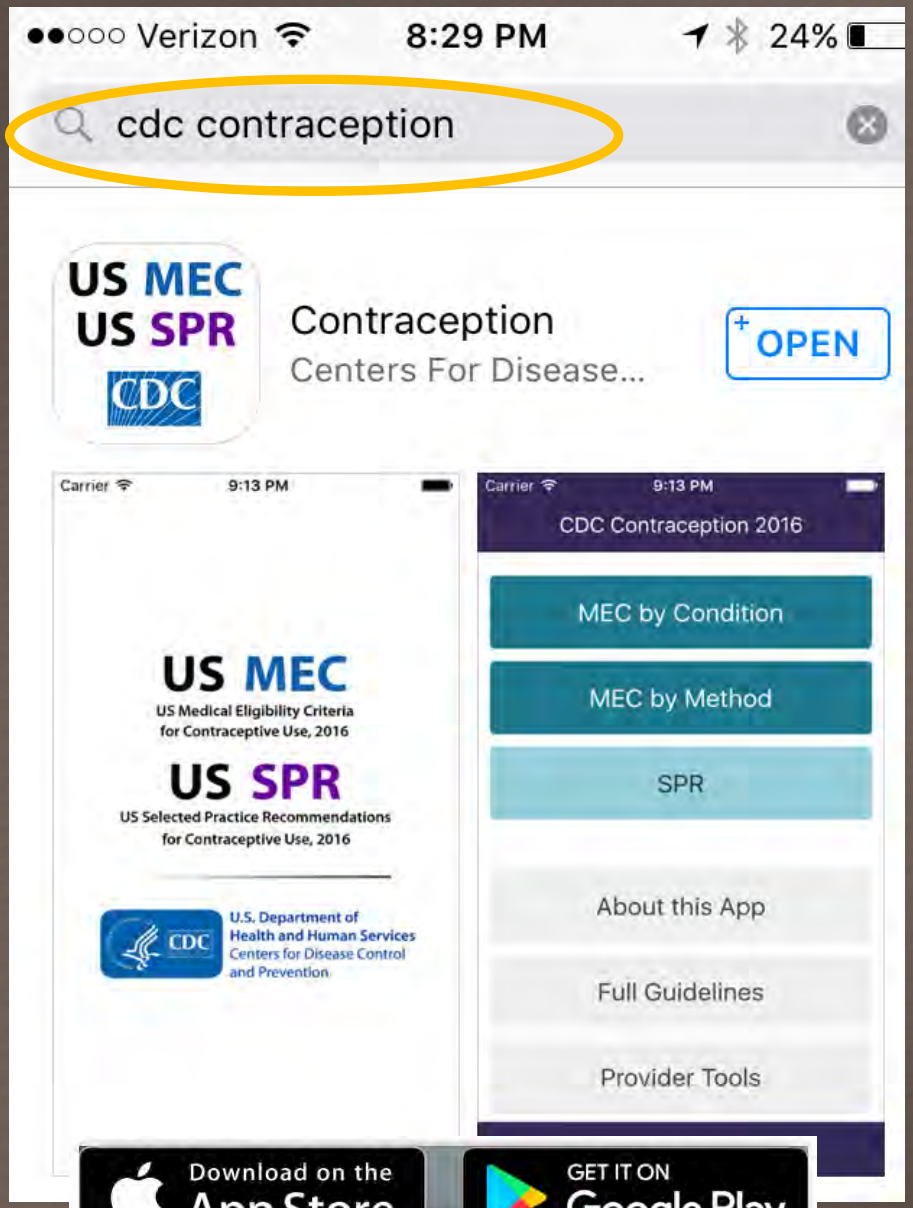
Download Free App for 3:30p Session



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Contraception Eligibility and Management: 2016 Updates from the CDC
June 14, 2017

Brooke Bokor, MD, MPH
Division of Adolescent & Young Adult Medicine

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At the session's end, participants will be able to …

- Apply the CDC's 2016 US Medical Eligibility Criteria (MEC) updates to clinical management
- Apply the CDC's 2016 US Selected Practice Recommendations updates to clinical management
- Use the MEC and SPR point-of-care tools to guide clinical management

Providing Quality Family Planning Services

US MEC

US Medical Eligibility Criteria for Contraceptive Use, 2016

US SPR

US Selected Practice Recommendations for Contraceptive Use, 2016

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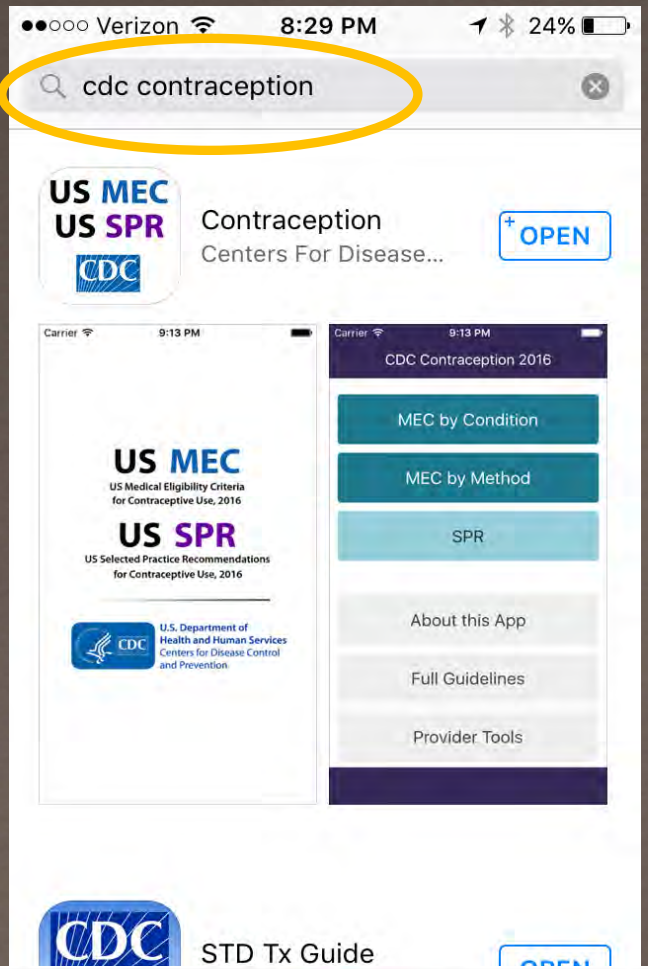
Summary Chart of U.S. Medical Eligibility Criteria for Contrace

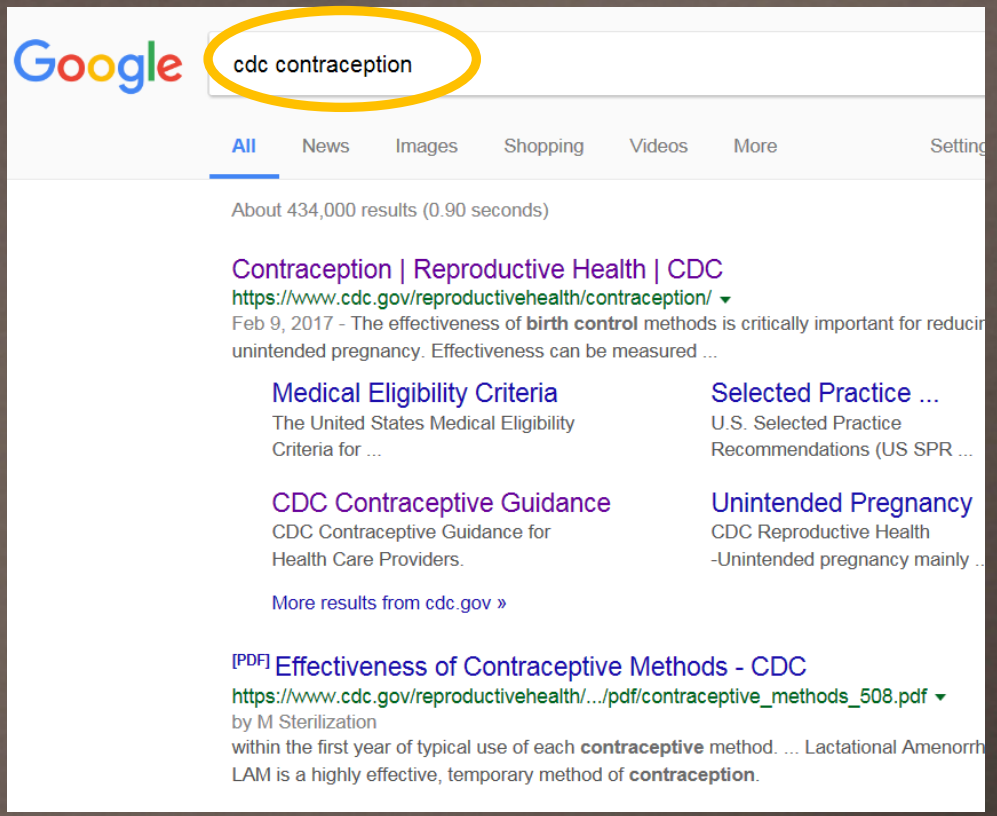
Condition	Sub-Condition	Cu-IUD		LNG-IUD		Implant		DMPA		POP		CHC	
		I	C	I	C	I	C	I	C	I	C	I	C
Hypertension	a) Adequately controlled hypertension	1*		1*		1*		2*		1*		3*	
	b) Elevated blood pressure levels (*properly taken measurements*)												
	i) Systolic 140-159 or diastolic 90-99	1*		1*		1*		2*		1*		3*	
	ii) Systolic ≥160 or diastolic ≥100‡	1*		2*		2*		3*		2*		4*	
	c) Vascular disease	1*		2*		2*		3*		2*		4*	
Inflammatory bowel disease	(*Ulcerative colitis, Crohn's disease*)	1		1		1		2		2		2/3*	
Ischemic heart disease‡	Current and history of	1		2	3	2	3	3		2	3	4	
Known thrombogenic mutations‡		1*		2*		2*		2*		2*		4*	
Liver tumors	a) Benign												
	i) Focal nodular hyperplasia	1		2		2		2		2		2	
	ii) Hepatocellular adenoma‡	1		3		3		3		3		4	
	b) Malignant‡ (hepatoma)	1		3		3		3		3		4	
Malaria		1		1		1		1		1		1	
Multiple risk factors for atherosclerotic cardiovascular disease	(e.g., older age, smoking, diabetes, hypertension, low HDL, high LDL, or high triglyceride levels)	1		2		2*		3*		2*		3/4*	
Multiple sclerosis	a) With prolonged immobility	1		1		1		2		1		3	
	b) Without prolonged immobility	1		1		1		2		1		1	
Obesity	a) Body mass index (BMI) ≥30 kg/m²	1		1		1		1		1		2	
	b) Menarche to <18 years and BMI ≥ 30 kg/m²	1		1		1		2		1		2	
Ovarian cancer‡		1		1		1		1		1		1	
Parity	a) Nulliparous	2		2		1		1		1		1	
	b) Parous	1		1		1		1		1		1	
Past ectopic pregnancy		1		1		1		1		2		1	
Pelvic inflammatory disease	a) Past												
	i) With subsequent pregnancy	1	1	1	1	1		1		1		1	
	ii) Without subsequent pregnancy	2	2	2	2	1		1		1		1	
	b) Current	4	2*	4	2*	1		1		1		1	
Peripartum cardiomyopathy‡	a) Normal or mildly impaired cardiac function												
	i) <6 months	2		2		1		1		1		4	
	ii) ≥6 months	2		2		1		1		1		3	
	b) Moderately or severely impaired cardiac function	2		2		2		2		2		4	
Postabortion	a) First trimester	1*		1*		1*		1*		1*		1*	

Condition	
Pregnancy	
Rheumatoid arthritis	a) On im
	b) Not c
Schistosomiasis	a) Unco
	b) Fibro
Sexually transmitted diseases (STDs)	a) Curre infect
	b) Vagin *and b*
	c) Other
Smoking	a) Age <
	b) Age ≥
	c) Age ≥
Solid organ transplantation‡	a) Comp
	b) Unco
Stroke‡	History
Superficial venous disorders	a) Varico
	b) Supe (acut
Systemic lupus erythematosus‡	a) Positi antib
	b) Sever
	c) Immu
	d) None
Thyroid disorders	Simple
Tuberculosis‡ *(see also Drug Interactions)*	a) Nonp
	b) Pelvic
Unexplained vaginal bleeding	(suspici evaluat
Uterine fibroids	
Valvular heart disease	a) Unco
	b) Comp
Vaginal bleeding patterns	a) Irregu
	b) Heav
Viral hepatitis	a) Acute
	b) Carrie
Drug Interactions	
Antiretroviral therapy All other ARV's are	Fosamp

App & Online Access

https://www.cdc.gov/reproductivehealth/contraception/contraception_guidance.htm





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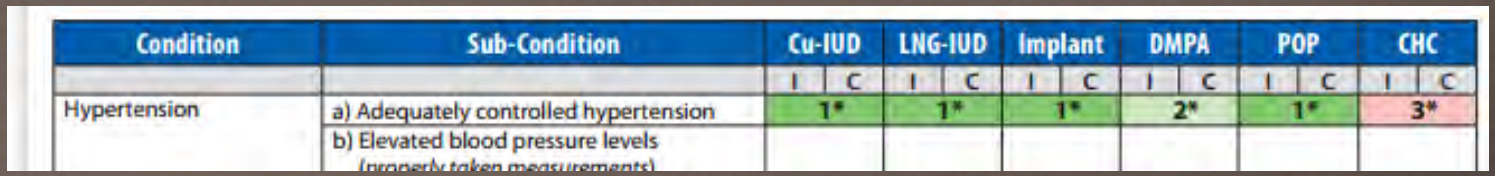
MEC Classifications

1	Can use the method	No restrictions
2	Can use the method	Advantages generally outweigh theoretical or proven risks.
3	Should not use method unless no other method is appropriate	Theoretical or proven risks generally outweigh advantages
4	Should not use method	Unacceptable health risk

What's New in 2016 to the US MEC?

- New medical conditions
  - Cystic fibrosis, multiple sclerosis, use of SSRIs and St. John's Wort
- New emergency contraception method
  - Addition of ulipristal acetate (UPA)
- Hormonal method revisions
  - Migraine headaches, superficial venous disease, known dyslipidemia, use of Anti-Retrovirals
- Intrauterine devices revisions
  - Gestational trophoblastic disease, HIV, factors related to STDs; postpartum/breastfeeding
- Formatting and Terminology



Condition	Sub-Condition	Cu-IUD		LNG-IUD		Implant		DMPA		POP		CHC	
		I	C	I	C	I	C	I	C	I	C	I	C
Hypertension	a) Adequately controlled hypertension	1*		1*		1*		2*		1*		3*	
	b) Elevated blood pressure levels (properly taken measurements)												

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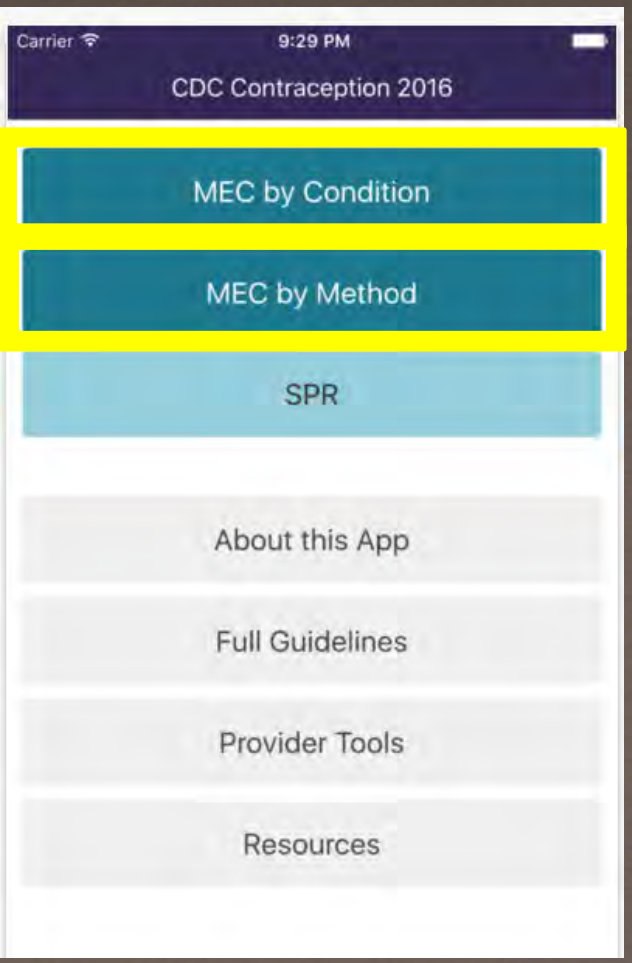
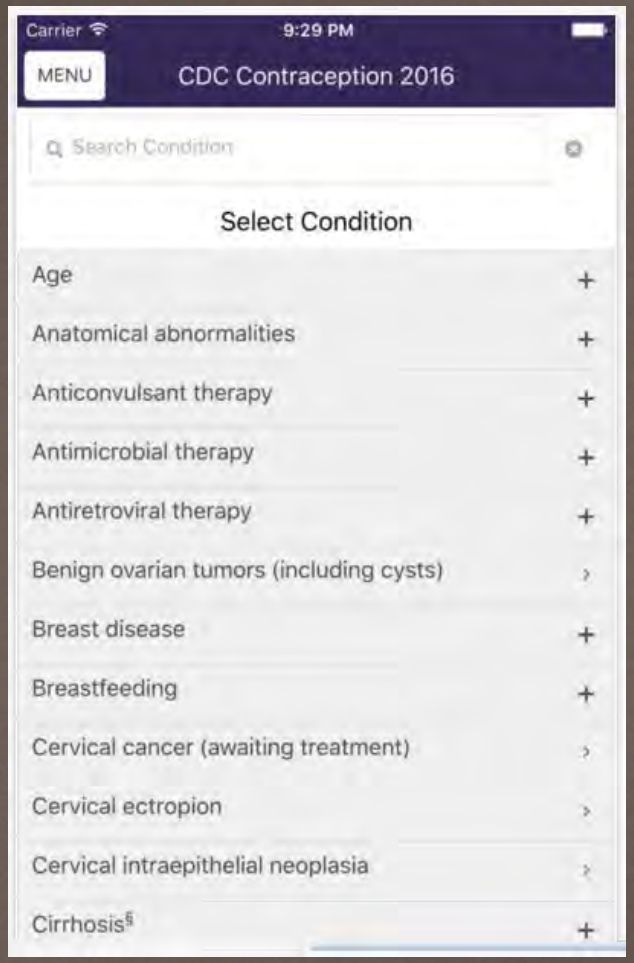
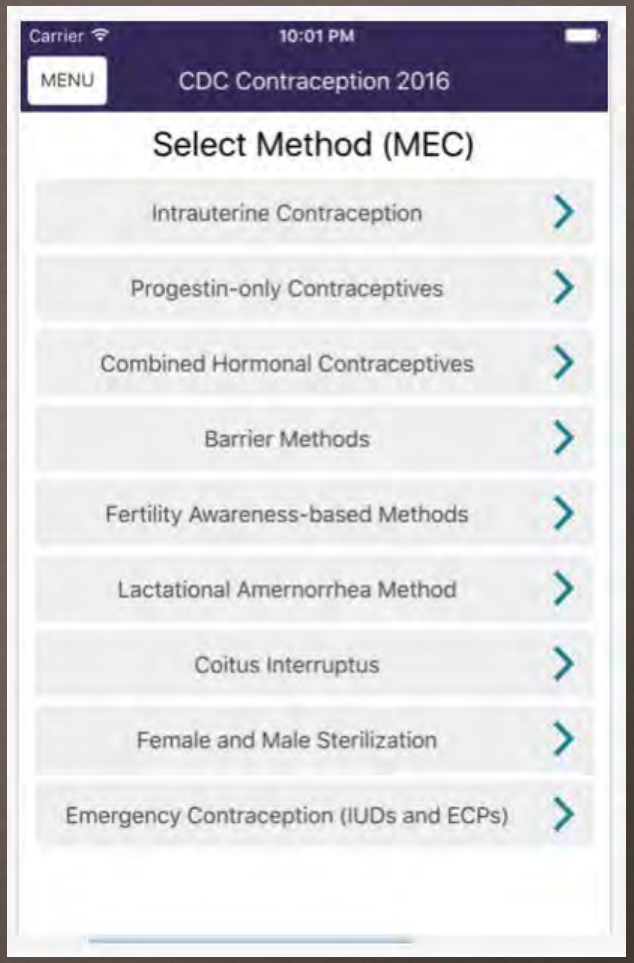
Mobile App: US MEC

US MEC

US Medical Eligibility Criteria for Contraceptive Use, 2016



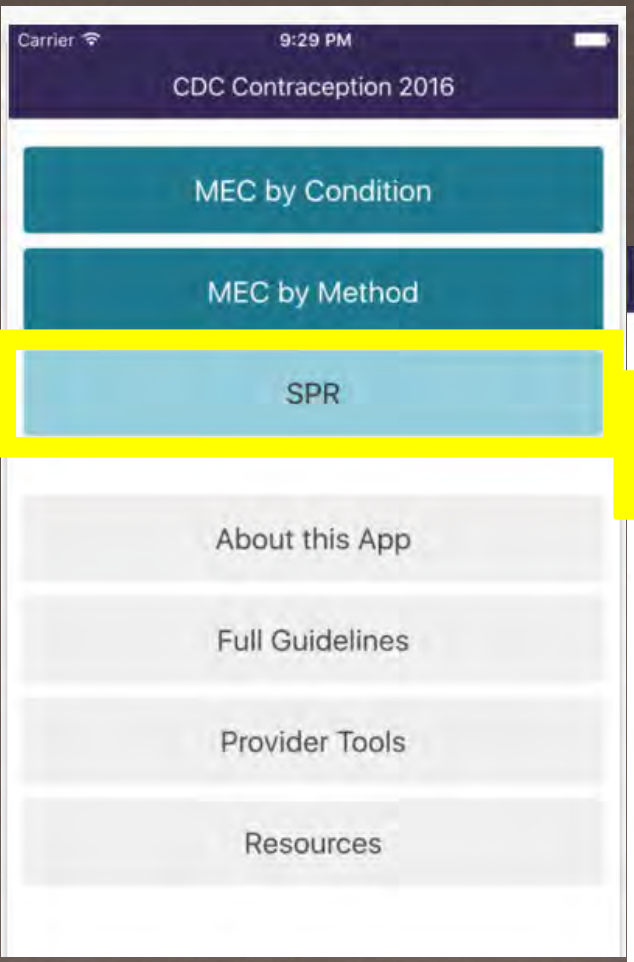


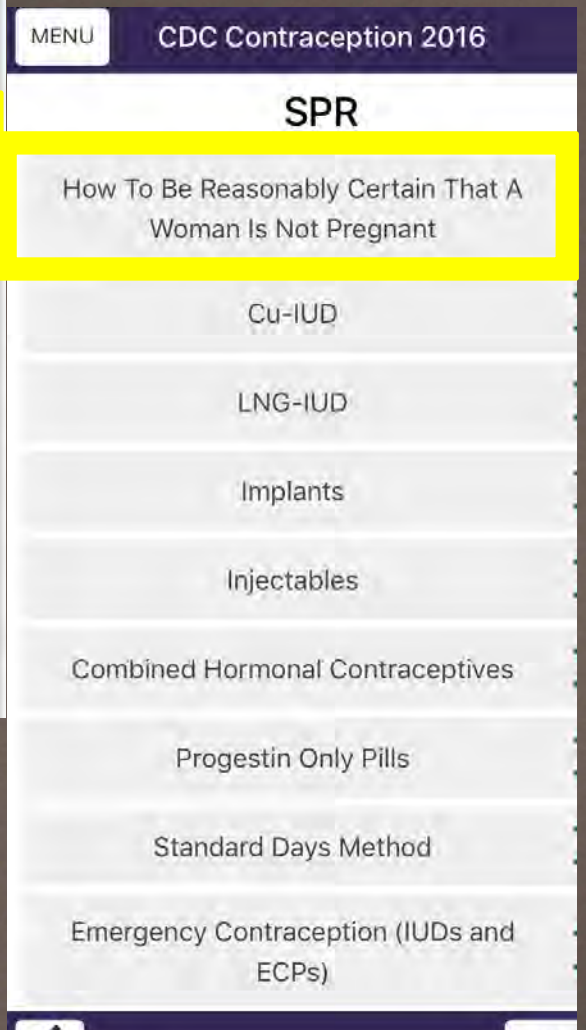


Mobile App: US SPR

US SPR

US Selected Practice Recommendations for Contraceptive Use, 2016





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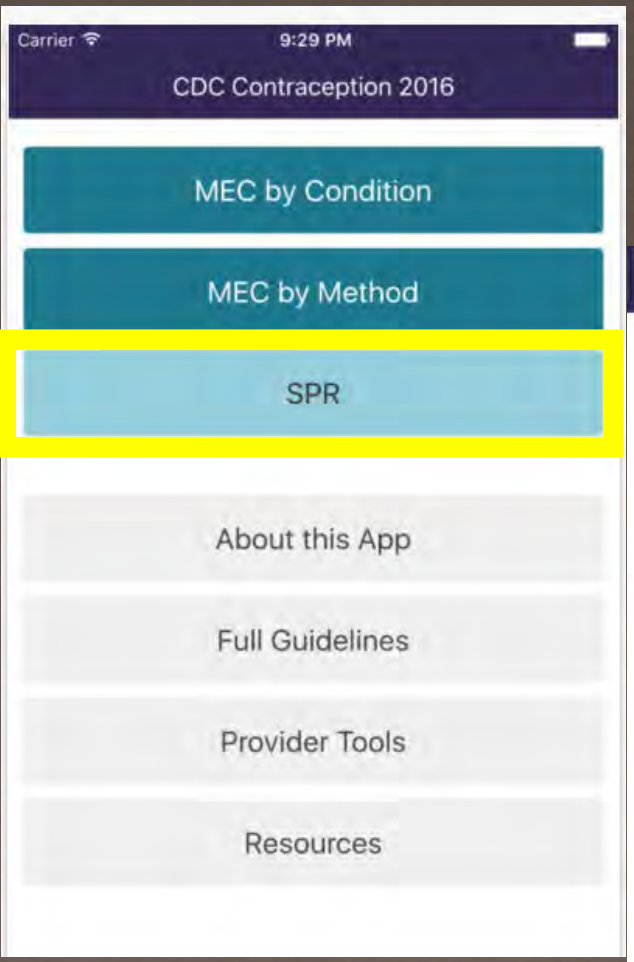
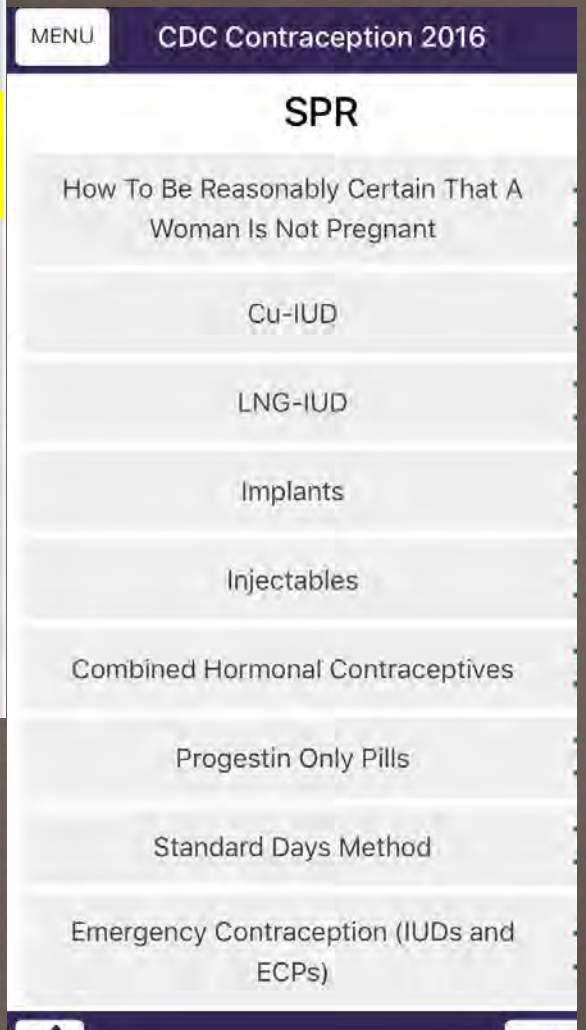
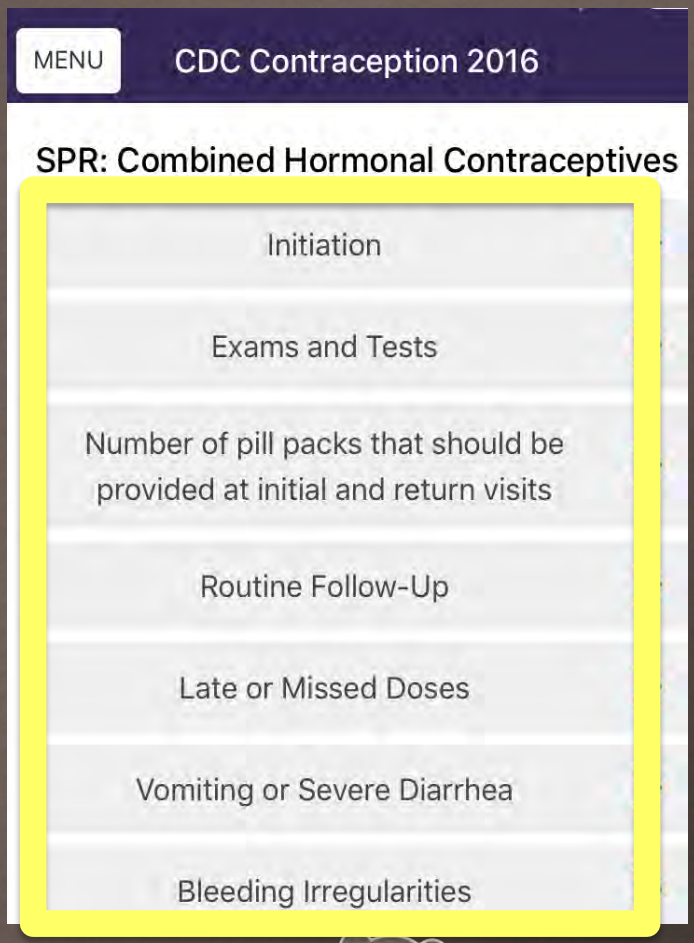
Mobile App: US SPR





US SPR

US Selected Practice Recommendations for Contraceptive Use, 2016



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What's New in 2016 to the US SPR?

- New recommendation
  - Using medications to ease IUD insertion
- Update of existing recommendation
  - When to start regular contraception after ulipristal acetate ECP

Highlights of more topics in the 2016 US SPR

- OCPs
  - Management of side effects
- Depo-Provera
  - Timing of repeat injections

5 Steps for Contraception Counseling & Education

1. Establish & maintain rapport
2. Obtain social and clinical information
3. Work w/client interactively to select the
   most effective (tiered) & *appropriate* method
   - medically accurate, balanced, nonjudgmental
4. Conduct a physical assessment related to contraceptive use ONLY when warranted
5. Provide instructions about correct & consistent use
   - Include STI protection
   - Help youth develop a plan use, follow up, and confirm client understanding

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Case: Celine

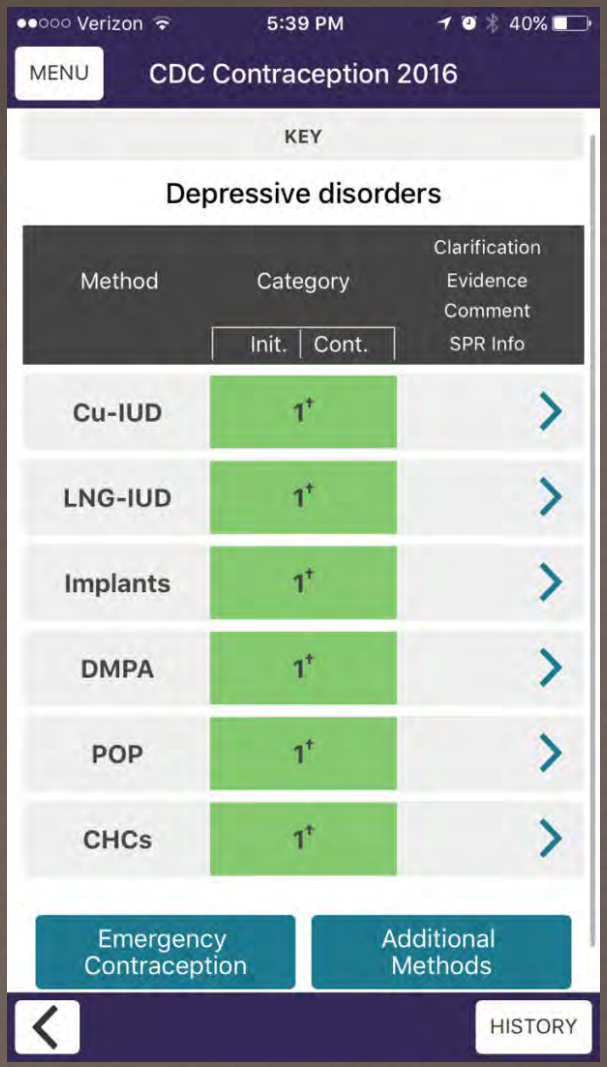
- 17 year old female
- Wants contraception
- History of depression with prior suicide attempt
  - Was told by current mental health provider to avoid hormonal methods
- You wonder if she's limited to non-hormonal methods

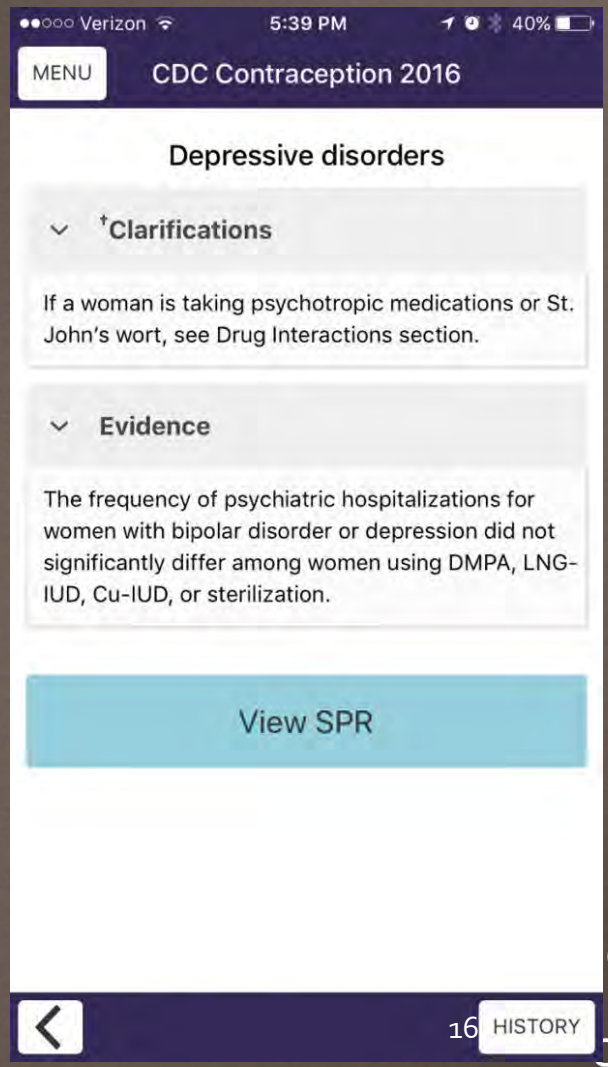
Case 2: Celine (continued)

- No prior history of hormonal contraception use
- Symptoms well-controlled on fluoxetine 40 mg daily

US MEC

Condition	Sub-Condition	Cu-IUD		LNG-IUD		Implant		DMPA		POP		CHC	
		I	C	I	C	I	C	I	C	I	C	I	C
Depressive disorders		1*		1*		1*		1*		1*		1*	





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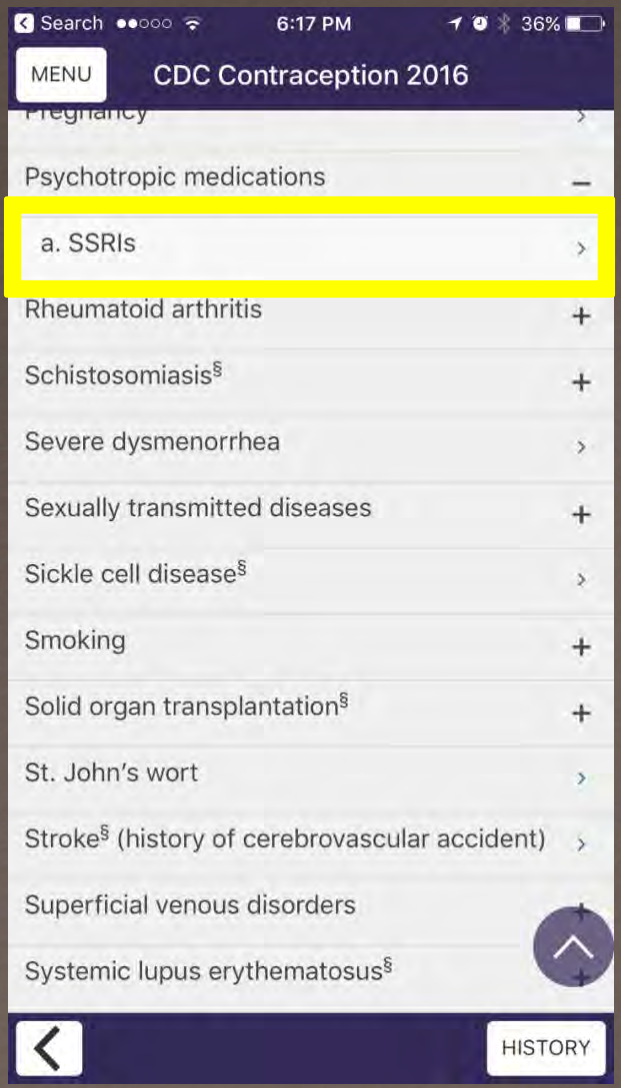
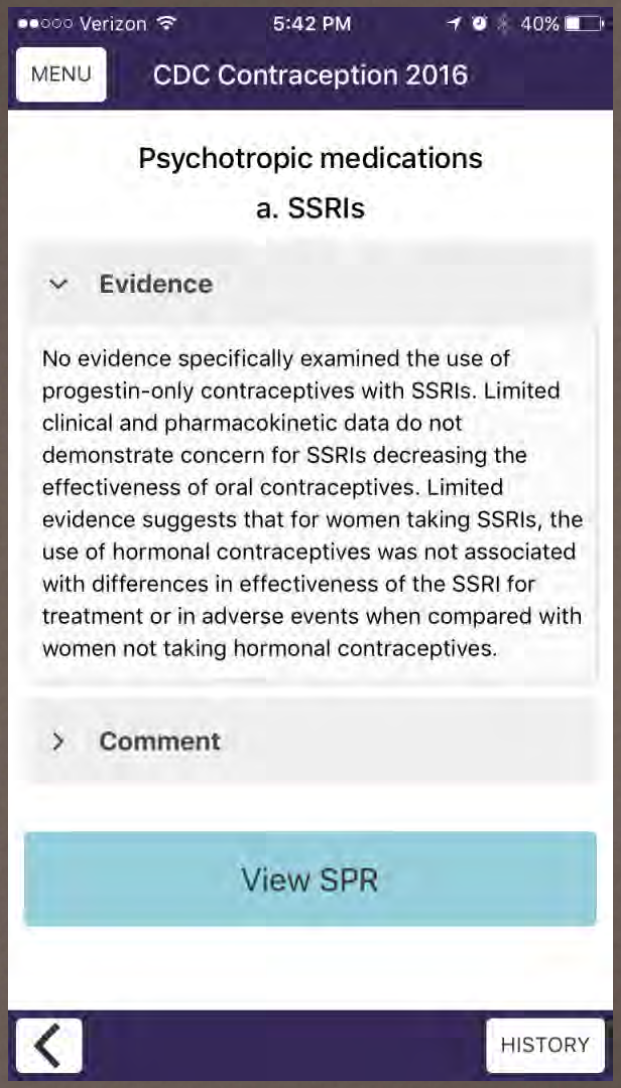
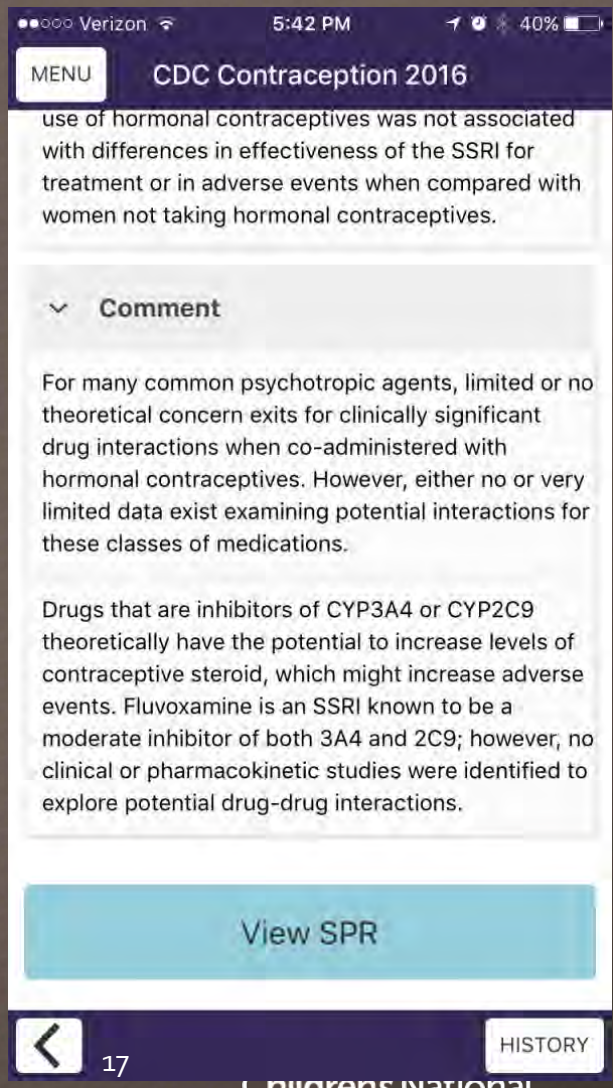
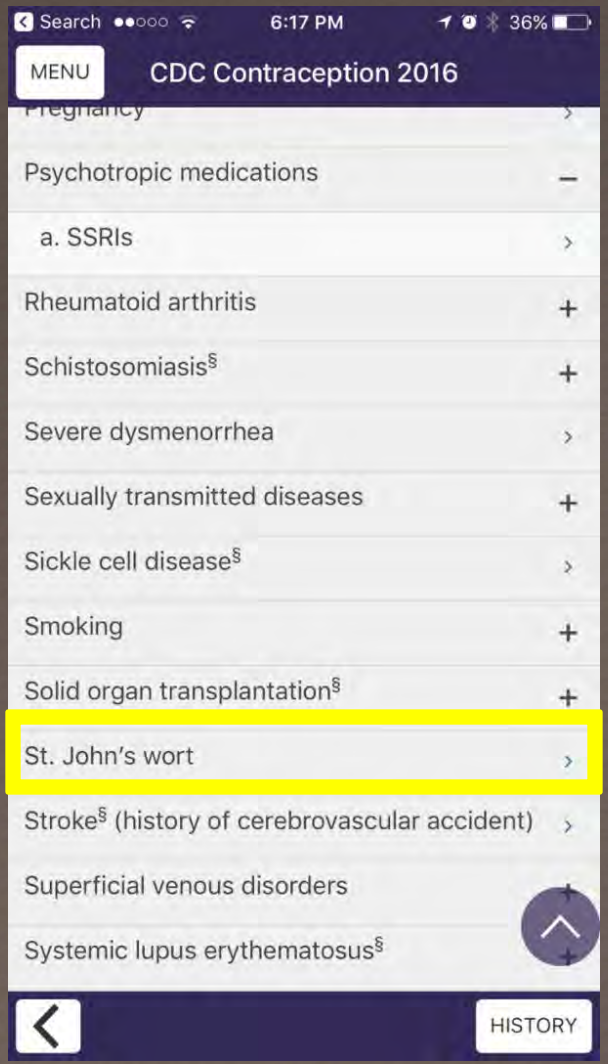
MEC: Drug Interactions

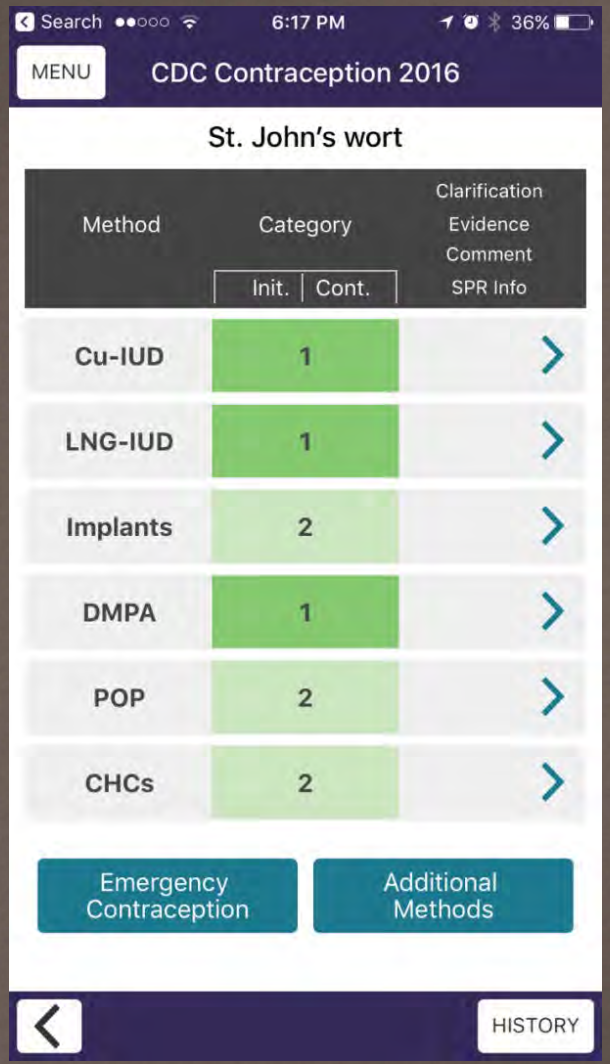


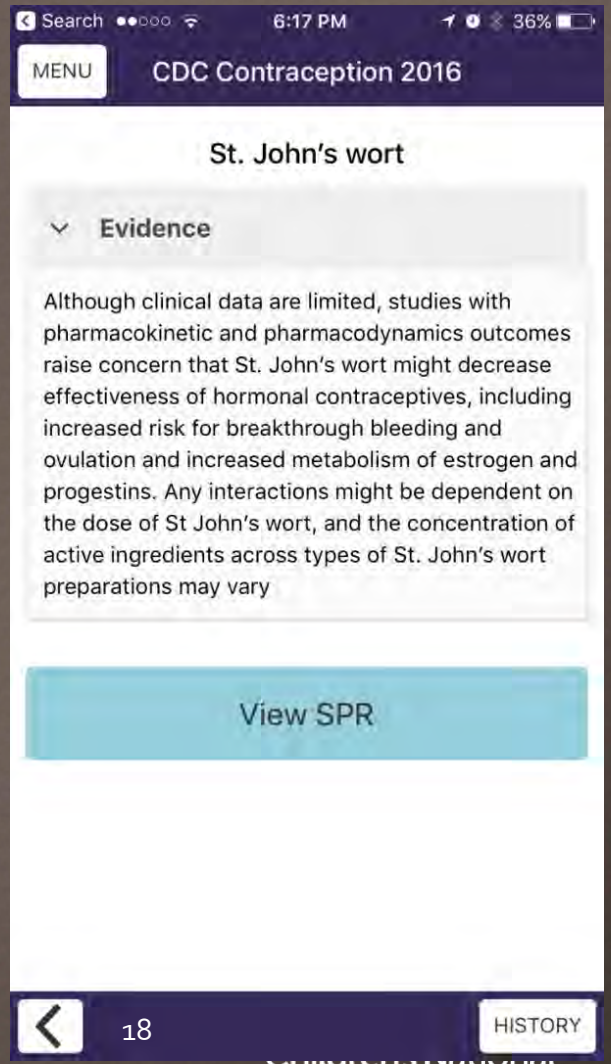


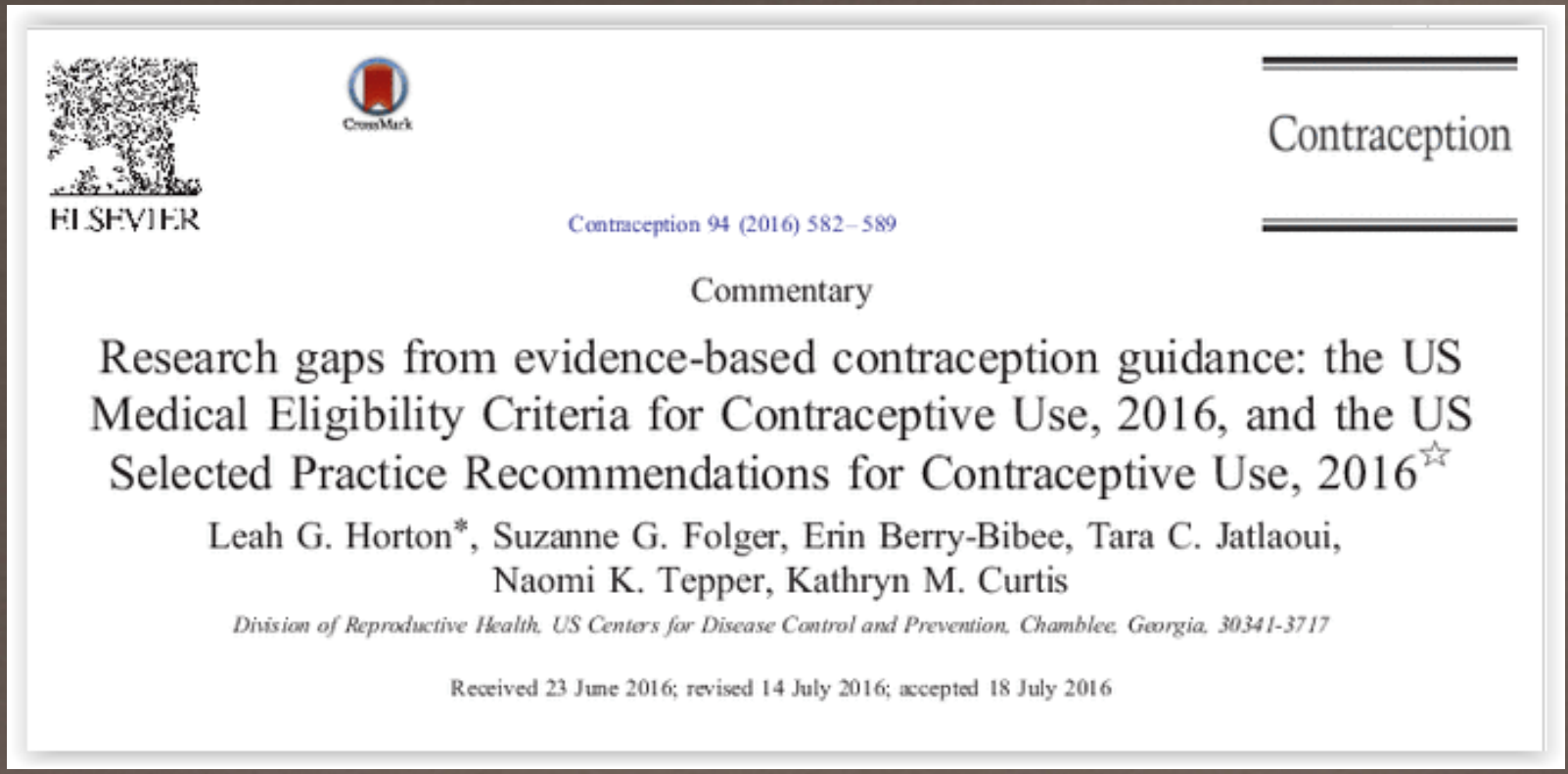


St. John's Wort









ELSEVIER

Contraception

Contraception 94 (2016) 582–589

Commentary

Research gaps from evidence-based contraception guidance: the US Medical Eligibility Criteria for Contraceptive Use, 2016, and the US Selected Practice Recommendations for Contraceptive Use, 2016☆

Leah G. Horton*, Suzanne G. Folger, Erin Berry-Bibee, Tara C. Jatlaoui, Naomi K. Tepper, Kathryn M. Curtis

Division of Reproductive Health, US Centers for Disease Control and Prevention, Chamblee, Georgia, 30341-3717

Received 23 June 2016; revised 14 July 2016; accepted 18 July 2016

- Breastfeeding guidance
- Psychotropic medications
- Transgender patients

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Case 2: Celine (continued)

- After reviewing the MEC and presenting her contraceptive options, she chooses the levonorgestrel implant (Nexplanon)
- Her urine pregnancy test is negative in the office today
- LMP 10 days ago
- Last sex 4 days ago, with condom

Questions:

- **When can she start?**
- **When is it effective?**

How to Be Reasonably Certain That a Woman is Not Pregnant

A health-care provider can be reasonably certain that a woman is not pregnant if she has no symptoms or signs of pregnancy and meets any one of the following criteria:

- is ≤7 days after the start of normal menses
- has not had sexual intercourse since the start of last normal menses
- has been correctly and consistently using a reliable method of contraception
- is ≤7 days after spontaneous or induced abortion
- is within 4 weeks postpartum
- is fully or nearly fully breastfeeding (exclusively breastfeeding or the vast majority [≥85%] of feeds are breastfeeds), amenorrheic, and <6 months postpartum

Celine

LMP 10 days ago

Last sex 4 days ago

with condom

Adapted from U.S. SPR for Contraceptive Use, 2016, Box 1

Answer: The implant is effective starting 7 days after placement

Method	When to start, if provider is reasonably certain woman is not pregnant	Need for back-up contraception
Copper IUD	Any time	Not needed
LNG IUD	Any time	If > 7 days after menses started, use back-up method or abstain for 7 days
Arm Implant	Any time	If > 5 days after menses started, use back-up method or abstain for 7 days
Injectable	Any time	If > 7 days after menses started, use back-up method or abstain for 7 days
Combined hormonal (pill, ring, patch)	Any time	If > 5 days after menses started, use back-up method or abstain for 7 days
Progestin-only pill	Any time	If > 5 days after menses started, use back-up method or abstain for 2 days

Adapted from U.S. SPR for Contraceptive Use, 2016, Appendix B

If checklist is NOT satisfied…

- Patient wants hormonal method besides IUD
  - Risks of not starting method --versus– starting in woman who is already pregnant
  - Consider starting anytime, with follow-up pregnancy test in 2-4 weeks
  - Consider EC as appropriate

- Patient wants IUD
  - Risks of IUD in pregnant women include higher risk for spontaneous abortion, septic abortion, preterm delivery, chorioamnionitis
  - Consider bridging method until can be reasonably certain not pregnant

Case 2: Celine (continued)

Question:

- **Does she need any exams or tests before initiating the implant?**

Exams and tests before starting contraception

- Class "A": essential and mandatory
- Class "B": contributes substantially to safe and effective use, but implementation may be considered within the public health and/or service context
- Class "C": does not contribute substantially to safe and effective use of the contraceptive method

Exam or test	IUDs	Implant	Injectable	CHCs
Blood pressure	C	C	C	A
BMI	+	+	+	+
Breast exam	C	C	C	C
Bimanual exam	A	C	C	C
Glucose	C	C	C	C
Lipids	C	C	C	C
Liver enzymes	C	C	C	C
Hemoglobin	C	C	C	C
Pap smear	C	C	C	C
STD screen	*	C	C	C
HIV test	C	C	C	C

Adapted from U.S. Selected Practice Recommendations for Contraceptive Use, 2016, Appendix C

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U.S. MEC Recommendation: Obesity

Condition	All hormonal methods
≥ 30 kg/m^2 BMI	+
Menarche to < 18 years and ≥ 30 kg/m^2 BMI	+

+ Measuring weight and calculating BMI at baseline might be helpful for monitoring any changes and counseling women who might be concerned about weight change perceived to be associated with their method.

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Case 2: Celine (continued)

- She returns 2 months later because she has had frequent spotting on contraceptive implant (Nexplanon) that she finds very annoying

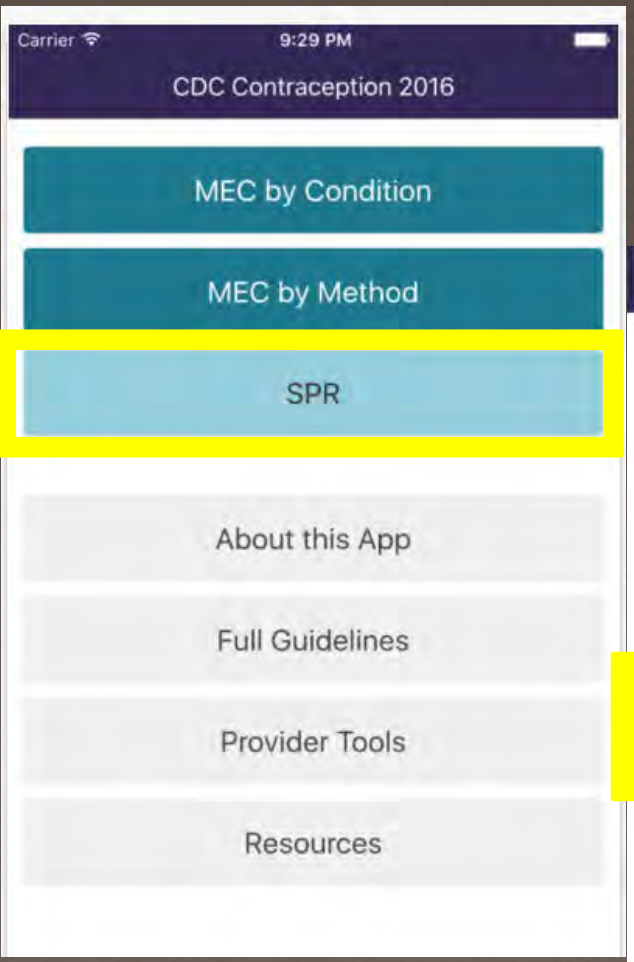
Questions:

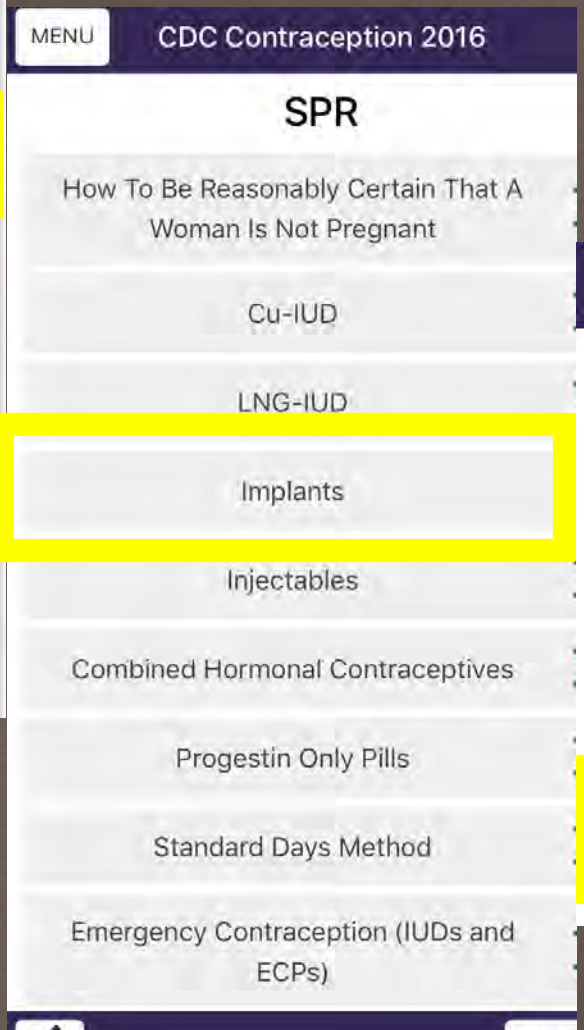
- **Is this concerning?**
- **Is there anything to help irregular bleeding?**

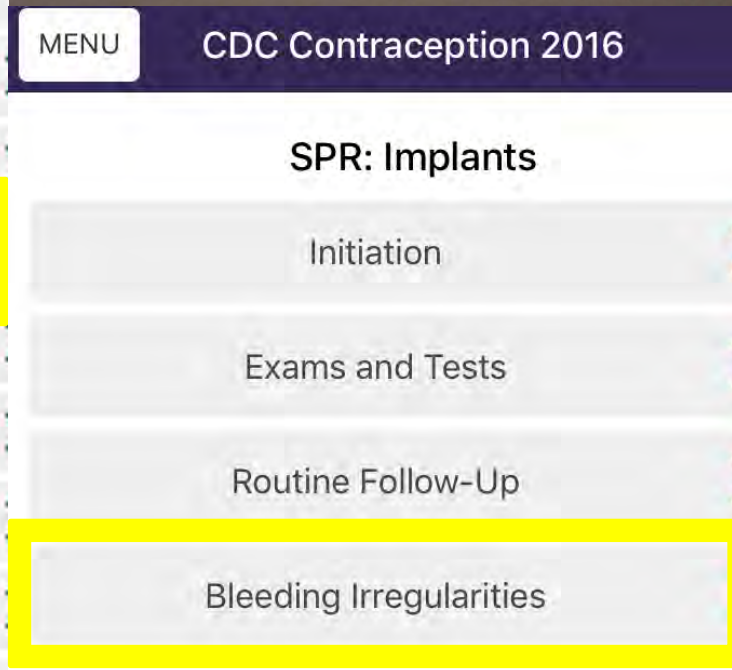
Mobile App: US SPR

US SPR

US Selected Practice Recommendations for Contraceptive Use, 2016







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Unscheduled bleeding:

Differential diagnosis

- Pregnancy
- STIs
- Hormonal contraceptive use
- Medications, eg St. John's Wort
- Smoking
- Blood dyscrasia
- Hyperthyroidism
- Structural lesion
  - Leiomyoma
  - Polyp
- Endometrial hyperplasia/cancer
- Cervical cancer

Testing

- HCG
- CT/GC/trichomoniasis NAAT
- CBC
  - Anemia
  - Thrombocytopenic bleeding
- Screen for bleeding disorders
  - PT/PTT
- TSH
- Speculum/Bimanual exam
- Pelvic Ultrasound
- Pap

Bleeding irregularities during implant use

- **Provide enhanced counseling about expected bleeding patterns**
- **Provide reassurance that bleeding irregularities are generally not harmful**
- These approaches shown to reduce discontinuation (extrapolated from DMPA users)

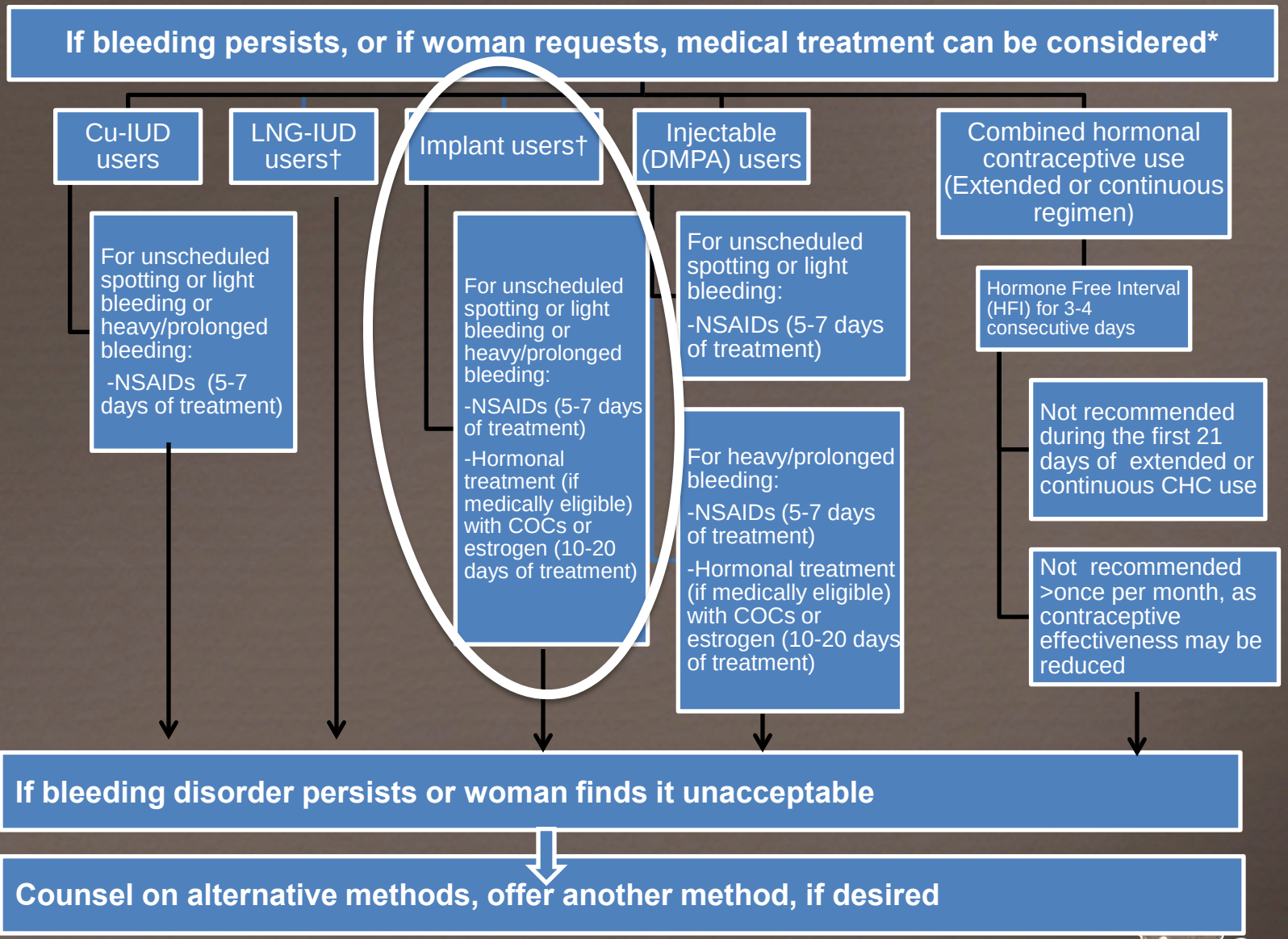
Mansour D et al. Eur J Contracept Reprod Health Care, 2008; 2. Canto de Cetina TE et al. Contraception, 2001 and Lei ZW et al. Contraception, 1996.

Case 2: Celine (continued)

- She returns 2 months later because she has had frequent spotting that she finds annoying

- **Question: How should breakthrough bleeding be addressed?**
- **Answer: Consider underlying gynecological problem. If problem ruled out, consider treatment with NSAID for 5-7 days.**

Management of Bleeding Irregularities while Using Contraception – Appendix E



*If clinically warranted, evaluate for underlying condition. Treat the condition or refer for care.
†Heavy or prolonged bleeding, either unscheduled or menstrual, is uncommon.

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A 16-year-old female patient arrives for her next medroxyprogesterone injection (DepoProvera). Your nurse notifies you that she is 3 weeks late for her shot.

Last Depo = 16 weeks ago

urine HCG = negative

You use the QFP approach to contraceptive services and check the SPR for guidance on the timing of repeat injections…

Children's National

QFP Services Approach

Step 1: Establish and Maintain Rapport

Step 2: Obtain Social AND Clinical Information

Medical History:

Obesity (BMI=28; 94th%)

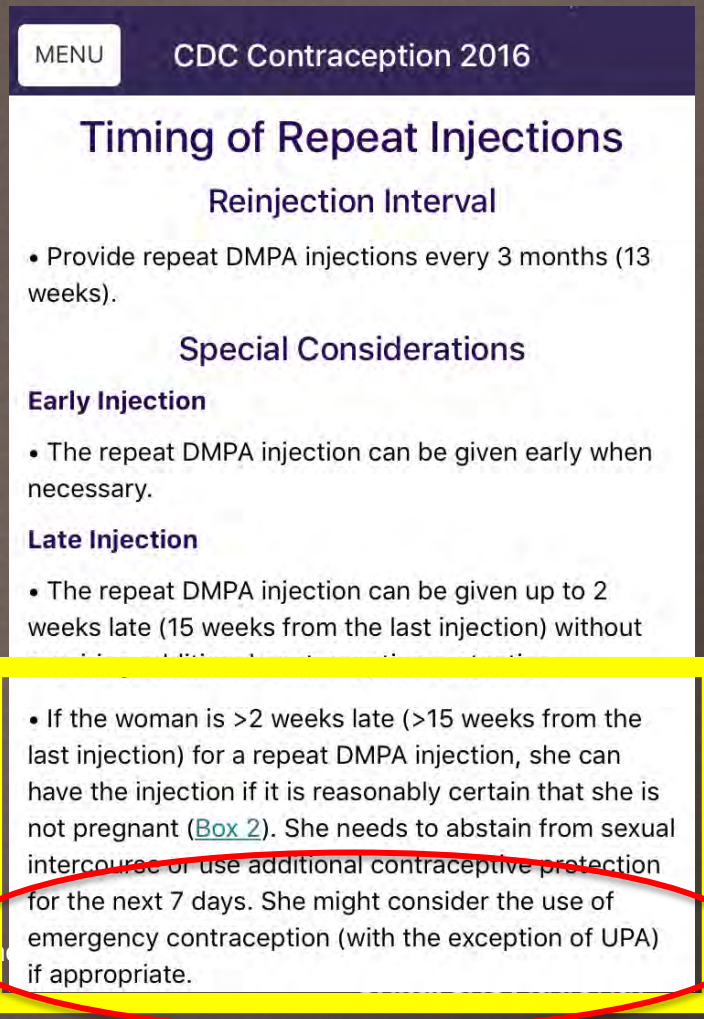
Sexual History:

LSA 4 days ago with male, no condom

Desires pregnancy in >10 years

Wants to continue Depo

Wants emergency contraception pill (upon your suggestion)



MENU CDC Contraception 2016

Timing of Repeat Injections

Reinjection Interval

- Provide repeat DMPA injections every 3 months (13 weeks).

Special Considerations

Early Injection

- The repeat DMPA injection can be given early when necessary.

Late Injection

- The repeat DMPA injection can be given up to 2 weeks late (15 weeks from the last injection) without

- If the woman is >2 weeks late (>15 weeks from the last injection) for a repeat DMPA injection, she can have the injection if it is reasonably certain that she is not pregnant (Box 2). She needs to abstain from sexual intercourse or use additional contraceptive protection for the next 7 days. She might consider the use of emergency contraception (with the exception of UPA) if appropriate.

Gavin L, Moskosky S, Carter M. Providing Quality Family Planning Services: Recommendations of [illegible] U.S. Office of Population Affairs. MMWR 2014;63(4):RR1-54.

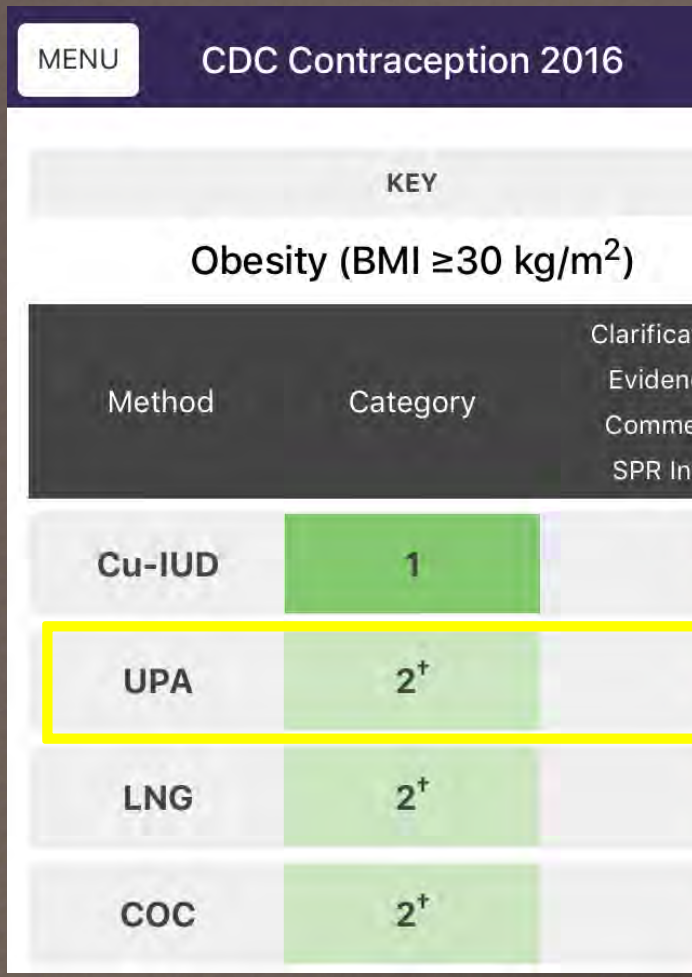
Options for emergency contraception (EC)

- Ulipristal acetate (Ella): effective up to 5 days (120 hours) after unprotected intercourse
- Levonorgestrel (Plan B One-Step): overall reduction in pregnancy rate 60-93%, with decreasing efficacy if used more than 72 hours
- Yuzpe regimen – two step method with ethinyl estradiol and levonorgestrel ; not effective if used more than 72 hours
- IUD: copper-bearing IUD (Copper-T): can be used as EC; requires office appointment with trained provider

Children's National

Ulipristal acetate (UPA) in the US MEC

- Obesity (BMI ≥30)
  - May be less effective than among women with BMI<25
  - More effective than LNG in 72-120 hour post-coital window or closer to ovulation
- Breastfeeding
  - Pump and dump for 24 hours after UPA



Ulipristal acetate (UPA) in the US SPR

- Provide advance supply of ECPs
- Wait 5 days before starting regular contraception to avoid reduction in effectiveness (except Cu-IUD)
- Weigh delay of regular contraception initiation vs. need to return to office for method (DMPA, IUD, or Implant)

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Providing Contraceptive Services

Step 1: Establish and Maintain Rapport

Step 2: Obtain Social AND Clinical Information

Step 3: Work Interactively: Find Most Effective and Appropriate Method

Step 4: Physical Assessment, When Warranted

What exam / tests do you have to do?

Gavin L, Moskosky S, Carter M. Providing Quality Family Planning Services: Recommendations of the CDC and the U.S. Office of Population Affairs. MMWR 2014;63(4):RR1-54.

Providing Contraceptive Services

Step 1: Establish and Maintain Rapport

Step 2: Obtain Social AND Clinical Information

Step 3: Work Interactively: Find Most Effective and Appropriate Method

Step 4: Physical Assessment, When Warranted

Answer : Urine HCG→ negative, but LSA 4 days ago

Gavin L, Moskosky S, Carter M. Providing Quality Family Planning Services: Recommendations of the CDC and the U.S. Office of Population Affairs. MMWR 2014;63(4):RR1-54.

Of the following, the BEST choice for emergency contraception for this girl is

A. Intrauterine device placement
B. Levonorgestrel
C. Ulipristal acetate
D. Yuzpe regimen

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QFP Services: Take Home Messages

Step 1: Establish and Maintain Rapport

Step 2: Obtain Social AND Clinical Information

Step 3: Work Interactively: Find Most Effective and Appropriate Method

Step 4: Physical Assessment, When Warranted

Step 5: Provide Method, Instructions, Follow-Up Plan

- Quick start
- Year supply
- Phone alarms for adherence
- ***Condoms***

ECP + quick start counseling for Depo since can't be "reasonably sure she isn't pregnant"

Gavin L, Moskosky S, Carter M. Providing Quality Family Planning Services: Recommendations of the CDC and the U.S. Office of Population Affairs. MMWR 2014;63(4):RR1-54.

New in 2016 to the US MEC

- New medical conditions
  - Cystic fibrosis, multiple sclerosis, use of SSRIs and St. John's Wort
- New emergency contraception method
  - Addition of ulipristal acetate (UPA)
- Hormonal method revisions
  - Migraine headaches, superficial venous disease, known dyslipidemia, use of Anti-Retrovirals
- Intrauterine devices revisions
  - Gestational trophoblastic disease, HIV, factors related to STDs; postpartum/breastfeeding
- Formatting and Terminology

US SPR: Take Home Messages

- Most women can start most methods anytime
- Few, if any, exams or tests are needed
- Recommendations for anticipatory counseling for potential bleeding problems and proper management are provided
- Routine follow-up generally not required
- Regular contraception should be started after EC

Appropriate patients for co-management with a contraception specialist

- Patients with complex medication regimens or medical problems:
  - Seizure disorder
  - Uncontrolled hypertension
  - HIV
  - Lupus
  - DVT history
- Patients with refractory side effects from their method
- Implant placement
- IUD placement

Referrals

- Contraception and Menstrual Co-Management

  Adolescent Health Center, 202-476-5464, ages 12-21 years
  - Nexplanon placement/removal: same day placement possible; ideal for patient to be informed about method in advance
  - 7 Female Nexplanon providers: Drs. Bokor, Malcolm, Woodward, Chokshi, Someshwar, & Gyamfi
  - Have patient specify "nexplanon" or "implant" to ensure they are scheduled with the correct providers
  - No IUD placements at this time

- IUD Placements
  - Under anesthesia (implants, too), Children's National Gynecologic Surgery Division, Dr. Gomez-Lobo, 202-877-4099
  - Not under anesthesia, Washington Hospital Center GYN, Dr. Gomez-Lobo, 202-877-4099

www.YoungWomensHealth.org

Ask Us | Health Guides | Guías de la Salud | Quizzes | Parents | Clinicians

Center for Young Women's Health

General Health | Sexual Health | Gynecology | Medical Conditions

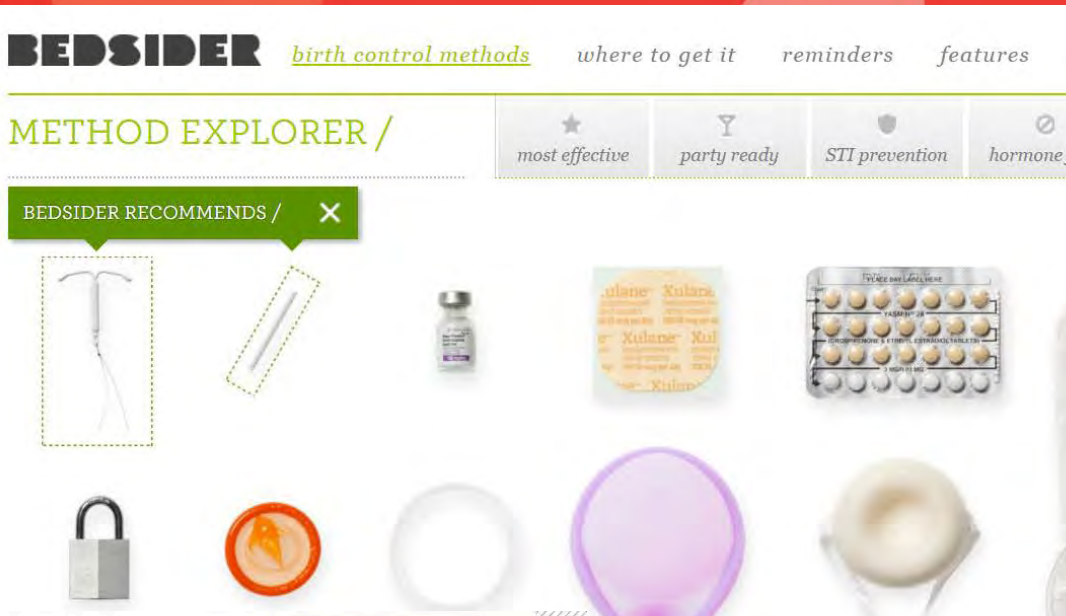
Pros and Cons of Different Contraceptive Methods

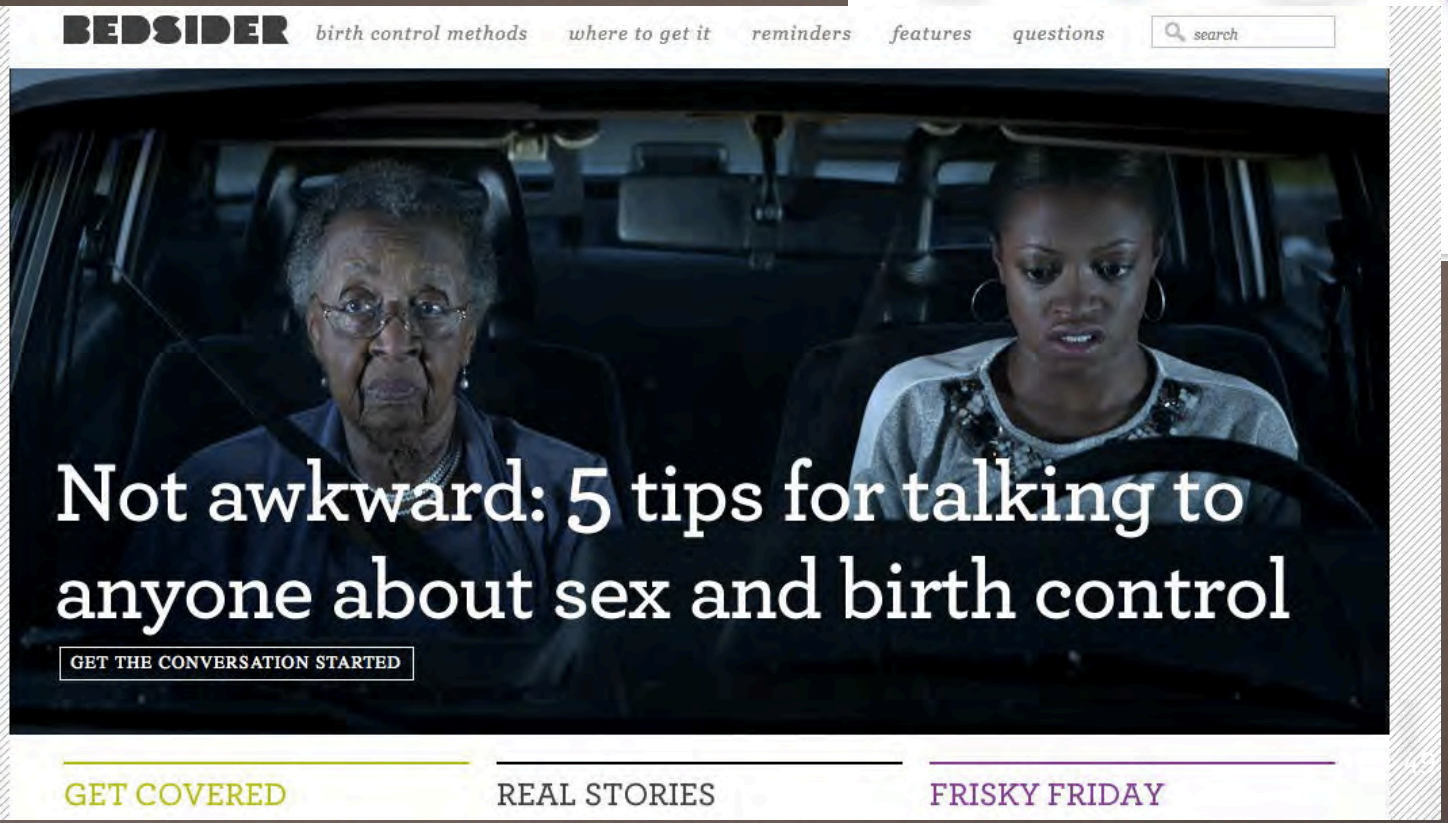
Here's a list of the many available types of contraception, and the pros and cons of using each.

Minimum effectiveness: 95%
Birth Control Pills

Also… www.YoungMensHealthSite.org

www.bedsider.org





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References

- Thanks to my SAHM colleagues for allowing adaptation of their presentation, particularly Dr. David A. Klein, Family Medicine & Pediatrics, Uniformed Services University
- Curtis KM, Tepper NK, Jatlaoui TC, et al. U.S. Medical Eligibility Criteria for Contraceptive Use, 2016. MMWR Recomm Rep 2016;65(No. RR-3):1–104. DOI: http://dx.doi.org/10.15585/mmwr.rr6503a1
- Curtis KM, Jatlaoui TC, Tepper NK, et al. U.S. Selected Practice Recommendations for Contraceptive Use, 2016. MMWR Recomm Rep 2016;65(No. RR-4):1–66. DOI: http://dx.doi.org/10.15585/mmwr.rr6504a1

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

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

Condition	Sub-Condition	Cu-IUD		LNG-IUD		Implant		DMPA		POP		CHC	
		I	C	I	C	I	C	I	C	I	C	I	C
Age		Menarche to <20 yrs:**2**		Menarche to <20 yrs:**2**		Menarche to <18 yrs:**1**		Menarche to <18 yrs:**2**		Menarche to <18 yrs:**1**		Menarche to <40 yrs:**1**	
		≥20 yrs:**1**		≥20 yrs:**1**		18-45 yrs:**1**		18-45 yrs:**1**		18-45 yrs:**1**		≥40 yrs:**2**	
						>45 yrs:**1**		>45 yrs:**2**		>45 yrs:**1**			
Anatomical abnormalities	a) Distorted uterine cavity	**4**		**4**									
	b) Other abnormalities	**2**		**2**									
Anemias	a) Thalassemia	**2**		**1**		**1**		**1**		**1**		**1**	
	b) Sickle cell disease‡	**2**		**1**		**1**		**1**		**1**		**2**	
	c) Iron-deficiency anemia	**2**		**1**		**1**		**1**		**1**		**1**	
Benign ovarian tumors	(*including cysts*)	**1**		**1**		**1**		**1**		**1**		**1**	
Breast disease	a) Undiagnosed mass	**1**		**2**		**2***		**2***		**2***		**2***	
	b) Benign breast disease	**1**		**1**		**1**		**1**		**1**		**1**	
	c) Family history of cancer	**1**		**1**		**1**		**1**		**1**		**1**	
	d) Breast cancer‡												
	i) Current	**1**		**4**		**4**		**4**		**4**		**4**	
	ii) Past and no evidence of current disease for 5 years	**1**		**3**		**3**		**3**		**3**		**3**	
Breastfeeding	a) <21 days postpartum					**2***		**2***		**2***		**4***	
	b) 21 to <30 days postpartum												
	i) With other risk factors for VTE					**2***		**2***		**2***		**3***	
	ii) Without other risk factors for VTE					**2***		**2***		**2***		**3***	
	c) 30-42 days postpartum												
	i) With other risk factors for VTE					**1***		**1***		**1***		**3***	
	ii) Without other risk factors for VTE					**1***		**1***		**1***		**2***	
	d) >42 days postpartum					**1***		**1***		**1***		**2***	
Cervical cancer	Awaiting treatment	**4**	**2**	**4**	**2**	**2**		**2**		**1**		**2**	
Cervical ectropion		**1**		**1**		**1**		**1**		**1**		**1**	
Cervical intraepithelial neoplasia		**1**		**2**		**2**		**2**		**1**		**2**	
Cirrhosis	a) Mild (*compensated*)	**1**		**1**		**1**		**1**		**1**		**1**	
	b) Severe‡ (*decompensated*)	**1**		**3**		**3**		**3**		**3**		**4**	
Cystic fibrosis‡		**1***		**1***		**1***		**2***		**1***		**1***	
Deep venous thrombosis (DVT)/Pulmonary embolism (PE)	a) History of DVT/PE, not receiving anticoagulant therapy												
	i) Higher risk for recurrent DVT/PE	**1**		**2**		**2**		**2**		**2**		**4**	
	ii) Lower risk for recurrent DVT/PE	**1**		**2**		**2**		**2**		**2**		**3**	
	b) Acute DVT/PE	**2**		**2**		**2**		**2**		**2**		**4**	
	c) DVT/PE and established anticoagulant therapy for at least 3 months												
	i) Higher risk for recurrent DVT/PE	**2**		**2**		**2**		**2**		**2**		**4***	
	ii) Lower risk for recurrent DVT/PE	**2**		**2**		**2**		**2**		**2**		**3***	
	d) Family history (*first-degree relatives*)	**1**		**1**		**1**		**1**		**1**		**2**	
	e) Major surgery												
	i) With prolonged immobilization	**1**		**2**		**2**		**2**		**2**		**4**	
	ii) Without prolonged immobilization	**1**		**1**		**1**		**1**		**1**		**2**	
	f) Minor surgery without immobilization	**1**		**1**		**1**		**1**		**1**		**1**	
Depressive disorders		**1***		**1***		**1***		**1***		**1***		**1***	

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

Key:

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

Abbreviations: C=continuation of contraceptive method; CHC=combined hormonal contraception (pill, patch, and, ring); COC=combined oral contraceptive; Cu-IUD=copper-containing intrauterine device; DMPA = depot medroxyprogesterone acetate; I=initiation of contraceptive method; LNG-IUD=levonorgestrel-releasing intrauterine device; NA=not applicable; POP=progestin-only pill; P/R=patch/ring ‡ Condition that exposes a woman to increased risk as a result of pregnancy. *Please see the complete guidance for a clarification to this classification: www.cdc.gov/reproductivehealth/unintendedpregnancy/USMEC.htm.

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

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

Condition	Sub-Condition	Cu-IUD		LNG-IUD		Implant		DMPA		POP		CHC	
		I	C	I	C	I	C	I	C	I	C	I	C
Hypertension	a) Adequately controlled hypertension	1*		1*		1*		2*		1*		3*	
	b) Elevated blood pressure levels (*properly taken measurements*)												
	i) Systolic 140-159 or diastolic 90-99	1*		1*		1*		2*		1*		3*	
	ii) Systolic ≥160 or diastolic ≥100‡	1*		2*		2*		3*		2*		4*	
	c) Vascular disease	1*		2*		2*		3*		2*		4*	
Inflammatory bowel disease	(*Ulcerative colitis, Crohn's disease*)	1		1		1		2		2		2/3*	
Ischemic heart disease‡	Current and history of	1		2	3	2	3	3		2	3	4	
Known thrombogenic mutations‡		1*		2*		2*		2*		2*		4*	
Liver tumors	a) Benign												
	i) Focal nodular hyperplasia	1		2		2		2		2		2	
	ii) Hepatocellular adenoma‡	1		3		3		3		3		4	
	b) Malignant‡ (hepatoma)	1		3		3		3		3		4	
Malaria		1		1		1		1		1		1	
Multiple risk factors for atherosclerotic cardiovascular disease	(e.g., older age, smoking, diabetes, hypertension, low HDL, high LDL, or high triglyceride levels)	1		2		2*		3*		2*		3/4*	
Multiple sclerosis	a) With prolonged immobility	1		1		1		2		1		3	
	b) Without prolonged immobility	1		1		1		2		1		1	
Obesity	a) Body mass index (BMI) ≥30 kg/m²	1		1		1		1		1		2	
	b) Menarche to <18 years and BMI ≥ 30 kg/m²	1		1		1		2		1		2	
Ovarian cancer‡		1		1		1		1		1		1	
Parity	a) Nulliparous	2		2		1		1		1		1	
	b) Parous	1		1		1		1		1		1	
Past ectopic pregnancy		1		1		1		1		2		1	
Pelvic inflammatory disease	a) Past												
	i) With subsequent pregnancy	1	1	1	1	1		1		1		1	
	ii) Without subsequent pregnancy	2	2	2	2	1		1		1		1	
	b) Current	4	2*	4	2*	1		1		1		1	
Peripartum cardiomyopathy‡	a) Normal or mildly impaired cardiac function												
	i) <6 months	2		2		1		1		1		4	
	ii) ≥6 months	2		2		1		1		1		3	
	b) Moderately or severely impaired cardiac function	2		2		2		2		2		4	
Postabortion	a) First trimester	1*		1*		1*		1*		1*		1*	
	b) Second trimester	2*		2*		1*		1*		1*		1*	
	c) Immediate postseptic abortion	4		4		1*		1*		1*		1*	
Postpartum (*nonbreastfeeding women*)	a) <21 days					1		1		1		4	
	b) 21 days to 42 days												
	i) With other risk factors for VTE					1		1		1		3*	
	ii) Without other risk factors for VTE					1		1		1		2	
	c) >42 days					1		1		1		1	
Postpartum (*in breastfeeding or non-breastfeeding women, including cesarean delivery*)	a) <10 minutes after delivery of the placenta												
	i) Breastfeeding	1*		2*									
	ii) Nonbreastfeeding	1*		1*									
	b) 10 minutes after delivery of the placenta to <4 weeks	2*		2*									
	c) ≥4 weeks	1*		1*									
	d) Postpartum sepsis	4		4									

Condition	Sub-Condition	Cu-IUD		LNG-IUD		Implant		DMPA		POP		CHC	
		I	C	I	C	I	C	I	C	I	C	I	C
Pregnancy		4*		4*		NA*		NA*		NA*		NA*	
Rheumatoid arthritis	a) On immunosuppressive therapy	2	1	2	1	1		2/3*		1		2	
	b) Not on immunosuppressive therapy	1		1		1		2		1		2	
Schistosomiasis	a) Uncomplicated	1		1		1		1		1		1	
	b) Fibrosis of the liver‡	1		1		1		1		1		1	
Sexually transmitted diseases (STDs)	a) Current purulent cervicitis or chlamydial infection or gonococcal infection	4	2*	4	2*	1		1		1		1	
	b) Vaginitis (*including trichomonas vaginalis and bacterial vaginosis*)	2	2	2	2	1		1		1		1	
	c) Other factors relating to STDs	2*	2	2*	2	1		1		1		1	
Smoking	a) Age <35	1		1		1		1		1		2	
	b) Age ≥35, <15 cigarettes/day	1		1		1		1		1		3	
	c) Age ≥35, ≥15 cigarettes/day	1		1		1		1		1		4	
Solid organ transplantation‡	a) Complicated	3	2	3	2	2		2		2		4	
	b) Uncomplicated	2		2		2		2		2		2*	
Stroke‡	History of cerebrovascular accident	1		2		2	3	3		2	3	4	
Superficial venous disorders	a) Varicose veins	1		1		1		1		1		1	
	b) Superficial venous thrombosis (acute or history)	1		1		1		1		1		3*	
Systemic lupus erythematosus‡	a) Positive (or unknown) antiphospholipid antibodies	1*	1*	3*		3*		3*	3*	3*		4*	
	b) Severe thrombocytopenia	3*	2*	2*		2*		3*	2*	2*		2*	
	c) Immunosuppressive therapy	2*	1*	2*		2*		2*	2*	2*		2*	
	d) None of the above	1*	1*	2*		2*		2*	2*	2*		2*	
Thyroid disorders	Simple goiter/ hyperthyroid/hypothyroid	1		1		1		1		1		1	
Tuberculosis‡ (*see also Drug Interactions*)	a) Nonpelvic	1	1	1	1	1*		1*		1*		1*	
	b) Pelvic	4	3	4	3	1*		1*		1*		1*	
Unexplained vaginal bleeding	(suspicious for serious condition) before evaluation	4*	2*	4*	2*	3*		3*		2*		2*	
Uterine fibroids		2		2		1		1		1		1	
Valvular heart disease	a) Uncomplicated	1		1		1		1		1		2	
	b) Complicated‡	1		1		1		1		1		4	
Vaginal bleeding patterns	a) Irregular pattern without heavy bleeding	1		1	1	2		2		2		1	
	b) Heavy or prolonged bleeding	2*		1*	2*	2*		2*		2*		1*	
Viral hepatitis	a) Acute or flare	1		1		1		1		1		3/4*	2
	b) Carrier/Chronic	1		1		1		1		1		1	1
Drug Interactions													
Antiretroviral therapy All other ARV's are 1 or 2 for all methods.	Fosamprenavir (FPV)	1/2*	1*	1/2*	1*	2*		2*		2*		3*	
Anticonvulsant therapy	a) Certain anticonvulsants (phenytoin, carbamazepine, barbiturates, primidone, topiramate, oxcarbazepine)	1		1		2*		1*		3*		3*	
	b) Lamotrigine	1		1		1		1		1		3*	
Antimicrobial therapy	a) Broad spectrum antibiotics	1		1		1		1		1		1	
	b) Antifungals	1		1		1		1		1		1	
	c) Antiparasitics	1		1		1		1		1		1	
	d) Rifampin or rifabutin therapy	1		1		2*		1*		3*		3*	
SSRIs		1		1		1		1		1		1	
St. John's wort		1		1		2		1		2		2	

Updated July 2016. This summary sheet only contains a subset of the recommendations from the U.S. MEC. For complete guidance, see: http://www.cdc.gov/reproductivehealth/unintendedpregnancy/USMEC.htm. Most contraceptive methods do not protect against sexually transmitted diseases (STDs). Consistent and correct use of the male latex condom reduces the risk of STDs and HIV.

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