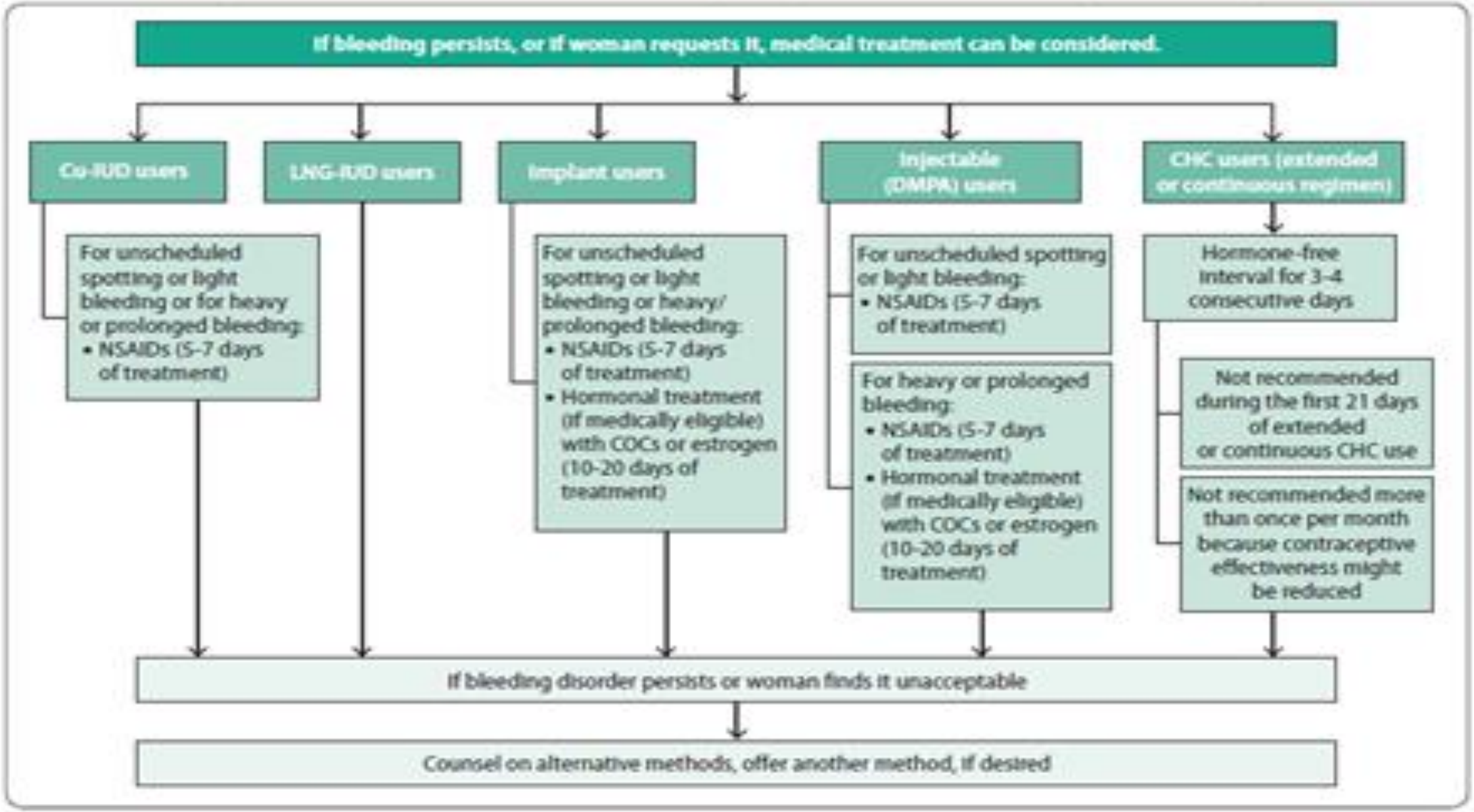
- Take the late or missed pill as soon as possible.
- Continue taking the remaining pills at the usual time (even if it means taking two pills on the same day).
- No additional contraceptive protection is needed.
- Emergency contraception is not usually needed but can be considered (with the exception of UPA) if hormonal pills were missed earlier in the cycle or in the last week of the previous cycle.

If two or more consecutive hormonal pills have been missed: (≥48 hours since a pill should have been taken)

- Take the most recent missed pill as soon as possible (any other missed pills should be discarded).
- Continue taking the remaining pills at the usual time (even if it means taking two pills on the same day).
- Use back-up contraception (e.g., condoms) or avoid sexual intercourse until hormonal pills have been taken for 7 consecutive days.
- If pills were missed in the last week of hormonal pills (e.g., days 15-21 for 28-day pill packs):
  - Omit the hormone-free interval by finishing the hormonal pills in the current pack and starting a new pack the next day.
  - If unable to start a new pack immediately, use back-up contraception (e.g., condoms) or avoid sexual intercourse until hormonal pills from a new pack have been taken for 7 consecutive days.
- Emergency contraception should be considered (with the exception of UPA) if hormonal pills were missed during the first week and unprotected sexual intercourse occurred in the previous 5 days.
- Emergency contraception may also be considered (with the exception of UPA) at other times as appropriate.



Management of Women with Bleeding Irregularities While Using Contraception*



SEXUALLY TRANSMITTED INFECTIONS



CDC:
STD QUALITY CLINIC SERVICE GUIDELINES

- 20 million new cases of (STDs) occur every year in the US, with approximately half among persons aged 15–24 years
- STDs account for $16.9 billion annually in health care costs
- Traditional STD/public health clinics are closing
- Patients have sought care for STDs at primary care clinics, emergency departments, and family planning clinics
- Recommendations for operationalizing STD care in health care settings are needed because provision of STD services varies.
- This report (hereafter referred to as *STD QCS*) describes what constitutes quality STD clinical services in primary care and STD specialty care settings

CURRENT PRACTICE ON SELECTED CLINICAL SERVICES IN THE UNITED STATES



Most PCP obtain a sexual hx if it is relevant to the chief complaint but less frequently at an initial or routine annual visit and seldom at acute care, non-STD–related visits



studies have documented that 1/3- 1/2 of PCP routinely screen men or women for STDs (chlamydia, gonorrhea, syphilis, or HIV)



uninsured young adults were 3X to 4Xmore likely to NOT fill a STD Rx



The median time to treatment for patients not treated the same day was 8 days

Quality STD Clinical Services (STD QCS)		STI Treatment Guidelines
*Roadmap for **providing optimal clinical care services***		*Roadmap for **managing people with or at risk for infection***
Focuses on providing guidance related to **assessment and evaluation** by clinical setting		Focuses on **assessment and evaluation** of people with or at risk for infection
Outlines **prevention services** to have available by clinical setting		Provides guidance on **recommended strategies** for STI prevention
Identifies **laboratory tests** to have available by clinical setting		Indicates **laboratory tests** that are used for diagnosing people with infection
Highlights treatments to have available by clinical setting		Outlines **STI treatment** recommendations

SEXUAL HISTORY AND PHYSICAL EXAMINATION

- *Part of initial comprehensive or annual visit; a visit for reproductive, genital, or urologic issues; or a visit for STD-related symptoms, STD-related concerns, or concerns about preventing or achieving pregnancy.*
- *The five "P"s stand for: • Partners • Practices • Protection from STDs • Past history of STDs • Prevention of pregnancy*
- *A physical examination for STDs includes inspection of the skin, pharynx, lymph nodes, anogenital area, and neurologic system*



THE FIVE "P'S"

- Partners
- Practice
- Protection from STDs
- Past History of STDs
- Pregnancy Protection

CDC 2021 STI GUIDELINES

- *now be known as the STI Treatment Guidelines*
- *U=U or Undetectable equals Untransmittable*
- *Recommendation regarding universal testing for hepatitis C in ALL pregnant women. Population prevalence of greater than 1.1%, every pregnant woman with every pregnancy gets rescreened*
- *In the adolescent section, there is some more permissive language for rectal chlamydia and gonorrhea testing to be considered in females based on reported sexual behaviors*
- *Expanded section on the importance of rectal and pharyngeal testing*
- *HIV testing should be performed on all persons not known to have HIV infection who present with genital anal or perianal ulcers*
- *genital herpes, herpes PCR is the preferred diagnostic test with call for a Biokit or a Western blot as the second test for confirmation.*
- *Separating out HSV1 & HSV2, in terms of different counseling messages*
- *Adult syphilis, there's expansion in the clinical presentation and which patients there's an increased clinical notability of atypical presentations of syphilis, including painful, multiple lesions, especially occurring perennially that can mimic herpes presentation.*
- *FDA cleared test do use the NAATs at the rectal and pharyngeal sites, both for chlamydia and gonorrhea*

CDC's 2021 STI Treatment Guidelines Update Webinar(link is external)
https://npin.cdc.gov/sites/default/files/CDC_STI_Transcript_FINAL_0114.pdf

CDC 2021GUIDELINES: CHLAMYDIA

- NAATs that are FDA-cleared for use with vaginal swab specimens can be collected by a provider or self-collected in a clinical setting.
- Self-collected vaginal swab specimens are equivalent in sensitivity and specificity to those collected by a clinician using NAATs
- Rectal and pharyngeal sites cleared by FDA for NAAT testing
- Diagnosis of urethral infection in men can be made by testing a urethral swab or first-catch urine specimen.
- Since women with symptomatic chlamydia urethritis have a clinical presentation like an UTI, the potential exists to miss the diagnosis of chlamydia if testing is not performed

- **Treatment:**
  - **Doxycycline** 100 mg orally twice a day for 7 days (if rectal coinfection is possible)
  - **Alternative: Azithromycin** 1 g orally in a single dose

CDC's 2021 STI Treatment Guidelines Update Webinar(link is external)
https://npin.cdc.gov/sites/default/files/CDC_STI_Transcript_FINAL_0114.pdf

CDC 2021 GUIDELINES: GONORRHEA

- urogenital, rectal, or pharyngeal gonorrhea
- NAATs that are FDA-cleared for use with vaginal swab specimens can be collected by a provider or self-collected in a clinical setting.
- Self-collected vaginal swab specimens are equivalent in sensitivity and specificity to those collected by a clinician using NAATs

Treatment:

- Ceftriaxone 500 mg IM as a single dose for persons weighing <150 kg (300 lb)
  - For persons weighing ≥150 kg (300 lb), 1 g of IM ceftriaxone should be administered.
- If chlamydial infection has not been excluded, providers should treat for chlamydia with doxycycline 100 mg orally twice daily for 7 days.
- During pregnancy, azithromycin 1 g as a single dose is recommended to treat chlamydia.
- Partner therapy: Cefixime 800 mg orally as a single dose (Doxycycline 100mg BID x 7day if chlamydia not excluded).
- Need a test of cure for pharyngeal infections, only

CDC's 2021 STI Treatment Guidelines Update Webinar(link is external)
https://npin.cdc.gov/sites/default/files/CDC_STI_Transcript_FINAL_0114.pdf

CDC 2021 GUIDELINES: TRICHOMONIASIS

- *NAAT testing in women with vaginal discharge and HIV+*
- *OB considerations: PROM 1.4, preterm birth1.4, endometritis 2.2, HIV acquisition 1.4*

- ***Treatment:***
- *Men: metronidazole 2gm orally once*

- *Women: Metronidazole 500 mg bid x 7*
  - *Alternative Tinidazole 2gm x once*

Test of Cure by NAAT in 3 weeks !

CDC's 2021 STI Treatment Guidelines Update Webinar(link is external)
https://npin.cdc.gov/sites/default/files/CDC_STI_Transcript_FINAL_0114.pdf

CDC 2021 GUIDELINES: BV

- *BV increases risk of other STIs: HSV, HPV, MG*
- *NAAT for diagnosis*
- *Treatment*
- *Metronidazole 500 mg po BID x7*

- *Alternate treatments*
  (single dose therapy, non pregnant women)
- *Secnidazole 2gm granules po x once*
- *Metro Gel 1.3% vaginally*
- *Clindamycin 2% vaginally*

CDC's 2021 STI Treatment Guidelines Update Webinar(link is external)
https://npin.cdc.gov/sites/default/files/CDC_STI_Transcript_FINAL_0114.pdf

CDC 2021 STI GUIDELINES: CANDIDIASIS

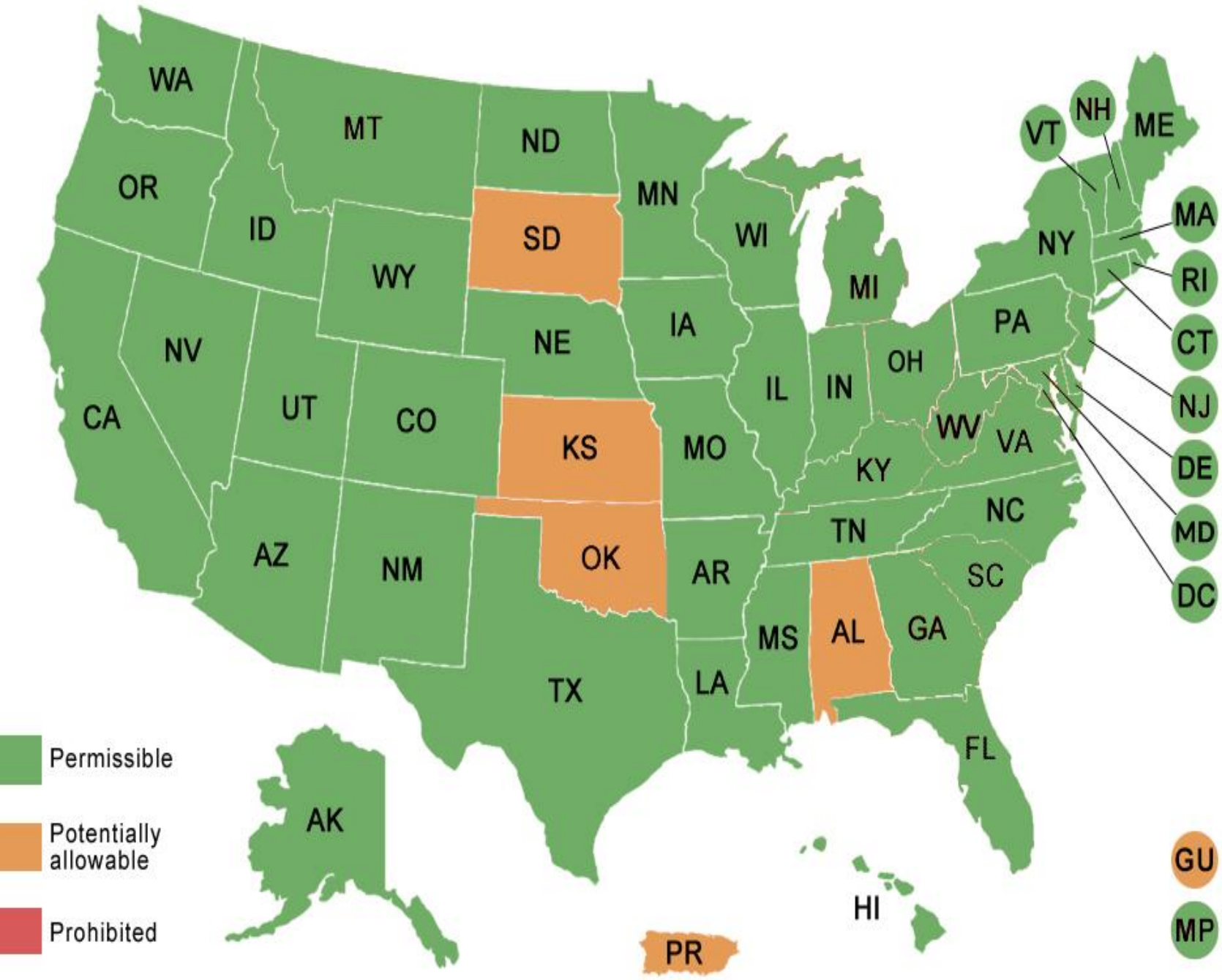
- *NAAT testing*
- *Culture remains gold standard for susceptibility testing*
- *C. albicans azole resistance is becoming more common*
- *Recurrent VVC (≥ 3 episodes/year)*
  - *Fluconazole (100mg, 150mg 200mg) weekly for 6 months*
- *Pregnancy warning: Fluconazole*
  - *Increased risk for congenital anomalies,*
  - *Spontaneous abortions*

CDC's 2021 STI Treatment Guidelines Update Webinar(link is external)
https://npin.cdc.gov/sites/default/files/CDC_STI_Transcript_FINAL_0114.pdf

EXPEDITED PARTNER THERAPY

PARTNER SERVICES (EPT)

- *Treatment of sex partners prevents reinfection and is essential to interrupting transmission of STDs*
- *Strategies include*
  - *1) guidance regarding notification and care of sex partners,*
  - *2) interactive counseling for partner notification,*
  - *3) EPT, and*
  - *4) health department disease intervention specialist (DIS) elicitation of sex partner information to identify those who might be infected and to identify patient follow-up needs*



EXPEDITED PARTNER THERA (EPT) 4/2021

- *is the clinical practice of treating the heterosexual sex partners of patients diagnosed with chlamydia or gonorrhea by providing prescriptions or medications to the patient to take to his/her partner* ***without the health care provider first examining the partner***

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