CDC Updates Eligibility Criteria for Contraceptive Use

Key Points for Practice

- The use of IUDs in postpartum women is safe and does not increase IUD-associated risks.
- Combined hormonal contraceptives present an unacceptable health risk, or category 4, for breastfeeding women fewer than 21 days postpartum.
- For women with a history of or acute superficial venous thrombosis, combined hormonal contraceptives are a category 3, whereas other forms of contraception are category 1.
- STI screening at the time of IUD insertion is not necessary in most women.

From the AFP *Editors*

Coverage of guidelines from other organizations does not imply endorsement by *AFP* or the AAFP.

This series is coordinated by Sumi Sexton, MD, Associate Deputy Editor.

A collection of Practice Guidelines published in *AFP* is available at http://www.aafp.org/afp/practguide.

CME This clinical content conforms to AAFP criteria for continuing medical education (CME). See CME Quiz Questions on page 868.

Author disclosure: No relevant financial affiliations.

Almost one-half of pregnancies in the United States are unintentional. These pregnancies are linked to increased risks of adverse outcomes for the mother and infant, and greater health care costs. Many safe and effective methods for contraception exist, all of which require evidence-based guidance for health care professionals.

The Centers for Disease Control and Prevention (CDC) first published the *U.S. Medical Eligibility Criteria for Contraceptive Use*, which is a companion document to the *U.S. Selected Practice Recommendations for Contraceptive Use*, in 2010 to provide guidelines on safely using a variety of contraceptive methods. These guidelines update the 2010 report.

Using the Guidelines

These guidelines, which discuss the use of contraceptives in persons with certain characteristics (e.g., age) or known medical conditions (e.g., diabetes mellitus), can be used when discussing different methods with patients. The recommendations do not consider the use of these methods for other medical conditions.

The conditions that affect the eligibility for each method are categorized as follows: 1 = condition for which there is no restriction for the use of the method, 2 = condition for which the advantages of using the method generally outweigh the theoretical or proven risks, 3 = condition for which the theoretical or proven risks usually outweigh the advantages of using the method, and 4 = condition that represents an unacceptable health risk if the method is used.

Updates and Changes

The full guidelines provide categorizations for all contraceptive methods across a variety of conditions. Some of the changes and updates are highlighted in this summary (http://www.cdc.gov/mmwr/volumes/65/rr/rr6503a1_appendix.htm#modalIdString_CDCTable_0).

POSTPARTUM

A few things should be kept in mind when evaluating postpartum women for contraceptive use, including the benefits of breastfeeding for women and their infants. Public health goals from the U.S. Department of Health and Human Services include increasing the number of infants who are breastfed initially, solely breastfeeding for at least six months, and continuing to breastfeed for at least a year.

In postpartum women, the presence of additional risk factors for venous thromboembolism (VTE) may change the categorization for combined hormonal contraceptives from a 3 to a 4.

The use of intrauterine devices (IUDs) in postpartum women is safe and does not increase IUD-associated risks (e.g., infection). Rates of expulsion, however, are increased in the postpartum period, which should be considered as it relates to effectiveness vs. access to interval placement for patients at a later time when expulsion rates are lower.

Breastfeeding. Implants, depot medroxyprogesterone acetate (DMPA; Depo-Provera), and progestin-only pills are category 1 in breastfeeding women 30 or more days postpartum, and category 2 in those 21 to 30

days postpartum, regardless of VTE risk factors. Combined hormonal contraceptives are category 4 for breastfeeding women fewer than 21 days postpartum; a 3 in those 21 to 30 days postpartum, regardless of VTE risk factors; a 3 in those 30 to 42 days postpartum with risk factors for VTE; and a 2 in those 30 to 42 days postpartum without VTE risk factors and in women more than 42 days postpartum. Copper-containing IUDs are a 1, and levonorgestrel-releasing IUDs (Mirena) are a 2 within 10 minutes of placenta delivery in all breastfeeding women. However, both types are categorized as a 2 between 10 minutes after delivery and less than four weeks postpartum.

Nonbreastfeeding. Implants, DMPA, and progestin-only pills are category 1 in nonbreastfeeding women 21 to more than 42 days postpartum, regardless of VTE risk factors. Combined hormonal contraceptives are a 1 in nonbreastfeeding women more than 42 days postpartum; a 2 in those 21 to 42 days postpartum without VTE risk factors and a 3 in those with risk factors; and a 4 in those fewer than 21 days postpartum. IUDs are a 1 within 10 minutes of placenta delivery in all nonbreastfeeding women.

SUPERFICIAL VENOUS DISORDERS

For women with a history of or acute superficial venous thrombosis, which can be associated with a higher risk of VTE, combined hormonal contraceptives are a category 3, whereas other forms of contraception are category 1. If risk factors for deep venous thrombosis are present, or the patient currently has or previously had it, the recommendations for deep venous thrombosis and pulmonary embolism in the full guidelines should be followed. Combined hormonal contraceptives may be an option in women with superficial venous thrombosis related to a peripheral intravenous catheter.

HEADACHES

Combined hormonal contraceptives are a category 1 for nonmigraine headache, a 2 for migraines without aura, and a 4 for migraines with aura. Levonorgestrel-releasing IUDs, implants, DMPA, and progestin-only pills are category 1 in women with migraines, regardless of whether aura is present.

MULTIPLE SCLEROSIS

IUDs, implants, and progestin-only pills are category 1 in all women with multiple sclerosis, and DMPA is a 2. For those with prolonged immobility, combined hormonal contraceptives are a 3, and for those without, this method is a 1.

SEXUALLY TRANSMITTED INFECTIONS

Screening for sexually transmitted infections (STIs) at the time of IUD insertion is not necessary in most women. If there is a risk of STI and the patient has not been tested for gonococcal and chlamydial infections as outlined by CDC guidelines, testing may be done at the IUD insertion visit. Physicians should not postpone insertion to perform testing.

Pregnant women with human immunodeficiency virus (HIV) infection who are not clinically well or are not taking antiretroviral therapy have a higher risk of adverse health outcomes. Initiating and continuing IUDs are category 1 in those clinically well and receiving antiretroviral therapy; continuing an IUD is category 1 and initiating an IUD is a 2 in those not clinically well or not receiving antiretroviral therapy. The criteria related to taking antiretrovirals and other medications have been updated. See Appendix A in the full guidelines for details.

Research regarding a possible increased risk of HIV infection in women prescribed progestin-only injectable contraception is mixed. The CDC has not changed its current recommendations based on this indecisive information; however, it should still be recommended to women using this method to also use condoms and employ other HIV preventive measures. Further research is needed regarding the risk of HIV and contraceptive methods; therefore, this guidance will be continually reviewed.

EMERGENCY CONTRACEPTION

In pregnancy, IUDs are associated with the risk of serious infection of the pelvis, as well as septic spontaneous abortion. If emergency contraceptive pills are accidentally used while pregnant, the patient, her fetus, or the pregnancy will generally not be affected.

Copper-containing IUDs and ulipristal (Ella) are category 1 in women who breastfeed, have had an ectopic pregnancy or

bariatric surgery (including restrictive and malabsorptive procedures), with rheumatoid arthritis if not on immunosuppressives, with migraines; with inflammatory bowel disease, or who repeatedly use emergency contraceptive pills. When prescribed ulipristal, breastfeeding should be avoided for at least a day and the milk discarded. Ulipristal's highest concentration in breast milk is in the first 24 hours, with maximum serum levels in the mother occurring within three hours. Breast milk concentrations are significantly reduced within the first 24 hours, and slowly reduced over five days.

Levonorgestrel is a category 1 in women with inflammatory bowel disease. Ulipristal is category 2 in women with a history of cardiovascular disease; with severe liver disease; or with obesity (body mass index [BMI] of at least 30 kg per m^2). Emergency contraceptive pills may be less effective in women who are obese vs. women with a BMI less than 25 kg per m^2; however, there are no safety issues with regard to use in women who are obese. Medications that are strong CYP3A4 inducers could also make emergency contraceptive pills less effective.

Copper-containing IUDs are category 2 in those with rheumatoid arthritis who are taking immunosuppressives or with uncomplicated solid organ transplantation, as well as in those who have experienced sexual assault. They are a 3 in those with a complicated organ transplant. Sexual assault survivors have a higher risk of STIs; therefore, the CDC recommends routinely and presumptively treating chlamydia, gonorrhea, and trichomonas in these women. If purulent cervicitis, chlamydia, or gonorrhea is present, IUDs are category 4 and should not be used.

Guideline source: Centers for Disease Control and Prevention

Evidence rating system used? Yes

Literature search described? Yes

Guideline developed by participants without relevant financial ties to industry? No

Published source: *Morb Mortal Wkly Rep.* July 29, 2016;65(3):1-103

Available at: http://www.cdc.gov/mmwr/volumes/65/rr/pdfs/rr6503.pdf

LISA HAUK, *AFP* Senior Associate Editor ■