2019 FMX Women's Health Handouts

(PBL) Navigating the Complexities of Contraceptive Care (CME269-270)


Advanced Concepts: Preconception Counseling (CME273-274)

First Trimester Pregnancy Complications (CME275-276)

Heart Disease in Women: The Real Heartbreak - Disparities in Women's Cardiovascular Health (CME285-286)

Navigating the Complexities of Contraceptive Care (CME279-280)

Non-Cancerous Urinary Tract Disorders in Women Update (CME281-282)

Preconception Counseling: What Is Supported by Evidence? (CME283-284)

Safe Medical Abortion Care (CME277-278)

Understanding Trauma Informed Care of Trafficked Women and GLBTQ Patients (CME287-288)
(PBL) Navigating the Complexities of Contraceptive Care

Angeline Ti, MD, MPH
Santina Wheat, MD, MPH, FAAFP

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The content of my material/presentation in this CME activity will include discussion of unapproved or investigational uses of products or devices as indicated: Discussion of evidenced-based but off-label uses of certain contraceptive methods.

Angeline Ti, MD, MPH

Assistant Professor, Department of Gynecology and Obstetrics, Department of Family and Preventive Medicine, Emory University School of Medicine, Atlanta, Georgia

Dr. Ti earned her Master of Public Health from Johns Hopkins Bloomberg School of Public Health, and is a graduate of the University of Michigan Medical School in Ann Arbor, Michigan. She completed her residency in Family and Community Medicine and a fellowship in Family Planning at the University of California, San Francisco, conducting research on the family planning values and preferences of incarcerated girls. Dr. Ti also completed a 2-year research position in the Division of Reproductive Health at the Centers for Disease Control and Prevention (CDC), working on the CDC contraception guidance. She is now faculty in the Division of Family Planning, and is the medical director of the Title X clinic at Grady Memorial Hospital. She currently provides primary care, transgender care, and family planning care. She also serves on the Georgia AFP Public Health Committee and the Georgia Department of Public Health Maternal Mortality Review Committee Action Committee.
Santina Wheat, MD, MPH, FAAFP

Assistant Professor, Department of Family and Community Medicine, Northwestern University Feinberg School of Medicine, Chicago, Illinois; Program Director, Northwestern McGaw Family Medicine Residency at Humboldt Park, Chicago, Illinois; Physician, Erie Family Health Centers, Chicago, Illinois

Dr. Wheat earned her medical degree from the University of Illinois College of Medicine at Chicago, and she earned her Master of Public Health (MPH) degree at the University of Illinois at Chicago School of Public Health. She completed a residency in family medicine at Northwestern McGaw Family Medicine Residency at Humboldt Park in Chicago, Illinois. Dr. Wheat has a strong interest in reproductive health and social determinants of health, and she works with a largely Spanish-speaking patient population at a federally qualified health center (FQHC) in Chicago. She provides full primary care to patients living with HIV/AIDS and hepatitis C. Dr. Wheat is the program director for the Northwestern McGaw Family Medicine Residency. She runs an outpatient procedure clinic with the residents in her program and is part of the maternity care team.

Learning Objectives

1. Practice applying new knowledge and skills gained from Navigating the Complexities of Contraceptive Care sessions, through collaborative learning with peers and expert faculty.

2. Identify strategies that foster optimal management of contraceptive care, within the context of professional practice.

3. Formulate an action plan to implement practice changes, aimed at improving patient care.
Associated Sessions

• Navigating the Complexities of Contraceptive Care

Screening for pregnancy intention

• One Key Question

• Intention-oriented vs service-oriented
  – “Do you want to get pregnant soon?”
  – “Can we help you today with birth control or pregnancy planning?”

“Power to Decide, One Key Question”: https://powertodecide.org/one-key-question
Let’s practice!

- Provider: You are seeing a new patient for an annual exam.
  - Screen your patient for pregnancy intention

- Patient: You are a 32 year old G2P2 with no significant past medical history

Let’s practice!

- Provider: You are seeing a patient for a routine follow-up visit to discuss diabetes.
  - Screen your patient for pregnancy intention and briefly discuss contraception or pre-pregnancy planning

- Patient: You are a 38 year old G0 with diabetes. Your recent HgA1c was 9.5.
Let’s practice!

• Provider: You are seeing a patient for an urgent care visit – Screen your patient for pregnancy intention and discuss pregnancy risk

• Patient: You are a 26 year old G1P0 with symptoms of a urinary tract infection.

Debrief

• What worked? What didn’t work?

• Any “ah ha” moments?

• How can this work in your practice?
Shared decision-making

- Patient values, preferences, and situation
- Medical evidence, risks and benefits
- Individualized decision

Let’s practice!

- 19 year old G1P1 interested in contraception.
  - Elicit patient preferences and needs
  - Personalize counseling on methods related to patient preferences
  - Interactively establish a plan
Let’s practice!

• 28 year old G0 who is 4 weeks post-bariatric surgery. Hopes that weight loss will help her fertility and desires pregnancy ASAP.
  - Elicit patient preferences
  - Personalize counseling on risks and benefits
  - Interactively establish a plan

Let’s practice!

• 37 year old P3 with hypertension. Blood pressure today 145/85. Wants to re-start combined oral contraceptives (COCs) (MEC 3).
  - Elicit patient preferences
  - Personalize counseling on risks and benefits
  - Interactively establish a plan
Debrief

• What worked? What didn’t work?

• Any “ah ha” moments?

• How can this work in your practice?

US MEC

Summary Chart of U.S. Medical Eligibility Criteria

<table>
<thead>
<tr>
<th>Risk Level</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Method can be used without restriction</td>
</tr>
<tr>
<td>2</td>
<td>Advantages generally outweigh theoretical or proven risk</td>
</tr>
<tr>
<td>3</td>
<td>Theoretical or proven risks usually outweigh the advantages</td>
</tr>
<tr>
<td>4</td>
<td>Unacceptable health risk (method not to be used)</td>
</tr>
</tbody>
</table>

Let’s practice!

- 24 year old presents requesting COCs. She has lupus that has been uncomplicated without any recent flares and also has migraines without aura that are well controlled with a triptan.

- Do you feel comfortable prescribing COCs?

Assessing risk of multiple conditions

- Migraines without aura and SLE
Let’s practice!

• 35 year old presents requesting DMPA. She has well-controlled hypertension on a regimen of lisinopril/hydrochlorothiazide and has a partner who is HIV+ and not taking medication

• Do you feel comfortable prescribing DMPA?

Assessing risk of multiple conditions

• Controlled HTN and high risk for HIV
Let’s practice!

• 30 year old G0 presents requesting a copper IUD. She has sickle cell anemia and a history of PID 4 years ago.

• Would you feel comfortable placing a copper IUD?

Assessing risk of multiple conditions

• Sickle cell anemia and history of PID
Contraceptive management

- Emergency contraception
- Starting methods

Let’s practice!

- COCs: LMP 4 days ago, last sex 3 days ago, uses condoms 100% of the time
  - Can you rule out pregnancy?
  - Can method start today?
  - Should you offer EC?
    - If yes, can your patient still start their method today?
Contraceptive management

• COCs: LMP 4 days ago, last sex 3 days ago, uses condoms 100% of the time
  – Can rule out pregnancy
    • May consider effectiveness of condoms
  – Can start method today
  – EC generally not necessary
    • If offer EC, need to wait 5 days to start COCs if using UPA

Let’s practice!

• DMPA: LMP 3 weeks ago, last unprotected sex yesterday
  – Can you rule out pregnancy?
  – Can method start today?
  – Should you offer EC?
    • If yes, can your patient still start their method today?
Contraceptive management

- DMPA: LMP 3 weeks ago, last unprotected sex yesterday
  - Cannot rule out pregnancy
  - Can still start method today
  - EC would be a great idea
    - If offer EC, need to wait 5 days to start DMPA if using UPA

Let’s practice!

- Cu-IUD: LMP 2 weeks ago, last unprotected sex 4 days ago
  - Can you rule out pregnancy?
  - Can method start today?
  - Should you offer EC?
    - If yes, can your patient still start their method today?
Contraceptive management

• Cu-IUD: LMP 2 weeks ago, last unprotected sex 4 days ago
  – Cannot rule out pregnancy
  – Can still start method today…
  – A Cu-IUD 4 days after unprotected sex is EC!

Some useful resources

• Bedsider: https://providers.bedsider.org/
• CDC contraception guidance: https://www.cdc.gov/reproductivehealth/contraception/contraception_guidance.htm
• Reproductive Health Access Project: https://www.reproductiveaccess.org/
• UCSF transgender guidelines: https://transcare.ucsf.edu/guidelines
Contact us with questions!

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Advanced Concepts: First Trimester Pregnancy Complications - Managing Ectopics, Gestational Trophoblastic Disease, and Spontaneous Abortion Diagnostic Challenges

Carrie Pierce, MD
Julie Johnston, MD, FAAFP

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The content of my material/presentation in this CME activity will include discussion of unapproved or investigational uses of products or devices as indicated: We will discuss effective and evidence-based regimens using methotrexate to treat ectopic pregnancies. Methotrexate is FDA-approved for other uses and is used off-label to manage ectopic pregnancy.

Carrie Pierce, MD

Faculty, Cascades East Family Medicine Residency, Klamath Falls, Oregon

Dr. Pierce is a graduate of Rush Medical College in Chicago, Illinois. She completed her residency at the University of Illinois-Chicago Advocate Illinois Masonic Medical Center Family Medicine Residency and a reproductive health care and advocacy fellowship at the Reproductive Health Access Project in New York, New York. Dr. Pierce enjoys practicing the full scope of family medicine, from newborns to geriatric patients. Her passion is reproductive health care, helping women and families plan when and whether to have children, and subsequently helping them have the healthiest pregnancies and babies possible.
Julie Johnston, MD, FAAFP

Medical Director, Health Quarters, Lawrence, Massachusetts; Faculty, Lawrence Family Medicine Residency, Massachusetts

Dr. Johnston is a graduate of Brown University's Alpert Medical School in Providence, Rhode Island. She completed her residency at Lawrence Family Medicine Residency, Massachusetts, and participated in the Physicians for Reproductive Health Leadership Training Academy. At Lawrence Family Medicine Residency, she coordinates the women’s health rotation and the women’s health area of concentration. Her areas of interest include the empowerment of women, reproductive health access, immediate postpartum long-acting reversible contraception provision, and political action. Dr. Johnston served as the 2018 women’s delegation co-convener and delegate for the National Conference of Constituency Leaders (NCCL). In addition, she has leadership roles at the state level, including serving as the family medicine representative on the Massachusetts Department of Public Health Perinatal Advisory Committee and the Special Legislative Commission on Postpartum Depression.

Learning Objectives

1. Describe medical management of ectopic pregnancy, including initial management, followup, patient inclusion criteria, and when obstetrical consultation is necessary.

2. Explain management of gestational trophoblastic disease

3. Accurately diagnose the causes in less straightforward cases of early pregnancy bleeding.
Case 1

Mary is a 24 yo G2P1 comes in after a positive pregnancy test at home. She has a history of PCOS and very irregular menses, unsure of her LMP. This is a desired pregnancy.

- Notes 2 days of vaginal spotting

- Initial HCG 1900. Progesterone 5ng/mL
- Repeat HCG 48 hours later 1575
2 days later…..

Patient presents to the ER with severe pelvic pain and was diagnosed with an ectopic pregnancy.

Was there a clue?

Poll Question 1
All of these 48 hour HCG values are associated with an ectopic pregnancy except….

1. HCG decreases 18%
2. HCG decreases 25%
3. HCG increases 30%
4. HCG increases 25%
HCG rise and fall in 48 hours

❖ Viable pregnancy: increase >53%
❖ Spontaneous abortion: decrease >21-35%
❖ Ectopic pregnancy: rise or fall in HCG less than these values


Progesterone’s role?

<6ng/mL excludes a viable pregnancy

low levels DO NOT distinguish intrauterine from ectopic pregnancy

OB/Gyn Consultation needed:

- Varies by hospital
- When ectopic is diagnosed
- May be a specific HCG ex. 5000
- When surgical treatment is required

Role of uterine aspiration

- Pregnancy of unknown location (PUL)
  - used diagnostically
  - If chorionic villi are found the evaluation is complete
- Want to avoid methotrexate if not needed
  - Presumptive treatment does not decrease cost or complications with PUL
  - Debate about length of time after treatment to delay pregnancy
- Do not see expected HCG drop after first dose of MTX and this is a PUL
Contraindications for Methotrexate

Relative
- Cardiac activity
- Gestational sac size >4cm
- HCG >2000m IU/mL
- Alcoholism

Absolute
- Severe asthma
- Active peptic ulcers
- Breastfeeding
- Creatinine clearance <50ml/min/1.73m^2
- Sensitivity to methotrexate
- Hematologic problems

1 or 2 doses?
- Single dose regimen is the simplest
- Increased success with 2 doses if HCG > 3600-5000 mIU/mL
- Faster resolution with 2 doses (25.7 days vs. 31.9 days)

Methotrexate

- Day 1
  - Single dose 50 mg/m²
- Day 4 and 7
  - Repeat HCG levels
- Repeat Mtx if <15% decrease
- Measure HCG to 0

Expectant Management

- Appropriate if low and decreasing HCG
- No ectopic on ultrasound or <3 cm mass
- Extensive counseling is needed
- Risk of tubal rupture at any HCG
- Follow HCG weekly until 0
Poll Question 2
Which does NOT increase the risk of ectopic pregnancy?

1. IUD use
2. Pregnancy with ART (assisted reproductive technology)
3. Prior ascending pelvic infection
4. History of ectopic pregnancy

What about IUDs?

IUD’s reduce the risk of all pregnancies but… 53% pregnancies that occur with an IUD in place are ectopic.

Ectopic pregnancy learning points

- Minimum decline with a miscarriage at 48 hours is 21-35%
- There can be rupture at any HCG level
- HCG should decrease by >15% from day 4-7
- Always document ectopic precautions


Case #2

- Simone is a 34 yo G3P2 presents with a positive home pregnancy test. Worried that she might have twins as she has had more morning sickness than in previous pregnancies.
- Her exam reveals a uterus larger than expected by her LMP 6 weeks ago.
POCUS

Gestational Trophoblastic Disease

- Irregular vaginal bleeding (most common)
- Hyperemesis
- Uterine enlargement out of proportion to gestational age
- Early failed pregnancy

Poll Question 3
What is the preferred treatment?

1. Misoprostol and mifepristone
2. Suction curettage
3. Sharp curettage
4. Medical induction of labor

Management of Molar Pregnancy

❖ Suction curettage
❖ Rhogam is needed for partial but not complete moles
❖ Hysterectomy may be preferred to reduce sequelae
❖ Serial HCG measurements
Gestational trophoblastic disease (GTD)

Partial Mole
• 90% are triploid, evidence of a fetus

Complete Mole
• 75-80% are diploid, no fetal tissue

Gestational Trophoblastic Neoplasia
• persistent GTD

Follow up care

HCG should be measured within 48 hours of treatment, then q 1-2 weeks until levels drop and monthly for at least 6 months (to 12 Months).
Gestational Trophoblastic Neoplasia (GTN)

❖ May occur after a molar pregnancy, a non-molar pregnancy, or a live birth
❖ **Vaginal bleeding** is the most common presenting symptom for diagnosis after an abortion, miscarriage, or birth
❖ 1 study showed the median time between pregnancy and choriocarcinoma was 5-6 months


When should Gyn-onc be consulted?

• At diagnosis of the molar pregnancy?
• After routine uterine evacuation?
• If her HCG plateaus or increases?
Contraception after a Molar Pregnancy

- Hormonal contraceptives are safe during period of HCG follow up
- IUDs are safe unless there is persistent levels or malignant disease
- Higher risk of IUD expulsion after molar evacuation c/w second trimester uterine size
Case #3

- Mary, a 28 yo who presents with vaginal bleeding “like a period”. She is 6 months remote from an uncomplicated vaginal delivery at 39 weeks.

Case continues

- Her exam revealed a normal vaginal canal with scant red blood in the vault. Uterus was non-tender, no signs of infection.
- HCG 3000
- Ultrasound with empty gestational sac
- She elects medication management
Case continues...

You have given her Mifepristone 200mg in the office and have prescribed 800 mcg of misoprostol.

She calls after 24 hours and reports no bleeding. What is the next step?

Troubleshooting medication management

No bleeding
○ May repeat misoprostol 24-48 hours if no bleeding
○ Aspiration procedure can be offered

Vomiting
○ Can prescribe zofran to take prior to the mifepristone
○ Dose can be repeated, consider if less than 20 minutes
○ Have the patient take the misoprostol vaginally if nauseous
Case #4

Emily is a 35 yo G4P1 who had a positive home pregnancy test 4 weeks ago. Her menses were irregular and she is unsure about an LMP. She comes into your office with vaginal spotting.

Early pregnancy bleeding

- Subchorionic hematoma
- Infection
- Ectopic
- Miscarriage
- GTD
Case continues...

Minimal dark blood noted in the vaginal vault. Her HCG is 5000. The patient is unable to get to her scheduled ultrasound. Her HCG 2 days later is 6750. She has had not further bleeding.

Poll Question 4
What do you tell her?

1. You are not worried about an ectopic because the HCG increased.
2. This must be an ectopic because the HCG increase was so small.
3. This is definitely a miscarriage.
4. You need more testing, this could still be a viable pregnancy.
Vanishing Twins

- Incidence: 10-40% of all twin pregnancies
- Mean 2-day hcg increase was lower (114.3% vs. 128.8%)
- 2.2% had 2 day increases < 53% and had a live birth
- 80% of those with a 2 day increase <53% had a 3rd level >53%

Considerations

- Consider a 3rd HCG level to follow a trend
- There are outliers
- 35% 48 hour hcg increase includes more of the outliers
Take home points

1. Viable pregnancy: generally hcg increases >53%
2. Spontaneous abortion: hcg decrease >21-35%
3. Ectopic pregnancy: rise or fall in HCG less than these values
4. Contraception including IUDs are safe following a molar pregnancy
5. HCG levels needed for any bleeding 6 weeks following any pregnancy to rule out GTN
6. Consider a 3rd HCG level if considering vanishing twins

Recommended Practice Changes

1. Manage ectopic pregnancies safely and confidently in the family medicine office when appropriate patient criteria are met.
2. Manage some cases of gestational trophoblastic disease and be comfortable with contraceptive management.
3. Diagnose the cause of early pregnancy bleeding when laboratory or ultrasound findings are not initially diagnostic.
Contact Information

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Questions
Advanced Concepts:
Preconception Counseling

Heather Paladine, MD, MEd, FAAFP
Tenessa MacKenzie, MD, FAAFP

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Dr. Paladine is a family physician who lives and practices in Manhattan, New York, where she supervises residents and medical students, and treats a predominantly Latino, low-income patient population. She focuses on women’s health, including maternity care and reproductive health. In addition to her work as a physician, Dr. Paladine mentors residents and medical students as a preceptor in clinic and hospital environments. She is a member of the board of directors of the New York State Academy of Family Physicians and a member of its Education Commission. She believes that the United States needs a health care system based on primary care and that the public must learn more about family medicine to pave the way.
Tenessa MacKenzie, MD, FAAFP

Family physician, University of California, San Francisco (UCSF) Family Medicine Center at Lakeshore; Assistant Clinical Professor, Department of Family and Community Medicine, UCSF

Dr. MacKenzie has been an outpatient primary care clinician at the UCSF Family Medicine Center at Lakeshore since 2014. She teaches UCSF medical students and provides pediatric, adult, and prenatal care. She earned her medical degree at the University of Florida in Gainesville in 2009 and completed a residency in family medicine at Beth Israel Medical Center in New York in 2012. Prior to joining UCSF, Dr. MacKenzie worked as a locum tenens physician in Canada and New Zealand. In 2016, she completed the UCSF Family Medicine Faculty Development Fellowship Program. Her clinical interests include comprehensive women's health care, outpatient procedures, pediatrics, medical education, and healthy lifestyle counseling.

Learning Objectives

1. Effectively manage medical conditions such as obesity, diabetes mellitus, and hypothyroidism in women of reproductive age in order to improve maternal and neonatal outcomes.

2. Develop a framework for counseling women with opioid use disorder in the preconception period and will be aware of evidence-based recommendations for buprenorphine therapy for women planning and in the early stages of pregnancy.

3. Develop a strategy for how and when to order preconception carrier screening tests based on patient and partner risk factors.
Outline

Introduction
Common medical conditions in women of reproductive age
  – Hypertension
  – Diabetes mellitus
  – Hypothyroidism
  – Opioid use disorder
Contraception
Preconception carrier screening
Introduction

Preconception health care is focused on:

– Reducing maternal and fetal morbidity
– Increasing the chances of conception when pregnancy is desired
– Contraceptive counseling to prevent unintended pregnancy
– Providing resources and access to termination when pregnancy is not desired

Preconception care IS primary care

Basic preconception counseling talk

• Obstacles & opportunities for preconception care
• Pregnancy intention- consider using One Key Question: Would you like to become pregnant in the next year?
• Preventive care— folic acid, caffeine, alcohol, tobacco, vaccines, infections, obesity, and more!
• Preconception counseling for men
• Coding and reimbursement
Consider a case

36yo female patient G2 P1011
NSVD 2 years ago, pregnancy complicated by mild pre-eclampsia
BP 150s/80s at 6-12 months postpartum
Started HCTZ 25mg 6 months ago, today BP 125/70
Using condoms (sometimes) for contraception
Considering another pregnancy

Polling Question 1:
Your patient is considering pregnancy. Hx pre-eclampsia, currently taking HCTZ 25mg for chronic HTN. How do you counsel this patient? (Choose ALL correct answers)

a. Stop HCTZ now & counsel on lifestyle modifications
b. Continue HCTZ
c. Switch HCTZ to Nifedipine
d. Start prenatal vitamin with at least 400mcg folic acid and 150mcg iodine
e. Start baby aspirin
Hypertension

Prevalence in women of reproductive age: about 8% (NHANES 1999-2008)

Prevalence in pregnancy: 0.9-1.5%

- Increased rates in obese, African Americans, advancing age


ACOG Practice Bulletin No. 203: Chronic Hypertension and Pregnancy, 2019

Effects of chronic HTN on pregnancy

Maternal
- end-organ damage
- preeclampsia
- planned C-section
- postpartum hemorrhage
- placental abruption

Fetal
- stillbirth
- preterm delivery
- fetal growth restriction
- congenital anomalies

ACOG Practice Bulletin No. 203: Chronic Hypertension and Pregnancy, 2019
Hypertension management

- Discuss risk of complications
  - Emphasis on severe uncontrolled HTN
- Lifestyle and dietary education
- No evidence that treating mild to moderate hypertension in pregnancy improves perinatal outcomes
  - Mild essential HTN: consider stopping meds (short term)

ACOG Practice Bulletin No. 203: Chronic Hypertension and Pregnancy, 2019

Hypertension management

Severe HTN, BP>160/110
- Start antihypertensive therapy
- BP goal in pregnancy <160/100
- Start aspirin 81mg ideally between 12-16 weeks, continue until delivery

Medication recommendations
- Avoid ACE inhibitors, ARB, spironolactone
- Choose Nifedipine, Labetalol; (HCTZ is 2nd line)

ACOG Practice Bulletin No. 203: Chronic Hypertension and Pregnancy, 2019
ACOG Practice Bulletin No. 212: Pregnancy and Heart Disease, 2019
Contraception and Blood Pressure

BP <140/90 (not on antihypertensives): may use any method (USMEC category 2)

BP 140-159/90-99: avoid CHC, unless no other method is appropriate/acceptable to patient (USMEC category 3)

BP>160/100: should not use CHC (USMEC category 4)

ACOG Practice Bulletin No. 206: Use of Hormonal Contraception in Women with Coexisting Medical Conditions, 2019

Polling Question 2:
Your patient is considering pregnancy. Hx pre-eclampsia, currently taking HCTZ 25mg for chronic HTN. How do you counsel this patient? (Choose ALL correct answers)

a. Stop HCTZ now & counsel on lifestyle modifications
b. Continue HCTZ
c. Switch HCTZ to Nifedipine
d. Start prenatal vitamin with at least 400mcg folic acid and 150mcg iodine
e. Start baby aspirin
Polling Question 3:
Which of the following statements regarding diabetes is FALSE?

a. HbA1c levels between 5-6% are associated with rates of congenital malformations close to that observed in normal pregnancies

b. Glucose is teratogenic at high levels

c. Patients with diabetes should not use combined hormonal contraceptives (USMEC category 3-4)

d. The 2-hour OGTT at 6-12 weeks postpartum is the preferred screening test for diabetes for patients with a history of GDM

Diabetes mellitus

Prevalence in women of reproductive age: 3-7%

Pregestational/preexisting DM in 1-2% of pregnancies

- Increased rates in older, non-Hispanic black, and Hispanic women

- Undiagnosed diabetes poses challenges

ACOG Practice Bulletin No. 201: Pregestational Diabetes Mellitus, 2018

Effects of diabetes on pregnancy

Decreased fertility
Increased risk of SAB
Increased risk of fetal malformations
  • Anomalies occur before 8 weeks gestation
  • Common: heart defects, sacral agenesis, GU malformations
  • A1c levels correlate directly with frequency of anomalies (a1c 10 associated with fetal anomaly rate 20-25%)

ACOG Practice Bulletin No. 201: Pregestational Diabetes Mellitus, 2018

Diabetes management

• Discuss risks of complications
• Use contraception until blood glucose is optimized
• Lifestyle and dietary education
• Optimize HbA1c<6
• Generally switch to insulin, but can continue metformin/glyburide until pregnant
• Stop ACE-I, ARB, statins, ASA

ACOG Practice Bulletin No. 201: Pregestational Diabetes Mellitus, 2018

Interconception care: Screening for T2DM after pregnancy with h/o GDM

Table 1. Preferred Testing Strategy Based on Postpartum Timeframe

<table>
<thead>
<tr>
<th>Postpartum Timeframe</th>
<th>Oral Glucose Tolerance Test</th>
<th>Fasting Plasma Glucose</th>
<th>Hemoglobin A1c</th>
</tr>
</thead>
<tbody>
<tr>
<td>4 weeks–6 months</td>
<td>Preferred</td>
<td>Acceptable</td>
<td></td>
</tr>
<tr>
<td>After 6 months</td>
<td>Acceptable</td>
<td>Acceptable</td>
<td>Acceptable</td>
</tr>
</tbody>
</table>

ACOG, Women’s Preventive Services Initiative (WPSI), 2017

Contraception and Diabetes

Uncomplicated diabetes: may use any method (USMEC category 2)

Diabetes >20 years or evidence of microvascular disease (retinopathy, nephropathy, or neuropathy): should not use CHC (USMEC category 3-4)

ACOG Practice Bulletin No. 206: Use of Hormonal Contraception in Women with Coexisting Medical Conditions, 2019
Polling Question 4:
Which of the following statements regarding diabetes is FALSE?

a. HbA1c levels between 5-6% are associated with rates of congenital malformations close to that observed in normal pregnancies
b. Glucose is teratogenic at high levels
c. Patients with diabetes should not use combined hormonal contraceptives (USMEC category 3-4)
d. The 2-hour OGTT at 6-12 weeks postpartum is the preferred screening test for diabetes for patients with a history of GDM

Polling Question 5:
Which of the following statements regarding hypothyroidism is FALSE?

a. Iodine supplementation should be started 3 months prior to pregnancy
b. Routine screening for thyroid disease in pregnancy is recommended
c. Thyroid hormone requirements increase in early pregnancy
d. Patients with hypothyroidism and a positive home pregnancy test should independently increase their levothyroxine dose by 20-30%
Hypothyroidism

Prevalence in women of reproductive age: about 2-4%
Prevalence in pregnancy: 2-10 per 1000 pregnancies

Universal screening for thyroid disease in pregnancy is NOT recommended (A)

Effects of untreated hypothyroidism on pregnancy

- Impacts on fertility, menstrual cycles
- Adverse perinatal outcomes including SAB, preeclampsia, preterm birth, placental abruption, and fetal death
- Associated with low birth weights and cognitive impairment in offspring
Hypothyroidism management

- Discuss risks
  - Reassure no increased risks if adequately controlled before/during pregnancy

- Achieve euthyroidism (TSH<2.5) before pregnancy
  (Strong recommendation, moderate-quality evidence)

  2017 Guidelines of the American Thyroid Association for the Diagnosis and Management of Thyroid Disease During Pregnancy and the Postpartum, Thyroid, Vol. 27, No. 3

  ACOG Practice Bulletin No. 148: Thyroid Disease in Pregnancy, 2015

---

Hypothyroidism management

- Educate on increased need thyroid replacement therapy in early pregnancy
  - Recommend 2 extra doses per week as soon as finding out about pregnancy, check TSH ASAP
  (Strong recommendation, high-quality evidence)

  2017 Guidelines of the American Thyroid Association for the Diagnosis and Management of Thyroid Disease During Pregnancy and the Postpartum, Thyroid, Vol. 27, No. 3
Iodine supplementation (all patients)

Planning pregnancy:
• supplement diet with 150mcg iodine daily-
  the usual dose in prenatal vitamins
  (Strong recommendation, moderate-quality evidence)

Currently pregnant:
• ingest 250mcg iodine daily
  (Strong recommendation, high-quality evidence)

2017 Guidelines of the American Thyroid Association for the Diagnosis and Management of Thyroid Disease During Pregnancy and the Postpartum, Thyroid, Vol. 27, No. 3

Polling Question 6:
Which of the following statements regarding hypothyroidism is FALSE?

a. Iodine supplementation should be started 3 months prior to pregnancy

b. **Routine screening for thyroid disease in pregnancy is recommended**

c. Thyroid hormone requirements increase in early pregnancy

d. Patients with hypothyroidism and a positive home pregnancy test should independently increase their levothyroxine dose by 20-30%
Opioid use is common

- Reported past-month heroin use among women of childbearing age increased 31% from 2011-2012 to 2013-2014 (CBHSQ, 2015, Table 6.71A)

- CDC estimates 1/3 of reproductive-age women enrolled in Medicaid and >1/4 of those with private insurance filled a prescription for an opioid pain medication each year between 2008-2012 (Ailes et al., 2015)

- OUD during pregnancy more than doubled between 1998 and 2011 to 4 per 1,000 deliveries (Maeda, Bateman, Clancy, Creanga, & Leffert, 2014)

Obstacles to care

- Legal consequences that sanction pregnant women with OUD
- Shame associated with OUD in pregnancy and motherhood
- Misinformation among health care providers and systems

- Drive women away from care
- Increased risks of preterm delivery, low infant birth weight, and transmitting HIV to their infants (Binder & Vavrínková, 2008)
Opportunities

- Patient engagement
- Planning pregnancy or pregnancy is a time of great potential for positive change
- Family physicians can provide continuity of care for the whole family

SAMHSA, Clinical Guidance for Treating Pregnant and Parenting Women With Opioid Use Disorder and Their Infants, 2018

Management of OUD in Pregnancy

- Engage patient in care
- Discuss risks of of opioid use in pregnancy
- Offer treatment with medication-assisted therapy (MAT) and provide reassurance
  - safe in preconception period and pregnancy
  - no evidence of increase in birth defects
  - minimal long-term neurodevelopmental impact

SAMHSA, Clinical Guidance for Treating Pregnant and Parenting Women With Opioid Use Disorder and Their Infants, 2018
### Medication-assisted therapy (MAT)

<table>
<thead>
<tr>
<th>Considerations</th>
<th>Buprenorphine</th>
<th>Methadone</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Selection</td>
<td>May be preferable for patients who are new to treatment because it is easier</td>
<td>May be preferable for patients who do not like or want buprenorphine</td>
</tr>
<tr>
<td></td>
<td>to transfer from buprenorphine to methadone (it can be very difficult to</td>
<td>treatment or who have requested this medication.</td>
</tr>
<tr>
<td></td>
<td>transfer from methadone to buprenorphine), who do not like or want methadone,</td>
<td></td>
</tr>
<tr>
<td></td>
<td>or who have requested this medication.</td>
<td></td>
</tr>
<tr>
<td>Care</td>
<td>Includes a prenatal healthcare professional, parenting classes, and SUD</td>
<td>Includes a prenatal healthcare professional, parenting classes, and SUD</td>
</tr>
<tr>
<td></td>
<td>treatment.</td>
<td>treatment.</td>
</tr>
<tr>
<td>Dispensing</td>
<td>May be prescribed in an office setting with weekly or biweekly</td>
<td>Requires daily visits to a federally certified opioid treatment program;</td>
</tr>
<tr>
<td></td>
<td>prescribing/dispensing or provided in an opioid treatment program.</td>
<td>take-home medication is provided for patients meeting specific</td>
</tr>
<tr>
<td>Treatment Retention</td>
<td>Some studies show treatment dropout is higher than that for</td>
<td>requirements.</td>
</tr>
<tr>
<td></td>
<td>methadone.</td>
<td></td>
</tr>
</tbody>
</table>

### Counseling about MAT effects on infants

| Risk of NAS          | Approximately 50% of exposed neonates are treated for NAS; NAS may be      | Approximately 50% of exposed neonates are treated for NAS.                |
|                      | milder with buprenorphine compared with full mu opioid agonists such as    |                                                                           |
|                      | most opioid analgesics and methadone.                                      |                                                                           |
| Time to NAS Onset    | American Academy of Pediatrics (AAP) recommends monitoring                | AAP recommends monitoring prenatal opioid-exposed neonates for a           |
|                      | prenatally opioid-exposed neonates for a minimum of 4–7 days after        | minimum of 4–7 days after delivery (Hudak, Tan, & AAP, 2012).             |
|                      | delivery (Hudak, Tan, & AAP, 2012).                                        |                                                                           |
| Duration of NAS      | Most studies show shorter NAS duration compared with methadone.           | Most studies show longer NAS duration compared with buprenorphine.        |
| Breastfeeding        | Generally safe if the mother is stable and the ABM Clinical Protocol #21   | Generally safe if the mother is stable and the ABM Clinical Protocol #21   |
| Considerations       | breastfeeding with SUD guidelines are met.                                  | breastfeeding with SUD guidelines are met.                                |
Contraception and OUD

• Women of reproductive age who have OUD experience a high rate of unintended pregnancy (Heil et al., 2011)

• One study found that only about half of the women with current opioid use were using contraception (Terplan, Hand, Hutchinson, Salisbury-Afshar, & Heil, 2015)

• Postpartum period is especially vulnerable time to return to substance use

SAMHSA, Clinical Guidance for Treating Pregnant and Parenting Women With Opioid Use Disorder and Their Infants, 2018

More on contraception

• Observational study over 3 years comparing women with chronic condition receiving prescription contraceptive vs women without chronic condition

• Conclusion: Despite a greater risk for adverse outcomes with an unplanned pregnancy, women with these chronic conditions were less likely to receive prescription contraception

Receipt of Prescription Contraception by Commercially Insured Women With Chronic Medical Conditions, Journal of Obstetrics & Gynecology, 2014
Check for use of teratogenic medications

- Systemic retinoids
- Anticonvulsants
- Warfarin
- ASA, NSAIDS in first trimester
- ACE inhibitors, ARBs
- Statins
- SSRIs, antipsychotics

- No more FDA pregnancy risk categories: revised labeling is coming
Consider a case

You are seeing a couple in their mid-30s who desire pregnancy. No known family history of any genetic disorders. They are concerned about their risks of genetic conditions given their age and ask what testing is recommended before they try to conceive.

Summary of Use during Lactation:

Because of the low levels of buprenorphine in breastmilk, its poor oral bioavailability in infants, and the low drug concentrations found in the serum and urine of breastfed infants, its use is acceptable in nursing mothers. Monitor the
Polling Question 7:
Which of the following is NOT recommended by ACOG as part of routine preconception care?

a. Counsel all patients about the decision to get carrier screening
b. Offer spinal muscular atrophy (SMA) carrier screening to all women
c. Offer cystic fibrosis carrier screening to all women
d. Check a CBC to assess for anemia and screen for hemoglobinopathies in all women
e. Offer Fragile X carrier screening to all women
f. Offer Tay-Sachs screening if either member of a couple is of Ashkenazi Jewish, French–Canadian, or Cajun descent

ACOG Committee Opinion Number 691: Carrier Screening for Genetic Conditions, 2017

Preconception carrier screening

Analyzes genes for conditions you might pass on to a child

Primary purpose is to inform reproductive decision-making

Carrier screening is different from NIPS (noninvasive prenatal screening) which tests for chromosome conditions in a current pregnancy

ACOG FAQ179: Carrier Screening, 2018
Options for preconception carrier screening

**All:** carrier screening for CF, hemoglobinopathies, SMA

**Targeted:** based on ethnicity or family history
  - Fragile X, Tay-Sachs

**Expanded** carrier screening (ECS): screen for many disorders using a single sample without regard to race or ethnicity
  - Offered by commercial companies, ex) Counsyl, Natera

Counseling around ECS

- No genetic test can identify all DNA changes with disease potential
  - Carrier screening can only be used to reduce the risk of having a child with some diseases
- Many genetic diseases caused by random DNA errors
- Might find out unexpected information
- Almost everyone carries at least one genetic disease, so chances are the test will come back ‘positive’ for something
  - Options to test one person, then partner (consider cost, anxiety); or test both simultaneously

ACOG FAQ179: Carrier Screening, 2018

Polling Question 8:
Which of the following is NOT recommended by ACOG as part of routine preconception care?

a. Counsel all patients about the decision to get carrier screening
b. Offer spinal muscular atrophy (SMA) carrier screening to all women
c. Offer cystic fibrosis carrier screening to all women
d. Check a CBC to assess for anemia and screen for hemoglobinopathies in all women
e. **Offer Fragile X carrier screening to all women**
f. Offer Tay-Sachs screening if either member of a couple is of Ashkenazi Jewish, French–Canadian, or Cajun descent

ACOG Committee Opinion Number 691: Carrier Screening for Genetic Conditions, 2017

Practice Recommendations

1. Check for use of teratogenic medications as part of preconception care, and change to safer medications if possible. Use the fewest medications at the lowest dose to control disease (SORT C)

2. Counsel patients with diabetes mellitus about the importance of glycemic control before conception. Assist patients in achieving an A1C level as close to normal as possible to reduce the risk of congenital anomalies (SORT A)

3. Assess the patient’s risk of chromosomal or genetic disorders based on family history, ethnic background, and age; offer cystic fibrosis and other carrier screening as indicated (SORT C)
Resources

Information for providers and patients
https://www.cdc.gov/ncbddd/index.html
https://beforeandbeyond.org
https://www.acog.org/Womens-Health/Prepregnancy-Counseling-and-Interpregnancy-Care

Mobile app- preconception care quick reference

Resources

AAFP articles on preconception care
https://www.aafp.org/afp/2013/1015/p499.html
Resources

Clinical Guidance for Treating Pregnant and Parenting Women With Opioid Use Disorder and Their Infants


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Questions
First Trimester Pregnancy Complications

Carrie Pierce, MD
Julie Johnston, MD, FAAFP

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All individuals in a position to control content for this session have indicated they have no relevant financial relationships to disclose.

The content of my material/presentation in this CME activity will include discussion of unapproved or investigational uses of products or devices as indicated: We will be discussing the most effective evidence-based regimen for medication management of early pregnancy loss (EPL), which includes mifepristone and misoprostol. Both medications are approved by the FDA for other uses, and are used off-label for the treatment of EPL. These products should not be considered “investigational”, as they are commonly used to treat EPL.

Carrie Pierce, MD

Faculty, Cascades East Family Medicine Residency, Klamath Falls, Oregon

Dr. Pierce is a graduate of Rush Medical College in Chicago, Illinois. She completed her residency at the University of Illinois-Chicago Advocate Illinois Masonic Medical Center Family Medicine Residency and a reproductive health care and advocacy fellowship at the Reproductive Health Access Project in New York, New York. Dr. Pierce enjoys practicing the full scope of family medicine, from newborns to geriatric patients. Her passion is reproductive health care, helping women and families plan when and whether to have children, and subsequently helping them have the healthiest pregnancies and babies possible.
Julie Johnston, MD, FAAFP

Medical Director, Health Quarters, Lawrence, Massachusetts; Faculty, Lawrence Family Medicine Residency, Massachusetts

Dr. Johnston is a graduate of Brown University’s Alpert Medical School in Providence, Rhode Island. She completed her residency at Lawrence Family Medicine Residency, Massachusetts, and participated in the Physicians for Reproductive Health Leadership Training Academy. At Lawrence Family Medicine Residency, she coordinates the women’s health rotation and the women’s health area of concentration. Her areas of interest include the empowerment of women, reproductive health access, immediate postpartum long-acting reversible contraception provision, and political action. Dr. Johnston served as the 2018 women’s delegation co-convener and delegate for the National Conference of Constituency Leaders (NCCL). In addition, she has leadership roles at the state level, including serving as the family medicine representative on the Massachusetts Department of Public Health Perinatal Advisory Committee and the Special Legislative Commission on Postpartum Depression.

Learning Objectives

1. Detect abnormalities during the first trimester of pregnancy that vary from the normal progression of pregnancy.

2. Differentiate between possible causes of first trimester bleeding, including ectopic pregnancy and miscarriage.

3. Compare the risks and benefits of expectant management vs. medical or surgical intervention.

4. Provide appropriate follow-up care and make referrals to mental health professionals when necessary.
Why you should care about early pregnancy problems

- Pregnancy is a common need for an office visit
- 25% of women experience bleeding in the first trimester*
- Even if you don’t do prenatal care/OB, you probably see patients who can get pregnant (and they will come to you with early pregnancy problems)

*Hendricks, Am Fam Phys 2019
Not all bleeding in pregnancy is early pregnancy loss (EPL)

- Subchorionic hemorrhage
- Cervical polyp
- Vaginitis or cervicitis
- Cervical/vaginal trauma

Case 1

- 32yo G2P1001
- EGA 7 weeks by sure LMP
- Talks with on-call provider at 0530 because she’s started having vaginal bleeding
  - No cramping
  - Started light with wiping after urinating, got heavier, still lighter than a period
  - Hemodynamically stable by history
POLL QUESTION 1

What advice should this patient receive?

A: "It sounds like you might be having a miscarriage, you should go to the ER right away."
B: “There are a lot of reasons for bleeding in pregnancy. I’d like to see you in the office today so we can do further evaluation.”
C: “Bleeding in pregnancy is really common, so this is nothing to worry about. I’ll see you in 2 weeks for your OB appointment.”

Bleeding in pregnancy doesn’t have to mean an ER visit

• Bleeding doesn’t necessarily mean EPL
• EPL can’t be stopped in the ER (or anywhere else)
• ER visits for bleeding in early pregnancy are a big cost to health care system
  • ~1.5% of ALL ER visits in US*

*Wittels AJOG 2008
Reasons to seek ER care with bleeding in early pregnancy

• Hemodynamic instability
• Ectopic symptoms
  • Severe pelvic pain
  • Acute abdomen
  • Unilateral pelvic pain, +/- radiating to shoulder
  • Adnexal mass*

*adnexal mass can be worked up outpatient if patient is stable and can get urgent ultrasound outside of ER

Back to our patient

• 32yo G2P1001
• EGA 7 weeks by sure LMP
• Light-moderate bleeding, no cramping

• Other information you want to know
  • Blood type?
  • Has she had an ultrasound so far this pregnancy?
  • Has she had blood tests so far this pregnancy?
You see her in the office later the same day

- Vitals stable.
- Abdomen soft, nontender, nondistended.
- No adnexal masses, uterus size approx 6-7 weeks EG
- Speculum: no products of conception (POCs) seen. Os closed. No active bleeding seen.

reproductiveaccess.org/resource/first-trimester-bleeding-algorithm/  Nov 2017
Our patient’s ultrasound

Mean sac diameter = 20mm

Image from Office Management of Early Pregnancy Loss- Presentation of Reproductive Health Access Project, by permission with CC BY-NC-SA 4.0

Viable 7 week pregnancy

Image from X.Compagnion,
https://commons.wikimedia.org/w/index.php?curid=840791, used with permission by CC BY 2.5
Our patient has a probable EPL

• If pt does not want to stay pregnant: treat now as likely miscarriage

• If pt does want to stay pregnant:
  • Repeat US in 2 weeks- if still no fetal pole, definite EPL
  OR
  • check serum progesterone level
    • Progesterone < 6 ng/ml excludes viable pregnancy*

*Hendricks, Am Fam Phys 2019
Back to our patient- her preferences and feelings

• Strongly desires this pregnancy
• Wants resolution ASAP

• Shared decision making: check progesterone level today (and Rh and hgb)

• Wants to talk about results in person
  • You arrange for serum draw today, appt tomorrow to follow up

The next day

• Results: Rh negative, Progesterone level 7ng/ml
• Rh negative:
  • Insufficient evidence to recommend Rho D immunoglobulin for threatened abortion (bleeding in first trimester)
  • RhoD immunoglobulin IS indicated for EPL, ectopic, abdominal trauma, or when uterine aspiration is performed
• Our patient opts against Rho D immunoglobulin today.
• When to repeat ultrasound?
When to repeat ultrasound?

• If no embryo 2 weeks from first US, EPL is confirmed

• “But I can’t live with this anxiety for 2 weeks!”

• Shared decision making: repeat US in 1 week, knowing that if GS > 25mm (was 20mm last time), EPL is diagnosed
Our patient’s ultrasound (1 week after initial)

Mean sac diameter 28mm

*Image from Office Management of Early Pregnancy Loss- Presentation of Reproductive Health Access Project, by permission with CC BY-NC-SA 4.0*

Our patient has an intrauterine anembryonic pregnancy

- One variety of EPL- no embryonic tissue
- Cannot become a viable pregnancy
- Will eventually have spontaneous abortion
Treatment options for early pregnancy loss

- Expectant management
- Medical management
- Procedural management- office-based uterine aspiration or OR D&C

Expectant management

- “Watch and wait”
- Very effective for incomplete abortion (some but not all products of conception passed)
- Less effective for anembryonic pregnancy or embryonic demise, but still > 50%
  - Up to 80% at 8 weeks*
- More days of bleeding and longer time to resolution than procedural management

*ACOG Prac Bull on EPL, 2018
Expectant management

- Pain management- NSAIDs +/- narcotic

- Contraindications:
  - Hemodynamic instability
  - Relative:
    - Anemia
    - Bleeding/clotting disorder
    - Social factors
    - Infection

Medication management

- Most effective regimen:
  - Mifepristone 200mg PO*
  - 24 hours later: misoprostol 800mcg vaginal or buccal

- Misoprostol alone:
  - Common regimen: 800mcg misoprostol buccal or vaginally, repeat at 24-48 hours if no (or inadequate) bleeding and cramping

* more on mifepristone to come
Medication management

- Pain control - similar to expectant management
  - NSAIDs, maybe narcotics
- Contraindications:
  - Same as expectant management, + allergy to meds
- Follow up - approx 1 week
  - Beta hcg or ultrasound to confirm completion

Medication management

- No benefit over expectant management for incomplete abortion (bleeding, os open)
- Improves efficacy for embryonic demise or anembryonic gestation
- Overall efficacy after 2-3 days*
  - mifepristone + misoprostol 84%
  - misoprostol alone 67%

*Shriever NEJM 2018
Procedural management in office

• Efficacy > 99%
• Contraindications
  • Hemodynamic instability
  • Severe anemia

Image from Office Management of Early Pregnancy Loss- Presentation of Reproductive Health Access Project, by permission with CC BY-NC-SA 4.0

Procedural management in OR

• Same as in office, but can provide additional anesthesia
• Good for pts with contraindications to outpatient management- ie severe anemia, bleeding disorder, etc
Cost of different options

- Most expensive: Procedure in operating room
- middle: procedure in office
- inconsistent data: expectant management and medical management (though in one study medical management was least expensive)

*ACOG Prac Bull EPL, 2018

POLL QUESTION 2

What is the best treatment option for our patient?
A: Expectant management. This is a natural process and she doesn’t need us to intervene
B: Medication management. She can take medicines in the comfort of her own home and complete her miscarriage privately.
C: Procedural management in the office. She can be done with this as quickly as possible, and in a familiar setting.
D: Procedural management in the OR. She can be done with this process quickly, and have more anesthesia options than the office
E: Whichever option she chooses is fine.
Our pt picks med mgmt

- Set patient expectations:
  - Bleeding- heavier than menses
  - misoprostol side effects - diarrhea, nausea, vomiting, shivering, low-grade temp elevation
  - if no significant bleeding in 24 hours, repeat misoprostol

- When to call
  - soaking 2 pads/hr for 2 consecutive hours
  - severe pain not improving w NSAIDs, pain meds
  - fever > 100.4
  - no bleeding in 24 hours (or 48 if 2 doses of miso)

Our patient- follow up

- Comes back in a week
- US in office is non-pregnant.
- She desires pregnancy again right away, continues prenatal vitamin, no further follow up needed
- Emotionally doing well, declines mental health resources
Would emphasize in the notes that not all desired pregnancies that end in miscarriage choose to try for pregnancy quickly. Always offer birth control. There is no set time to wait after a miscarriage to try again.

Julie Johnston, 7/15/2019

i had these points later on, will move that slide to follow closer to here

carrie pierce, 7/15/2019
General after care

• Okay to get pregnant again right away, but many women want to wait (or didn’t desire the pregnancy in the first place)
  • Always assess contraceptive needs

• Mental health
  • wide variety of emotional reactions to EPL
  • assess coping skills, social support, need for formal counseling

POLL QUESTION 3

Which of the following has been shown to help prevent EPL?
A: Pelvic rest
B: Bed rest
C: Progesterone supplementation
D: None of the above
E: All of the above
Case #2

- G3P1011 at 5 weeks by approximate LMP
- spotting x 2 days
- mild cramps intermittently

hcg = 1000 mIU/ml

Image from Nevit, commons.wikimedia.org/wiki/File:Ultrasound_Scan_ND_1230114207_1146150.png, used with permission by CC BY-SA 1.0

reproductiveaccess.org/resource/first-trimester-bleeding-algorithm/  Nov 2017
Case 2

repeating hcg in 48 hours *

viable pregnancy = increase > 53%
EPL= decrease > 21-25%
ectopic= anything between these ranges

Our patient- hcg now 2000 (viable pregnancy)
Ultrasound confirmation recommended

*Seeber, Obstet Gynecol, 2006
When to suspect molar pregnancy/gestational trophoblastic disease

• beta hCG level much higher than anticipated
• uterus larger than expected for dates
• hyperemesis gravidarum
• pregnancy-associated hypertension before 20 weeks
• molar pattern on ultrasound

NUTS AND BOLTS

• Billing
• Coding
• Using mifepristone for EPL
• Resources for patients
ICD 10 codes for first-trimester complications

- Early pregnancy loss
  - O03.9 Spontaneous pregnancy loss
  - O03.4 Incomplete spontaneous abortion without complication
  - O02.1 Embryonic demise
  - O02.0 Anembryonic pregnancy

- Others
  - O20.0 Threatened abortion
  - O01.9 Trophoblastic disease
  - O00.10 Tubal pregnancy without intrauterine pregnancy
  - O00.80 Other ectopic pregnancy without intrauterine pregnancy

Billing

- E&M codes as appropriate

- CPTs for Point-of-Care Ultrasound:
  - 76817 Transvaginal ultrasound, pregnant uterus
  - 76815 Limited ultrasound, pregnant uterus
  - 76801 Ultrasound for pregnancy viability

- CPTs for surgical management of EPL:
  - 59820 Treatment of missed abortion (surgical)
  - 59812 Treatment of incomplete abortion (surgical)
  - 64435 Paracervical nerve block
Billing

- Medication codes
  - J2000 Lidocaine
  - J2210 Methergine
  - 90384 Rhogam 300mcg (full dose, for use after 12 weeks gestational age)
  - 90385 MicRhoGam 50mcg (for use before 12 weeks gestational age)
  - S0191 Misoprostol, 200mcg
  - S0190 Mifepristone, oral, 200 mg

- Laboratory codes (ie, urine pregnancy test, Rh typing) as appropriate

What was that you said about mifepristone again?

- Mifepristone has a REMS
- REMS = Risk Evaluation and Mitigation Strategies
  - FDA classification for medications with serious safety concerns
    - Isotretinoin
    - many anti-neoplastic agents
    - thalidomide
- Mifepristone REMS in not evidence-based
  - AAFP policy supports removing it
What does REMS mean for mifepristone access?

- Sold to physicians, NOT to pharmacies
- Only 1 company currently sells it in the US
- To get mifepristone for your office:
  - Fill out Prescriber Agreement Form (on website) and fax back
  - Distributor will call to confirm account and arrange first order

What does REMS mean for mifepristone access?

- Not so hard to do!
  - One prescriber with valid agreement can oversee use of medication by all prescribers in the office (or clinic/hospital network)
  - Company accepts expired pills for refund or exchange (shelf-life 18 mo)
  - 24/7 hotline staffed by physicians- 1-877-432-7596
  - Improves care for patients dealing with EPL
Patient information and counseling resources

Reproductive Health Access Project, reproductiveaccess.org
- patient info sheet comparing expectant, medication, and procedural management of EPL
- detailed patient info sheets on each of the above options

All Options Talkline- 1-888-493-0092- general counseling for EPL
Faith Aloud counseling line- 1-888-717-5010- Faith-based counseling for EPL

Recommended practice changes

• Recognize signs and symptoms of normal vs abnormal first trimester pregnancy
• Use exam, laboratory, and imaging data to differentiate between miscarriage, ectopic pregnancy, and other bleeding in the first trimester
• Offer all women in the process of miscarriage full management options including expectant management, medical management, and procedural management
References


W Biggs et al. Diagnosis and Management of Adnexal Masses. Am Fam Phys. 2016; 93(8)


B Seeber et al. Suspected ectopic pregnancy. Obstet Gynecol 2006 Feb;107(2 Pt 1)


Questions
Figure 1. Evaluation of first trimester bleeding

Bleeding in desired pregnancy, < 12 weeks gestation

Physical exam

- Peritoneal signs or hemodynamic instability
  - Transfer to ED

- Non-obstetric cause of bleeding identified
  - Diagnose and treat as indicated

- Products of conception (POC) visible on exam
  - Incomplete abortion, treat as indicated

- Patient stable, no POC or other causes of bleeding
  - Transvaginal ultrasound (TVUS) and β-hCG level

  - Ectopic or signs suggestive of ectopic pregnancy
    - Presume ectopic; refer for high-level TVUS and/or treatment

  - Viable intrauterine pregnancy (IUP)
    - Threatened abortion; repeat TVUS if further bleeding

  - Nonviable IUP
    - Embryonic demise, anembryonic gestation or retained POC; discuss treatment options

  - IUP, viability uncertain
    - Repeat TVUS in 7-14 days and/or follow serial β-hCG’s; consider progesterone levels

  - No IUP, no ectopic seen
    - IUP seen on prior TVUS
      - Repeat TVUS
      - Yes
      - Completed abortion; expectant management
      - No
      - See Figure 2 (PUL)
**Figure 2. Evaluation of first trimester bleeding in Pregnancy of Unknown Location (PUL)**

- **No intrauterine (IUP) or ectopic pregnancy seen on transvaginal ultrasound (TVUS):**
  - IUP seen on prior TVUS? Yes → Completed abortion; expectant management
  - No → PUL
  - Initial $\beta$-hCG $> 3000^*$ → Bleeding history not consistent with having passed POC → Ectopic precautions, repeat $\beta$-hCG in 48 hrs
  - Initial $\beta$-hCG $< 3000^*$ → Repeat $\beta$-hCG in 48 hrs

**Initial $\beta$-hCG $> 3000^*$**
- Bleeding history consistent with having passed POC → Repeat $\beta$-hCG fell $\geq 50%$
- Ectopic precautions, repeat $\beta$-hCG in 48 hrs

**Initial $\beta$-hCG $< 3000^*$**
- Repeat $\beta$-hCG fell $\geq 50%$
  - Suggests resolving PUL; ectopic precautions, follow $\beta$-hCG weekly to $< 5$ mIU/mL**
  - Suggests early pregnancy loss or ectopic; Serial $\beta$-hCGs +/- high-level TVUS until definitive diagnosis or $\beta$-hCG $< 5$ mIU/mL**
- Repeat $\beta$-hCG rose $> 40%$***
  - Suggests viable pregnancy but does not exclude ectopic; Follow $\beta$-hCG until $> 1500 – 3000^*$, then TVUS for definitive diagnosis

- Bleeding history not consistent with having passed POC → Concerning for ectopic but does not exclude early IUP or retained POC; Obtain high-level TVUS and serial $\beta$-hCGs. Consider urgent referral for evaluation and treatment of ectopic pregnancy

- Ectopic precautions, repeat $\beta$-hCG in 48 hrs

---

* the $\beta$-HcG level at which an intrauterine pregnancy should be seen on transvaginal ultrasound is referred to as the discriminatory zone and varies between 1500-3000 mIU depending on the machine, the sonographer, and number of gestations.

** $\beta$-hCG needs to be followed to zero only if ectopic pregnancy has not been reliably excluded. If a definitive diagnosis of completed miscarriage has been made, there is no need to follow further $\beta$-hCG levels.

*** In a viable intrauterine pregnancy, there is a 99% chance that the $\beta$-hCG will rise by at least 33-49% in 48 hours depending on the initial $\beta$-hCG values.
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The content of my material/presentation in this CME activity will include discussion of unapproved or investigational uses of products or devices as indicated: We present a number of off-label uses – not necessarily yet approved by the FDA, but all backed in strong evidence-based medicine.

Sarah McNeil, MD, FAAFP

Core Faculty, Contra Costa Family Medicine Residency, Martinez, California; Assistant Clinical Faculty, University of California, San Francisco (UCSF)

Dr. McNeil is a graduate of Dartmouth College’s Geisel School of Medicine in Hanover, New Hampshire. She completed her family medicine residency at Contra Costa Regional Medical Center in Martinez, California, where she served as chief resident. She also completed the UCSF Faculty Development Fellowship. At the Contra Costa Family Medicine Residency, Dr. McNeil leads the reproductive health curriculum, staffs labor and delivery, precepts residents in the family medicine clinic, and attends at the urgent care clinic. She is active in reproductive health advocacy work and serves on the Committee on Continuing Professional Development for the California Academy of Family Physicians.
Catherine Romanos, MD, FAAFP

Physician, Women’s Med Center, Dayton, Ohio; Community Preceptor, Grant Family Medicine Residency Program, Columbus, Ohio

Dr. Romanos earned her undergraduate degree in Spanish literature from New York University and her medical degree from the University of Connecticut School of Medicine. She completed a residency in family medicine at the Lawrence Family Medicine Residency Program in Massachusetts, where she then served as a faculty member until moving to Columbus, Ohio, six years ago. Since then, she has practiced abortion care throughout the state of Ohio, including surgical termination and medication abortion. As a preceptor for family medicine residents, she enjoys bringing her reproductive health interests to the primary care setting. Dr. Romanos is a graduate of the Physicians for Reproductive Health Leadership Training Academy and is an advocate for abortion rights.

Learning Objectives

1. Characterize the safety and efficacy of medical abortion care in the family medicine setting.

2. Identify patients who need additional evaluation with ultrasound prior to medical abortion care.

3. Identify the rare complications of medical abortion and appropriate management of those complications.
Ground rules

- Our common understanding is: abortion is a safe and legal medical procedure.
- We support our patients’ decisions to continue or terminate pregnancies without judgement or shame.
- We will not use this session to discuss options counseling prior to pregnancy termination.
Case #1: Linda

- 30yo G3P2 who has a sure LMP that puts her at 7w4d gestation.
- “We talked it over and decided that we can’t have another baby, that adoption is not an option for us, and we really need to be referred for an abortion.”

Medication & aspiration abortion: both safe and effective
<table>
<thead>
<tr>
<th>Medication abortion</th>
<th>Vacuum aspiration</th>
</tr>
</thead>
<tbody>
<tr>
<td>High success rate (96-99%)</td>
<td>High success rate (99%)</td>
</tr>
<tr>
<td>Usually avoids instrumentation</td>
<td>Instruments inserted into the uterus</td>
</tr>
<tr>
<td>Requires at least two visits</td>
<td>Can be done in one visit</td>
</tr>
<tr>
<td>Abortion usually within 24hrs of second med</td>
<td>Procedure completed in 5-10 minutes</td>
</tr>
<tr>
<td>May be used in early pregnancy</td>
<td>May be used in early pregnancy</td>
</tr>
<tr>
<td>Oral pain medication</td>
<td>Anesthesia/Sedation can be used</td>
</tr>
<tr>
<td>Happens at home</td>
<td>Done in a medical office or clinic</td>
</tr>
<tr>
<td>Medications cause a process similar to miscarriage</td>
<td>Clinician performs the procedure</td>
</tr>
</tbody>
</table>

### Different medication regimes

- **Mifepristone + Misoprostol**: 96-99%
- **Methotrexate + Misoprostol**: 88-96%
- **Misoprostol alone**: 75-90%

Medical Management of First Trimester Abortion, Society of Family Planning Clinical Guideline, 2014
Case #1: Linda

- 30yo G3P2 who has a sure LMP that puts her at 7w4d gestation.
- “We talked it over and decided that we can’t have another baby, that adoption is not an option for us, and we really need to be referred for an abortion.”

Steps of medication abortion

1. Pre medAB checklist
2. Mifepristone 200mg PO in office then Misoprostol 800mcg buccal 24-48 hours later at home
3. Follow-up to confirm completion
Pre-medAB checklist

- Options counseling
- Consent
- Dating: LMP < 70d
- No contraindications
- Hgb & Rh if indicated
- Access to a telephone and ER
- Ability to confirm completion of med AB

Contraindications to medication AB

- Hemorrhagic disorder or anticoagulant therapy
- Chronic adrenal failure
- Long-term systemic corticosteroids
- Suspected or confirmed ectopic
- Inherited porphyrias
- IUD in place (must be removed before med AB)
- Allergy to mifepristone, misoprostol, or other prostaglandin.
- No access to follow-up
Linda’s eligibility

- LMP < 70 days ago ✔ (7wk by sure LMP c/w exam)
- Hgb > 8-10, Rh ✔ (hgb 9.8; Rh positive)
- Access to a telephone and an ER ✔
- Ability to confirm completion of med AB ✔

She signs the consents, including all clinic/state requirements

To-go bag

- 24hr phone number
- After-care instructions
- Misoprostol 800mcg buccal to be taken at home 24-48hrs after mife
- NSAID (Ibuprofen 800mg)
- Antiemetic
- +/- narcotic
Follow-up

- Linda returns in two weeks; her urine HCG is negative
- She’s so grateful that she didn’t have to be referred out of your clinic
AES Polling Question 1
The failure rate of a medication abortion is:

1. 1%
2. 1-4%
3. 4%
4. 4-6%
5. 6%
Case #2: Linda

• 30yo G3P2 who doesn’t know her last LMP because she’s still breastfeeding.

Pre-medAB checklist

• Options counseling
• Consent
• **Dating: LMP < 70d**
• No contraindications
• Hgb & Rh if indicated
• Access to a telephone and an ER
• Ability to confirm completion of med AB
Dating

Abdominal US shows CRL 11mm = 7w3d

Linda’s eligibility

- LMP < 70 days ago ✔️ (ultrasound confirmed)
- Hgb > 8-10, Rh ✔️ (hgb 9.8; Rh positive)
- Access to a telephone and transportation to an emergency room ✔️
- Ability to confirm completion of med AB ✔️

She signs the Danco consent, as well as all clinic/state requirements
Mifepristone dispensing

- Office must register with Danco and pre-order pills
- Pills come with “Medication Guides” and “Patient Agreement Form”
- Provider administers Mifepristone 200mg PO in the office

Mifepristone
- Causes progesterone blockade
  - Decidual necrosis
  - Cervical ripening
  - Detachment

Misoprostol
- Causes uterine cramping and expulsion
Side Effects

**Mifepristone**
- Mild nausea
- Rare bleeding

**Misoprostol**
- Bleeding (intended)
- Cramping (intended)
- Nausea/Vomiting
- Diarrhea
- Low grade fever
- Chills

AES Polling Question 2
The correct dose of mife/miso is:

1. Mife 800mcg - miso 200mg po
2. Mife 200mg - miso 800mcg buccal
3. Mife 200mcg - miso 800mcg buccal
4. Mife 200mg - miso 800mg po
The correct dose of mife/miso is:

1. Mife 800mcg - miso 200mg po
2. Mife 200mg - miso 800mcg buccal
3. Mife 200mcg - miso 800mcg buccal
4. Mife 200mg - miso 800mg po

Follow-up

- Linda returns in two weeks; she is no longer bleeding; POCUS shows an endometrial stripe.
- She’s so grateful that she didn’t have to be referred out of your clinic
Case #3: Linda

- 30yo G3P2.
- Her pregnancy test at home was positive.
- Thinksher last period was about 4 weeks ago.

Pre-medication checklist

- Options counseling
- Consent
- **Dating: LMP < 70d**
- No contraindications
- Hgb & Rh if indicated
- Access to a telephone and ER
- Ability to confirm completion of med AB
Ultrasound

Indications for ultrasound
- Unsure dates
- Unable to confirm dates by sizing
- Size not consistent with dates
- Any signs of symptoms of and ectopic pregnancy

No ectopic signs/symptoms Normal exam
LMP < 35 days
Positive pregnancy test

< 2000 → evaluate 48 to 72hrs after misoprostol
> 2000 → evaluate or refer for ectopic immediately

>50% drop → abortion complete
<50% drop → evaluate or refer for ectopic immediately

Administer mife 200mg, draw beta hcg that same day
Pregnancy of unknown location (PUL)

- If patient has no signs/symptoms of ectopic and LMP < 4.5 weeks, you can dispense mifepristone 200mg PO and draw a beta hcg that same day.
- If beta hcg > 2000 --> ectopic referral
- If beta hcg < 2000 --> repeat beta hcg 24-48 hours after miso; goal of > 50% drop

Linda

- Takes mifepristone 200mg PO.
- Beta hcg drawn that day: 1050.
- 24-48hrs after her mife, she takes misoprostol 800mcg buccally at home.
- Returns for repeat HCG 24-48 hours after miso
Follow-up

• Linda returns in 72hrs; beta hcg returns at 200.
• She’s so grateful that she didn’t have to be referred out of your clinic

AES Polling Question 3

At follow-up, Linda is worried that she should have gotten antibiotics. You should give her antibiotics now?

1. True
2. False
At follow-up, Linda is worried that she should have gotten antibiotics. You should give her antibiotics now?

1. True
2. False

Case #4: Linda

- 30yo G3P2
- 7w2d by bedside ultrasound.
AES Polling Question 4

Medication abortion has been shown to be safe and effective up to

1. 49 days from LMP
2. 70 days from LMP
3. 77 days from LMP

Medication abortion has been shown to be safe and effective up to

1. 49 days from LMP
2. 70 days from LMP
3. 77 days from LMP
Steps of medication abortion

1. Pre medication checklist complete
2. Mifepristone 200mg PO in office then Misoprostol 800mcg buccal 24-48 hours later at home
3. Follow-up to confirm completion

Call from the ER

• Three days later, Linda has been having heavy bleeding (2 pads already today) and went into her local ER. They call you for advice.
• Vital signs are stable, hgb is 9.2 (down from 9.8).
AES Polling Question 5

What do you advise?

1. Aspiration
2. Repeat miso 800 mcg buccal
3. Follow-up in clinic
4. Patient choice
What do you advise?

1. Aspiration
2. Repeat miso 800 mcg buccal
3. Follow-up in clinic
4. Patient choice

Safety of medication abortion

• Less than 5% of patients using mife/miso before 63 days, required surgical evacuation.

• Medication abortion is not associated with an increased risk of adverse outcomes in subsequent pregnancies

Implementation is the next step!

- Values clarification for staff and admin
- Danco
- Pregnancy dating
- On-call system
- Follow-up

CHAT AND CHEW is coming up!

Practice Recommendations

- Medication abortion is safe and effective
- A preMed AB checklist makes the steps easier
- Dating a pregnancy can be done by a good LMP and bimanual exam
- The meds are: Mifepristone 200mg PO in office then Misoprostol 800mcg buccal 24-48 hours later at home
- Confirmation of completion can be done with ultrasound OR symptoms and a urine pregnancy OR βhcg
- Having good telephone triage is important; bleeding through more than 2 pads/hr for 2 hrs in a row is too much
- It’s important to treat the patient’s symptoms and not the US
Questions?
Contact Information

Sarah McNeil, MD
smcneil@ccfamilymed.com

Catherine Romanos, MD
catherine.romanosmd@gmail.com

References and Resources
• Alan Guttmacher Institute www.agi-usa.org
• Planned Parenthood www.plannedparenthood.org
• Women Help Women www.abortionpillinfo.org
• Reproductive Health Access Project www.reproductiveaccess.org
Questions
Heart Disease in Women: The Real Heartbreak - Disparities in Womens Cardiovascular Health

Maya Bass, MD
Anna Lowell, DO, MPH, AAHIVS

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Maya Bass, MD
Assistant Professor, Department of Family, Community, and Preventive Medicine, Drexel University College of Medicine, Philadelphia, Pennsylvania

Dr. Bass earned her medical degree and completed a family and community medicine residency at Jefferson Medical College (now called Sidney Kimmel Medical College) in Philadelphia, Pennsylvania. She earned a master's degree in stem cell and developmental biology from Wesleyan University in Middletown, Connecticut. In addition to her role at Drexel University College of Medicine, she provides family planning services at South Wind Women's Center in Oklahoma City, Oklahoma. Her main interests are women's health, care for gender nonconforming people, wellness, chronic pain, addiction, underserved care, and family planning.
Anna Lowell, DO, MPH, AAHIVS

Family Physician, Manatee County Rural Health Services Southwest Health Center, Bradenton, Florida

Dr. Lowell earned her medical degree and a Master’s in Public Health degree (MPH) from Nova Southeastern University (NSU) in Fort Lauderdale, Florida. During this time, she had unique opportunities to partner with youth shelters, free clinics, and health centers locally and internationally. She chose family medicine as her career path because she can morph into a listener, observer, teacher, advocate, and healer all in a day’s work! In 2017, she graduated from the Mount Sinai Downtown Residency in Urban Family Medicine in New York City, where she cared for diverse patient populations and chaired the residency’s Advocacy Committee and Community Service Committee. Currently, Dr. Lowell works full-time at a federally qualified health center (FQHC) and is a part-time provider with Planned Parenthood. She provides primary care services with a focus on care of patients living with HIV infection and hepatitis C infection. In 2018, she completed a fellowship through the Physicians for Reproductive Health Leadership Training Academy. She has served as the Florida Academy of Family Physicians Minority Delegate and currently serves as a member of the FAFP Government Relations Committee. She is passionate about addressing health care disparities, especially in medically underserved areas, reproductive health care, LGBTQ care, and global health.

Learning Objectives

1. Implement an evidence-based gender specific risk classification strategy into practice.
3. Identify barriers specific to the risk identification and prevention strategies for female patients.
4. Counsel female patients on the impact of cardiovascular disease in women with a focus on reduction of modifiable risk factors.
Audience Engagement System

Poll Question #1

Which of the following statements is **accurate** per the AHA Scientific Statement on Acute Myocardial Infarction (AMI) in Women?

A. Nausea & vomiting are symptoms of AMI that are more common in women.

B. Women have more obstructive coronary artery disease than men.

C. Variation in clinical presentation does not explain the excess mortality risk in women following AMI.

D. Caucasian women have a higher risk for cardiovascular disease compared to non-Caucasian women.
Answer A was Right

• Women tend to present with *atypical* CVD signs & symptoms
• Women *less likely than men to have obstructive CAD*
• Variations in symptoms do play a role in *delaying care & treatment* which likely play a role in *women’s ↑ mortality risk*
• *Black women, Asian Indian, Hispanic women have ↑ risks of CVD* compared to Caucasian women

1 in 4
American women *die* of heart disease

CDC, NCHS. Underlying Cause of Death 1999-2013 on [CDC WONDER Online Database](https://wonder.cdc.gov), released 2015.
### CVD Disparities

- **Women** undetreated & underserved when it comes to CVD
- CVD long associated as a “**man’s disease**”
  - Men tend to be treated more aggressively & earlier
- **More women than men die** from heart disease in U.S.
  - Women **present later** & have **more extensive disease**

### CVD = Women's #1 Health Threat

- Between **age 45 - 64**:
  - 1 in 9 women develop some form of CVD
  - By age 55, **CVD deaths surpass breast cancer deaths**
- After **age 65+**:
  - Ratio of developing CVD climbs to **1 in 3 women**
## Biopsychosocial Determinants

- CVD death rate **25% higher for Black Women** vs. Caucasian Women (in 2015)
- Black women have **higher prevalence of AMI & CVD** vs. Caucasian women (48% vs. 35%)
- Asian Indian women have **higher mortality rate after AMI**
- Hispanic women have **higher overall risk of AMI & stroke**

## Why Such a Gap?

- Lack of **awareness**
- **Unrecognized** signs, symptoms, & risk factors
- **Women underrepresented** in clinical trials  
  - Generally make up only ~20% of enrolled patients
- **Underuse** of **sex-specific** screening, diagnostic testing, preventative measures & treatment options
Lack of Awareness

- Only 36% of Black women & 34% of Hispanic women knew CVD is their #1 cause of death
  - Vs. 65% of Caucasian women

- Only one third of women recall discussing CVD risks with their physician
  - < 25% of women can name HTN & HLD as CHD risk factors
  - ~90% of PCPs unaware that CHD kills more women vs men

We Don’t See the Signs

- Misperception by patients & physicians that women at inherently low risk for developing heart disease

- Women not referred as often for appropriate diagnostic or therapeutic procedures vs. men

- Women more likely to be misdiagnosed or sent home
  - GI vs. Anxiety
Diagnostic Challenges in Women

- **Smaller coronary arteries & thinner heart walls**
  - Angiography, angioplasty, & CABG more difficult
  - Reduces chances of proper diagnosis & good outcomes

- **Exercise stress test has lower accuracy** in women
  - Due to **older age at presentation**
  - ↑ frequency of **co-morbidities** & ↓ exercise capacity

We Aren’t as Good at Treating Them

- **Lower** utilization rates of coronary angiography & revascularization

- **Less likely to prescribe** ASA, ACEi/ARB, β-blockers, & statin in women post-MI, especially minority women

- **Less likely to be referred** to Cardiac Rehab
CVD Outcomes Worse in Women

- Women with (+) exercise test more likely to have **no further cardiac evaluation** vs. men (62% vs. 38%)

- After STEMI, women have **higher rate of cardiogenic shock & higher in-hospital mortality**

- Women less likely to adhere to prescribed cardiac rehab
  - Due to **patient-level barriers** ie, family responsibilities

Barriers to Care

- Women still more likely to be **primary caretakers** leading to:
  - ↑ Stress
  - ↑ Sleep deprivation
  - ↑ Fatigue
  - ↑ Lack of personal time
  - ↑ Unhealthy eating habits
  - ↑ Sedentary lifestyle
CVD Risk Factors in Women

**Unmodifiable**
1. Family Hx CHD
2. Hx Pre-eclampsia
3. Gestational DM
4. Endometriosis
5. PCOS
6. Age 55+
7. Post-menopause

**Partially Modifiable**
1. HTN*
2. HCHOL
3. DM*
4. High Stress*
5. Chronic Conditions
6. OSA

**Modifiable**
1. BMI 26+*
2. Smoking*
3. Sedentary Lifestyle
4. Unhealthy Diet

Cardiovascular Disease in Women, Volume: 118, Issue: 8, Pages: 1273-1293, DOI: (10.1161/CIRCRESAHA.116.307547)
Women May Have CVD Risk Factors that Men Don’t

- Oral contraceptive or HRT use
- PCOS; endometriosis; early menarche
- Pregnancy & its complications
  - Gestational HTN/DM, pre-eclampsia
- Post-menopausal status; prior hysterectomy

Mechanisms of CVD in Women

- Abnormal coronary reactivity, microvascular dysfunction, plaque erosion, distal microembolization
- Differences in hormones
  - Post-menopause → ↑ total cholesterol, ↑ BP
- Differences in management of psychosocial stress
- Autonomic influences
- Certain autoimmune diseases
CVD Can Be “Silent Killer”

**Women**
- Chest pressure/tightness
- Nausea/Vomiting
- Fatigue
- Dizziness
- Abdominal pain
- **No symptoms**

**Men**
- Squeezing chest pain
- Angina
- Cold sweats

**More likely to be triggered by mental stress, non-exertional**

**More likely to be triggered by physical exertion**

Poll Question #2

Which screening measure has the most impact on assessing women’s CVD risk?

A. Screening EKG in asymptomatic women
B. CVD Risk Calculator ie, Framingham risk score
C. High sensitivity C-reactive protein (hs-CRP) blood test
D. CT-derived coronary artery calcium (CAC) score
E. The History and Physical
### Cardiovascular Disease Risk: Screening With Electrocardiography

**Release Date: June 2018**

**Recommendation Summary**

<table>
<thead>
<tr>
<th>Population</th>
<th>Recommendation</th>
<th>Grade (What’s This?)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adults at low risk of CVD events</td>
<td>The USPSTF recommends against screening with resting or exercise electrocardiography (ECG) to prevent cardiovascular disease (CVD) events in asymptomatic adults at low risk of CVD events.</td>
<td>D</td>
</tr>
<tr>
<td>Adults at intermediate or high risk of CVD events</td>
<td>The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of screening with resting or exercise ECG to prevent CVD events in asymptomatic adults at intermediate or high risk of CVD events. See the Clinical Considerations section for suggestions for practice regarding the I statement.</td>
<td>I</td>
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</table>

### Cardiovascular Disease: Risk Assessment With Nontraditional Risk Factors

**Release Date: July 2018**

**Recommendation Summary**

<table>
<thead>
<tr>
<th>Population</th>
<th>Recommendation</th>
<th>Grade (What’s This?)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adults</td>
<td>The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of adding the ankle-brachial index (ABI), high-sensitivity C-reactive protein (hsCRP) level, or coronary artery calcium (CAC) score to traditional risk assessment for cardiovascular disease (CVD) in asymptomatic adults to prevent CVD events. See the Clinical Considerations section for suggestions for practice regarding the I statement.</td>
<td>I</td>
</tr>
</tbody>
</table>
CVD Screening in Women

• Assessment of CVD risk is foundation of primary prevention

• Risk assessment must be sex-specific
  – Risk factors & their relative importance differ between women & men

• Hormonal status, diabetes, smoking, & family hx of premature CHD appear to be more important in women

CVD Risk Assessment

1. **History**: PMHx, FHx, SHx, & Pregnancy Complication Hx
2. **Symptoms** of CVD
3. **Depression screening** in women with CVD
4. **Physical Exam**: including BP, BMI, waist size
5. **Lab tests**: including fasting lipoproteins, glucose
6. CVD Risk Assessment **Calculator**
Patient Case

- RG is a 65 y.o. Black woman establishing care with you.
- Hx: Currently lives with her female partner & their dog. Denies ever smoking & does Qi Gong 5 days a week. No FHx of CHD.
- Medication: Alendronate for osteoporosis.
- You ask her if she has had any pregnancy complications?
  - She had 3 spontaneous vaginal deliveries (SVD).
  - Last delivery induced at 39 weeks for pre-eclampsia.

Poll Question #3

What history detail most increases her CVD risk?

A. Qi gong practice
B. Hx of pre-eclampsia
C. Sexual Orientation
D. Osteoporosis status
E. Having more than 2 pregnancies
Current CVD Prediction Models

- ID pts more likely to develop CVD within defined period
- Based on Framingham CHD Risk Score
  - Study conducted in mostly Caucasian male patients
- Do NOT:
  - Consider lifetime risk
  - Include FHx premature CHD or reproductive factors
  - Include race, socioeconomic status, geographic info

2019 ACC/AHA Guideline on Primary Prevention of CVD

- Suggests race- & sex-specific Pooled Cohort Equation (PCE) (ASCVD Risk Estimator Plus) to estimate 10-year ASCVD risk for asymptomatic adults aged 40-79 years
  - Low Risk (<5%)
  - Borderline (5 to <7.5%)
  - Intermediate (≥7.5 to <20%)
  - High (≥20%)
Back to RG’s Case...

- Recall: 65 y.o., Black female, non-smoker, no FHx premature CHD, (+) hx of pre-eclampsia.
- Her PHQ-2 score is 0. BP is 120/80. BMI is 26.
- Her ROS and physical examination is normal.
- Labs reveal: Total cholesterol of 200 mg/dL, HDL 40 mg/dL, LDL 100 mg/dL, and triglycerides of 145 mg/dL. A1C of 5.6%.
Take out your phones & Calculate her CVD risk

Think about recommendations you would discuss in regards to her CVD health...

Poll Question #4

What recommendation would you make to RG?
A. Refer for cardiac rehab program
B. Start aspirin 81 mg
C. Consider statin therapy
D. Supplement vitamin E
E. Start hormone replacement therapy
Answer C was Right

- **Use Your Clinical Judgment**
- Her 10-year ASCVD Risk is **7.3% (borderline)**
  - Consider low or moderate intensity statin since she has (+) “risk-enhancing factor” with hx of pre-eclampsia
  - Emphasize **lifestyle modification** to maintain her healthy BMI, BP, lipid, glucose levels
  - ASA 81 mg NOT necessary unless ASCVD risk ≥10%

Source:
https://www.ahajournals.org/doi/10.1161/CIR.00000000000000625
CVD Treatment

- **Primary/Secondary** Interventions
  - Remember unique **non-modifiable** risk factors
- **Address Modifiable Risk Factors**
  - ie, Women significantly less likely to meet Federal Guidelines for Physical Activity
  - 39% of Caucasian women vs. 57% of non-Caucasian do not get enough exercise
2019 ACC/AHA Guideline on Primary Prevention of CVD

- Emphasizes patient-physician shared decisions
- Multidisciplinary team-based approach
- Sensitivities to social determinants of health
  - Barriers to care
  - Limited health literacy/education level
  - Financial distress
  - Cultural influences
  - Other socioeconomic risk factors

Source: https://www.heart.org/-/media/files/health-topics/cholesterol/chlstrmngmntgd_181110.pdf
Lifestyle Changes in Women

- **Control BMI, BP, lipid, & glucose**
  - ↓ by 500 kcal or 800-1500 kcal/day
  - Mediterranean Diet; DASH Diet

- **High levels of physical activity**
  - 200-300 minutes/week

- **Clinically meaningful weight loss (≥ 5% initial wt.)**
  - Goal waist size <35 inches

- **Smoking Cessation, Limit Alcohol, & Stress Reduction**

---

**Recommendation Summary**

**Summary of Recommendation and Evidence**

<table>
<thead>
<tr>
<th>Population</th>
<th>Recommendation</th>
<th>Grade (What's This?)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adults who are overweight or obese and have additional CVD risk factors</td>
<td>The USPSTF recommends offering or referring adults who are overweight or obese and have additional cardiovascular disease (CVD) risk factors to intensive behavioral counseling interventions to promote a healthy diet and physical activity for CVD prevention.</td>
<td>B</td>
</tr>
</tbody>
</table>
Motivational Interviewing (MI)

<table>
<thead>
<tr>
<th>Engage</th>
<th>Focus</th>
<th>Evoke</th>
<th>Plan</th>
</tr>
</thead>
</table>
| ● The “Hello”  
  ● Create trusting relationship  
  ● Find common values | ● The “What”  
  ● Find clear direction & goal  
  ● Patient picks target behavior | ● The “Why”  
  ● Identify internal motivation for change | ● The “How”  
  ● Create SMART goals  
  ● Be Specific |

Physicians who reported **time as a barrier** were less likely to discuss smoking cessation with their **female** patients.
MI doesn’t take as long as you think

Please turn to your neighbor, use MI to come up with a lifestyle modification for each of you.

We can all get healthier!

Remember the “RULE” of MI

- **RESIST** telling them what to do
- **UNDERSTAND** their motivation
- **LISTEN** with empathy
- **EMPOWER** them
Summary of Practice Recommendations

- **USPSTF**: Screen women ≥45 y.o. for lipid disorders if at increased CHD risk. (Grade A)

- **USPSTF**: Screen women 20-45 y.o. for lipid disorders if at increased CHD risk. (Grade B)

Practice Recommendations

- Primary prevention with **statin** based on ASCVD risk score
  - Caution if planning pregnancy

- Utilize CDC’s U.S. **Medical Eligibility Criteria for Contraceptive Use** to find option with least CVD risks

- Consider **metformin** in patients with pre-DM/DM
  - Potential **wt. loss & CVD benefits**
Practice Recommendations

• **USPSTF**: Aspirin 81 mg/d if 50-59 y.o. with ≥10% 10-year CVD risk (Grade B)

• **USPSTF**: Aspirin 81 mg/d as preventive medication after 12 weeks of gestation if at high risk for preeclampsia. (Grade B)

Practice Recommendations

• **Secondary prevention** with statin therapy post-CVD event

• **ASA, ACEi/ARBs, β-blockers** may be of benefit in select patients following ACS/AMI (SOR A)

• Post-ACS or revascularization, eligible pts should be referred to comprehensive cardiac rehab (SOR A)
Changes in Clinical Practice

• Engage with female patients of all ages & advocate to ensure they get the very best cardiovascular care

• Use Motivational Interviewing & ASCVD Risk Estimator tools
  – ie, Demo calculator & show how risk changes if not smoker

• Have CVD discussions throughout women’s life cycle so risk factors can be monitored & controlled
  – ie, Counseling during preconception, contraception, intra-/post-partum, post-menopause

Have a “Heart to Heart” Talk with Women

• Emphasize CVD health especially at well visits & at follow-up visits for HTN/DM/HLD/BMI or lab review

• Take detailed history especially pregnancy complications
  – ie, Focused questions on hx of gestational DM, pre-eclampsia, preterm birth, birth of SGA infant

• Be familiar with patient’s socioeconomic status
  – Healthy lifestyles & medication adherence may be difficult
Help Close the Gap

- Very few women perceive CVD as **greatest threat to health**
- CVD largely **preventable**
  - Emphasize use of **proven primary/secondary treatments**
  - Pay close attention to underserved populations
- CVD has **widely different** presentations, effects, & outcomes in women vs. men
  - Pay close attention to traditional & non-traditional risk factors, especially female reproductive factors

CVD Advocacy for Women

- **Heart disease Education, Analysis, Research, and Treatment for Women Act (HEART for Women Act S. 438/H.R. 3526)**
  - Bill to improve prevention, diagnosis & treatment of CHD & stroke in women
  - AHA is monitoring implementation of 27 steps in FDA's Action Plan
- AHA supports legislation **addressing barriers** to cardiac rehab for women (S. 1361/ H.R. 1155)
- AHA supports funding for “WISEWOMAN” Program
  - Provides **free CVD screening & lifestyle counseling** to low income women
- AHA supports improved reporting of health care data by **sex, race, & ethnicity**
- AHA supports **equitable use** of female cells, tissues, & animals in basic research
- “**GoRedForWomen**” Campaign; **Women’s Preventive Services Initiative (WPSI)**
Contact Information

• Maya Bass
  mayaalexabass@gmail.com

• Anna Lowell
  annalowell@gmail.com

Questions
CVD Care Resources

- “AFP By Topic” > “Coronary Artery Disease/Coronary Heart Disease”: aafp.org/afp
- Download ASCVD Risk Estimator: tools.acc.org/ASCVD-Risk-Estimator-Plus
- 2019 ACC/AHA Guideline on Primary Prevention of Cardiovascular Disease: ahajournals.org/doi/10.1161/CIR.0000000000000678
- U.S. Preventive Services Task Force > Category: “Cardiovascular Disorders (Heart & Vascular Diseases)”: uspreventiveservicestaskforce.org/BrowseRec/Index
- ACLS Training Center: acls.net/heart-disease-in-women.htm
- CDC MEC for Contraceptive Use: cdc.gov/reproductivehealth/contraception/mmwr/mec/
- http://www.motivationalinterview.net
- Americans in Motion-Healthy Interventions (AIM-HI): www.americansinmotion.org
- Dietary Guidelines & Physical Activity Guidelines: Health.gov
- CDC Toolkit “WISEWOMAN”: cdc.gov/wisewoman/evaluation_toolkit.htm

References

8. CDC, NCHS. Underlying Cause of Death 1999-2013 on CDC WONDER Online Database, released 2015.
Navigating the Complexities of Contraceptive Care

Angeline Ti, MD, MPH
Santina Wheat, MD, MPH, FAAFP

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Assistant Professor, Department of Gynecology and Obstetrics, Department of Family and Preventive Medicine, Emory University School of Medicine, Atlanta, Georgia

Dr. Ti earned her Master of Public Health from Johns Hopkins Bloomberg School of Public Health, and is a graduate of the University of Michigan Medical School in Ann Arbor, Michigan. She completed her residency in Family and Community Medicine and a fellowship in Family Planning at the University of California, San Francisco, conducting research on the family planning values and preferences of incarcerated girls. Dr. Ti also completed a 2-year research position in the Division of Reproductive Health at the Centers for Disease Control and Prevention (CDC), working on the CDC contraception guidance. She is now faculty in the Division of Family Planning, and is the medical director of the Title X clinic at Grady Memorial Hospital. She currently provides primary care, transgender care, and family planning care. She also serves on the Georgia AFP Public Health Committee and the Georgia Department of Public Health Maternal Mortality Review Committee Action Committee.
Santina Wheat, MD, MPH, FAAFP

Assistant Professor, Department of Family and Community Medicine, Northwestern University Feinberg School of Medicine, Chicago, Illinois; Program Director, Northwestern McGaw Family Medicine Residency at Humboldt Park, Chicago, Illinois; Physician, Erie Family Health Centers, Chicago, Illinois

Dr. Wheat earned her medical degree from the University of Illinois College of Medicine at Chicago, and she earned her Master of Public Health (MPH) degree at the University of Illinois at Chicago School of Public Health. She completed a residency in family medicine at Northwestern McGaw Family Medicine Residency at Humboldt Park in Chicago, Illinois. Dr. Wheat has a strong interest in reproductive health and social determinants of health, and she works with a largely Spanish-speaking patient population at a federally qualified health center (FQHC) in Chicago. She provides full primary care to patients living with HIV/AIDS and hepatitis C. Dr. Wheat is the program director for the Northwestern McGaw Family Medicine Residency. She runs an outpatient procedure clinic with the residents in her program and is part of the maternity care team.

Learning Objectives

1. Consider screening for pregnancy intendedness and offering preconception and/or contraception counseling in the primary care setting for all patients at risk of unintended pregnancy.

2. Assess the special contraceptive needs for women with chronic diseases, for women who are planning to have bariatric surgery, and for trans-men at risk of undesired pregnancy.

3. Counsel patients on the appropriate use and access to emergency contraception, including advanced provision prescription.
Associated Sessions

• (PBL) Navigating the Complexities of Contraceptive Care

Audience Engagement System
Pregnancy in the US

![Pie chart showing contraception use during month of conception]

Intended, 55%
Unintended, 45%
Nonuse, 54%
Inconsistent use, 41%
Consistent use, 5%

Data from Guttmacher Institute, Unintended Pregnancy in the United States, Sept 2016.

Increasing rates of chronic disease among reproductive-aged women

<table>
<thead>
<tr>
<th>Age groups (years)</th>
<th>Depression</th>
<th>Diabetes</th>
<th>Hypertension</th>
<th>Overweight/Obesity</th>
</tr>
</thead>
<tbody>
<tr>
<td>18-24</td>
<td>19%</td>
<td>1.0%</td>
<td>5.0%</td>
<td>33%</td>
</tr>
<tr>
<td>25-34</td>
<td>23%</td>
<td>2.4%</td>
<td>9.2%</td>
<td>57%</td>
</tr>
<tr>
<td>35-44</td>
<td>23%</td>
<td>5.3%</td>
<td>17%</td>
<td>62%</td>
</tr>
</tbody>
</table>

Why does this matter?

Preventable Pregnancy Deaths in America Are ‘Alarmingly’ High
The New York Times

New Title X Regulations: Implications for Women and Family Planning Providers
Laurie Sobel, Alina Salganicoff, and Britni Frederiksen
Published: Mar 08, 2019

So where do we start?
Amy

24 year old patient comes to the office for a same-day appointment with new UTI symptoms.

AES Polling Question 1

• How frequently do you ask patients about their pregnancy intentions?
  – A) I ask nearly all patients
  – B) I ask nearly all female patients
  – C) I sometimes ask, depending on the visit type
  – D) I never or rarely ask
  – E) What do you mean, “pregnancy intentions”?
Screening for pregnancy intention

• One Key Question

• Intention-oriented vs service-oriented
  – “Do you want to get pregnant soon?”
  – “Can we help you today with birth control or pregnancy planning?”

“Power to Decide, One Key Question”: [https://powertodecide.org/one-key-question](https://powertodecide.org/one-key-question)

Screening for pregnancy intention

• Starts a conversation
• Proactively identify need for **contraception** or **pre-pregnancy planning**
• Will change as individual circumstances change
Alice

• 36 year old patient with hypertension comes for a routine follow-up visit and a med refill.

Alice

• BP 145/90, BMI 32

• Not planning pregnancy and open to discussing contraception
AES Polling Question 2

• What contraception is safe for Alice?
  – A) Non-hormonal methods
  – B) Progestin-only methods
  – C) Estrogen-containing methods
  – D) A & B
  – E) All of the above

CDC contraception guidance

• US Medical Eligibility Criteria for Contraceptive Use (MEC)
  – Safe use of contraceptive methods by patients with certain characteristics or medical conditions
  – More than 1800 recommendations for over 120 medical conditions and sub-conditions
**US MEC**


---

**Risk Level**

1. Method can be used without restriction
2. Advantages generally outweigh theoretical or proven risk
3. Theoretical or proven risks usually outweigh the advantages
4. Unacceptable health risk (method not to be used)

---

**Hypertension**

b. Elevated blood pressure levels (properly taken measurements)
   i. Systolic 140–159 mm Hg or diastolic 90–99 mm Hg

†Clarifications

For all categories of hypertension, classifications are based on the assumption that no other risk factors exist for cardiovascular disease. When multiple risk factors do exist, risk for cardiovascular disease might increase substantially. A single reading of blood pressure level is not sufficient to classify a woman as hypertensive.
Look at the US MEC

<table>
<thead>
<tr>
<th>Condition</th>
<th>Method</th>
<th>Category</th>
<th>Confirmation</th>
<th>Evidence</th>
<th>Contraception</th>
</tr>
</thead>
<tbody>
<tr>
<td>Liver tumors</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Malaria</td>
<td></td>
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<tr>
<td>Multiple risk factors for atherosclerotic cardiovascular disease (e.g., older age, smoking, diabetes, hypertension, low HDL, high LDL, or high triglycerides)</td>
<td></td>
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<tr>
<td>Multiple evidence for efficacy</td>
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<td>About this App</td>
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<td>Full Guidelines</td>
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<td>Provider Tools</td>
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<tr>
<td>Resources</td>
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</tr>
</tbody>
</table>

Look at the US MEC

Obesity

a. BMI ≥ 30 kg/m²

- Evidence

Obese women who use COCs are more likely than obese women who do not use COCs to experience VTE. Research examining the interaction between COCs and BMI on VTE risk is limited, particularly for women in the highest BMI categories (BMI ≥ 35 kg/m²). Although the absolute risk for VTE in otherwise healthy women of reproductive age is small, obese women are at 2-3 times higher risk for VTE than normal weight women regardless of COC use. Limited evidence suggests that obese women who use COCs do not have a higher risk for acute mesenteric ischemia or stroke than do obese nonusers. Limited evidence suggests that effectiveness of some COC formulations might decrease with increasing BMI, however the observed reductions in effectiveness are minimal and evidence is conflicting. Effectiveness of the patch might be reduced in women > 80 kg. Limited evidence suggests obese women are no more likely to gain weight during COC or vaginal ring use than normal weight or overweight women.

b. Menarche < 16 years and BMI ≥ 30 kg/m²

- Evidence

Obese women who use COCs are more likely than obese women who do not use COCs to experience VTE. Research examining the interaction between COCs and BMI on VTE risk is limited, particularly for women in the highest BMI categories (BMI ≥ 35 kg/m²). Although the absolute risk for VTE in otherwise healthy women of reproductive age is small, obese women are at 2-3 times higher risk for VTE than normal weight women regardless of COC use. Limited evidence suggests that obese women who use COCs do not have a higher risk for acute mesenteric ischemia or stroke than do obese nonusers. Limited evidence suggests that effectiveness of some COC formulations might decrease with increasing BMI, however the observed reductions in effectiveness are minimal and evidence is conflicting. Effectiveness of the patch might be reduced in women > 80 kg. Limited evidence suggests obese women are no more likely to gain weight during COC or vaginal ring use than normal weight or overweight women.
Anna

• 31 year old patient who is scheduled for bariatric surgery next month. She was referred to primary care for contraception.

Increased maternal risks in pregnancy

• Breast, endometrial, or ovarian cancer
• Complicated valvular heart disease
• Cystic fibrosis
• Diabetes
• Epilepsy
• Hypertension (>160/100)
• History of bariatric surgery in last 2 years
• HIV (uncontrolled)
• Ischemic heart disease
• Hepatoma
• Peripartum cardiomyopathy
• Severe cirrhosis
• Sickle cell disease
• Solid organ transplantation with in the last 2 years
• Thrombogenic mutations

Bariatric surgery and reproductive health

Rapid weight loss following surgery may lead to increased fertility

Recommendations to delay pregnancy for 1-2 years after surgery


AES Polling Question 3

• What contraception can Anna use?
  – A) Any method
  – B) Any non-oral method
  – C) Only the most effective methods- LARC or sterilization
  – D) It depends on the type of surgery
Anna

• Anna has been struggling with infertility for many years and tells you that she actually plans on trying to get pregnant as soon as she’s recovered from her surgery.
Pregnancy risks after bariatric surgery

• Misdiagnosing pregnancy vs surgical complications
• Continued obesity
• Micronutrient deficiencies
• Inconclusive evidence for patient-oriented outcomes


Shared decision-making

Patient values, preferences, and situation

Medical evidence, risks and benefits

Individualized decision
Andy

• 24 year old patient, assigned female at birth who is about to start gender-affirming testosterone.
• Not interested in pregnancy

AES Polling Question 4

• Which contraceptive methods are safe for Andy?
  – A) All of them
  – B) Any method without estrogen
  – C) Any method without hormones
Contraception & testosterone

- Amenorrhea ≠ anovulation
  - Category D in pregnancy

- Method-specific considerations:
  - Estrogen is safe when taken with testosterone, but may counter its effects
  - Testosterone can cause vaginal dryness


Andy

- After discussion options, Andy would like to start depo-medroxyprogesterone (DMPA). Last menstrual period was 2 weeks ago, and last unprotected vaginal sex was 3 days ago.
CDC contraception guidance

- US Selected Practice Recommendations for Contraceptive Use (SPR)
  - Guidance for common contraceptive management topics such as:
    - How to be reasonably certain a patient is not pregnant
    - When to start contraception
    - Medically indicated exams and tests
    - Follow-up and management of certain problems


CDC pregnancy checklist

- You can be reasonably certain Andy is not pregnant if any of the criteria apply:
  - Is $\leq$ 7 days after the start of normal menses
  - Has not had sex since last menses
  - Has been correctly using contraception
  - Is $\leq$ 7 days after spontaneous or induced abortion
  - Is within 4 weeks postpartum
  - Meets criteria for lactational amenorrhea

What about that unprotected sex?

Emergency Contraception (EC)

- Indications:
  - Unprotected sex
  - Concern for contraceptive failure
  - Incorrect use
  - Sexual assault
- Timing: within 5 days (120 hours)

WHO. Emergency Contraception. 2 Feb 2018. Available at: https://www.who.int/news-room/fact-sheets/detail/emergency-contraception
Available methods of EC

<table>
<thead>
<tr>
<th>Medication</th>
<th>Copper</th>
<th>Ulipristal Acetate</th>
<th>Progestin Pills</th>
</tr>
</thead>
<tbody>
<tr>
<td>Copper IUD</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ulipristal Acetate Pills</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Progestin Pills</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

What is it?
Emergency contraception (EC) is birth control you can use after unprotected sex.

What does it do?
EC prevents a pregnancy after unprotected sex. EC does not end a pregnancy and will not work if you are pregnant.

Medication
- Copper
- Ulipristal acetate
- Levonorgestrel

Additional considerations for EC

- **Failure (pregnancy) rates:**
  - LNG EC: 1.2-2.1%
    - Increased with higher BMI, >72 hours since unprotected sex
  - UPA EC: 1.2%
  - Cu IUD: <1%

- **Combined oral contraceptives (Yuzpe method)**

WHO. Emergency Contraception. 2 Feb 2018. Available at: https://www.who.int/news-room/fact-sheets/detail/emergency-contraception
AES Polling Question 5

- Andy doesn’t want a pelvic exam so chooses EC pills. Can Andy also start DMPA today?
  - A) Yes
  - B) No
  - C) Depends on what kind of EC he chooses

Contraception after EC

- Copper IUD: none needed!
- Levonorgestrel (LNG) EC: can start same day as EC
- Ulipristal acetate EC: starting hormonal contraception within 5 days may decrease effectiveness of EC
- Pregnancy test in 3 weeks if not withdrawal bleed

Shared decision-making

Patient values, preferences, and situation

Medical evidence, risks and benefits

Individualized decision

Increasing access to EC

• Advanced provision leads to increased use and more timely use
• One form of LNG EC is available over the counter for ~ $50/pill
  – Availability to other brands varies by state, insurance, age


Practice recommendations

• Screen patients regularly for pregnancy intention: intention-oriented vs service-oriented

• Utilize evidence-based guidance to provide contraception safely to all patients, including those with chronic medical conditions

• Assess the need for emergency contraception and recognize best practices for implementation

Billing & Coding

ICD 10 Codes:

- Z30.011 Initial, contraceptive pills
- Z30.012 EC prescription
- Z30.013 Initial, Injection
- Z30.014 Initial, IUC
- Z30.015 Initial, Ring
- Z30.016 Initial, Patch
- Z30.017 Initial, Implant

- Z30.41 surveillance, contraceptive pills
- Z30.42 Surveillance, Injection
- Z30.43 Surveillance, IUC
- Z30.44 Surveillance, Ring
- Z30.45 Surveillance, Patch
- Z30.46 Surveillance, Implant
Billing & Coding

Procedure (CPT) Codes:
• 58300 Insertion of IUD
  – Z30.430 encounter for insertion of IUC
  – J7298 Mirena, J7297 Liletta, J7300 Paragard, J7301 Skyla,
• 58301 IUD removal
  – Z30.432 encounter for removal of IUC
• 58300 & 58301 for IUD removal & reinsertion
  – Z30.433 & relevant J code

Billing & Coding

CPT Codes:
• 11981 Insertion Implant
  – Z30.017 encounter for insertion of Implant
  – J7307 Nexplanon
• 11982 Removal Implant
  – Z30.46 encounter for surveillance of Implant
  – J7307
• 11983 Removal & Reinsertion Implant
  – Z30.46
Billing & Coding

Other helpful codes:
• J2000 Lidocaine
• A4550 Surgical Tray
• 53 modifier can be used for attempted, but unsuccessful, IUD insertions

Some useful resources
• Bedsider: https://providers.bedsider.org/
• CDC contraception guidance: https://www.cdc.gov/reproductivehealth/contraception/contraception_guidance.htm
• Reproductive Health Access Project: https://www.reproductiveaccess.org/
• UCSF transgender guidelines: https://transcare.ucsf.edu/guidelines
Contact us with questions!

Angeline Ti ati@emory.edu
Santina Wheat tina.wheat@gmail.com

Questions
Non-Cancerous Urinary Tract Disorders in Women Update

Heather Paladine, MD, MEd, FAAFP
Krishna M. Desai, MD

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Dr. Paladine is a family physician who lives and practices in Manhattan, New York, where she supervises residents and medical students, and treats a predominantly Latino, low-income patient population. She focuses on women's health, including maternity care and reproductive health. In addition to her work as a physician, Dr. Paladine mentors residents and medical students as a preceptor in clinic and hospital environments. She is a member of the board of directors of the New York State Academy of Family Physicians and a member of its Education Commission. She believes that the United States needs a health care system based on primary care and that the public must learn more about family medicine to pave the way.
Krishna M. Desai, MD

Assistant Professor, Family Medicine, Columbia University/New York-Presbyterian Hospital, New York City

Dr. Desai earned her medical degree from University of Cincinnati College of Medicine, Ohio, and completed residency training in family medicine at Carolinas Medical Center in Charlotte, North Carolina. She went on to complete a fellowship in faculty development at the University of Pittsburgh Medical Center, Pennsylvania, and a fellowship in integrative medicine at the University of Arizona in Tucson. Dr. Desai is board certified in both integrative medicine and family medicine. She serves as the director of the Integrative Medicine Consultation Clinic and the chair of the Clinical Competency Committee. She has published articles relevant to family medicine in peer-reviewed journals, including Journal of Family Practice and Evidence-Based Practice, and she was a contributing author for an edition of the AAFP monograph series FP Essentials. In addition to precepting residents and caring for her own patients, Dr. Desai trains medical students and residents at Columbia University in integrative medicine, which includes herbals/botanicals, nutritional supplements, aromatherapy, and mind-body therapies.

Learning Objectives

1. Establish evidence-based screening protocols in women who are at risk for identifying urinary tract disorders.

2. Counsel patients regarding first-line treatment options, including behavioral therapy and lifestyle modifications, emphasizing adherence and follow-up.

3.Prescribe second or third line treatment options if first-line therapies are unsuccessful, coordinating referral and follow-up care for surgical treatment as necessary.

4. Review preventive measures, the workup and non invasive treatments prior to referral.
Audience Engagement System

Presentation Outline

1. Introduction

1. Review 3 common lower urinary tract disorders in women
   • Recurrent UTI
   • Urinary Incontinence
   • Pelvic Organ Prolapse

3. Summarize practice recommendations for patient care
INTRODUCTION
Lower Urinary Tract Symptoms (LUTS) in women

Symptoms
3 groups: storage, voiding, post-voiding
- frequency
- urgency
- nocturia
- dribbling
- weak stream
- hesitancy
- dysuria
- incomplete emptying
- genital and LUT pain

Poll Question 1: Flo is a 34 year old healthy female who presents to you with her third episode of burning with urination, frequency, and urgency over the last 6 months. She is sexually active with her boyfriend of 8 months. You review the EMR and find the last time she came in with these symptoms she had a positive urine culture (100,000 CFU/ml of E. Coli). Which of the following is true about recurrent UTIs (RUTIs) in women?

A. Most women with RUTIs have an identifiable anatomic or physiological abnormality
B. Urine culture should be obtained in all patients with RUTIs to guide management
C. There is strong evidence that post coital voiding is associated with decreased frequency of RUTIs
D. Treatment should NOT be initiated until urine culture results are available to guide choice of antibiotic
Recurrent Urinary Tract Infections

What and Who?

What: Definition
- Recurrence of symptoms after an episode
- 3x/1 yr or 2x/6 mo
- Reinfection (same or different organism)
- Inadequate treatment

Who: Epidemiology
- Very common!
- 27% of college women 6 mo after 1st episode
- 53% of women age > 55 y/o
- usually healthy women without anatomical or functional abnormalities


Recurrent Urinary Tract Infections

Risk Factors: It's all about sex baby!

Risk Factors Associated with Recurrent UTIs: Odds Ratios

#1 Risk Factor for recurrent UTIs is frequency of sexual intercourse

Recurrent Urinary Tract Infections

**Diagnosis:** *History alone* is sufficient to diagnose UTI

combination of typical symptoms + absence of vaginal discharge

**90% probability** of diagnosing UTI

*Just listen...*


---

**Poll Question 2:** Flo is a 34 year old healthy female who presents to you with her third episode of burning with urination, frequency, and urgency over the last 6 months. She is sexually active with her boyfriend of 8 months. You review the EMR and find the last time she came in with these symptoms she had a positive urine culture (100,000 CFU/ml of E. Coli). **Which of the following is/are appropriate management strategies for this patient (select all that apply)?**

- A. Wait for urine culture before initiating treatment
- B. Prescribe antibiotic based on previous urine culture and sensitivities
- C. Counsel patient to increase fluid intake to 1.5 liters per day
- D. Refer patient for renal ultrasound for further evaluation of cause of RUTIs
- E. Offer post coital antibiotic therapy for preventative treatment
Recurrent Urinary Tract Infections
3 Management Strategies

#1 Post-coital antibiotic
#2 Antibiotic prophylaxis x 6-12 months
#3 Self initiated antibiotic treatment x 3 days


Recurrent Urinary Tract Infections
Antibiotic prophylaxis

<table>
<thead>
<tr>
<th>Medicine</th>
<th>Dosage</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nitrofurantoin</td>
<td>50-100 mg QHS</td>
<td>once post sex</td>
</tr>
<tr>
<td>Cephalexin</td>
<td>250 mg QHS</td>
<td>once post sex</td>
</tr>
<tr>
<td>Ciprofloxacin</td>
<td>125 mg QHS</td>
<td>once post sex</td>
</tr>
<tr>
<td>TMP-SMX</td>
<td>40/200 mg QHS</td>
<td>once post sex</td>
</tr>
</tbody>
</table>

Doc, I don’t really want to take antibiotics

Isn’t there something else I can take to prevent UTIs?

- Drink 1.5-3 L water per day and **urinate** more often
- **Urinate** when you gotta go!
- **Urinate** after sex
- Clean genital area before/after sex wiping front to back
- Keep out of vagina: douches, spermicides, diaphragms, bubble bath liquids, bath oils, vaginal oils/creams, deodorant sprays or soaps


Doc, I don’t really want to take antibiotics

Isn’t there something else I can take to prevent UTIs?

- **D-mannose** no different than nitrofurantoin
- **Cranberry** supplements may reduce the risk by 26% (small studies, variable products)
- **Probiotics**: intravaginal, oral supplements may reduce RUTIs (~20%)

<table>
<thead>
<tr>
<th>Suspect complicated UTIs</th>
<th>Diabetes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Renal insufficiency</td>
<td></td>
</tr>
<tr>
<td>Transplant patients</td>
<td></td>
</tr>
<tr>
<td>Indwelling catheters</td>
<td></td>
</tr>
<tr>
<td>Ureteral stents</td>
<td></td>
</tr>
<tr>
<td>Nephrostomy tubes</td>
<td></td>
</tr>
<tr>
<td>PCKD</td>
<td></td>
</tr>
<tr>
<td>Vesicoureteral reflux</td>
<td></td>
</tr>
<tr>
<td>Strictures</td>
<td></td>
</tr>
<tr>
<td>Renal stones</td>
<td></td>
</tr>
<tr>
<td>Cystocele</td>
<td></td>
</tr>
<tr>
<td>Multiple sclerosis</td>
<td></td>
</tr>
<tr>
<td>Neurogenic bladder</td>
<td></td>
</tr>
</tbody>
</table>


I’m really good at multitasking: I can laugh, cough, sneeze, and pee all at the same time!
Urinary Incontinence - First Steps!

### Voiding Diary

<table>
<thead>
<tr>
<th>Time</th>
<th>Oral Intake</th>
<th>Voided Urine</th>
<th>Pad change, leakage</th>
</tr>
</thead>
</table>

**Medication Triggers?**
- muscle relaxants
- opioids
- sedatives
- anticholinergic SEs

**Assess renal function**
- BMP
- UA/Ucx (infxn)

---


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### 5 Types of Urinary Incontinence

<table>
<thead>
<tr>
<th>Type</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>01 STRESS</td>
<td>sphincter weakness</td>
</tr>
<tr>
<td>02 URGE</td>
<td>detrusor overactivity</td>
</tr>
<tr>
<td>03 MIXED</td>
<td>stress + urge</td>
</tr>
<tr>
<td>04 OVERFLOW</td>
<td>overdistension of bladder</td>
</tr>
<tr>
<td>05 FUNCTIONAL</td>
<td>cognitive/functional</td>
</tr>
</tbody>
</table>
STRESS (cough, sneeze, laugh)

URGE

detrusor hyperactive

MIXED

AND sphincter with too little tone

OVERFLOW

bladder can't hold anymore urine

I know it will happen whenever I cough, sneeze, go jogging.
It’s only a small amount
Stress Incontinence: Diagnosis

*Cough stress test*

First line
- Weight loss
- Smoking cessation
- Fluid restriction
- Pelvic floor muscle exercises
- Bladder irritants

Second line
- Extracorporeal magnetic innervation
- Pessaries

Third line
- Periurethral injections
- Sling
- Urethropexy surgery

Pelvic Floor Exercises

- Isolate muscles: hold urine while urinating
- Hold x 3-5 seconds → build up to 10 seconds
- 3 sets of 10 at least 3-4x/week
- Continue for at least 15-20 weeks

Stress Incontinence

Treatment

https://familydoctor.org/kegel-exercises-for-your-pelvic-muscles/

Urge Incontinence

It comes on suddenly
It happens when I hear running water or just when I’m coming home.
I have to pee all of the time!
Poll Question 3: Flo is a 34 year old healthy female who often has an uncontrollable urge to urinate when coming home from work. Which of the following is/are first line treatments for urge incontinence?

A. Pelvic floor muscle training (Kegel’s exercises)
B. Bladder training
C. Weight loss
D. Anticholinergic medications

Urge Incontinence Treatment

First line
- Weight loss
- Smoking cessation
- Fluid restriction
- Pelvic floor muscle exercises!
- Bladder training
- Bladder irritants

First or Second Line
- anticholinergic or beta-adrenergic medications

Third line
- botulinum toxin
- nerve stimulation
Urge Incontinence: Bladder Retraining

- Don’t move
- Distraction and relaxation techniques to reduce urgency
- Walk slowly to the bathroom and void
- Extend the time that urination can be postponed  
  ~start with 5 minutes → aim to void every 3-4 hours without incontinence

https://familydoctor.org/bladder-training-urinary-incontinence/

Urge Incontinence: Bladder Irritants

- Caffeine
- Carbonated beverages
- Artificial sweeteners
- Acidic foods
- Alcohol
**Urge Incontinence: Medications**

- Oxybutynin (Ditropan)
- Tolterodine (Detrol)
- Trospium (Sanctura)

Start at **low doses** and titrate up
Watch for **urinary retention**!

---

**Overflow Incontinence**

I didn’t know I was peeing.
My underwear was wet.
I was dribbling urine.
It’s hard to start peeing.
Poll Question 4: Flo reports that her underwear is often wet with urine but she did not realize she had to urinate. You suspect she has overflow incontinence. **Which of the following can be a cause of overflow incontinence?**

A. Pelvic organ prolapse  
B. Diabetes  
C. Fecal impaction  
D. Decongestants

---

**Overflow Incontinence: Diagnosis**

Diagnosed by PVR >200  
Rectal exam: neuropathy, r/o fecal impaction
Overflow Incontinence: Treatment

- Refer to urology!
- Clean intermittent or indwelling catheter
- Alpha adrenergic blockers (tamsulosin)

I think I’m losing my mind...
But as long as I keep the part that tells me when I need to pee, I’m ok.
Pelvic Organ Prolapse

What and Who?

What: Definition
- Herniation of pelvic structures into the vagina
- Can have anterior, posterior, or apical prolapse

Who: Epidemiology
- 50% with prolapse on exam
- 3-5% of post-menopausal women with sx
- elevated BMI
- increased parity
- chronic cough or constipation
- connective tissue disorders


I can feel a bulge near my vagina.
It’s uncomfortable to have sex.
I lose my urine.
I have to put a finger in my vagina to have a bowel movement.

Pelvic Organ Prolapse: Diagnosis
1. External exam
2. Use a split speculum
3. Look for vaginal atrophy, skin irritation
4. Ask pt to bear down
   
   may assess standing
Pelvic Organ Prolapse: POP Q

https://www.augs.org/patient-services/pop-q-tool/

Pelvic Organ Prolapse: Treatment

Contraindications to observation:
- Hydronephrosis
- Recurrent UTI
- Severe vaginal or cervical erosions

Observation
Surgery
(Pessary)
(Kegels)
Pelvic Organ Prolapse

Pelvic Floor Muscle Training

- Some evidence of improvement
- Study included 6 months of supervised therapy


Pelvic Organ Prolapse

Pessaries

60% will improve!

Pelvic Organ Prolapse
Surgery

• Mesh controversy (*more women require repeat surgery*)

• Surgical treatment may lead to stress incontinence
  – women with anterior or apical prolapse

• 6-30% recurrence

Lower Urinary Tract Symptoms (LUTS) in Women
Summary

**Recurrent UTIs**

- Document at least 1 urine culture demonstrating a urinary pathogen
- Imaging + cystoscopy are rarely necessary in otherwise healthy women
- 3 options for prophylaxis:
  - post-coital, QHS x 6-12 mo, self initiated x 3 days
- Don’t forget the behavioral modifications (*pee a lot!* and supplements (*cranberry, d-mannose, probiotics*))
Lower Urinary Tract Symptoms (LUTS) in Women

Summary

**Pelvic Organ Prolapse**
- Symptoms are key; Do an exam! POP-Q
- Pessaries should be first line
- Surgery is not without risk

**Urinary Incontinence**
- 5 types of incontinence: stress, urge, mixed, overflow, functional
- For all types: voiding diary, assess medications, and assess renal fxn (BMP, UA)
- Stress, Urge, Mixed: behavioral modifications, pelvic floor muscle retraining
- Overflow: refer to urology
- Functional: evaluate underlying conditions

LUTS in Women: Practice Recommendations

<table>
<thead>
<tr>
<th>Practice Recommendation</th>
<th>SORT</th>
</tr>
</thead>
<tbody>
<tr>
<td>History alone is sufficient to diagnose an uncomplicated UTI</td>
<td>B</td>
</tr>
<tr>
<td>Continuous and postcoital antimicrobial prophylaxis have demonstrated effectiveness in reducing the risk of recurrent UTIs</td>
<td>A</td>
</tr>
<tr>
<td>Behavioral therapies are effective for both stress and urge incontinence</td>
<td>C</td>
</tr>
<tr>
<td>A post-void residual measurement should be used to confirm a suspected diagnosis of overflow incontinence</td>
<td>C</td>
</tr>
<tr>
<td>Pessaries are an effective treatment for many women with symptomatic pelvic organ prolapse</td>
<td>B</td>
</tr>
</tbody>
</table>
May your coffee, intuition, self-appreciation, and **pelvic floor** be strong.

THANK YOU!
Your feedback is important... please complete the evaluation.

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Krishna Desai: krishnadesai.119@gmail.com

Questions
Preconception Counseling: What Is Supported by Evidence?

Heather Paladine, MD, MEd, FAAFP
Tenessa MacKenzie, MD, FAAFP

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Dr. MacKenzie has been an outpatient primary care clinician at the UCSF Family Medicine Center at Lakeshore since 2014. She teaches UCSF medical students and provides pediatric, adult, and prenatal care. She earned her medical degree at the University of Florida in Gainesville in 2009 and completed a residency in family medicine at Beth Israel Medical Center in New York in 2012. Prior to joining UCSF, Dr. MacKenzie worked as a locum tenens physician in Canada and New Zealand. In 2016, she completed the UCSF Family Medicine Faculty Development Fellowship Program. Her clinical interests include comprehensive women’s health care, outpatient procedures, pediatrics, medical education, and healthy lifestyle counseling.

Learning Objectives

1. As a part of primary care visits, provide pregnancy intendedness screening for all women of reproductive age and then education and health promotion counseling to those sexually active and not using contraception to reduce reproductive risk and improve pregnancy outcomes.

2. Counsel pregnant and postpartum patients on interconception health care needs including needed immunizations, new and ongoing risk factors for future pregnancies, and contraception options to prevent unintended pregnancy and to space pregnancies for optimum health.

3. Use pregnancy visits and postpartum visits as an opportunity to review and encourage good health habits such as exercise, smoking cessation, and healthy diet.

4. Preconception visits should include advice about foods to avoid during pregnancy, folic acid, smoking cessation, BMI measurement with discussion of health weights and depression screening.
Audience Engagement System

Outline

- Introduction
- Obstacles to preconception care
- Opportunities for preconception care
- Pregnancy intention
- Preventive counseling - folic acid, substance use, vaccines, other infections, obesity
- Preconception counseling for men
- Coding and reimbursement
Advanced Preconception Care

Common medical conditions in women of reproductive age
• Hypertension
• Diabetes mellitus
• Hypothyroidism
• Opioid use disorder

Contraception
Preconception carrier screening

Introduction

Preconception health care is actually periconception/interconception health care

Even more, it’s just good health care!
Obstacles to Preconception Care - Patient

- Lack of knowledge/understanding of goals of preconception care
- Unplanned pregnancy
- Lack of access: women at highest risk often have less access to care
- Disparities

Obstacles to Preconception Care - Provider

- Lack of evidence – what works?
- Poor reimbursement (?)
  - is this care cost-effective?
- Limited time in primary care visits
- Lack of training
Opportunities for Preconception Counseling

- Health maintenance visit
- Postpartum visit
- Well child visit
- Negative pregnancy test

Seize the day!

Importance of Pregnancy Intention

- 45% of pregnancies in the US are unplanned
- Consider using **One Key Question**: *Would you like to become pregnant in the next year?*
  - Yes, No, I Don’t Know
  - Pilot studies have shown feasibility, acceptability, increased prescription of contraception
  - RCT in progress

[www.powertodecide.org](http://www.powertodecide.org)

Would you like to become pregnant in the next year?

[https://powertodecide.org/system/files/resources/primary-download/One%20Key%20Question%20Research%20Summary.pdf](https://powertodecide.org/system/files/resources/primary-download/One%20Key%20Question%20Research%20Summary.pdf)
Preventive Counseling

1. Folic Acid
2. Caffeine, alcohol, tobacco, other substances
3. Vaccines, other infections
4. Obesity

Poll Question 1

Folic acid supplementation prior to pregnancy and in the first trimester is associated with a lower risk of which of the following conditions:

A) Autism
B) Neural tube defects
C) Genitourinary malformations
D) All of the above
Folic Acid

- Periconception folic acid decreases neural tube defects
- Not associated with increased rate of conception
- Does not affect rates of miscarriage, ectopic, stillbirth
- Increase in multiple births – most likely from confounding from IVF

JAMA USPSTF evidence summary: https://jamanetwork.com/journals/jama/fullarticle/2596299

But wait, there’s more!

Wilcox et al BMJ 2007;334:464
Suren et al JAMA 2013;309(6):570-577
Folic Acid

• Dose for primary prevention is 0.4 to 0.8mg one month before conception through first 2-3 months of pregnancy
• Secondary prevention 4 mg a day

What about diet fortification?

Folic Acid

• Chuang Preventive Medicine 2011; 53(1-2): 85-88
  – Survey 33,000 women
  – Women intending pregnancy in next 12 months 57% higher odds taking daily folic acid vs. those not intending pregnancy
• Williams Maternal and Child Health Journal 2012; 16(9): 1854–1861
  – Women who received preconception care more likely to take pre-pregnancy multivitamins
  • AOR 4.4 95% CI 4.0-4.7)
Caffeine

• No convincing evidence of birth defects, hypertensive disorders of pregnancy, preterm delivery, early miscarriage
• Late miscarriage and stillbirth rates higher in women consuming >300 mg/day
• Drinking >6 cups coffee/tea a day increased risk of SGA infants

Soda 37mg
Tea 48mg
Coffee 137mg

Caffeine

• Moderate caffeine intake $<$200 mg/day does not appear to be a major contributing factor in miscarriage or preterm birth
• A final conclusion can not be made whether there is a correlation between high caffeine intake and miscarriage
• The relationship to IUGR remains undetermined

ACOG Committee Opinion 2010: https://www.acog.org/Clinical-Guidance-and-Publications/Committee-Opinions/Committee-on-Obstetric-Practice/Moderate-Caffeine-Consumption-During-Pregnancy
Alcohol

No evidence of a “safe” threshold
- 7 drinks a week can cause fetal growth restriction
- Binge drinking and heavy alcohol consumption can lead to childhood learning difficulties, behavior problems, physical disabilities
- Fetal alcohol syndrome seen with alcohol exposures in all trimesters
  - Strongest association second half of first trimester


Alcohol

- Cochrane review 2009
  - Pre-pregnancy health promotion was associated with lower rates of binge drinking (RR 1.24)
- Williams 2012
  - Women who received preconception care were more likely to stop drinking prior to pregnancy (AOR 1.395% CI 1.2-1.5)
Poll Question 2

Smoking in pregnancy is associated with an increased risk for all of the following EXCEPT:

A) low birth weight
B) pre-eclampsia
C) fetal and neonatal death
D) preterm premature rupture of membranes (PPROM)
E) ectopic pregnancy
F) placenta previa

Tobacco

5% of perinatal deaths
20-30% of low birth weights
15% of preterm births

ACOG Committee Opinion on Smoking Cessation During Pregnancy, 2017
Tobacco

12% of women in the US smoke cigarettes
• Higher in the South and Midwest
• 60% of women tried vaping or e-cigarettes
• Hookah use is only 1% but more common in women and younger people

www.cdc.gov/tobacco

Tobacco

• Twice as likely to experience delay to conception
• OR at 12 months of failing to achieve a pregnancy in a smoker 1.54 (1.19-2.01)
• 30% higher odds of having infertility

The Practice Committee of the American Society for Reproductive Medicine, Smoking and Infertility, 2008.
Tobacco

- USPSTF: Behavioral interventions and pharmacotherapy are effective to reduce rates of smoking in adults (SOR: A)

- Not enough information to recommend electronic nicotine delivery systems

USPSTF Evidence Summary: https://www.ncbi.nlm.nih.gov/books/NBK321744/

Other Substances

- ACOG recommends avoiding marijuana use due to lack of safety data in pregnancy, possible increased risk of stillbirth

- Screen for opioid use
Poll Question 3

Which of the following is FALSE about rubella?

A) Women with equivocal rubella immunity should be retested following pregnancy.
B) Rubella vaccination in the United States has reduced the incidence of congenital rubella syndrome by 99%
C) Most women who had an infant born with congenital rubella syndrome in the United States had contact with the health care system and a missed opportunity for vaccination prior to pregnancy.
D) Women should be advised to wait 1 month following live virus vaccine prior to attempting pregnancy.

Rubella immunity

• Congenital rubella syndrome still occurs
• Most of these women had missed opportunities for screening/vaccination
• Women with equivocal or negative tests should be revaccinated after pregnancy
• Special attention to women born in other countries
• Recommend waiting one month after vaccination before attempting pregnancy

What about varicella and measles? Other vaccines?

Other infections

- STIs - test for gonorrhea and chlamydia
- HIV - test for HIV
- Zika
  - CDC recommends condom use or abstaining from sex after travel to an area with Zika exposure
    - For three months for the male partner
    - For two months for the female partner
Obesity

Cedergren, Obstet Gyn 2004
Baeten, Am J Public Health 2001
Kim, Prev Chronic Dis 2012

Obesity
Obesity

- USPSTF - intensive counseling and behavioral interventions in obese adults results in weight loss (up to 6% body weight) (SOR: B)
- Cochrane review 2015: not enough data to make practice recommendations for preconception weight loss

Preconception Counseling for Men

Smoking cessation
Factors that can contribute to infertility
- Alcohol
- Marijuana
- Cocaine
- Anabolic steroids
- Exposures through work or hobbies
Coding and Reimbursement

Can bill for preventive visit code if not done in the past year
May be covered under Medicaid for family planning - varies by state
Z31.69 Encounter for other general counseling and advice on procreation

Practice Recommendations

- Routinely assess pregnancy intention (SOR: C)
- Prescribe folic acid supplementation for women who may become pregnant (SOR: A)
- Use behavioral and/or pharmacotherapeutic interventions to help women quit smoking (SOR: A)
- Intensive behavioral interventions are effective for weight loss in women with obesity (SOR: B)
Resources

- [www.beforeandbeyond.org](http://www.beforeandbeyond.org) Information for clinicians and patients, including a mobile app
- [www.powertodecide.org](http://www.powertodecide.org) Data and implementation strategies for One Key Question
- CDC Preconception Care: [https://www.cdc.gov/preconception/index.html](https://www.cdc.gov/preconception/index.html)

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Questions
Understanding Trauma Informed Care of Trafficked Women and GLBTQ Patients

Ronald Chambers, MD, FAAFP

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Dr. Chambers graduated from George Washington University School of Medicine in Washington, DC, and completed his residency at Dignity Health Methodist Hospital in Sacramento, California. Subsequently, he completed fellowships in faculty development and program director development. He serves as clinical faculty at the University of California (UC) Davis School of Medicine, Sacramento, and is a clinical associate professor at California Northstate University College of Medicine, Elk Grove. In addition to his role as the program director for Dignity Health Methodist Hospital of Sacramento Family Medicine Residency Program, Dr. Chambers is the Designated Institutional Official (DIO); chair of the family medicine department; and medical director for Mercy Family Health Center. He also serves as a physician advisor for the Dignity Health Human Trafficking Response Program and medical director for Human Trafficking Medical Safe Haven. His primary interests are the creation of trauma-informed, victim-centered longitudinal medical homes for survivors of human trafficking and related resident physician education and training on the use of survivor-informed practices.
Learning Objectives

1. Develop communication strategies and an environment inviting to patients to disclose sexual and physical trauma histories without pushing for details that could be re-traumatizing to disclose.

2. Formulate plans to discuss family dynamics and community resources for GLBT patients who may require support or conflict management.

3. Be aware of community resources that offer sensitive mental health services for GLBT patients.

4. Understand the additional health risks for GLBT patients and offer appropriate screening and follow up.
Please Note

This talk may contain triggers. Please practice self care or excuse yourself as necessary.

Example stories are discussed to exemplify concepts, details adjusted to be non-identifiable. Our goal is not to re-exploit an individual’s story

Meet Josie

https://www.youtube.com/watch?v=myZrUgEE5OY
**Human Trafficking As United States Defines It**

The *inducement, recruitment, harboring, transportation, obtaining, or providing* of a person

*by force, fraud, or coercion* for

Commercial Sex or Labor/Services

Unless...

It is commercial sex and the victim is under **18 years of age**

Note: Human Trafficking is **NOT** the same as Human Smuggling. Undocumented immigrants are a vulnerable population.

**National Statistics on Human Trafficking**

National HT Hotline: Human trafficking reported **in all 50 states, D.C.** 2016 Statistics:

Areas affected by human trafficking, 2015

(Polaris, national anti-trafficking organization, operates National HT Hotline)
So, let’s break down the general categories...

**Most Commonly Identified**

- [Link](https://humantraffickinghotline.org/states)

**Where Our Patients Experience Labor Trafficking**

- Farm Work
- Construction Sites
- Hotels
- Factories (sweatshops)
- Domestic Worker/Service
- Restaurants
- Landscaping

Labor trafficking does not get as much attention in the media as sex trafficking.

Foreign national victims *may not speak English*, *may not know rights* in America. *May be threatened, intimidated*. *May feel legally/morally obligated to serve contract.*
Where Our Patient Experience Sex Trafficking

- Strip Clubs
- Pornography
- Prostitution
- Massage Parlors
- Truck Stops
- Online Escorts
- Brothels (Ex: Latino)
- Major Sporting Events (debateable)

United Nations ILO Report¹ Estimates (Controversy surrounds....)

Prevalence of 1.5 per 1000 capita*

Population 314 million**

= 471,000 Victims

*Developed Economies and European Union
**Extrapolated to United States
Are We Sensationalizing It?  
Commonly Cited but Perhaps Misleading Statistics...

- According to the Justice Department’s National Incidence Study[^1] 1.7 million children run away each year.

- 357,000 get reported as missing (21%).[^2]

- 1 in 7 runaways reported missing in 2017 was likely a victim of sex trafficking in the U.S.[^3]

- 100,000 - 300,000 youth are **at risk** of being sexually exploited for commercial use in the U.S.[^4]

- Survivors report trafficking victimization by pimps or gangs as young as 12 years old[^5]... some younger

Sensationalized?

In our clinic patients have disclosed:

- Younger age of onset for familial.

- Described recruitment (knocked) more frequently done by women.

- Buyers ("Johns, Tricks", "Dates") come from various backgrounds. Many described as middle class married males with family.

- Included Demographics: doctors, lawyers, law enforcement, clergy.
Domestic Minor Sex Trafficking 8
...and a very controversial number.

100,000

(Recanted!)

Ernie Allen, former President & CEO of the National Center for Missing & Exploited Children in Congressional Testimony July 2010

(recanted due to criticism, but let’s try to evaluate with tools at hand…)

The Controversy of Resource Allocation,"

If 50,000 U.S. girls are trafficked this year, then a teenage girl is:

20X

as likely to be trafficked as to die in an automobile accident

50X

as likely to be trafficked as to commit suicide

2000X

as likely to be trafficked as ANY citizen is to be killed in a terrorist attack
Redefining Victim Stereotypes

"While trafficking affects all demographics, traffickers frequently target individuals who lack strong support networks, are facing financial strains, have experienced violence in the past, or who are marginalized by society.”

-Polaris Project

LGBTQ+ Individuals Bear Increased Burden

Traffickers often target young people living on streets:

• 380,000 youth experience homelessness annually
• Up to 40% of homeless youth identify as LGBTQ

• Of these:
  - 46% ran away because of family rejection.
  - 7.4x more likely to experience acts of sexual violence than their heterosexual peers.
  - 3-7x more likely to engage in survival sex to meet basic needs.
LGBTQ+ Individuals Bear Increased Burden

25%

Almost one quarter of the transgender community in California report they have worked in the street economy at some time in their lives. ¹³

Discrimination leads to unemployment. Poverty increases vulnerability.

“After beginning transition, I was asked/forced to leave a high paying management job after years of successive promotions.”

• Almost half of California’s transgender population reports they had experienced some loss of employment as a result of their gender identity.

• Those persons who have lost a job due to their gender identity are significantly more likely to have lower income (< $10,000 annually).

Ernie Allen,
Former President and CEO, National Center for Missing and Exploited Children

“The only way not to find this in any American city is simply not to look for it.”¹³

¹³Ernie Allen, Former President and CEO, National Center for Missing and Exploited Children

“The only way not to find this in any American city is simply not to look for it.”
What Makes the News vs. A More Insidious Reality

*Erosguide, P411, Skip the Games, Adultlook, Private Delights, CityVibe***

Why Such a Problem? Money.

**500 Dollars**
- 1 Girl
- $500/day
- 365 days/year
  - $182,000
- 3 Girls
- $500/day
- 365 days/year
  - $546,000

**1000 Dollars**
- 1 Girl
- $1000/day
- 365 days/year
  - $364,000
- 3 Girls
- $1000/day
- 365 days/year
  - $1,092,000
Profiles of a Trafficker

“Gorilla” Pimp
- Severe violence as primary control
- May employ forced drug use
- “Bottom” girl may be present
- Physically Beats/Bullies
- May abduct or lure youth and traffic out of area

Gang Pimp
- On the rise
- Often employs forced drug use
- “Bottom” girl may be present
- Girls often used violently and sexually in gang initiation
- Victim may have loyalty to both gang and “boyfriend”

Finess/“Romeo” Pimp
- Stage 1: Initial Contact
  - Meets on internet, mall, etc.
  - May act as boyfriend
  - Buys gifts, tells beautiful
- Stage 2: Control
  - Limits contact with friends
- Stage 3: Separation
  - Girl leaves house, friends
  - May move to new location –reliant on pimp.
- Trauma Bonding
  - Alternate love and affection with trauma
  - May have child with victim
  - Girl dependent (Stockholm Syndrome)

Victor Moreno-Hernandez, 28, was sentenced to 30 years in prison for charges related to selling a 13-year-old girl for sex multiple times out of a strip club in Oregon (KPTV, 2013). Photo used with permission from the Washington County Sheriff’s Office.

Learn to be a Pimp?

The Pimp Game: Instructional Guide Paperback – 1998 by Mickey Royal (Author)
The Role of Societal Acceptance (Pimpology, Pimp Game, etc.)

PIMP'S BUSINESS GOAL 3: Selling the “Product”

“You'll start to dress her, think for her, own her. If you and your victim are sexually active, slow it down. After sex take her shopping for one item. Hair and/or nails is fine. She'll develop a feeling of accomplishment. The shopping after a month will be replaced with cash. The love making turns into raw sex. She'll start to crave the intimacy and be willing to get back into your good graces. After you have broken her spirit she has no sense of self value. Now pimp, but a price tag on the item you have manufactured.”

--The Pimp Game

From the book: The Pimp Gang, Mickey Royal

A Word on Trauma Bonding (AKA: Trauma-Coerced Attachment)

A term developed by Patrick Carnes to describe “the misuse of fear, excitement, sexual feelings, and sexual physiology to entangle another person.”

Trauma-Coerced Attachment involves a powerful emotional dependency on the abusive partner and a shift in world- and self-view, which can result in feelings of gratitude or loyalty toward the abuser and denial or minimization of the coercion and abuse.

Intensity often mistaken for intimacy.

Overlaps with Stockholm Syndrome.
## An Example Story

Healthcare Interaction with Human Trafficking Victims

### Are Victims Seen? Studies Vary Widely

- >90% of patients seen at our center reported contact with a healthcare system while being trafficked. (Demographics include labor trafficking, cross ethnicities, genders, and languages but majority are US Citizen English speaking female sex trafficking victims).  
  - No Interventions
- 87.8% of victims interviewed in 2014, who identified as “female sex trafficking survivors” reported contact with a healthcare system.\(^{17}\)  
  - No interventions.
- 77% of sexually exploited youth in Oakland, CA. reported seeing a physician regularly.\(^{18}\)  
  - 33% currently on prescribed meds, 49% hospitalized.
  
*Likely lower incidence in populations which include men, foreign nationals, labor trafficking*\(^{**}\)

(Only 37% of foreign nationals in recent, small study saw health care provider)
So, how prepared are we in Health Care?

2017 Survey of Family Medicine Program Directors
Analogy: AIDS Epidemic in the early 1980s?

Preparing Providers
To Provide Trauma-Informed Care
Center for Health Care Strategies (CHCS)

https://www.youtube.com/watch?v=fWken5DsJcw

A Trauma-Informed and Patient-Centered Approach...

...is ultimately a mechanism for delivering quality healthcare from a position of empathy.
Guiding Principles of Trauma-Informed Approach

Trauma can affect how individual engages in major life areas, including ongoing health services. Health systems and professionals encouraged to practice SAMHSA’s guiding principles in all aspects of patient care and services:

- **Safety**: Throughout organization, staff and people they serve should feel physically and psychologically safe.
- **Trustworthiness and transparency**: Organizational operations and decisions are conducted with transparency and with goal of building and maintaining trust among staff, patients, and family members.
- **Peer support and mutual self-help**: These are integral to organizational and service delivery approach and are understood as key vehicle for building trust, and for establishing safety and empowerment.
- **Collaboration and mutuality**: There is true partnering and leveling of power differences between staff and patients and among staff.

Guiding Principles, Continued

- **Empowerment, voice, and choice**: Throughout organization and among persons served, individuals’ strengths are recognized, built on, and validated.
- **Consideration of cultural, historical, and gender issues**: Organization actively moves past cultural stereotypes and biases, offers gender responsive services, leverages healing value of traditional cultural connections, and recognizes and addresses historical trauma.

By practicing principles, health professionals can promote patient-centered experience and resist re-traumatization of patients.
Implementing Organizational Change

As seen in video, CHCS recommends organizational practices to reorient culture of health care setting to address trauma in patients and staff:\(^3\)

- Lead and communicate about being trauma-informed
- Engage patients in organizational planning
- Train both clinical and non-clinical staff
- Create a safe physical and emotional environment
- Prevent secondary traumatic stress in staff
- Build a trauma-informed workforce

Learn more from CHCS’s Trauma-Informed Care Implementation Resource Center: www.traumainformedcare.chcs.org/

Implementing Clinical Change

CHCS recommends these clinical practices to address impact of trauma on individual patients:

- Involve patients in treatment process
- Screen for trauma according to best practices
- Train staff in trauma-specific services to prevent, intervene, and treat traumatic stress and co-occurring disorders
- Engage referral sources and partner organizations
  - Local crisis centers, shelters, LGBTQ centers

(pati38241 /iStock)
Train and Grow in Gender Affirming Care Best Practices

- Initial trainings for staff and providers
  - Trauma-Informed approaches for Gender Affirming Care
  - Provide time and space for peer-based learning and reflection
- **Survivor Informed Best Practice**
  - Example: National Survivor Expert: Nat Paul, LGBTQ+ training for all staff
  - Local Gender Health Center training for all staff
- Implement affirming identifiers within healthcare space (i.e., rainbow on stethoscope)
- Referrals to community partners and organizations

National Human Trafficking Resources: At a Minimum, Know This...

National Human Trafficking Hotline (NHTH) can connect patients with local, national resources. Hotline Specialists have interpreting services and they are not mandated reporters.

1 (888)-373-7888

Text: “BeFree” (233733)
Creating a Human Trafficking Medical Safe Haven
Dignityhealth.org/msh

Mercy Family Health Center: Creating a Medical Safe Haven
- Recognition: Protocol Development
  - Our Past: 90% of our patients who were trafficked report having been seen by a medical provider while they were being trafficked. 0% identified, many re-traumatized.
  - Our Present: All physicians and medical staff have undergone extensive education and training on human trafficking.
  - Victims are now recognized.
- Longitudinal Care
  - Creating the wheel...
  - Goal: to provide a safe primary care medical environment for victims and survivors of exploitation and human trafficking led by understanding physicians and medical staff extensively trained in victim-centered, trauma-informed care.
  - Family Medicine is full scope care, the “one stop shop” for victims and their children.

A Medical Home for Human Trafficking Victims
Medical Safe Haven Patient Demographics

<table>
<thead>
<tr>
<th>HT Patient Age Range (M/F)</th>
<th>0-63</th>
<th>Reported Onset of Trafficking: Age 5-24</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trafficker: Partner/Boyfriend, Pimp, or Family Member</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Number of Medical Safe Haven Patient Visits Provided >1200

Patient Ethnicity
- African American - 39%
- Asian - 3%
- Caucasian - 28%
- Hispanic - 26%
- Not disclosed - 4%

Patient Outcomes
- 4 Fold Program Completion Rate
- Improved PTSD, Depression (PHQ-9), Anxiety (GAD-7)
- 100% Enrolled with Health Insurance

Preliminary Data from the Medical Safe Haven

Significantly Decreased Morbidity in Patients
- Decreased PTSD symptoms
- Improved Depression Scores (PHQ-9)
- Decreased Anxiety (GAD-7)
- Four fold Community Program Completion Rate
- Improved Physician Satisfaction with Occupation
  - Paradox effect with “burnout” reported
  - Physician reporting translation of skill set to other patient conditions
- Improved collaboration between health care, law enforcement, hospital staff, community agencies.
### Common Medications We Use (www.dignityhealth.org/msh)

- **STIs**
  - Doxycycline (Azithromycin)
  - Ceftriaxone
  - PCN
  - Metronidazole
- **Plan B**
- **LARC**
- **PreP**
  - **Substance Use (Regiment Dependent)**
    - Suboxone, Methadone
    - Naltrexone, Acamprosate, Anatabuse, Librium
    - Clonidine, Gabapentin
- **Infectious (Regiment Dependent)**
  - TB, Hepatitis, HIV
- **Mood Lability/Intensity**
  - Quetiapine (Seroquel)
  - Olanzapine (Zyprexa)
  - Lurasidone (Latuda) if pregnant
  - Lamotrigine (Lamictal)
- **Nightmares, Hyperarousal**
  - Prazosin
- **Depression/GAD/PTSD**
  - Escitalopram (Lexapro)
  - Sertraline (Zoloft)
  - Duloxetine (Cymbalta)
  - Venlafaxine (Effexor)
  - Fluoxetine (Prozac)

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### Know Your Local Service Providers - Community Organizations Working with Victim/Survivors

- Stand Up Placer
- WEAVE
- Community Against Sexual Harm
- Chicks In Crisis
- City of Refuge Sacramento
- Open Doors
- My Sister’s House
- Bridge Network CO
Manuals to Create Response Protocol and Replicate Medical Safe Haven
www.dignityhealth.org/msh

- **Step 1**: Identify the Physician/Staff Champion
- **Step 2**: Create Clinic Documents
- **Step 3**: Implement Provider Training
- **Step 4**: Establish Protocols for Recognizing and Responding to New Victims
- **Step 5**: Outline work flows for seeing patients in the outpatient medical safe haven setting.
- **Step 6**: Create Patient Handouts
- **Step 7**: Communicate Ability to take Referrals/Patients
- **Step 8**: Invite Community Agencies/Law Enforcement into clinic to collaborate and discuss services.

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**Practice Recommendations**

- Implement response protocols at hospitals across the country*
- Develop centers able to provide longitudinal victim-centered trauma-informed care for human trafficking victims
- Incorporate human trafficking training into residency education across the country
The Take Home Points

Family Medicine Can Create Medical Safe Havens for trafficking survivors

1. It is low utilization (cheap)
2. It could provide widespread care
3. In residencies it concurrently trains the doctors of tomorrow to care for this vulnerable patient population (ripple effect)

Feedback

Victim Organizations
“a true blessing to the women we serve, women who have never received such compassionate and understanding care can now trust and believe in the medical system because of him and his team.”

“I just am so thankful for a medical group that has truly operated in a way that speaks of your name...One woman we brought in had a history of 25 pimps, and childhood sexual abuse. She was fearful of doctors and had never had a health exam...she was treated with compassion and expertise...she is now finishing trade school and is proud of the woman she has become...this intervention saved her life.”

Resident Physicians
“There have been an abundance of transformative moments for me in my training...none have been quite as earth shattering in nature as my work with survivors of human trafficking.”

“They require (and deserve) gentle empowerment, need more empathy than I previously thought I had, and call for more creativity and sensitivity in treating and preventing disease”

“To say that I have benefitted from this training is an understatement. It is a privilege. It is humbling. It makes me a better family doctor.”
Feedback from our Patients

What Healthcare Was Like Before...

“While I was in the “life” I went to the doctor because my pimp (trafficker) beat me. No one really asked me questions. I can’t even remember a police report being filed.”

I always went to the doctor for treatment but I associated them with law enforcement. How could I trust doctors when they are the “johns” buying me, along with cops and politicians. It made me not trust anyone in authority.”

“When I went to an ER because my pimp beat me up, I felt judged, like I was just another drug addict.”

What I Experience Now...

“I feel like I have a great relationship with my doctor. I see my doctor and it’s so different from how I was treated before...he listens and treats me like a person. He addresses my issues right away.”

“My doctor at Mercy is so caring. I have an amazing relationship with my doctor! She takes care of my physical wellbeing and my emotional wellbeing...my doctor and other physicians check in on me to see how I am doing.”

“I like how it feels like a family environment...they take things slow and make sure I am comfortable, everyone is so friendly.”

Contact Information

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Questions

References

References