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INSIDE

Teen pregnancy: Removing financial barriers makes an impact . . . . . Cover

Uterine fibroids: Initiative looks at treatment options 136

Bariatric surgery: Check impact on birth control options 137

Reproductive healthcare: Many teens fall through cracks 139

HPV: Are you recommending the vaccine to adolescent males? 140

Teen Topics: Use motivational interviewing with teens 142

Inserted in this issue:

STI Quarterly: What's behind the increase in HIV infections in gay and bisexual men? New data examines chlamydia rates in young women

2014 Index

Contraceptive Survey

AHC Media

Removing financial barriers impacts teen pregnancy, abortion rates

Removing barriers might offer substantial public health impact

Teenagers who received free contraception and were educated about the benefits and disadvantages of various birth control methods in the Contraceptive CHOICE Project conducted in St. Louis were dramatically less likely to get pregnant, give birth, or obtain an abortion compared with other sexually active teens, data suggests in a recently released study.[1]

The Contraceptive CHOICE Project, a large prospective cohort study conducted by researchers at the Washington University School of Medicine in St. Louis, was designed to promote the use of long-acting, reversible contraceptive (LARC) methods to reduce unintended pregnancy in the St. Louis region. Participants were educated about reversible contraception, with an emphasis on the benefits of LARC methods, provided their choice of reversible contraception at no cost, and were followed for two to three years.

To perform the currently published analysis, researchers looked at pregnancy, birth, and induced-abortion rates among females ages 15 to 19 years in this cohort and compared them with those observed nationally among U.S. teens in the same age group.

> "THIS STUDY DEMONSTRATES THERE IS A LOT MORE WE CAN DO TO REDUCE THE TEEN PREGNANCE RATE."

Of the 1,404 participants enrolled in CHOICE, 72% chose an intrauterine device (IUDs) or implant (LARC methods); 28% selected another method. This statistic compares with an estimated 5% U.S. teens who choose long-acting birth control.[2] Almost 500 of the teens in the study were of minor age (ages 14-17) upon enrollment; half

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of these minors reported having had a prior unintended pregnancy, and 18% had had at least one abortion. Participants ages 14-17 years provided written assent, and a parent or guardian provided written consent. Minors could enroll under a waiver of parental consent if they did not know the whereabouts of their parents or guardians or if they did not want their parents or guardians to know that they were seeking contraception; just four out of the 484 teens ages 14-17 (under 1%) were enrolled under waiver.[1]

During the 2008-2013 study period, the mean annual rates of pregnancy, birth, and abortion among CHOICE participants were 34.0, 19.4, and 9.7 per 1,000 teens, respectively. In comparison, rates of pregnancy, birth, and abortion among sexually experienced U.S. teens in 2008 were 158.5, 94.0, and 41.5 per 1,000, respectively.[1] "When we removed barriers to contraception for teens such as lack of knowledge, limited access, and cost in a group of teens, we were able to lower pregnancy, birth, and abortion rates," said **Gina Secura**, PhD, the study's first author and director of the CHOICE Project in a statement. "This study demonstrates there is a lot more we can do to reduce the teen pregnancy rate."

Teen pregnancy has been designated by the Centers for Disease Control and Prevention as one of six Winnable Battles because of the magnitude of the problem and the belief that it can be addressed by known, effective strategies. The agency's Winnable Battle target is to reduce the teen birth rate by 20%, from 37.9 per 1,000 teens in 2009 to 30.3 per 1,000 teens by 2015.[3]

Two-thirds of teens in the CHOICE study still were using IUDs and implants at 24 months after beginning use, compared with one-third of teens still using shorter-acting methods, such as birth control pills. What are some of the reasons these LARC adopters continued to use their chosen methods?

LARC methods are easy and forgettable, according to **Jeffrey Peipert**, MD, MPH, MHA, Robert J. Perry Professor of Obstetrics and Gynecology and vice chair for clinical research at Washington University School of Medicine in St. Louis. These advantages are the key ingredient of LARC methods, which makes intrauterine and implant

EXECUTIVE SUMMARY

Teens who received free contraception and were educated about the benefits and disadvantages of various birth control methods in the Contraceptive CHOICE Project in St. Louis were dramatically less likely to get pregnant, give birth, or obtain an abortion compared with other sexually active teens, data suggests in a just-released study.

- Of the 1,404 participants enrolled in the study, 72% chose an intrauterine device or implant; 28% selected another method.
- During the study period, the mean annual rates of pregnancy, birth, and abortion among participants were 34.0, 19.4, and 9.7 per 1,000 teens, respectively. In comparison, rates of pregnancy, birth, and abortion among sexually experienced U.S. teens in 2008 were 158.5, 94.0, and 41.5 per 1,000, respectively.

contraceptives "get-it-and-forget-it" methods, says Peipert.

The CHOICE Project provided a place where young women could call, come in, have questions answered and concerns addressed, which helped young women with method continuation. The regular check-in phone calls, made at three months, six months, and every six months for the duration of the project, allowed participants to communicate about method usage, notes Peipert.

Women in the CHOICE Project who selected LARC methods were able to receive non-contraceptive benefits from their chosen contraception, such as reduced bleeding and painful periods in levonorgestrel intrauterine device users, and reduced painful periods in implant users, as well as highly effective birth control, says Peipert. "With a continued need for contraception, why NOT continue?" Peipert states. *(To read more about the Project, see the* Contraceptive Technology Update *article, "Short-term bleeding and cramping with LARC method satisfaction eyed," November 2014, p. 121.)*

Three steps to success

Lack of information about effective contraception, limited access, and cost remain barriers to the use of LARC methods for many teens.[4-6]

What are some steps providers can take to make "LARC First" in their own practices? In a September 2014 webinar sponsored by the American College of Obstetricians and Gynecologists, **David Eisenberg**, MD, MPH, FACOG, assistant professor division of clinical research in the Department of Obstetrics & Gynecology at Washington University School of Medicine, outlined three steps:

• Provide education regarding all methods, especially LARC.

Reframe the conversation to start with the most effective methods, Eisenberg suggests.

• Promote access to providers who will offer and provide LARC methods.

Clinicians can dispel myths and increase the practice of evidence-based medicine when it comes to LARC methods, says Eisenberg. Providers who perform intrauterine contraceptive and implant insertions should sign up in the national *My Provider* registry. That registry is operated by the Association of Reproductive Health Professionals and the Bedsider online resource. Visit LARC.arhp.org for more information.

• Make LARC methods affordable contraception.[7]

The Affordable Care Act (ACA) added contraceptive counseling and supplies, including LARC methods, to its list of preventive services for women, based on recommendations from the Institute of Medicine.[8] Health coverage offered through the expansion of the Medicaid program must comply with the ACA contraceptive coverage requirement.

To determine whether an insurance plan is complying with the ACA requirement, refer your patients to a guide, *Getting the Coverage You Deserve,* created by the National Women's Law Center. *(Access the guide at http://bit.ly/1fVBQAX.)* The guide is designed to provide women with information on the coverage of preventive services in the healthcare law and tools they can use if they encounter problems with their coverage.

For financial assistance with obtaining the levonorgestrel intrauterine system, eligibility requirements and applications are available online through the Arch Foundation (http://bit.ly/1tmygqS). Information on obtaining assistance with the copper-T intrauterine device is available online at http://bit.ly/1p4cz7M.

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Duke Clinical Research Institute's initiative to look at options for uterine fibroids

The Duke Clinical Research Institute in Durham, NC, is working with nine centers across the United States in a five-year project to evaluate the effectiveness of different treatment strategies for women with uterine fibroids. The project, a collaboration between the Patient-Centered Outcomes Research Institute and the Agency for Healthcare Research and Quality, is designed to help patients and clinicians make more informed choices about treatment options.

In addition to the Research Institute's role as a leader in patient registries, Duke Medicine and the Institute have been involved in research on fibroids treatment for more than a decade, said **Evan Myers**, MD, MPH, chief of the Division of Clinical and Epidemiological Research for the Department of Obstetrics and Gynecology at Duke University School of Medicine and senior fellow at its Center for Clinical Health Policy Research.

"We are excited to have the opportunity to continue to address questions that will help patients and clinicians make more informed choices about treatment options," said Myers in a statement accompanying the announcement of the research team. "The investigators at the clinical centers are among the leading experts on fibroid treatments in the country, treating a very diverse group of women with this condition."

In addition, patients are playing a major role in helping guide this research, said Myers. Scientists also will have ongoing input from experts in observational research, as well as from professional societies, insurers, and fibroid treatment manufacturers.

Myers will lead the team that will conduct the study titled, "Comparing Options for Management: Patient-Centered Results for Uterine Fibroids" (COMPARE-UF). The Agency for Healthcare Research and Quality has awarded the team a $3.95 million first-year award. Institutions participating in the research include the following, along with their principal investigators:

- Mayo Clinic Collaborative Network, Elizabeth Stewart, MD;
- University of California Fibroid Network, Vanessa Jacoby, MD, MAS;
- Henry Ford Health System, Ganesa Wegienka, PhD;
- University of Mississippi Medical Center, Kedra Wallace, PhD;
- Northwestern Memorial Hospital — Chicago Consortium, Erica Marsh, MD, MSci;
- University of North Carolina, Wanda Nicholson, MD, MPH;
- Brigham and Women's/Harvard, Raymond Anchan, MD, PhD;
- Inova Health Systems, Larry Maxwell, MD;
- Department of Defense Clinical Consortium, William Catherino, MD, PhD.

> "... WOMEN, THEIR FAMILIES, AND THEIR CLINICIANS FACE SIGNIFICANT UNDERTAINTIES WHEN DECIDING ON A COURSE OF TREAMENT"

Fibroids, also known as uterine leiomyomas, are the most common benign uterine tumors in women of reproductive age.[1] Fibroids can cause anemia from heavy bleeding, pelvic pain, pressure, dysmenorrhea, reduced quality of life, and infertility. Treatment options include watchful waiting; treatment with drugs or hormones, embolization, or ultrasound; and invasive procedures such as partial or total hysterectomy. However, there is little evidence about the effectiveness of these therapies or their outcomes, including fibroid reoccurrence and women's ability to have children.

Uterine fibroids result in more than 200,000 hysterectomies every year. In the United States, it is estimated that approximately 1% of women with employer-provided insurance have clinically significant uterine fibroids, and the direct costs associated with treating uterine fibroids are more than $1 billion annually.[2]

"Having little evidence on uterine fibroids therapies' comparative effectiveness means that women, their families, and their clinicians face significant uncertainties when deciding on a course of treatment," said **Joe Selby**, MD, MPH, executive director of the Patient-Centered Outcomes Research Institute.

Women need more information about how the various fibroid treatment options compare in efficacy and long-term durability, says **Vanessa Jacoby**, MD, assistant professor of obstetrics, gynecology and reproductive sciences at the University of California, San

EXECUTIVE SUMMARY

The Duke Clinical Research Institute is working with nine centers across the United States in a five-year project to evaluate the effectiveness of different treatment strategies for women with uterine fibroids.

• The project, a collaboration between the Patient-Centered Outcomes Research Institute and the Agency for Healthcare Research and Quality, is designed to help patients and clinicians make more informed choices about treatment options.

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Francisco. Unfortunately, there is not very much data to help inform these treatment decisions for women.

The benefit of a nationwide registry is that researchers will have a large volume of patients with fibroids, in a diverse patient population, which will allow scientists to better explore and compare the efficacy of surgical treatments, as well as medical management and even expectant management, Jacoby states.

Check presentation

How do women present with uterine fibroids? Symptoms include menstrual cramps and pain, heavy menstrual bleeding and anemia, problems with fertility or pregnancy, or bladder or bowel symptoms.[3]

Black women are disproportionately affected by fibroids.[3] They report more symptoms: 40% report menstrual pain and cramps, with a three-fold increased risk of anemia. Black women also face an elevated risk of hysterectomy or myomectomy.[4]

Clinicians now look to such treatment options for symptomatic uterine fibroids as watchful waiting; nonprocedural treatments such as hormonal therapies, oral contraceptives, and nonsteroidal anti-inflammatory drugs; and several procedural treatments ranging from surgical or incisional such as hysterectomy or myomectomy, to nonsurgical or minimally invasive treatments as uterine artery embolization and magnetic resonance image-guided focused ultrasound.[2]

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Check birth control after bariatric surgery

Nearly 50% of bariatric surgery patients are reproductive-age women. Obstetric and gynecology as well as surgery professional guidelines recommend a delay of pregnancy one to two years post-surgery.[1] What contraceptive options are available for these women?

What constitutes obesity? The Centers for Disease Control and Prevention estimate that 36.4% of U.S. women age 20 and older are obese (body mass index [BMI] at 30 or higher).[2] Bariatric surgery is considered for those patients who have one of the following:

• BMI at or above 40;

• BMI 35 and up in association with major co-morbidities such as severe sleep apnea, Pickwickian syndrome, or obesity-related cardiomyopathy;

• BMI of 35 and up in association with obesity-induced physical problems with lifestyle, including joint disease or body size problems interfering with employment, family function, and ambulation.[3]

There are two approaches to bariatric surgery: restrictive and restrictive/malabsorptive surgeries. According to the American Society of Metabolic and Bariatric Surgeons, the

most common bariatric procedures include adjustable gastric band and sleeve gastrectomy, both restrictive procedures; and gastric bypass (Roux-en-Y) and biliopancreatic diversion with duodenal switch, both malabsorptive procedures.[4] Rapid weight loss is typical after either procedure and results in improvement of polycystic ovary syndrome, anovulation, and irregular menses, thus leading to higher fertility rates.[5]

Family planners might see reduced fertility in obese women, primarily due to oligoovulation and anovulation.

In women who become pregnant, obesity can increase risks of gestational diabetes mellitus, preeclampsia, cesarean delivery, and infectious morbidity. Operative morbidity also is increased, and obese women are less likely to have successful vaginal birth after a previous cesarean delivery.

Bariatric surgery can improve menstrual regularity and fertility in women.[6] The American College of Obstetricians and Gynecologists and the American Society of Metabolic and Bariatric Surgeons recommend postponing pregnancy 12-18 months following bariatric surgery, as this is a time of rapid weight loss.[7]

Despite consistently recommending a delay in pregnancy, bariatric surgeons inconsistently address perioperative contraceptive needs of women of reproductive age, according to findings from a recent nationwide survey.[7] These findings highlight the need for greater collaboration between bariatric surgeons and women's healthcare providers to address the reproductive health needs of women having bariatric surgery, says **Patricia Chico**, MD, resident physician in family medicine at the University of Illinois at Chicago. Chico received funding from the Society of Family Planning to perform the survey of American Society of Metabolic and Bariatric Surgeons members.

EXECUTIVE SUMMARY

Nearly 50% of bariatric surgery patients are reproductive-age women. Obstetric and gynecology as well as surgery professional guidelines recommend a delay of pregnancy one to two years post-surgery.

- Despite consistently recommending a delay in pregnancy, bariatric surgeons inconsistently address perioperative contraceptive needs of women of reproductive age, according to findings from a recent nationwide survey.
- The U.S. Medical Eligibility Criteria for Contraceptive Use, 2010,gives a Category 3 rating (a condition for which the theoretical or proven risks usually outweigh the advantages of using the method) for use of combined hormonal pills or progestin-only pills in women after malabsorptive bariatric surgery.

What are the options

For women who have undergone restrictive bariatric surgery, the *U.S. Medical Eligibility Criteria for Contraceptive Use, 2010*, rates all methods (combined hormonal ring, patch, and pills; contraceptive injection; the Copper-T and levonorgestrel intrauterine devices; progestin-only pills and progestin implant) as Category 1: "A condition for which there is no restriction for the use of the contraceptive method."[8]

However, after malabsorptive bariatric surgery, use of combined hormonal pills or progestin-only pills, the guidance issues as Category 3 rating: "a condition for which the theoretical or proven risks usually outweigh the advantages of using the method."[8]

Why the Category 3 rating? There are concerns for malabsorption of oral contraceptive hormones, as well as uncertainty as to whether this malabsorption translates to decreased efficacy, according to **Anne Burke**, MD, MPH, associate professor in the Department of Gynecology and Obstetrics at the Johns Hopkins University of School of Medicine in Baltimore. Burke spoke on the effect of obesity on contraceptive efficacy at the 2013 Contraceptive Technology Quest for Excellence conference. Evidence on this subject is limited to a handful of pharmacokinetic and observational studies, she notes.[9]

More adolescents are having bariatric surgery procedures performed, and these patients need highly effective contraception. Research indicates there is increasing experience and success with the levonorgestrel intrauterine device placed at the time of surgery.[10]

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Many U.S. teenagers not receiving reproductive health care, according to CDC

A new national report indicates many at-risk teens are missing needed reproductive health services.

During the 12 months prior to participating in a survey interview, approximately 30% of sexually experienced females ages 15-19 did not receive contraceptive services, with nearly 70% not receiving recommended sexually transmitted infection (STI) services. In sexually active males in the same age range, 74% did not receive STI services.[1] Adolescents ages 15-19 without insurance coverage, younger females ages 15-17, and adolescents ages 15-19 with a previous pregnancy also had a lower prevalence of receiving reproductive health services.[1]

The report, issued by the Centers for Disease Control and Prevention, focuses on 11 clinical preventive services for infants, children, and adolescents. Three of the services are of particular interest to reproductive health clinicians: human papillomavirus (HPV) vaccination, chlamydia screening, and reproductive health services.[2] All 11 services prevent and detect conditions and diseases in their earlier, more treatable stages, which significantly reduces the risk of illness, disability, early death, and expensive medical care.

Through implementation of the Affordable Care Act, new opportunities exist to promote and increase use of such clinical preventive services, states the CDC. "The Affordable Care Act requires new health insurance plans to provide certain clinical preventive services at no additional cost, with no copays or deductibles," said **Lorraine Yeung**, MD, MPH, medical epidemiologist with CDC's National Center on Birth Defects and Developmental Disabilities, in a statement accompanying the report. "Parents need to know that many clinical preventive services for their children, such as screening and vaccination, are available for free with many health plans."

Male adolescents' sexual and reproductive health needs often go unmet. Look to a new report developed jointly by Johns Hopkins experts and the federally funded Male Training Center for Family Planning and Reproductive Health, which enumerates the reproductive and sexual health screening tests, exams, and interventions that all men should

EXECUTIVE SUMMARY

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- In sexually active males in the same age range, 74% did not receive STI services.
- A new report developed by Johns Hopkins University experts and the federally funded Male Training Center for Family Planning and Reproductive Health enumerates the reproductive and sexual health screening tests, exams, and interventions that all men should receive on a regular basis.

receive regularly. Guidance also is offered to help clinicians discuss reproductive and sexual health issues, such as how to prevent unplanned pregnancies and STIs.[3] *(Access the report at http://bit.ly/1vzTJcF.)*

Male adolescents and young adults have substantial sexual and reproductive healthcare needs in their own right, but few report receiving related preventive services by their healthcare providers, says **Arik Marcell**, MD, MPH, an adolescent medicine expert at the Johns Hopkins Children's Center. .

"It is our hope that this guidance can help providers start thinking about their male adolescent and young adult patients' sexual and reproductive healthcare needs, be more effective and efficient in their clinical practice by organizing and bundling relevant services to deliver to this population, use it as a tool to educate their male patients inclusive of parents, and serve as foundation for standards of care to deliver this population in the U.S."

The report recommends that clinicians provide the following services at least annually to reproductive-age adolescent males:

- a comprehensive clinical history and exam that include screening for mental disorders, depression, and alcohol and drug use;
- discussion of a patient's desire to have a family and development of an individualized plan reflecting any relevant preconception health needs;
- a thorough sexual health assessment, including conversations about sexual practices and partners;
- screening for STIs;
- discussion of intimate partner violence and any problems related to sexual function, which might signal other underlying disorders such as heart disease;
- a detailed vaccination history, including checking for HPV vaccination;
- a panel of lab tests for certain STIs;
- counseling on safer sex practices, including condom use, pregnancy prevention, and preconception health;
- counseling on sexuality, sexual identity, relationships, and sexual dysfunction.[3]

The report states it is not recommended to routinely counsel about testicular self-exam for cancer for male adolescents and adults. There is no evidence that teaching young men how to examine themselves for testicular cancer will improve health outcomes, even among men at high risk, including men with a history of undescended testes or testicular atrophy, the report states.[3]

What other tests should be no longer offered or recommended to patients due to lack of evidence of benefit? They include:

- prostate-specific antigen (PSA) testing to screen for prostate cancer,
- routine urinalysis,
- physical exams for hernia,
- routine testing for anemia.[3]

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Are you recommending HPV vaccine for males?

What's your practice when it comes to recommending the human papillomavirus (HPV) vaccine for young men? According to results of a national survey, physicians recommend HPV vaccination to less than 15% of their male patients ages 9-26. Pediatric specialists and doctors who support new vaccines were more likely to recommend the vaccine, data indicate.[1]

In 2009, the quadrivalent HPV vaccine was approved and permissively recommended for U.S. males ages 9-26 to protect against genital warts. The recommendation was moved to routine use in 2011.

The purpose of this study was to examine and explore factors associated with U.S. physicians' HPV vaccine recommendations to early (ages 11-12), middle (13-17), and late adolescent/young adult (ages18-26) males.

While the HPV vaccine is best known in the context of preventing cervical cancer, there are other HPV-related cancers that affect men, including anal and penile cancer, explains **Susan Vadaparampil**, PhD, MPH senior faculty member in the Health Outcomes and Behavior Program at the Moffitt Cancer

Center in Tampa. In fact, one of the most rapidly increasing cancers that is also linked to HPV is head and neck cancer, states Vadaparampil, a co-author of the current research. These cancers are more than twice as common in men as in women, she states.

The Moffitt Center researchers were motivated to conduct the survey because it is well-established that physician recommendation is one of the most important factors related to whether adolescents actually receive the vaccination, says Vadaparampil. "The Centers for Disease Control and Prevention [CDC] strongly supports increasing physician recommendation as a main way to increase adolescent HPV vaccination rates, yet, little is known about whether physicians actually recommend vaccination and their reasons for doing — or not doing — so," Vadaparampil says. "This information is greatly needed to develop interventions to increase physicians' HPV vaccine recommendations to males."

One way to increase uptake is to strongly encourage HPV vaccination of age-eligible males whenever other vaccines are administered. Case in point: Nearly 85% of adolescents received diphtheria, tetanus, and pertussis (Tdap) vaccines in 2012, but only about half of girls and 20% of boys received their first HPV vaccine dose.[2]

Four leading national medical associations — the American Academy of Family Physicians, the American Academy of Pediatrics, the American College of Physicians, and American College of Obstetricians and Gynecologists – and the Immunization Action Coalition and the CDC issued a call in February 2014 urging physicians across the United States to educate their patients about the HPV vaccine and to strongly recommend HPV vaccination.[3] Research findings indicate that when a provider strongly recommends HPV vaccination, patients are four to five times more likely to receive the HPV vaccine.[4] It is time for providers to strongly recommend the HPV vaccine to prevent cervical and other cancers, say public health advocates.

In a statement accompanying the physician call, **Deborah Wexler**, MD, executive director of the St. Paul, MN-based Immunization Action Coalition, says, "What you say matters, and how you say it matters even more. A lukewarm recommendation may lead people to perceive HPV vaccination as less important than other vaccines."

HPV vaccination should be viewed as a community effort against cancer by adolescent males and females, says **Melanie Gold**, DO, FAAP, medical director of school-based health centers at Columbia University in New York City. With more teens getting HPV vaccinations, the herd immunity effect begins to take place in protecting the population against HPV-related cancers, she notes.

It's time to get behind HPV vaccination, especially for males. Results of a new national survey indicate among males ages 13-17, 8.3% had received greater than or equal to one dose, and 1.3% had received up to three doses.[5] What can you do to make sure your patients are fully vaccinated against HPV? The CDC offers the following tips:

- Strongly recommend adolescent vaccines to parents of your patients ages 11-18. "Parents trust your opinion more than anyone else's when it comes to immunizations," states the CDC. "Studies consistently show that provider recommendation is the strongest predictor of vaccination."
- Use every opportunity to vaccinate your teen patients. Ask about vaccination status when they come in for sick visits and sports physicals.
- Patient reminder and recall systems such as automated postcards, phone calls, and text messages can be effective tools for increasing office visits.
- Educate parents about the diseases that can be prevented by adolescent vaccines. Parents may know very little about pertussis, meningococcal disease, or HPV.
- Implement standing orders policies so that patients can receive vaccines without a physician examination or individual physician order.[6]

Also, download free patient handouts from the CDC website, http://1.usa.gov/1eGPIdM. Click on "Handouts to Give Patients and

EXECUTIVE SUMMARY

According to results of a national survey, physicians recommend human papillomavirus (HPV) vaccination to less than 15% of their male patients ages 9-26. Pediatric specialists and doctors who support new vaccines were more likely to recommend the vaccine, data indicate.

- One way to increase uptake is to strongly encourage HPV vaccination of age-eligible males whenever other vaccines are administered.
- Nearly 85% of adolescents received diphtheria, tetanus, and pertussis (Tdap) vaccines in 2012, but only about half of girls and 20% of boys received their first HPV vaccine dose.

Parents" for vaccine fact sheets and schedules for parents and patients and HPV specific vaccine information sheets. Resources also are available in Spanish.

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TEEN TOPICS

Use motivational interviewing with teens

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Near the end of September 2014, the American Academy of Pediatrics (AAP) published its policy statement on contraception for adolescents.[1] The AAP has been addressing the issue of contraception since 1980, and this policy statement updated the 2007 statement on contraception and adolescents. The policy statement provides a description and rationale for best practices in counseling and prescribing contraception to adolescents and is supported by an accompanying technical report.[2] In addition to recommending long-acting reversible contraceptive methods (LARC) as first-line contraceptive choices for adolescents, the policy statement states the following: "Counseling should draw on motivational interviewing approaches, with the focus of the interview on future goals, belief in the adolescents' capacity to change, and engagement of the adolescent in the process of adopting health-promoting behaviors.[3] For an example of motivational interviewing for sexual health counseling, see Ott et al (2007),[4] and for a more detailed discussion of counseling approaches, see the accompanying technical report."[2]

Although motivational interviewing, or MI, emerged from the adult addictions field in the early 1980s, it is becoming a standard of care for counseling adolescents to facilitate health behavior change. Evidence-based research supports this recommendation. In a community-based randomized trial, MI was found to be an effective counseling intervention at reducing rapid repeat pregnancy among teen mothers.[5] Researchers found participants who received an MI intervention reported a greater frequency of keeping condoms available.[6] Sexually active participants also had a significant increase in self-reported condom use.

In a recent systematic review and meta-analysis of literature comparing MI to control conditions for adolescent health behavior change, Researchers reviewed 697 articles identified from PsycINFO, PubMed/Medline, and ERIC until June 2013.[7] To be included in the review, studies were required to (a) compare the efficacy of at least one session of MI intervention with a control condition using a between-groups design and (b) examine a non-substance-use health behavior in adolescents. A total of 15 studies met criteria for inclusion, representing 1,610 participants. Data were described qualitatively and quantitatively. Half of the abstracted studies used an interventionist with master's level or greater training in a mental health profession, while the other half of the sample included community paraprofessionals, nurses, physicians, and dieticians. A total of eight of 15 studies provided data after the post-treatment assessment and follow-up assessments ranged from four weeks

to two years (average 33.6 weeks).

The systematic review found that, compared with controls, MI interventions produced a small, but significant, aggregate effect size for short-term post-intervention effects (g = .16; 95% confidence interval [CI] [.05, .27]). Also, MI produced relatively stable effects over time (n = 8, g = .18; 95% CI [.05, .32]). The authors concluded that MI interventions for adolescent health behaviors appear to be effective and that the magnitude of the aggregate effect size does not appear to differ meaningfully from reports of interventions targeting only substance use in adolescents.

Of note, the average number of intervention sessions for the 15 studies assessed was 5.6, with three interventions producing a positive effect requiring only two sessions. This information is important because it suggests that a relatively small number of counseling sessions can produce meaningful change. Moreover, brief interventions such as MI allow for multiple intervention opportunities across repeated visits with the healthcare providers, which could multiply the effects of a small but reliable change and that could result in larger health behavior changes at a population level over time.

Family planning providers are renowned for their skill and comfort with counseling adolescents about sexual and reproductive health. Routinely incorporating MI style into family planning counseling, especially with adolescents, is a more effective and efficient counseling intervention compared to counseling interventions that are more didactic and directive. For more examples of MI for adolescent contraceptive counseling, see Gold and Delisi [8] and for other health behaviors, see Barnes and Gold.[9] *(Also look at the resources at the end of this article that will help family planning providers to gain the knowledge and skill necessary to follow the new AAP policy statement recommendations in using MI for counseling adolescents about contraception.)* New resources on MI, including a webinar, will be available this month on the New York-based site for adolescent providers, www.nypath.org.

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RESOURCES

Use these additional general resources on motivational interviewing with adolescents:

* Miller WR, Rollnick S. *Motivational Interviewing: Helping People Change.* Third ed New York: Guilford Press, 2013.
* Naar-King S; Suarez M. *Motivational Interviewing with Adolescents and Young Adults.* New York: Guilford Press, 2011.
* Douaihy A, Kelly TM, Gold MA. *Motivational Interviewing: A Guide for Medical Trainees.* New York: Oxford University Press, In press, 2014. ■

COMING IN FUTURE MONTHS

- Update: Costs decrease for patients' contraceptives
- Check gynecologic concerns in adolescent cancer patients
- Look for symptoms predictive of examination-related distress
- Communicate female condom information to teens

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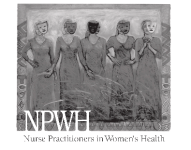

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CNE/CME QUESTIONS

1. Name a noncontraceptive benefit of the levonorgestrel intrauterine device.

A. Reduces bleeding and painful periods
B. Relieves premenstrual dysphoric disorder
C. Improves bone health
D. Reduces size of existing leiomyomas

2. Which of the following is NOT a treatment option for uterine fibroids?

A. Watchful waiting
B. Nutritional modifications
C. Embolization
D. Ultrasound

3. What is the most common restrictive/malabsorptive bariatric surgical procedure?

A. Endoluminal sleeve
B. Vertical banded gastroplasty
C. Roux-en-Y gastric bypass
D. Gastric balloon

4. What is the recommended age range for use of the quadrivalent human papillomavirus vaccine to protect against genital warts?

A. Ages 9-26
B. Ages 12-20
C. Ages 15-26
D. Ages 18-26

CNE/CME OBJECTIVES

After reading Contraceptive Technology Update, the participant will be able to:

1. identify clinical, legal, or scientific issues related to development and provisions of contraceptive technology or other reproductive services;
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3. integrate practical solutions to problems and information into daily practices, according to advice from nationally recognized family planning experts;
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STI QUARTERLY™

A SUPPLEMENT TO CONTRACEPTIVE TECHNOLOGY UPDATE

What's behind the increase in HIV infections in males who are gay or bisexual?

Put pre-exposure prophylaxis into play with PrEPline resource

Gay and bisexual men represent an estimated 2% of the U.S. population but are the most severely affected by HIV. Consider these statistics from the Centers for Disease Control and Prevention (CDC): In 2010, gay and bisexual men accounted for 63% of estimated new HIV infections and 78% of infections among all newly infected men. From 2008 to 2010, new HIV infections increased 22% among young gay and bisexual men ages 13-24 and 12% among gay and bisexual men overall.[1] Gay men are the only group in the country among whom new infections are on the rise.[2]

A 2014 survey shows that only one-third of men who are having sex with men (MSM) are aware of increasing infection, and more than half don't know about pre-exposure prophylaxis (PrEP) that can be used to prevent infection in HIV-negative men.[3] The survey was designed and analyzed by researchers at the Kaiser Family Foundation, supported by MAC AIDS Fund.

While the men surveyed named HIV as the leading health issue facing their population, more than half (56%) said they were not personally concerned about becoming infected. Just three in 10 (30%) gay and bisexual men said they were tested for HIV within the last year, including 19% who reported being tested within the last six months. Survey results indicate gay and bisexual men under the age of 35 (44%) were twice as likely as those who are older (21%) to report never having been tested for HIV.[3]

> GAY MEN ARE THE ONLY GROUP IN THE COUNTRY AMONG WHOM NEW INFECTIONS ARE ON THE RISE.

The CDC recommends all gay and bisexual men get tested for HIV at least once a year, and it says sexually active gay and bisexual men might benefit from tests every three to six months.[1]

"These survey results underscore the importance of getting the word out among gay and bisexual men about risk and new treatment and prevention options," said **Drew Altman**, PhD, Kaiser Family Foundation president and chief executive officer in a press statement accompanying the publication of the survey results.

Who can use PrEP?

Just one-fourth of gay and bisexual men surveyed (26%) said they know about PrEP, daily use of a pill (tenofovir disoproxil fumarate and emtricitabine [Truvada, Gilead Sciences, Foster City, CA]) that people who are HIV-negative can take to lower their risk of becoming infected. Eighty percent of men surveyed reported say they had heard little or nothing about the new prevention option.

Who should be using PrEP for HIV prevention? According to 2014 CDC guidance, it should be considered for HIV-uninfected patients with any of the following indications:

- anyone who is in an ongoing sexual relationship with an HIV-

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infected partner;

• a gay or bisexual man who has had sex without a condom or has been diagnosed with a sexually transmitted infection within the past six months, and is not in a mutually monogamous relationship with a partner who recently tested HIV-negative;

• a heterosexual man or woman who does not always use condoms when having sex with partners known to be at risk for HIV (for example, injecting drug users or bisexual male partners of unknown HIV status) and is not in a mutually-monogamous relationship with a partner who recently tested HIV negative;

• anyone who has, within the past six months, injected illicit drugs and shared equipment or been in a treatment program for injection drug use.[4] (*See the* Contraceptive Technology Update *article "New guidelines focus on PrEP use against HIV," August 2014, p. 89.)*

Use the PrEPLine

One reason for the low knowledge of PrEP in men at risk of HIV might lie with providers, who have not yet begun to prescribe the prophylactic drug. Since Truvada was approved for PrEP use in 2012 by the Food and Drug Administration, the drug manufacturer reports just 1,774 prescriptions filled for this indication between January 2011 and May 2013.[5]

Providers now have a pre-exposure prophylaxis consultation telephone service, PrEPline (855-448-7737), operated by the University of California San Francisco Clinician Consultation Center at the San Francisco General Hospital and Trauma Center. The PrEPline is made possible through CDC funding to the U.S. Health Resources and Services Administration AIDS Education and Training Centers Program, of which the Center is a participant.

The resource is available Monday through Friday, 11 a.m. to 6 p.m. ET. It is staffed with an expert team of HIV clinicians who provide free advice on PrEP to clinicians across the country.

Many clinicians who will be prescribing PrEP will have had limited experience prescribing antiretroviral drugs, says **Ronald Goldschmidt**, MD, Center director. The PrEPline team can help clinicians work through decisions about who might benefit from PrEP and for whom it's not advisable, how to provide follow-up to ensure safe medication use, and offer protocols for averting and identifying new transmissions. Key to PrEP will be continually evaluating patients' ability to adhere to a daily PrEP regimen, because missed doses can negate the benefits of the drug regimen, notes Goldschmidt.

The Center now offers four consultation services for clinicians only, says Goldschmidt. The PEPline is designed for information on occupational and non-occupational exposure, while the Perinatal HIV Hotline offers advice on HIV in pregnancy and infancy. The Warmline (now called the HIV/AIDS Consultation Service) offers consultation advice on HIV/AIDS management on such topics as antiretroviral decisions, new drugs and diagnostic techniques, drug interactions and toxicity, adherence, co-infection management, initiation of HIV care, and primary care of persons with AIDS.*(See the resources at the end of this article for telephone numbers and operation hours for all services.)*

As PrEP data became available, it was clear that clinicians would have questions about how PrEP would be implemented into practice, says **Shannon Weber**, MSW, the Center's Perinatal HIV Hotline director. With the Center's expertise in providing clinician consultation — the Warmline went live in 1992, followed by the PEPline in 1997 and the Perinatal HIV line in 2004 — the addition of the PrEPline is a natural fit.

"We are really thrilled that, as the CDC guidelines became available two months ago, there is now a line to go in conjunction with it," says Weber.

EXECUTIVE SUMMARY

A 2014 survey shows that only one-third of men who are having sex with men are aware of increasing infection, and more than half don't know about pre-exposure prophylaxis (PrEP) that can be used to prevent infection in HIV-negative men.

• Just three in 10 (30%) gay and bisexual men said they were tested for HIV within the last year, including 19% who reported being tested within the last six months.

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RESOURCE

- The **Clinician Consultation Center** (http://bit.ly/1rAEpvz) provides clinicians of all experience levels prompt, expert responses to questions about managing HIV/AIDS, perinatal HIV, and bloodborne pathogen exposures. It offers online and phone-based consultation in areas including testing and prevention, treatment, and post-exposure prophylaxis (PEP). All services are free and confidential. Services are for U.S.-based providers only. For the Warmline (HIV/AIDS Consultation Service), call (800) 933-3413 Monday to Friday 9 a.m. to 8 p.m. ET. For the PEPline call (888) 448-4911 seven days a week 9 a.m. to 2 a.m. ET. For the Perinatal HIV/AIDS Line, call (888) 448-8765, 24 hours a day, seven days a week. For the pre-exposure prophylaxis consultation telephone service, PrEPline, call (855) 448-7737 11 a.m. to 6 p.m. ET Monday to Friday.
- The **Clinician Consultation Center** offers a "Case of the Month," which highlights a case that represents current questions from its clinician consultations. Go to http://bit.ly/1zdN4d1 to review "Initiating PrEP and Providing Appropriate Follow-Up." Visit the archives at http://bit.ly/1rN6n51 to review such cases as "HIV Treatment in Sero-Discordant Couples" and "Pending HIV Test Results and Labor."
- Stay up to date on pre-exposure prophylaxis (PrEP) news by visiting **PrEPWatch**, http://bit.ly/ZUJxRk, a web site that serves as a clearinghouse for information on PrEP for HIV prevention. PrEP Watch includes information on data, additional research, cost, and access and advocacy efforts in the United States and across the globe. The website was created and is maintained by AVAC, a non-profit organization based in New York City that "uses education, policy analysis, advocacy, and a network of global collaborations to accelerate the ethical development and global delivery of new and emerging HIV prevention options as part of a comprehensive response to the HIV/AIDS pandemic."
- The **Centers for Disease Prevention and Control** offers several PrEP resources at its web site, http://1.usa.gov/1jZcByB. Download a free fact sheet to use with patients, as well as the first comprehensive clinical practice guidelines on PrEP. Links also are available for informational videos on the subject. ■

Nearly 5% of young U.S. women have chlamydia

New national data show that an estimated 1.8 million Americans ages 14-39 are infected with chlamydia, with rates of infection highest among young women. An estimated 4.7% of women ages 14-24 were infected with the disease in 2012, data suggests.[1]

Researchers at the Centers for Disease Control and Prevention (CDC) calculated nationally representative estimates for chlamydia prevalence overall, as well as by sex, age, and race/ethnicity. The results showed an overall chlamydia prevalence of 1.7% among those ages 14-39, which suggests the estimated 1.8 million prevalent infections nationally. Data indicates prevalence varied by age and race/ethnicity, with young people and African Americans most affected. Among sexually active females ages 14-24, chlamydia prevalence was highest (13.5%) among black females in this age group.[1]

According to **Elizabeth Torrone**, PhD, an epidemiologist in the CDC's Division of STD Prevention, the data on which the report is based comes from the National Health and Nutrition Examination Survey (NHANES), a household survey of a nationally representative sample of the U.S. non-institutionalized, civilian population. This data provides CDC and others in public health with a snapshot of chlamydia prevalence in the United States, explains Torrone.

"Chlamydia is a common infection that usually has no symptoms," notes Torrone. "The consequences of an untreated infection can be serious for women including infertility and ectopic pregnancy."

Because many chlamydial infections are asymptomatic and go undiagnosed, NHANES data help those in public health to better understand how many people are infected, who is infected, and what factors might be associated with infection, explains Torrone. Such information is critical to targeting important prevention efforts across the nation, she notes.

The U.S. Preventive Services Task Force has issued final recommendations that all sexually active women ages 24 years and younger and older women who are at increased risk for infection should be screened for chlamydia and gonorrhea.[2]

Michael LeFevre, MD, MSPH, chairman of the task force, says, "Screening can make a difference for young women and for older women at increased risk of infection. The Task Force found that there are effective screening tests for chlamydia, and treatment can prevent long-term complications."

The Task Force concludes that the current evidence is insufficient to assess the balance of benefits and harms of screening for chlamydia and gonorrhea in men. However, the CDC recommends all gay and bisexual men should be tested at least annually for HIV; syphilis; hepatitis B; hepatitis C (among gay men born from 1945 to 1965 or with risk behaviors); chlamydia and gonorrhea of the rectum if a patient has had receptive anal sex or been a "bottom" in the past year; chlamydia and gonorrhea of the penis if a patient has had insertive anal or oral sex in the past year; and gonorrhea of the throat if a patient has performed oral sex in the past year.[3]

In a new CDC report that analyzes 1999-2010 data from multiple data sources to estimate the prevalence of chlamydia screening among U.S. females ages 15-21, data indicates chlamydia screening rates have been suboptimal, with fewer than half of sexually active females in the age range screened on an annual basis.[4] Although testing and screening rates varied by demographic characteristics, insurance type, screening venue, and type of healthcare services used, suboptimal rates indicate that improvement in screening coverage is needed, CDC researchers state.

Analysis of the findings suggests that chlamydia testing rates were lowest at visits to pediatricians, who conduct 48% of all healthcare visits for teens ages 15-16, and 23% of all visits for those ages 17-18.[5] Both age groups have high rates of infection. During 2005 to 2010, Title X service providers tested 3.4 million female family planning users ages 15-19 for chlamydia, and the percentage of females tested for chlamydia at Title X sites increased from 49.8% in 2005 to 56.7% in 2010.[4]

EXECUTIVE SUMMARY

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CONTRACEPTIVE TECHNOLOGY UPDATE®

2014 Index

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Barrier contraceptives

Condom technology is now focus of research, FEB:17

Diaphragm: Update on this barrier contraceptive, JUN:66

Research targets new condom technology, AUG:92

Teen condom use drops — What can providers do? SEP:102

Use key instructions for correct condom use, FEB:19

Contraceptive implant

Contraceptive implant makes inroads as birth control option, APR:37

Contraceptives (Also see: Barrier contraceptives, Contraceptive implant, Injectables, Intrauterine contraception, Long-acting reversible contraceptives, Oral contraceptives)

Check birth control after bariatric surgery, DEC:137

Contraception focus: combined hormones, APR:44

Future contraceptive? Microchip may be option, OCT:11

Multipurpose methods show research advances, FEB:19

Options might begin to emerge with new data out on LARC, MAR:25

Removing financial barriers impacts teen pregnancy, abortion rates, DEC:139

Reproductive-age women with cancer need to have effective options, SEP:97

Research eyes safety of same-day IUD insertion, AUG:88

Emergency contraception

EC: Progress made, but challenges remain, OCT:116

FDA eyes LNG ECP label change in light of research on weight impact, FEB:13

Generic EC — One step to closer to OTC status, MAY:57

Injectables (Depo-Provera, DMPA)

Contraceptive injection offers effective option, JUL:77

Contraceptive shot offers family planning options, NOV:125

Intrauterine contraception

Intrauterine contraception safe and effective in teens and adults, MAY:49

Mirena obtains approval on new insertion device, SEP:101

Research eyes safety of same-day IUD insertion, AUG:88

Legislative

Contraceptive coverage heads to Supreme Court, MAR:34

Lawmakers step in to protect confidentiality, JAN:10

Marketplace plans hazy on abortion coverage, JUL:82

Pay for performance may impact family planning, NOV:128

What's next after ruling on contraceptive services? SEP:100

Long-acting reversible contraceptives (Intrauterine contraception, Contraceptive implant)

Are women getting their desired LARC methods? NOV:124
Get practice up to speed on LARC methods, APR:40
How to make LARC first at your clinic, OCT:115
LARC methods: 7 things you need to know, JAN:4
Options might begin to emerge with new data out on LARC, MAR:25
Short-term bleeding and cramping with LARC method satisfaction eyed, NOV:121
Time to look at LARC use in postpartum teens, AUG:81

Menopause

New terminology helps menopausal talks, NOV:127
The menopausal transition: Counsel on changes in bleeding patterns, JUL:73

Oral contraceptives

Extended OC use, Quick Start has arrived, APR:41
Pills are still popular with many women, APR:43
Put US SPR guidance into your practice, JAN:5

Provider resources

As healthcare reform rolls in, what is the forecast for family planners? JAN:1 supplement
Check new web site for Contraceptive Technology, MAY:59
How long have you worked in your present field? JAN:3 supplement
In the past year, how has your salary changed? JAN:2 supplement
New guidance uses best evidence to direct family planning services, AUG:85
Retention of patients is critical to family planning financial sustainability, JUN:61
Survey profile, APR:39
Survey snapshot, JAN:4 supplement
What is your highest academic degree? JAN:3 supplement
What is your salary level? JAN:1 supplement
What's the overview of the 2012 salary landscape? JAN:4 supplement

Reproductive tract infections/Sexually transmitted infections

Accelerate HPV vaccine uptake: Time to move, JUN:65
Are you recommending HPV vaccine for males? DEC:140
Biomedical prevention spotlighted at AIDS 2015, OCT:112
Boost chlamydia screens in adolescent females, SEP:105
CDC backs new HIV testing approach — Update your clinical lab practices, SEP:1 supplement
CDC issues guidance for lab detection of STIs, MAY:59
CDC offers webcast on hepatitis C, SEP:4 supplement
Check digital trends in STI prevention, JUN:63
Data mixed on increased risk of HIV in women using contraceptive shots, OCT:109
How you can remove HPV vaccination barriers, FEB:22
HPV vaccine continues to be underutilized, OCT:117
Nearly 5% of young U.S. women have chlamydia, DEC:3 supplement
New campaign spurs conversations on HIV, SEP:3 supplement
New data emerges on pre-exposure prophylaxis (PrEP), MAR:1 supplement
New guidelines focus on PrEP use against HIV, AUG:89
Potential HPV vaccine shows promise: What could it mean for young women? JAN:1
Science gives overview of HPV in healthy adults, AUG:94
Use retest reminders on chlamydia and gonorrhea, JUL:80
What is the role of express STI testing? MAR:3 supplement

What's behind the increase in HIV infections in gay and bisexual men? DEC:1 suppelemnt

Teens

Clinicians missing mark on sex talk with teens, MAR:32
How to get into the heads of teens in initial visit, JAN:8
How you can remove HPV vaccination barriers, FEB: 22
Many teens not getting reproductive health care: DEC:139
QuickStart: Why put off what you can do today? JUN:69
Teen births decline, but more work left to be done, JUL:78
Teen condom use drops — What can providers do? SEP:102
Telephone intervention successful in teens, NOV:130
Time to look at LARC use in postpartum teens, AUG:81
Use motivation interviewing with teens, DEC:142

Women's health

Add screening for violence by intimate partners, APR:45
Cervical cancer screens overused in some groups, FEB:16
Check treatment options for dysmenorrhea, MAR:29
Classify the causes of abnormal bleeding, JAN:7
Endometriosis is the focus of new scientific research, MAY:55
How to address deaths from ovarian cancer, FEB:21
HPV test approved as first-line screening, JUL:75
Initiative to look at uterine fibroid options, DEC:136
Interpregnancy interval — You can help women, MAR:28
New treatment eyed for pain of vulvodynia, MAY:53
Period problems: Can contraception help? SEP:104
Research stirs debate on mammography, MAY:51
Teratogenic drug use: Check contraception, JUN:68
Use guidance to cut stroke risk in women, MAY:56