the PRUDENT prescriber

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Pearls from UCSF's 2023 Controversies in Women's Health

Once again, this annual conference offered a splendid practical update for caring for women. The faculty for this conference are all senior professors at UCSF who are gifted teachers.

Breast Cancer Screening - Karla M Kerlikowske, MD

- Annual screening is occurring only in the US.
- UK now uses biennial screening for women 50–69 years and triannual screening for women 45–49 years and 70–74 years.
- Screening for breast cancer doesn't decrease all-cause mortality.
- 15%-30% of screen detected cancers are over-diagnosis.
- Screening is most efficient if strategy is based on risk. Target fixed number of women at high risk - decreases harms for low-risk women - decreases costs.
- The BCSC (Breast Cancer Surveillance Consortium) v3 risk calculator is the most discriminating tool (better than Gail for average risk patients) and is available as a free app for Android and iPhones.
- The BCSC calculator utilizes:
    - Age
    - Race/ethnicity
    - 1st degree and 2nd family history of breast cancer
    - History of breast biopsy and result
    - BI-RADS breast density category
    - Body mass index
    - Age at first live birth
    - Menopausal status (pre- or postmenopausal)

<u>Reducing weight reduces breast cancer risk</u>

- Meta-analysis – OR=0.82; 95%CI 0.67-0.97
- WHI – postmenopausal women – HR=0.88; 95%CI 0.78-0.98
- Nurses' Health Study – HR=0.77; 95%CI 0.65-0.91

- Bariatric surgery – Premenopausal HR = 0.72; 95%CI 0.54-0.94 – Postmenopausal HR = 0.55; 95%CI 0.42-0.72

Primary breast cancer prevention matters
- Maintain ideal body weight
- Alcohol in moderation
- Exercise regularly
- Limit postmenopausal E+P hormone therapy to 5 years or less

Dr. Kerlikowske's Approach to Breast Ca Screening
- Offer biennial screening ages 50-74
- Stop screening at age 74; discuss screening ages 75-79 if a woman has no comorbidities.
- Biennial screening age 40-49, if 5-year breast cancer risk greater than 1.3%, i.e., average-risk of 50-54 yo

Contraceptive Care - Eleanor Bimla Schwarz, MD

1 out of 20 US women of reproductive age experience an unintended pregnancy each year. **The best contraceptive for any given person is the one they want to use at this point in their life.**

Opill: FDA newly approved progesterone only OTC BCP (Birth Control Pill)
- Not a new product, norgestrel 0.075 mg tablets marketed in the US 1974-2005 as Ovrette®
- Expected on store shelves "early 2024"
- Effectiveness: 2 pregnancies per 100 woman-years of use, similar to COC (Combined Oral Contraceptive)
- Typical use failure in 1st year of 7%
- Label suggests backup for first 2 days and if >3 hours late for dose.

Provide a 12-month supply of OCP (Oral Contraceptive Pill)
- Since 2017, California law (CA SB999) has required health plans to cover up to 12-months of self-administered hormonal contraception. (Pills, patch, ring, shot)
- ***Less than a 12-month supply of OC triples rates of unintended pregnancy***.

- Continuation rates:
    - Pill, patch, ring: 50%-60% at 1 year; 40% at 2 years
    - IUD, implant: 80%-90% at 1 year; 77% at 2 years

Nexplanon subdermal implant
- Easier than placing an IV (intra-vaginal).
- Requires two hours of training to place.
- Single rod of etonogestrel.
- No estrogen or blood clots.
- Labeled for 3 years, effective for 5 years.
- 80% continuation at 1 year.
- Most common reason for discontinuation is spotting.

Many Estrogen-free options
- Nexplanon®
- Intrauterine Contraception (IUC)
    - 52mg LNG (Liletta®/Mirena®) good for 8 yrs
    - 19.5 mg LNG (Kyleena®) labeled for 5 yrs

    - 13.5 mg LNG (Skyla®) labeled for 3 yrs
    - Copper IUC (ParaGard®) labeled for 10 yrs good for 12+
- Self-Injectable subq DMPA (Depo-provera®)
- Progestin-only Pill (Slynd®, Micronor®,Opill®)
- Vaginal gel: Phexxi
- Condoms + Ella
- Vasectomy
- Tubal ligation

Women With Diabetes Receive Contraceptive Counseling Half As Often As Non-Diabetic Women

<u>Ella: Post-coital contraceptive pill</u>

- How does it work? Delays ovulation until sperm die.
- Requires an Rx (in the US)
- Can be used up to 5 days after sex
- Twice as effective as OTC Plan B
- $43-$49 for Ella vs $15-$45 for Plan B

<u>What is the most effective form of contraception?</u>

A) Recommitting to Abstinence
B) Tubal Ligation
C) Vasectomy
D) Levonorgestrel IUD (Liletta/Mirena)
E) Copper IUD
F) Subdermal arm implant (Nexplanon)

Per US CDC of every 1000 women, pregnancy occurs in the 1st year of use of:

- 0.5 using an implant
- 1.5 with vasectomy
- 2.0 using a LNG 52mg IUD
- 5.0 who undergo tubal ligation
- 8.0 using a copper IUD

Yes, the pearl of all pearls: A reversible form of contraception is the most effective form of birth control in the first year of use: Nexplanon.

<u>IUDs</u>

- No risk of blood clots
- Convenient
- Rapid return to fertility
- IUDs do not increase PID (Pelvic Inflammatory Disease)
- IUD self-removal is safe; leave the strings a little longer

Sexually Transmitted Infections – Michael Policar, MD

<u>Chlamydia Treatment Urogenital/ Rectal/ Pharyngeal</u>

- Recommended regimen Doxycycline 100 mg PO BID for 7 days (close to 100% effective)
- Alternative regimen – Azithromycin 1 gm orally, directly observed, first line treatment in pregnancy
- Not as effective for any Chlamydia infection (?80%), less so for rectal Chlamydia.

Preferred Gonorrhea and Chlamydia Treatment Cervical, Urethral, and Rectal Infections

- Ceftriaxone 500 mg IM if patient weighs less than 150 kg
- Ceftriaxone 1 g IM if the patient weighs more than 150 kg
- For pharyngeal, gonorrhea, same regimen as above, but a test for a cure is required 7 to 14 days post treatment.
- CDC is no longer recommending dual therapy with azithromycin.

Doxy/PEP: Post-Exposure Prophylaxis for Bacterial STI Prevention

- RCT using a single dose of doxycycline 200mg < 72 hours after condomless oral, anal, or insertive vaginal sex in MSM and transgender women.
- Of 501 participants, reduction in STIs per follow-up:

	Using HIV Prep	**Living with HIV**
Gonorrhea	Decreased 55%	Decreased 57%
Chlamydia	Decreased 88%	Decreased 74%
Syphilis	Decreased 87%	Decreased 77%

- Mucoprurulent Cervicitis potentially due to:
  - Chlamydia 15-40%
  - Gonorrhea 5-20%
  - Mycoplasma genitalium 15-25%
  - Trichomonas 5-20%
  - Herpes
  - Progesterone/progestins (no WBC)

Mycoplasma genitalium

- Intracellular bacteria, slow growing, very difficult to culture (months)
- Can cause cervicitis, PID, infertility, urethritis, prostatitis, epididymitis.
- Prevalence: 1 to 3% in males and females; in high-risk populations, 11–16% of females.
- Two-fold increased risk of cervicitis, PID, preterm birth, spontaneous abortion, and infertility.
- Sequential treatment for suspected/documented M. genitalium.
- Start with doxycycline to reduce bacterial load - Doxycycline 100 mg BID x 7days→ then→ Moxifloxacin 400 mg Q day x7 days

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