Title

ACOG Clinical Consensus No. 3: General Approaches to Medical Management of Menstrual Suppression

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performance of cell-free DNA screening for this microdeletion syndrome. The findings demonstrated a prevalence between 1:1,524 (entire cohort) and 1:2,280 (when all cases with anomalies that were detected before screening were excluded). Cell-free DNA screening had a sensitivity of 83.3% and a positive predictive value of 52.4% for detection of 22q11.2 deletions larger than 500 kb, with a low false-positive rate of 0.05%. Notably, all cases with the classical 3 Mb deletion were detected.

22q11.2 is a relatively common microdeletion, is associated with significant morbidity and mortality, has a reasonably high prevalence, is usually not otherwise reliably detected, can be confirmed with diagnostic testing, and outcomes can be improved with early diagnosis. We therefore would argue that this disorder is an appropriate target for routine prenatal screening.

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In Reply:

We greatly appreciate Dr. Dar and Dr. Norton's thoughtful response to our article in the June 2022 issue.[1] We agree that the performance of individual noninvasive prenatal screening tests should be evaluated on a case-by-case basis. It may be that certain expanded uses of cell-free DNA testing, such as testing for large 22q11.2 deletions, are ready to be applied in a low-risk patient population. Although it is difficult for us to assess precisely what sensitivity and positive predictive value are required to justify routine screening for a genetic condition, we propose that a regulatory body be tasked with determining these and other criteria. We welcome the increased use of noninvasive prenatal testing in the future, as long as expansion is predicated on established scientific and ethical standards.

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ACOG Clinical Consensus No. 3: General Approaches to Medical Management of Menstrual Suppression

I appreciate the American College of Obstetricians and Gynecologists' educational resource to guide menstrual suppression therapy, published in the September 2022 issue.[1] However, the guidance has errors related to definitions and long-acting reversible contraceptives (LARCs).

First, the consensus does not define amenorrhea. Amenorrhea is a pathologic term, implying a menstrual abnormality and not hormone-induced bleeding change; the medically appropriate term is "absence of bleeding and spotting."[2] For hormonal LARCs, the definition refers to no bleeding and spotting for 90 days.[2]

Second, the Committee quotes an amenorrhea rate of 50–60% with the levonorgestrel 52-mg intrauterine device (IUD). This rate appears to refer to the 13th 28-day cycle and is high compared with the most contemporary data.[3] Although spotting or absence of bleeding and spotting percentages are in this range during the 13th cycle, they differ for those who have baseline heavy menstrual bleeding and those who do not (51% vs 64%, respectively).[3] Absence of bleeding and spotting rates during the 13th cycle are lower and also differ based on absence or presence of baseline heavy menstrual bleeding (34% vs 21%, respectively, P=.003).[3] The 90-day absence of the bleeding and spotting rate varies from 38% in patients who had used a levonorgestrel 52-mg IUD before placement to only 17% in those who had not.[4] Patients with prolonged flow before placement had lower rates of absence of bleeding and spotting–18% if flow was shorter than 7 days and just 5% if flow lasted 7 days or more.[4]

Third, the consensus quotes a 22% absence of bleeding and spotting rate at 1 year with etonogestrel implant use, which is not consistent with any published evidence. The available data support that about 22% of users will experience absence of bleeding and spotting during any 90-day interval, but the bleeding pattern can change from interval to interval and the rate does not increase with continued use.[5] These data refer to a general

population, because few data are available on implant use in patients with bleeding symptoms requesting menstrual suppression.

Although overall bleeding will still be light in the majority of users, clinicians need to fully understand the evidence-based definitions and menstrual suppression rates with LARC use so that they can fully inform expectations for patients with and without abnormal bleeding.

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In Reply:

We thank Dr. Creinin for his interest in Clinical Consensus No. 3 in the September 2022 issue.[1] Our purpose with this article was to provide a high-level overview of the benefits and limitations of hormonal methods of menstrual suppression. Although we appreciate the additional suggested references, this document specifically excluded patients with heavy menstrual bleeding because it is already covered in other American College of Obstetricians and Gynecologists guidance.[2,3] Although rates of bleeding associated with the levonorgestrel-releasing intrauterine device are based on older studies, they are within the accepted range for those without heavy menstrual bleeding. Additionally, the Clinical Consensus agrees with Dr. Creinin's point that bleeding patterns are inconsistent with use of the etonogestrel implant. The 22% amenorrhea rate cited for this method is supported by the Centers for Disease Control and Prevention's current U.S. Selected Practice Recommendations for Contraceptive Use.[4] Finally, we appreciate the clarification regarding language; though, "amenorrhea" is a term used to describe the absence of bleeding in the medical literature, including the cited references, and is commonly is used by obstetrician–gynecologists. We will consider whether this term should be updated in future iterations of this document.

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