Family Planning for Patients with Chronic Illnesses

Elise J. Turner, MSN, CNM
Objectives

- Describe the impact of chronic disease on perinatal outcomes.
- Discuss the role of family planning in chronic disease management and preconceptual planning.
- Compare the pros and cons of various family planning methods when used with different chronic conditions.
In Mississippi, we have

- SERIOUS HEALTH PROBLEMS
- HIGH RATES OF PREGNANCY
- WHAT’S THE INTERSECTION?
Top Rankings

- Obesity
- Preterm births as percent
- Diabetes
- Hypertension
- Chlamydia, GC
- Overall poor health index - #2
Mental Health

- 40% of females report “poor mental health”
- 30% of males report “poor mental health”
- 114,000 with serious mental illness
Dental Health

- 40% went to the dentist in the last year
- 32% with NO TEETH by age 65+
- Dental health connection with pregnancy outcomes?
- What about other chronic conditions?
What’s Different Now?

- Diseases can be better controlled
- People live longer with diseases
- People retain fertility with diseases
- People feel “normal” when they aren’t
- Childbearing is seen by some as necessary or rite of passage
Comorbid Conditions

Many patients with chronic illnesses also

- Are obese
- Smoke/use alcohol or other recreational drugs
- Have psychiatric diagnoses
- Have trouble affording medications
- Have another chronic condition
- Have complex lives - ill children as well
Over the Years, I’ve Learned...

- Never doubt who will have sex
- There’s someone for everyone
- Sex makes people feel “OK”
- Pregnancy is a symbol - that “maybe I am not really that sick”
- Even very ill women can become pregnant against all odds
My Other Odd Job...

- Reviewing maternal deaths

- Some catastrophic disasters

- Some unfortunate situations

- Mostly women who became pregnant with serious chronic illnesses

- Even with good care, it was just too much for their bodies
What about pregnancy?
In a typical year:

- 1500 diabetics
- 1200 anemias
- 1000 chronic hypertension
- 550 lung disease
- 140 cardiac disease

- 5900 other medical conditions!
My Little Survey—Totally Unscientific

- Medical/surgical unit at large hospital
- Reproductive aged patients
- Sexually active
- Serious chronic illnesses
- 0% had reproductive risks identified
- 0% had family planning mentioned
- 0% counseled by disease specialist
What About the Providers?

- Patients often have non-reproductive healthcare providers as primary.
- May or may not have good coordination between primary and FP provider.
- Disease specialists often don’t see FP as “their job.”
What About Internists?

- Only 63% had ever recommended ECP
- Many were unsure about method
- Not a routine part of patient education
- Many didn’t think it was their role

(Chuang et al, 2004)
Contraceptive Methods

- Permanent Surgical
- Reversible Prescriptive
- Emergency Contraception
- Barrier Methods
- Fertility Awareness
Fertility Awareness

- Increases sense of health awareness
- Helps identify return to fertility
- Helps determine timing of intercourse
- May be used to avoid pregnancy
- May be used to achieve pregnancy

BBT, LAM, Ovulation, calendar, symptothermal
Unintended Pregnancy Within First Year

Percent of Women Experiencing an Unintended Pregnancy

- Combined Oral Contraceptives: 8.0%
- Patch: 8.0%
- Ring: 8.0%
- Injection: 3.0%
- IUD: 0.1%
- Implant: 0.05%
- Female Sterilization: 0.5%
- Male Sterilization: 0.15%

Permanent Methods

- Recommended - at least 21 years old
- Funding available through Health Dept.
- Only for persons who are sure they will never want more bio children
- Reversal is possible, but not very successful and not paid by insurance or other funds
Permanent Methods

- Surgical Tubal Ligation
  - Separating the fallopian tubes
  - Egg can’t be fertilized
  - Requires anesthesia, surgery
Non Surgical Sterilization

- No anesthesia
- Excellent outcomes
- Must use back-up method for 3 months and have occlusion verified by testing
Vasectomy

- Separating the vas deferens
- Sperm can’t leave the testes
- Can be done outpatient with local anesthesia
- Not instantly infertile
Vasectomy- Am I Sterile?

Only about 20% come for sperm check

12 weeks: 60% clear

22 weeks: 80% clear

20th ejaculation: 30% clear

1/3 had persistent, but low, sperm counts

3 months is best guideline
Birth Control Pills

- Require action EVERY day
- Skipped pills = unplanned pregnancy
- Have to start pill pack promptly
- Most common method prescribed, but continuation and compliance rates are low
- Not suitable for some co-morbid conditions
Many Different Types

- Progesterone only

- Estrogen and progesterone together
  - Monophasic
  - Biphasic
  - Triphasic
  - Extended use
Emergency Contraception

- 1960s first used in Holland
- 1970s DES used by college health
- 1970s Dr. Albert Yutzpe
- 1990s Estrogen and progesterone
- 2010 Ulipristal acetate
All Patients Should Know…

- Where to get ECP and how to take
- Best to get and keep at all times
- ECP are safer than alternatives for patients with serious medical conditions
- What medications may interact with ECP to decrease effectiveness?
Vaginal Ring

- Releases estrogen/progestin for contraception
- Must be left in for 3 weeks, 1 wk off
- Lower hormone dose
Estrogen Patch

- Same type hormones as birth control pills
- Patch has to be replaced promptly
- Hormonal side effects, 60% more estrogen
- Cannot be used irregularly
Intrauterine Devices

- Highly effective
- Reversible
- Long term
- With or without hormones
- Great choice for many patients with chronic illnesses
- Benefits for aging women
Teens and IUDS

- WHO supports IUD use from menarche
- Does not increase risk of STI acquisition
- Slight PID increase first 20 days
  - 0-2% when no infection present
  - 0-5% with documented infection
- After 20 days risk no different
- No increase in PID if chlamydia treated
- Progesterone type may lower risk of PID

ACOG Committee Opinion 392, 2007
Injections

- Very effective
- Every 3 months
- Slow return to fertility
- Not best for obese teens
- Progestosterone only
Male Condom

- Protects from some STDs
- Prevents pregnancy
- Male responsibility
- Use with spermicides
Receptive Condom

Called “female” condom

Protects from STD/HIV and pregnancy
<table>
<thead>
<tr>
<th>CATEGORY</th>
<th>WITH CLINICAL JUDGEMENT</th>
<th>WITH LIMITED CLINICAL JUDGEMENT</th>
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<tbody>
<tr>
<td>1</td>
<td>Use method in any circumstances</td>
<td>Yes (Use the method)</td>
</tr>
<tr>
<td>2</td>
<td>Generally use the method</td>
<td></td>
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<tr>
<td>3</td>
<td>Use of method not usually recommended unless other more appropriate methods are not available or not acceptable</td>
<td>No (Do not use the method)</td>
</tr>
<tr>
<td>4</td>
<td>Method not to be used</td>
<td></td>
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</tbody>
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SYSTEMIC LUPUS ERYTHEMATOSUS

- Positive or unknown antiphospholipid antibodies
  - Copper IUD
- Negative antiphospholipid antibodies
  - Most methods OK
- Severe thrombocytopenia
  - Avoid Depo and Implants
GESTATIONAL TROPHOBLASTIC DISEASE

- Decreasing or undetectable β-hCG levels
- Persistently elevated β-hCG levels or malignant disease
- IUDs not recommended
- Other methods OK
Hypertension

- Combined OC users: increased risk of stroke, acute myocardial infarction, and peripheral arterial disease compared with nonusers.
- Avoid estrogens
- Progesterone OK
- IUDs OK
- Pregnancy induced HTN
  - COC may be OK
CARDIOVASCULAR DISEASE

MULTIPLE RISK FACTORS FOR ARTERIAL CARDIOVASCULAR DISEASE
(such as older age, smoking, diabetes and hypertension)

Combination of level 2 risks isn’t necessarily additive

POPs, implants, IUDs OK
But not Depo
Diabetes

History of gestational disease
(More than half go on to actual diabetes)
- All methods OK with surveillance

No vascular disease
(insulin or non-insulin dependent)
- All methods OK with surveillance
Nephropathy/retinopathy/ neuropathy
- No estrogens or depo
- POPs, implants, IUDs OK

Other vascular disease or
  diabetes of > 20 years’ duration
- No estrogens or depo
- POPs, implants, IUDs OK
Diabetes and COCs

The development of non-insulin dependant diabetes in women with a history of gestational diabetes is not increased by the use of COCs.

Among women with insulin or non-insulin dependent diabetes, COC use had limited effect on daily insulin requirements and no effect on long term diabetes control (e.g., HbA1c levels) or progression to retinopathy.
Breast disease

- Undiagnosed mass
- Benign breast disease
- Family history of cancer
- Breast cancer
  - (i) current
  - (ii) past and no evidence of current disease for 5 years
Types of Headache

- Tension-type headaches
- Migraines with and without aura
- Cluster headache and other trigeminal autonomic cephalalgias (TAC)
- “Other” assorted primary headaches
- Headache attributed to other conditions

(International Headache Society, 2005)
What Kind of Headache is it?

Migraine With Aura  (MWA)

Recurrent disorder manifesting in attacks of reversible focal neurological symptoms that usually develop gradually over 5 – 20 minutes and last for less than 60 minutes.

Headache with the features of migraine without aura usually follows the aura symptoms. Less commonly, headache lacks migrainous features or is completely absent.
Migraine Without Aura (MWoA)

- Recurrent headache disorder manifesting in attacks lasting 4–72 hours.
- Typical characteristics of the headache are unilateral location, pulsating quality, moderate or severe intensity, aggravation by routine physical activity.
- Association with nausea and/or photophobia and phonophobia.

(International Headache Society, 2005)
Migraine with Aura

- Seems to be a different type of migraine
- 50-57% worse with OCPs
- DANGER
  - New onset aura with OCPs
  - Crescendo of migraines with OCPs
- Platelet aggregation seems to increase with OCPs and play a role
- Combined OCP are not recommended
Other CVA Risks

- Cardiovascular problems
- Prothrombotic conditions
- Migraine + smoking + OCPs = DANGER!
HIV Infection

- For women of childbearing age or any man, counsel on reproductive choices and family planning

- Depo provera good choice
- Implant
- IUDs with monitoring; not if suppressed
- Other methods depends on meds
- No progression with hormonal methods
Psychiatric Illnesses

- Depression
- Schizophrenia
- Bipolar disease

- What meds?
- Can patient manage the method?
Seizures

- Certain anticonvulsants decrease effectiveness of hormonal products
- Phenytoin, carbamazepine, barbiturates, primidone, topiramate, oxcarbazepine
- Depo: not interacting; sz decreased
  - Acts on GABA receptors?
- Estrogen products decrease effectiveness of lamotrigine monotherapy-POPs OK
Anemias

Thalassemia & Fe deficiency
- All hormonal methods OK
- Copper IUD with monitoring

Sickle cell anemia
- Crises decreased by use of combined pills
- Depo has even better effect!
Case Study

Susie is a 17 year old who weighs 289 lbs, and is hypertensive. She already has two children and says she doesn’t want any more.

What methods would be appropriate?
Chronic Illness and Pregnancy

- Effect of illness on fertility
- Effect of pregnancy on illness
- Effect of illness on pregnancy
- Effect of medications on fetus
- Ability of person with chronic illness to parent effectively
- Poor compliance patterns for self?
What Can Non-Reproductive Providers Do?

- Promote reproductive health
- STD/HIV testing/treatment/referral
- Promote adult immunizations
- Promote folic acid supplements
- Give patient parameters of optimum disease management to plan pregnancy attempts
Time Frames

- Time line that shows how long it takes to achieve optimum condition
- Specific laboratory/health measurements
- Length optimum condition should be maintained before pregnancy
- How long it takes for teratogens to be cleared from body before safe for conception
- How long it takes to stabilize on new meds
Counseling

Here are your risk factors

Here’s how long it would realistically take to modify/optimize your risks

Chart out the timeline with actions

Working toward health will improve so many aspects of motherhood.

Schedule visits for this plan.

What tools are needed?
When is it SAFE to have your baby?

What situations will make it difficult or impossible for you to reach your goal?
Realistic Counseling

- Need for **immediate** entry into prenatal care
- Management by perinatologist/OBGYN
- Map out increased surveillance needs
- Determine safe delivery plan & location
- Likelihood of preterm or LBW infant
- Postpartum adaptation plan
Preconception Contraception

- Effective contraception while preparing
- Rapidly reversible method
- Method that will not interfere with disease management for optimum state
- Encourage patient regarding her progress
- Praise efforts on baby’s behalf
- Enlist partner in family planning priorities
Negative Pregnancy Test

In a small study, 52% of women with negative pregnancy test had medical factors that could adversely affect a pregnancy!
Negative Pregnancy Test

- YOUR BIG OPPORTUNITY !!
- Teachable moment
- How do you feel about result?
- When do you want a baby?
- What about your partner?
- MAKE a follow up appointment- family planning, DV referrals, mental health care, preconceptual assessment, etc.
Helpful Websites

- www.bestmethodforme.com
  Site to help clients clarify which method best matches their needs and preferences

- www.managingcontraception.com
  *Contraceptive Technology* site with comprehensive info

- http://msdh.ms.gov/care/
  MS State Dept of Health Family Planning site

- www.cdc.gov/reproductivehealth/UnintendedPregnancy/USMEC.htm
  US Medical Eligibility Criteria for Contraceptive Use
Mississippi State Department of Health
Family Planning Program
PO Box 1700
Jackson, MS 39215
1-800-721-7222
www.ms dh.state.ms.us
or contact
the county health department nearest you

Regarding this presentation:
Elise.Turner@HindsCC.edu