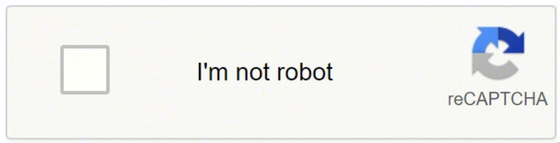

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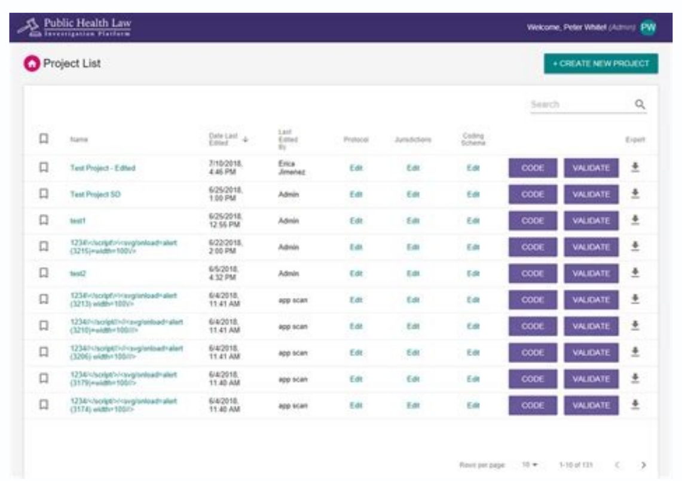
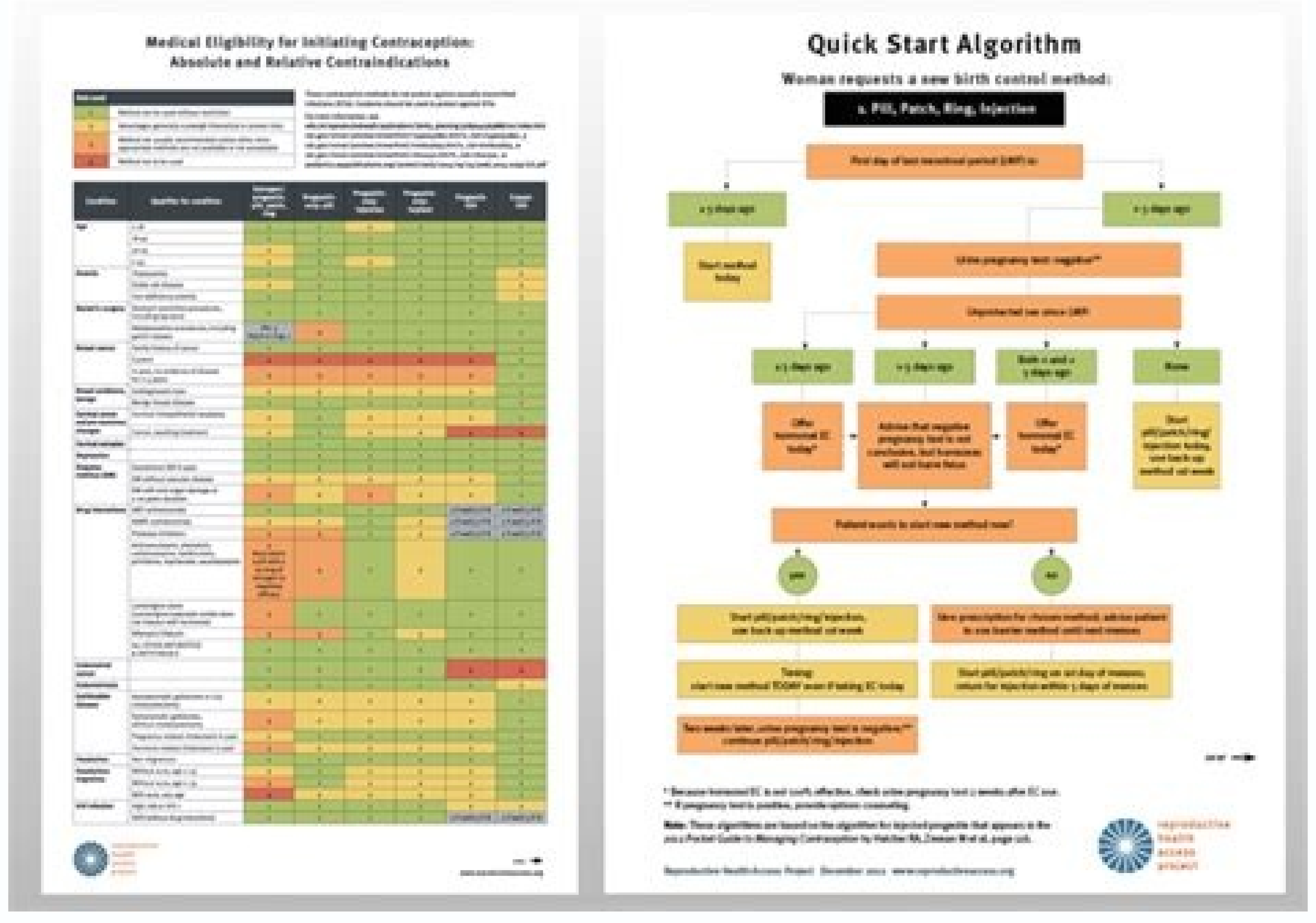
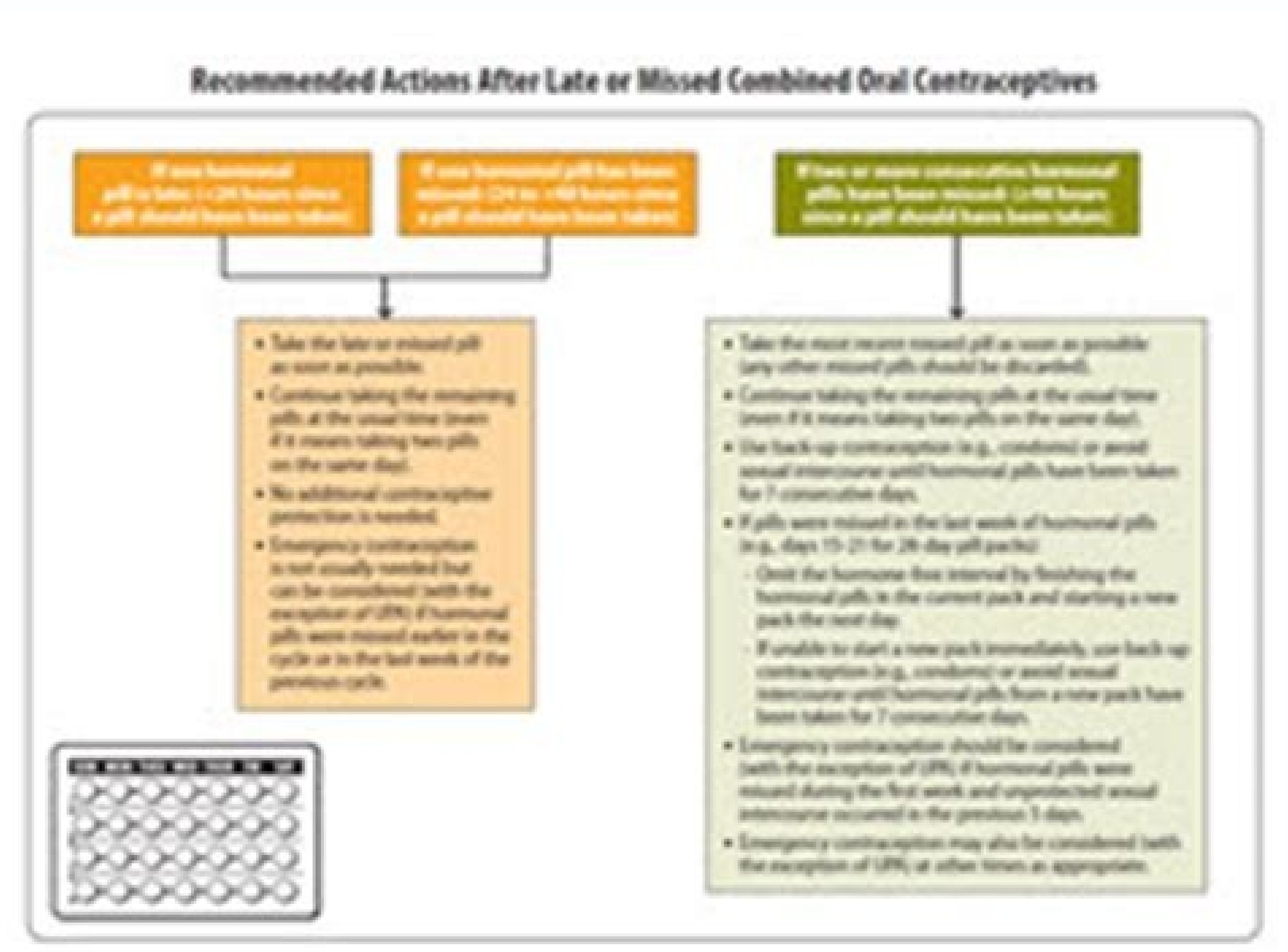
Sogc contraception guidelines







Sogc contraception guidelines part 2. Sogc emergency contraception guidelines. Sogc contraception guidelines part 4. Sogc contraception guidelines part 3.

The SOGC advises that providers include DMPA in their armamentarium, but that they weigh the risks and benefits of DMPA use with patients and advise youth who choose this method to optimize calcium and vitamin D intake, engage in weight-bearing exercise and reduce cigarette, caffeine and alcohol use to optimize bone health [17].Given the importance of bone mineralization, pills containing 30 mcg to 35 mcg of ethinyl estradiol (EE) should be prescribed preferentially because EE doses below 30 mcg may be associated with poorer bone mineralization in youth [18]. However, the SOGC has published a comprehensive Canadian Contraception Consensus that reviews all available methods in detail [5][9]–[11]. Arch Intern Med 1998;158(6):585–93.Stein PD, Matta F. Cochrane Database Syst Rev 2015;8:CD011054.Stegeman BH, de Bastos M, Rosendaal FR, et al. Depo now: Preventing unintended pregnancies among adolescents and young adults. The patch and the ring can be used in a similar manner to produce extended cycles.STARTING A METHODThe following strategies reduce common barriers to initiating and continuing contraceptive use.No pelvic exam neededTraditionally, contraceptive prescription has been tied to pelvic examination, Papanicolaou’s smear (or ‘Pap’) testing and screening for STIs. However, none of these steps are necessary for prescribing contraceptives (except in the case of IUSs or IUDs, where STI testing should occur at or around time of insertion). A systematic review. J Obstet Gynaecol Can 2015;37(11):1033–9.Black A, Guilbert E, Costescu D, et al. Further, providing pill packs on site improves continuation over providing a prescription [44]. Studies have demonstrated that when financial barriers are removed, many youth are interested in using LARCs, including intrauterine contraceptives (IUCs) [6]. Weight gain in obese and nonobese adolescent girls initiating depot medroxyprogesterone, oral contraceptive pills, or no hormonal contraceptive method. PodcastThe Canadian Paediatric Society gives permission to print single copies of this document from our website. Obstet Gynecol 2007;109(6):1270–6.Hatcher RA, Trussell J, Nelson AL, eds. Idiosyncratic responses to COCs do occur—sometimes associated with a reported dramatic increase in appetite—that appear to be progestin-related [34]. J Adolesc Health 2013;52(4 Suppl):S22–8.Black A, Guilbert E, Costescu D, et al. J Obstet Gynaecol Can 2016;38(2):182–222.Secura GM, Allsworth JE, Madden T, Mullersman JL, Peipert JF. J Obstet Gynaecol Can 2007;29(7 Suppl 2):S1–32.Canadian Task Force on Preventive Health Care, Dickinson J, Tsakonas E, et al. For example, the transdermal patch has been shown to have reduced effectiveness in women over 90 kg. This statement provides guidance for selecting and prescribing contraceptives for youth, including commonly prescribed hormonal contraceptives—the pill, patch, ring and injectable progestin—and long-acting reversible contraceptives (LARCs). Each office visit should include focused questions and specific education on contraceptive methods and their effectiveness (Table 1), promoting condom use to enhance the safety and effectiveness of other methods and prevent STIs, and counselling on EC in case of condom failure or inadequate protection. This approach can be used for any method of contraception, provided there is reasonable certainty that a patient is not pregnant.6. Provide long-term (i.e., 12-month) prescriptions for non-LARC contraception because they increase adherence, as does providing pill packs on site rather than issuing prescriptions.7. Offer technical guidance to youth around preferred methods of contraception (e.g., safer technique for condom removal). Contraception 2013;87(5):625–30.Foster DG, Parvataneni R, de Bocanegra HT, Lewis C, Bradsberry M, Darney P. J Fam Plann Reprod Health Care 2010;36(3):117–22.Gallo MF, Lopez LM, Grimes DA, Schulz KF, Helmerhorst FM. The efficacy of intrauterine devices for emergency contraception: A systematic review of 35 years of experience. However, the benefit of using hormonal contraception generally outweighs risk in cases of migraine without aura or other neurological phenomena. Clin Chest Med 2010;31(4):611–28.Lidegaard Ø, Nielsen LH, Skovlund CW, Skjeldestad FE, Løkkegaard E. J Obstet Gynaecol Can 2006;28(4):305–13.Agostino H, Di Meglio G. Methods used at the time of intercourse: Male and female condoms, diaphragms, cervical caps, sponges and spermicide.For patients who are uncomfortable with LARCs, using a hormonal method and an in-the-moment method together is almost as effective.4. Provide contraceptive prescriptions without a pelvic examination, unless required (e.g., in cases of IUC insertion). While the transdermal patch releases 20 mcg of EE daily, the pharmacokinetics are different and the overall exposure is higher than that of a 30 mcg EE pill [20]. Pediatrics 2014;134(4):e1257–81.Black A, Guilbert E, Costescu D, et al. Young women may experience breakthrough bleeding after several weeks on active pills. COC use increases the risk for venous thromboembolism (VTE) by two to four times [21] and for stroke by 1.5 to two times, compared with risk levels in nonusers [22]. Overweight youth are at much higher risk for weight gain than nonoverweight peers [36] and early weight gain is predictive of continued weight gain [37].Certain contraceptives may be less effective at higher weights. This does not decrease the effectiveness of the pill but can be an annoying side effect. Bone mineral density of total body, spine, and femoral neck in children and young adults: A cross-sectional and longitudinal study. Canadian contraception consensus (part 3 of 4): Chapter 7— Intrauterine contraception. These women should be offered an alternate contraceptive method or counselled regarding use of a backup.Choosing an oral hormonal contraceptivePrescribing a COC containing 30 mcg to 35 mcg EE is a good starting point. For permission to reprint or reproduce multiple copies, please see our copyright policy.Giuseppina Di Meglio, Colleen Crowther, Joanne Simms; Canadian Paediatric Society, Adolescent Health CommitteePaediatr Child Health 2018, 23(4):271–277 AbstractSexual and reproductive health is an important component of comprehensive health care for youth. New York: Ardent Media. Canadian consensus guideline on continuous and extended hormonal contraception, 2007. There have been no documented teratogenic effects from using COCs, POPs or DMPA in early pregnancy.It is possible to insert an IUC at any point during the menstrual cycle provided there is reasonable certainty that the youth is not pregnant. The WHO’s Medical Eligibility Criteria for Contraceptive Use [12] is an excellent resource for determining which methods are safe for individuals with health conditions.One often-missed absolute contraindication to estrogen-containing contraception (COCs, transdermal patch or vaginal ring) is migraine with aura, due to the increased risk for cerebrovascular accidents. Pregnancy in adolescence can have significant negative impacts on the physical, emotional and socioeconomic lives of the youths and children involved, as well as on their parents, extended family and community [2][3]. Contraception 2013;88(4):503–8.Hirschberg AL. Weight gain is not uniform: between 20% and 40% of users lose weight during DMPA use. J Pediatr Adolesc Gynecol 2010;23(4):195–201.Moreau C, Trussell J, Gilbert F, Bajos N, Bouyer J. www.contraceptivemedia.com/ (Accessed August 8, 2017).Cleland K, Zhu H, Goldstuck N, Cheng L, Trussell J. Combined oral contraceptives: Venous thrombosis. Low-dose oral contraceptives in adolescents: How low can you go? In: Hatcher RA Trussell J, Nelson AL, eds. Thrombotic stroke and myocardial infarction with hormonal contraception. Geneva, Switzerland: WHO, 2015. Does the progestogen used in combined hormonal contraception affect venous thrombosis risk? In populations where LARC use is high, the incidence of pregnancy in youth has declined significantly [7]. Obstet Gynecol 2011;117(4):793–7.Guilbert E, Boroditsky R, Black A, et al. Obstet Gynecol Clin North Am 2015;42(4):683–98.Silverstein MD, Heit JA, Mohr DN, Petterson TM, O’Fallon WM, Melton LJ 3rd. Comparison of ethinylestradiol pharmacokinetics in three hormonal contraceptive formulations: The vaginal ring, the transdermal patch and an oral contraceptive. Bone demineralization exceeds bone mineralization as early as 25 years of age [14]. Among youth choosing a COC, who can start their prescription without further provider involvement, it was found that instructing them to wait until their next period to start lowered the likelihood of succession to a second pack of pills [41]. By contrast, attempting to impose a particular method may lead to lower adherence.To support LARC use in youth, clinicians who do not insert IUCs should develop a network of providers willing to perform this service. N Engl J Med 2012;366(24):2257–66.James AH, Bushnell CD, Jamison MG, Myers ER. When anticipating a delay of more than a few days before insertion, recommending an alternate method (called ‘bridging’) until the device is placed can reduce the risk of an unplanned pregnancy in the interim.Health care providers must also discuss fertility awareness and contraception with male youth. Sex hormones, appetite and eating behaviour in women. Combination contraceptives: Effects on weight. Back-up use of condoms is advised for a minimum of 7 days and for 14 days if she has received ulipristal for EC, because ovulation may still occur in the first several days following initiation of contraception [42]. Strategies that eliminate obstacles to initiating and continuing contraception are provided.Keywords: Bone mineral density; Contraception; Combined oral contraception; Emergency contraception; Intrauterine contraception; Long-acting reversible contraception (LARC); Sexual and reproductive healthSexual and reproductive health (SRH) is an important component of comprehensive health care for youth. Health care providers must facilitate access to contraception and reinforce safer protective practices for all youth wishing to avoid pregnancy. COCs with 20 mcg EE have not been found to have fewer side effects [19] or risks (see below) than 30 mcg to 35 mcg pills. Medical Eligibility Criteria for Contraceptive Use, 5th edn. Provision of no-cost, long-acting contraception and teenage pregnancy. Fertil Steril 2008;90(6):2060–7.Scholes D, LaCroix AZ, Ichikawa LE, Barlow WE, Ott SM. The art of prescribing rests in being able to switch pill types to address side effects rather than in knowing which one is ‘perfect’ at the outset. Since 2012, several organizations—including the American Congress of Obstetricians and Gynecologists, the American Academy of Pediatrics and the Society for Adolescent Health and Medicine, have officially endorsed LARCs as first-line contraceptives for teens [8].This statement recommends using LARCs as first-line contraception for Canadian youth, while recognizing that the LARC options are limited to IUCs in Canada and that not all youth are comfortable with IUCs. Adapting discussion of contraceptive options for each individual’s preferences and needs and addressing all concerns with respect are parts of a collaborative decision-making process that promotes adherence. The copper IUD can be inserted for up to 7 days postcoitus, as a form of EC that is more effective than orally administered EC [43].Year-long prescriptionsThere is evidence that providing a year-long prescription for contraception, even when more frequent follow-up is planned, increases continuation of the method, decreases the number of pregnancy tests, decreases the number of pregnancies and decreases the number of abortions. Variations, taking into account individual circumstances, may be appropriate. Discuss sexual health, fertility, family planning and contraception with all youth, starting early in adolescence, preferably before they become sexually active. Different combined oral contraceptives and the risk of venous thrombosis: Systematic review and network meta-analysis. Costs from wastage are negligible when compared with the combined health care and social costs of repeat visits, pregnancy tests, unintended pregnancies, abortions and youth parenting.COUNSEL CONDOM USEBiological and social factors put youth at high risk for STIs. Even when they are using effective contraceptives, it is important to remind young patients that only condom use can protect them from contracting or spreading STIs. For youth using condoms alone, always remind them that EC is an option in the event of condom leaks, slips or breaks.RECOMMENDATIONSThe personal, health care and social costs of a single unintended or mistimed pregnancy are substantial. By contrast, studies of close follow-up (e.g., scheduling return visits or making follow-up phone calls) did not demonstrate improvements in contraceptive continuation among youth [45].In clinical settings where contraceptives are given directly to youth, cost concerns arising from pill wastage may arise. Consequently, many providers have adopted a ‘quickstart’ method. Cochrane Database Syst Rev 2014(1):CD003987.Roumen FJ. Obstet Gynecol 2006;108(5):1107–14.Trussell J. At worst, they may double the rate of VTE compared with COCs [24]. Int J Epidemiol 2007;36(2):368–73.Carr S, Espey E. A good medical history and a blood pressure measurement are all that is required in most cases. The intravaginal ring appears to cause less overall estrogen exposure than taking a 30 mcg EE pill, but its effect on bone mineral density in youth has not yet been evaluated.Hormonal contraceptives, thromboembolic events and strokeEstrogen-containing contraceptives increase risk for thrombosis. A young woman who is not in the first 7 days past starting her menstrual period (the traditional starting point), is screened for pregnancy risk. CMAJ 2013;185(1):35–45.Rickert VI, Tiezzi L, Lipshutz J, León J, Vaughan RD, Westhoff C. Canadian Contraception Consensus (Part 2 of 4). More limited data are available for the vaginal ring, [32] and IUS [33] but they, too, do not appear to be associated with weight gain. All providers of care to youth should put the following recommendations into practice with the patients and families they see every day:1. While involving parents in discussions, especially early on, can foster dialogue between parents and youth on this sensitive topic, it is also essential that youth have opportunities to discuss sexual issues with care providers alone and in confidence. For most youth, taking a complete medical history, along with weight and blood pressure measurement, are sufficient. J Bone Miner Res 1994;9(9):1451–8.Sabatier JP, Guaydier-Souquières G, Laroche D, et al. J Adolesc Health 2007;40(1):22–8.Westhoff C, Heartwell S, Edwards S, et al. www.who.int/reproductivehealth/publications/family_planning/MEC-5/en/ (Accessed September 13, 2017).Lu PW, Briody JN, Ogle GD, et al. Pill wastage is higher when more pills are dispensed, but these are not proportional losses [46]. If the test is negative, she starts hormonal contraception—whether injectable or oral—on that day. The effect of follow-up visits or contacts after contraceptive initiation on method continuation and correct use. Arch Pediatr Adolesc Med 2005;159(2):139–44.Black A; Ad hoc DMPA Committee of the SOGC. Confidentiality maximizes the likelihood of obtaining a complete sexual history and engaging on questions and concerns that youth might not be comfortable sharing with a parent. Internet addresses are current at time of publication. Contraceptive Technology, 20th edn. The product monograph reports an average 2.5 kg increase in the first year and 3.6 kg in the first 2 years [35]. Continuing dialogue at each health visit allows for follow-up regarding adherence and side effects, and offers opportunities to choose an alternative method. This statement reviews leading principles of contraceptive care for youth, along with safe, effective options and practical strategies for improving adherence.CONTRACEPTIVE OPTIONSTable 1 lists failure rates for individual contraceptive methods when they are used in ‘perfect’ conditions (i.e., the research setting) versus more ‘typical’ settings (i.e., in clinical practice). Therefore, the absolute risk posed by using hormonal therapy is also low [29].In the last decade, several studies have raised the possibility that VTE risk (but not stroke risk) is moderated by the type of progestin used in COCs [21]. Bone mineral density in adolescent females using injectable or oral contraceptives: A 24-month prospective study. If they continue to take active pills, the bleeding will stop eventually. Sex and sexual health: A survey of Canadian youth and mothers. Continue this dialogue into adult care whenever possible.2. Adopt a collaborative approach when discussing contraception options with youth to optimize adherence. A longer cycle can be obtained by using only the active pills for two or more cycles, followed by four to seven placebo days. Obstet Gynecol 2007;109(6):1277–85.van den Heuvel MW, van Bragt AJ, Alnabawy AK, Kaptein MC. J Obstet Gynaecol Canada 2015;39(4):229–68.WHO. Contraceptive efficacy. Thus, the long-acting reversible contraceptives (LARCs)—which act continuously over several years without patient intervention—have the lowest failure rate and are first-tier options. Product Monograph: Depo-Provera (rev. The contraceptive CHOICE project: Reducing barriers to long-acting reversible contraception. Bone mineral acquisition during adolescence and early adulthood: A study in 574 healthy females 10-24 years of age. The law protects youths’ right to receive confidential SRH care, including prescriptions for contraception and to treat STIs, as long as they are mature enough to understand the nature and consequences of treatment (and in Quebec, are at least 14 years old). Prepare youth for this transition and avoid switching pills too quickly unless side effects (e.g., frequency of headaches) are increasing rather than decreasing over time.Extended useWhile many COCs are packaged as 28-day cycles, with 21 active pills and seven placebos, it is also safe to have much longer cycles and even to be on active pills continuously, with no placebo interval [38]. She is tested for pregnancy, particularly if the last period was abnormal or she has had unprotected sex since her last period. Intrauterine devices and pelvic inflammatory disease among adolescents. Trends in the incidence of deep vein thrombosis and pulmonary embolism: A 25-year population-based study. Ask about a diagnosis of—or symptoms compatible with—migraines with aura, which is an absolute contraindication to estrogen use (COC, patch, vaginal ring).10. These methods include the male condom, female condoms, diaphragm, cap, sponge, spermicide, withdrawal and fertility awareness. Paediatr Child Health 2008;13(1):25–30.Hoffman SD, Maynard RA, eds. Oral contraceptive tolerance: Does the type of pill matter? Am J Obstet Gynecol 2010;203(2):115.e1–7.Secura GM, Madden T, McNicholas C, et al. J Obstet Gynaecol Canada 2015;37(10): 936–8.Black A, Guilbert E, Costescu D, et al. Arch Pediatr Adolesc Med 2006;160(1):40–5.Bonny AE, Secic M, Cromer B. Youth may neglect to report this condition and should be asked specifically about a prior diagnosis of migraine with aura and about symptoms compatible with this diagnosis. LARCs include the copper intrauterine devices (IUDs), the hormone-releasing intrauterine systems (IUSs) and the subdermal progestin-releasing implants, which are not available in Canada at the present time.The second tier comprises hormonal contraceptives, which depend on consistent use daily (i.e., combined oral contraceptives [COCs] and progesterone-only pills [POPs]), weekly (i.e., the transdermal patch), monthly (i.e., the vaginal ring), or quarterly (i.e., the depot medroxyprogesterone acetate injectable contraceptive [DMPA]).Third-tier contraceptives are used at time of intercourse and depend on individual motivation in the ‘heat of the moment’, technical skill and timing. Risk of venous thromboembolism from use of oral contraceptives containing different progestogens and oestrogen doses: Danish cohort study, 2001-9. Importantly, they should understand that EC is a ‘backup’, not a primary, method of birth control.9. Refer to the Society of Obstetricians and Gynaecologists of Canada’s Canadian Contraception Consensus and to the WHO’s Medical Eligibility Criteria for Contraceptive Use as resources for informing contraceptive choice. www.contraceptivemedia.com/ (Accessed August 8, 2017).Disclaimer: The recommendations in this position statement do not indicate an exclusive course of treatment or procedure to be followed. However, EC should be used as a backup rather than primary method.Health care providers should include the following key messages when discussing contraception with youth:While much less effective than the LARCs, third-tier methods are preferable to using no contraceptive at all.Using a first- or second-tier method with a third-tier method, or using two third-tier methods together, decreases contraceptive failure substantially. Epidemiology and incidence: The scope of the problem and risk factors for development of venous thromboembolism. Review of the combined contraceptive vaginal ring, NuvaRing. It was also reviewed by representatives of the Society of Obstetricians and Gynaecologists of Canada and the College of Family Physicians of Canada.CPS ADOLESCENT HEALTH COMMITTEEMembers: Giuseppina Di Meglio MD, Natasha Johnson MD, Margo Lane MD (Chair), Karen Leis MD (Board Representative), Mark Norris MD, Ellie Vyver MD; Elisabeth (Lisette) Yorke MD (CPS Resident member); Johanne Harvey MD (past-member); Gillian Thompson NP-Paediatrics (past-member)Liaisons: Megan Harrison MD, CPS Adolescent Health SectionPrincipal authors: Giuseppina Di Meglio MD, Colleen Crowther MD, Joanne Simms NP (ret.)ReferencesFrappier JY, Kaufman M, Baltzer F, et al. LARCs, specifically the IUD or IUS.ii. Cochrane Database Syst Rev 2014;3:CD010813.Roach RE, Helmerhorst FM, Lijfering WM, Stijnen T, Algra A, Dekkers OM. Early weight gain related to later weight gain in adolescents on depot medroxyprogesterone acetate. This respectful relationship must be maintained even when a youth elects to use a contraceptive method that is less effective, such as withdrawal. Transdermal and transvaginal contraceptives have not been studied as extensively with respect to VTE. A second pregnancy test is recommended 21 days later, to verify that she is not pregnant. Changing to a different progestin may address the problem.Many studies have reported weight gain with DMPA use. Alternatively, and provided active pills have been taken for a minimum of 21 days, they can stop the pill for 4 to 7 days, then start a new pack of pills. Weight change at 12 months in users of three progestin-only contraceptive methods. Initiation of oral contraceptives using a quick start compared with a conventional start: A randomized controlled trial. Combined oral contraceptives: The risk of myocardial infarction and ischemic stroke. This gap can be communicated to young patients by dividing contraceptive methods into three categories or tiers, based on ascending ‘typical use’ failure rates. Recommendations on screening for cervical cancer. www.pfizer.ca/sites/g/files/g10028126/f/201512/DEPO-PROVERA_PM_E.pdf (Accessed September 13, 2017).Bonny AE, Ziegler J, Harvey R, Debanne SM, Secic M, Cromer BA. Screening for STIs should be offered to sexually active youth but should not be a prerequisite for obtaining contraception except when inserting an IUC.5. Whenever possible, suggest a ‘quick start’ contraceptive approach, rather than waiting for next menses. It is important to prepare youth to expect weight gain over the course of normal adolescence and to use standard growth curves to evaluate reported changes in weight. IUDs in particular were strongly discouraged for youth, but previous guidance was based on a flawed interpretation of available data [4]. Oral contraceptives and venous thromboembolism consensus opinion from an international workshop held in Berlin, Germany in December 2009. Canadian Contraception Consensus (Part 4 of 4: Chapter 9: Combined hormonal contraception. Contraception for adolescents. Emergency contraception (EC) is another ‘near the moment’ method that all youth should be informed of, regardless of their contraceptive choice. BMJ 2013;347:f5298.Han L, Jensen JT. Weigh the effectiveness, risks, side effects and personal acceptability of each method with each patient.3. Recommend contraceptives in order of effectiveness:i. For methods where the youth must return to the clinical setting for initiation—e.g., a DMPA or IUC insertion—coordinating provider/patient availability could delay contraceptive initiation by months, with risk for pregnancy in the interim [40]. Hum Reprod 2012;27(7):1994–2000.Steenland MW, Rodriguez MI, Marchbanks PA, Curtis KM. Canadian Contraception Consensus (Part 1 of 4). By age 17, more than one-half of Canadian youth are sexually active [1]. Obstet Gynecol 2005;106(3):509–16.Reid RL, Westhoff C, Mansour D, et al. The role of specific progestins in the VTE risk associated with COCs

remains controversial [30].Hormonal contraceptives and body weightYouth are particularly concerned about weight gain on hormonal contraception. LARCs, including subdermal implants (which are not available in Canada) and intrauterine contraceptives (IUCs), are substantially more effective during typical use than hormonal contraceptives. Data are not yet available on COCs with 10 mcg of EE. The data offered here underscore the principle that the more user-dependent a protective method is, the more likely it is to fail. All health care providers must therefore include contraception and fertility awareness in management planning for youth.Discussions about sexuality, sexual activity, family planning and the prevention of sexually transmitted infections (STIs) should start early, before the initiation of sexual activity, and continue throughout adolescence. When considering potential impact on BMD, remember that pregnancy is also associated with bone demineralization. Encourage adjunctive condom use for all other methods of contraception to prevent transmission of sexually transmitted infections.8. Inform all youth about EC options. Canadian contraception consensus: Update on depot medroxyprogesterone acetate (DMPA). Contraceptive Technology. Number of oral contraceptive pill packages dispensed, method continuation, and costs. For example, the failure rate of an oral contraceptive pill + a male condom = the failure rate of an oral contraceptive pill (0.09) × the failure rate of a male condom (0.18) = 0.02 or 2%.For optimal effectiveness, technical guidance on the method of choice is essential (e.g., demonstrate technique for safe condom removal; be clear on how long after intercourse a diaphragm, cap or sponge must remain in place).Regardless of the contraceptive method, condom use should always be encouraged to reduce risk for STIs.Recommending LARCs as the method of first choice is an important change in practice. Advocate for introducing the subdermal contraceptive implant in Canada.AcknowledgementsThis position statement was reviewed by the Community Paediatrics Committee of the Canadian Paediatric Society. Incidence and risk factors for stroke in pregnancy and the puerperium. Maturitas 2012;71(3):248–56.Pfizer Canada Inc. Side effects often abate after two to three cycles of use. Osteoporos Int 1996;6(2):141–8.Cromer BA, Bonny AE, Stager M, et al. Kids having Kids: Economic Costs and Social Consequences of Teen Pregnancy. IUC insertion can disrupt pregnancy [5]. October 26, 2015). Contraception 2013;87(5):605–10.Steenland MW, Zapata LB, Brahmi D, Marchbanks PA, Curtis KM. Alternatively, a health care provider can prescribe ‘extended use’ packs, which comprise 84 active pills followed by a 7-day hormone-free interval (HFI) or seven days’ worth of pills containing 10 mcg of EE. The safety of intrauterine contraception in nulliparous youth is supported by the Society of Obstetricians and Gynaecologists of Canada (SOGC) [5]. Contraception 2005;72(3):168–74.de Bastos M, Stegeman BH, Rosendaal FR, et al. However, a Cochrane review has concluded there is little evidence to suggest a consistent association between oral or transdermal contraceptive use and weight gain [31]. In fact, Pap tests are no longer recommended for youth [39]. It is important to remember that despite the higher risk for VTE and stroke with using COCs, the baseline risk for such events in youth 15 to 19 years old is low (venous thrombosis: 4 to 11 per 100,000 per year [25]–[27]; stroke: 3 to 6 per 100,000 per year [28]). Change in bone mineral density among adolescent women using and discontinuing depot medroxyprogesterone acetate contraception. The risk for VTE or stroke is not statistically different between pills containing 20 mcg and 30 mcg of EE [22][23]. Ther Clin Risk Manag 2008;4(2):441–51.Vickery Z, Madden T, Zhao Q, Secura GM, Allsworth JE, Peipert JF. This statement endorses LARCs as the first-line option for contraception for Canadian youth, while emphasizing that providers must collaborate with youth to select a contraceptive method that is acceptable, safe, effective and practical for them. Progestin-only methods may be used with both types of migraine.Hormonal contraceptives and bone mineral densityFifty per cent of adult bone mass is laid down during adolescence [13]. There have been some reassuring findings, however: the decrease in bone mineral density (BMD) is highest in the first year of use and slows thereafter; and small studies have indicated that there is a rebound increase in bone mineral density after DMPA is discontinued [16]. How does the number of oral contraceptive pill packs dispensed or prescribed affect continuation and other measures of consistent and correct use? Hormonal methods: Oral contraceptives, the transdermal patch, the vaginal ring and injectable contraceptives (e.g., DMPA).iii. Thus, using a contraceptive method that can reduce bone mineralization in women under age 25 may negatively affect bone health in the longer term. N Engl J Med 2014;371(14):1316–23.Ott MA, Sucato GS; Committee on Adolescence. Teenage pregnancy and adverse birth outcomes: A large population based retrospective cohort study. A baseline weight allows for objective assessment of future complaints concerning weight gain.The recommendation not to require a pelvic examination is not intended to discourage screening for STIs, which can now be performed using patient-collected methods, but rather to ensure that patient or provider obstacles to screening do not impede access to contraceptives.Quick-startHistorically, health care providers have advised women to initiate a contraceptive during their menses to ensure that they were not pregnant. BMJ 2011;343:d6423.Lidegaard Ø, Løkkegaard E, Jensen A, Skovlund CW, Keiding N. Washington, D.C.: Urban Institute Press, 2008.Chen XK, Wen SW, Fleming N, Demissie K, Rhoads GG, Walker M. Condom use empowers young men to take personal responsibility for and an active role in their own reproductive health.HORMONAL CONTRACEPTION IN YOUTHComprehensive guidance on prescribing hormonal contraceptives is beyond the scope of this statement. DMPA has come under particular scrutiny because the hypoestrogenic state induced by this method has been associated with decreased bone mineralization [15].

Dr FIGARO. In person visits Mondays & Wednesdays 9:30am-5pm, Tues 1pm-4pm, Fri 9:30am-1pm . occasional Friday afternoon and Saturday morning. Dr OWENS. Mon & Wed 9:30-4pm, Tues 5:15pm-8pm, Fri 10am-1pm,. Thurs Walk In Clinic11am-2pm, Sat Walk in Clinic 9-12 *** occasional closures will be updated below * Schedule may be subject to change ** please call ... The SOGC Guidelines for Operative Vaginal Birth discusses the prerequisites and contraindications to assisted vaginal births along with the application procedures and potential complications. Footnote 187 It is recommended that hospitals have a policy on instrumental vaginal birth that is based on existing clinical guidelines such as those of ... Jan 07, 2022 · All pregnant people aged 16 and older are prioritized to receive their COVID-19 booster shot, eight weeks after their second dose. Book an appointment for a booster shot by calling 1-833-838-2323 and self-identify as pregnant. Postpartum contraception. Effective contraception is an important consideration until proper preparation occurs for a subsequent pregnancy in women with pre-existing diabetes. Regarding the choice of a contraceptive method, the same motivations and restrictions apply to women with type 1 and type 2 diabetes as with other women. Description. Habituellement réalisée par un gynécologue, l'hystérectomie peut être totale (retrait du corps, du fond de l'utérus et du col de l'utérus; souvent appelé « complet ») ou partielle (ablation du corps utérin en laissant le col intact, également appelé « supracervical »).. On parle « d'hystérectomie totale » (« non conservatrice » ou « avec annexectomie ») si l ... Dr FIGARO. In person visits Mondays & Wednesdays 9:30am-5pm, Tues 1pm-4pm, Fri 9:30am-1pm . occasional Friday afternoon and Saturday morning. Dr OWENS. Mon & Wed 9:30-4pm, Tues 5:15pm-8pm, Fri 10am-1pm,. Thurs Walk In Clinic11am-2pm, Sat Walk in Clinic 9-12 *** occasional closures will be updated below * Schedule may be subject to change ** please call ... Morin L, Van den Hof MC. SOGC clinical practice guidelines. Ultrasound evaluation of first trimester pregnancy complications. Int J Gynaecol Obstet 2006;93(1):77–81. Silva C, Sammel MD, Zhou L, et al. Human chorionic gonadotropin profile for women with ectopic pregnancy. Obstet Gynecol 2006;107(3):605–10.

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