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Integrated Neurology and Family Planning Clinic to Address Gynecologic Needs of Women With Epilepsy [11N]

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INTRODUCTION: The Affordable Care Act (ACA), signed into US law in 2010, required health plans to cover preventative medicine at 100%. This service was extended to include contraception in 2012/2013. An analysis was conducted to compare the combined cost of intrauterine devices (IUDs) and insertion before and after the ACA.

METHODS: Truven Health MarketScan database is a large claims database containing data from patients enrolled in employer and commercial health plans, including a sampling of Medicaid supplemental plans. Truven's Treatment Pathways 3.0 tool was used to retrospectively examine the total cost, including patient out-of-pocket cost and insurance reimbursement, associated with IUDs and insertion for the years 2010 through 2014. The data were summarized descriptively.

RESULTS: There was little change in the mean total cost for IUDs and insertion from 2010 to 2014 (\$146.09 to \$143.04, respectively; range: \$137.43 to \$146.09). On the other hand, mean patient out-of-pocket cost decreased substantially from \$25.06 in 2012 to \$5.88 in 2013 and \$4.76 in 2014. A corresponding increase in mean insurance reimbursement from \$112.36 in 2012 to \$138.90 in 2013 and \$138.27 in 2014 was noted.

CONCLUSION: While the overall mean cost of IUD insertion remained generally stable, a dramatic decrease in the cost to the patient was noted in 2013 following the ACA, which was sustained through 2014. Whether the decrease in patient out-of-pocket cost associated with IUD insertion will have an effect on the rate of IUD use among women in the US remains to be determined. Support: Teva Pharmaceuticals.

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Integrated Neurology and Family Planning Clinic to Address Gynecologic Needs of Women With Epilepsy [11N]

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INTRODUCTION: Reproductive-aged women on antiepileptic drugs (AEDs) require expertise in epilepsy management and effective contraception that minimizes drug interactions with AEDs. They also rely on hormonal contraception to suppress menstrual bleeding. We describe outcomes for patients who attend an integrated Neurology/Family Planning Clinic.

METHODS: We reviewed medical records of women who attended the integrated clinic between April 2014 and August 2015. We extracted demographic characteristics, previous method of contraception, and chosen method of contraception after integrated consultation.

RESULTS: Thirty-nine women receiving ongoing epilepsy care were referred for integrated consultation to address contraceptive needs and/or management of menstrual bleeding. Patients were young (median 21 years, range 13–50 years), nulliparous (77%) and sexually active (56%). Most of the 21 women who were sexually active and at risk of pregnancy used no contraception (n=10, 48%) or condoms (n=4, 19%). After consultation, 4 of the 12 who desired an implant or intrauterine device (IUD) received one. Among 6 sexually active women using contraception, 33% historically used a method that interacted with their AED and all chose an IUD after integrated consultation. Eleven of 18 women not at risk of pregnancy initiated hormonal contraceptive methods for menstrual suppression (injection [n=3, 27%]; implant [n=2, 18%]; and combined hormonal contraception [n=6, 55%]). Overall, 4 of 22 women who desired an injection, implant or IUD were accommodated for same-day initiation.

CONCLUSION: Women benefit from an integrated consultation by identifying treatment for menstrual suppression or more effective contraception. Facilitating same-day initiation of methods has the potential to increase contraceptive uptake in this population.

Financial Disclosure: The authors did not report any potential conflicts of interest.

BLUE RIBBON

Patient Uptake and Outcomes: An Immediate Postpartum IUD and Implant Program [12N]

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INTRODUCTION: In-hospital placement of long-acting reversible contraception (LARC) is increasingly popular after vaginal and cesarean delivery and responds to maternal motivation for highly effective postpartum contraception. The present study assessed in-hospital provision and expulsion of immediate postpartum copper T380 IUD (Cu IUD), levonorgestrel (LNG) IUDs, and contraceptive implants.

METHODS: Women presenting to the University of Utah Labor and Delivery Unit between October 2013 and March 2015 who requested an IUD or implant were offered enrollment in this prospective observational trial. Eligible patients received devices through the Ryan Residency Training LARC program. Data on expulsions and discontinuations at 3 months was obtained via patient report and supplemented with chart abstraction. Predictors of IUD expulsion were assessed.

RESULTS: During the study period, 404 patients requested a postpartum IUD or implant during prenatal care and 358 devices were placed (88% uptake) prior to discharge from the hospital. A total of 246 women enrolled in the prospective observational outcome study: 73 (30%) Cu IUD users, 93 (38%) LNG IUD users, and 80 (33%) implant users. To date, 85% (n=209) have reached 3 months postpartum and 89% (n=185) have completed follow-up. Three months postpartum, 15/67 (22%) of the LNG IUD users and 3/60 (5%) of the Cu IUD users had an expulsion ($P<.01$). Among LNG IUD users, primiparity and vaginal delivery were predictors of expulsion ($P<.05$).

CONCLUSION: Immediate postpartum LNG IUD users have higher expulsion rates than Cu IUD users. LNG IUD expulsion rates are highest for primiparous women having a vaginal delivery.

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Obesity in Surgical Abortion: A Risk Factor for Complications? [13N]

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INTRODUCTION: More than one-third of reproductive-aged women in the U.S. are obese. Obesity is a known risk factor for obstetric and surgical complications, but its association with abortion-related complications is not clear. Our objective was to evaluate obesity as an independent risk factor for complications of surgical abortion.

METHODS: We performed a retrospective chart review of women who underwent surgical abortion in the first or second trimester in the outpatient setting between September 2012 and June 2014. Primary outcome was a composite of complications: estimated blood loss greater than or equal to 200 mL, uterine reaspiration, cervical laceration, uterine perforation, infection, emergency department visit, and hospitalization. Multivariable analysis was performed with log-binomial regression to calculate relative risk of complications based on BMI and adjusted for age, gestational age, history of prior cesarean section, and other comorbidities.

RESULTS: We included 4977 women in our analysis. The majority (77%) were performed in the first trimester. Forty-seven percent were normal weight or underweight, 28% were overweight, and 25% of

