Contraception

If you prescribe teratogens, this is your conversation · not a specialty someone else owns

Ask about aura
and lead with the top tier

⚠ WHY THIS IS A GENERAL MEDICINE PAGE

⚠ TERATOGENS ARE PRESCRIBED IN YOUR CLINIC

Methotrexate, ACE inhibitors and ARBs, warfarin, valproate, topiramate, mycophenolate, isotretinoin -started in general medicine every day, often with no contraception discussion. **Ask pregnancy intention and current method BEFORE starting, document it, and revisit at every renewal**: a patient can begin a drug safely and conceive two years later on the same prescription. **In reverse**, a woman planning pregnancy needs the teratogen changed **in advance**, not at the first positive test.

EFFECTIVENESS IS ABOUT USER DEPENDENCE

<1% failure: implant, hormonal IUD, copper IUD, sterilization -**nothing depends on the user**, so typical use ≈ perfect use. **6-9%:** pill, patch, ring, injectable -**the perfect-vs-typical gap IS the story**, and quoting the perfect-use figure is misleading. **18%+:** condoms, diaphragm, withdrawal, fertility awareness. **Condoms remain essential for STI protection** regardless of what else is used -a separate indication.

LEAD WITH EFFECTIVENESS, NOT FAMILIARITY

Patients arrive expecting the pill because it is what they have heard of. **Presenting the tiers in order, starting with long-acting methods, materially shifts what people choose** -most have never been told an implant or IUD is **over ten times more effective in practice**. **This is information, not steering**: the choice stays theirs, and coercion around long-acting methods has a real history that makes the distinction matter.

⚠ US MEC 2024: THE CATEGORY 4 CONDITIONS YOU WILL MEET

1 no restriction · 2 benefits outweigh risks · 3 risks outweigh benefits · 4 unacceptable, do not use · a lookup table, safer than instinct

Category	Meaning
⚠ Category 4 for COMBINED hormonal methods pill, patch, ring	**MIGRAINE WITH AURA at any age** -the one most often missed; the concern is ischemic stroke, so **ask specifically about aura rather than accepting "migraines". Age ≥ 35 AND ≥ 15 cigarettes/day. Current or past VTE, or known thrombophilia. Vascular disease, ischemic heart disease or stroke. Severely uncontrolled hypertension. Current breast cancer. Severe decompensated cirrhosis or liver tumors. Lupus with positive or unknown antiphospholipid antibodies. Complicated diabetes. Under 21 days postpartum**
⚠ THE ESCAPE EVERYONE MISSES	**Every one of those is a contraindication to ESTROGEN, not to contraception. Progestin-only methods and BOTH IUDs are generally acceptable** in migraine with aura, smokers over 35, after VTE, and in most cardiovascular disease. **The copper IUD is hormone-free entirely.** So **"she can't take the pill" is almost never "she can't have contraception"** -yet patients are routinely left with nothing after a combined method is correctly refused

THE METHODS, AND WHAT DECIDES BETWEEN THEM

Method	Practical points
Etonogestrel implant progestin only	**The most effective reversible method.** Subdermal, lasts several years, **no estrogen -usable in migraine with aura, smokers over 35 and after VTE**. **Irregular bleeding is the main reason for discontinuation** -counsel up front or she stops early and unprotected
Hormonal IUD levonorgestrel	Top-tier effectiveness for years. **Substantially reduces bleeding and treats heavy menstrual bleeding** -often one answer to two problems. **Minimal systemic hormone**, so usable where estrogen is contraindicated. Also gives the **endometrial protection** needed alongside estrogen in perimenopause
Copper IUD hormone-free	**Completely hormone-free** -the answer when hormonal options are unwanted or contraindicated. Longest duration of any method. **⚠ Expect heavier, more painful periods**, the usual reason for removal
Depot injectable medroxyprogesterone	Every ~3 months, private, and **unaffected by enzyme inducers**. **⚠ Return to fertility is delayed, sometimes many months** -a poor choice if pregnancy is planned soon. Reversible bone density loss
Pill · patch · ring combined	Cycle control plus the non-contraceptive benefits, and **immediately reversible**. But **user-dependent**, and the whole Category 4 list above applies. **Progestin-only pills** avoid the estrogen issues but are **less forgiving of late doses**
⚠ Postpartum timing	**Combined methods are Category 4 under 21 days postpartum** because of VTE risk, and remain restricted longer with additional risk factors or breastfeeding. **Progestin-only methods and IUDs can start much earlier**, and immediate postpartum IUD placement is an option -worth planning before discharge rather than at a visit she may not attend

INTERACTIONS THAT ACTUALLY CAUSE FAILURE

Interaction	Detail
⚠ Enzyme inducers	**Rifampin and rifabutin**, plus enzyme-inducing anticonvulsants -**carbamazepine, phenytoin, phenobarbital, primidone, higher-dose topiramate**- accelerate hormone metabolism and cause contraceptive failure. **The reliable answer is a method not dependent on hepatic metabolism: copper IUD, hormonal IUD, or depot injectable. ⚠ Most other antibiotics do NOT do this**, contrary to widespread belief -the rifamycins are the genuine exception
⚠ Lamotrigine, both ways	Combined hormonal contraception **LOWERS lamotrigine levels** (seizure risk), and levels **RISE again during the hormone-free interval** (toxicity). **Coordinate with neurology** rather than starting or stopping a combined method unilaterally
Antiretrovirals · obesity	Some ART regimens interact meaningfully -**IUDs are unaffected** and are a clean answer. Most methods retain efficacy at higher body weight, but **oral levonorgestrel emergency contraception is less effective**
Emergency contraception	**⚠ The COPPER IUD is the most effective by a wide margin** -up to ~5 days, and it continues as ongoing contraception. Consistently under-offered because it needs a procedure. **Ulipristal beats levonorgestrel** and works to **120 h**. **Levonorgestrel is less effective at higher body weight** and with delay. **None is an abortifacient** -they prevent or delay ovulation, and saying so plainly affects uptake

WHAT YOU DO NOT NEED · AND THE BONUS INDICATIONS

⚠ DO NOT REQUIRE THESE TO START

No pelvic examination. No cervical cancer screening. No breast examination. No routine labs. Requiring them is a **real access barrier with no safety benefit**. **What you DO need**: a **blood pressure before any combined method**, reasonable certainty she is not already pregnant, and the history that drives the US MEC lookup. **Bimanual and speculum examination are needed for IUD INSERTION** -a different thing from screening before prescribing a pill.

TWO PROBLEMS, ONE PRESCRIPTION

The hormonal IUD substantially reduces menstrual bleeding and is a genuine treatment for heavy menstrual bleeding -often the single answer to two problems. **Combined methods** reduce dysmenorrhea, treat acne, and help endometriosis and PCOS symptoms, with a **sustained reduction in ovarian and endometrial cancer risk** that persists after stopping. **And where a chronic disease makes pregnancy hazardous** -pulmonary hypertension, severe cardiac disease, active lupus nephritis, recent bariatric surgery- **effective contraception IS therapy**, and deserves the same seriousness as the drug regimen.

References: CDC U.S. Medical Eligibility Criteria for Contraceptive Use, 2024, and the accompanying U.S. Selected Practice Recommendations · published typical-use and perfect-use contraceptive failure rates · CDC guidance on emergency contraception.

Educational aid; verify against current guidance and patient factors.

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