CLINICAL PEARLS
ADOLESCENT REPRODUCTIVE HEALTH

PEARL #1

You just did STD testing on your patient and she has Chlamydia. What do you do now?

STD screening is recommended for all sexually active females annually until age 25. The NAAT is the most sensitive and specific test, and is usually done via urine specimen, or vaginal swab (provider or self-collected).

Before testing for STDs in teens, it's important to collect their cell phone number or have them call back in 1-2 days for the results. Colorado law allows minors of any age to consent to STD testing and treatment.

Here are the steps for treating Chlamydia:

1. Prescribe/dispense: Azithromycin 1 gram x single dose; use CDC resources to confirm that treatment recommendations have not changed, and/or when alternatives are needed.
2. Offer and explain Expedited Partner Therapy (EPT) for her partner. If requested, get partner name, birth date, and preferred pharmacy and call in a prescription for them, or dispense treatment for them when possible. This practice is recommended and supported by all major professional organizations and is legally supported in Colorado. Remember that you are not treating your patient if her partner doesn't get treatment.
3. Counsel patient that there should be no sexual contact (oral, vaginal, anal) until one week after both partners have been treated.
4. Teach condoms; where to get them, how to use them, how to talk to her partner about them and how to negotiate for their use. Avoid outdated language that relies on fear, shame, or judgment. Ask permission to share the information that condoms prevent Chlamydia and other STDs when used consistently and correctly.
5. Bring your patient back for repeat STD testing in three months. There is a high chance of reinfection and so follow-up testing is recommended. She also should have a RPR to screen for syphilis and an HIV test.
6. Finally, ask about contraception. Does she like her current method, and can she come in today to discuss options?

GREAT RESOURCES

- CDC's STD Treatment Guidelines and/or download the free smart phone app
- Expedited Partner Therapy information from the CDC
- Video for teens on how to use a concom from AMAZE, sex education for tweens and teens

PEARL #2

A 15-year-old arrives for a clinic visit to discuss birth control. She is not accompanied by her parent or guardian. Can she be seen today?

Yes. Colorado law allows minors to consent to their own care for certain services including:

- Birth control information, procedures, and supplies
- STD testing and treatment
- Pregnancy testing and prenatal care

A teen can consent to her own care for a contraception visit, and any release of information should not occur without her permission, unless life-threatening circumstances or abuse of the child is disclosed. All clinics that serve teens can, and should, allow them to consent when service exceptions apply.

If billing and coding issues cannot be addressed, the provider/clinic should facilitate referral to a Title X clinic, county health clinic, or family planning clinic that has strong protocols for maintaining confidentiality. Ideally, all clinics that serve teens will have in place a protocol for confidential visits when needed.

GREAT RESOURCES

- Teen-friendly clinic finder on www.teensource.org
- Toolkit developed for Colorado School-based Health Centers called Understanding Minor Consent and Confidentiality in Colorado with useful tables, FAQs, and more
- Guttmacher Institute's review of minor consent laws in all 50 states
- Position paper from the Society of Adolescent Medicine outlining the essential aspect of confidential care for adolescent patients

PEARL #3

Your 15-year-old patient is upset because she got an implant (Nexplanon) for birth control but has been bleeding for five weeks in a row. What can be done?

Before implant insertion, teens must be counseled to expect changes in their bleeding pattern. About 20% of users will have amenorrhea (none to very little bleeding), but others will have infrequent to frequent bleeding which can be prolonged. Due to the progestin effect on the endometrium, significant blood loss is uncommon, however, frequent bleeding is an understandable cause of frustration and dissatisfaction with this method.

The first step is to listen to your patient's concerns. Have her explain her bleeding pattern and ask for permission to explain why this can occur and how it is not dangerous. Reassure her that the implant is still working to prevent pregnancy by blocking ovulation.

The next step is to consider STD testing and pregnancy testing if clinically indicated. Uterine conditions like polyps or fibroids are very rare in an adolescent population and pelvic ultrasound is not indicated. If there are concerns for anemia, CBC and ferritin should be assessed.

If treatment is requested, a short-term treatment with NSAIDs (for example, five days of ibuprofen 600mg every six hours) can be initiated. If medically appropriate, hormonal treatment with an OCP, patch, or ring can be added. There are additional medications that have been studied and may be effective (see resources below).

If the adolescent is dissatisfied with her bleeding, other contraceptive methods should be discussed and offered. Removal of the implant is an option at any time.

GREAT RESOURCES

- CDC's US Selected Practice Recommendations for Contraceptive Use -> Implants -> Bleeding Irregularities During Implant Use
- Review article Management of Unscheduled Bleeding in Women using Contraception from *UpToDate*

PEARL #4

Your 16-year-old patient has an IUD for birth control and just got diagnosed with Chlamydia. Can she keep her IUD?

Yes. Any STDs diagnosed during IUD use should be treated per the CDC's recommendations. It is unnecessary to remove the IUD, even when PID (Pelvic Inflammatory Disease) is diagnosed in an IUD user.

IUD use does NOT increase the risk of acquiring an STD from sexual contact. Furthermore, a history of STD, PID, or ectopic pregnancy is not contraindication to IUD use.

GREAT RESOURCES

- CDC US Selected Practice Recommendations -> Intrauterine Contraception -> Management of the IUD when a Cu-IUD or LNG-IUD User is Found to have PID
- CDC US Medical Eligibility for Contraceptive Use

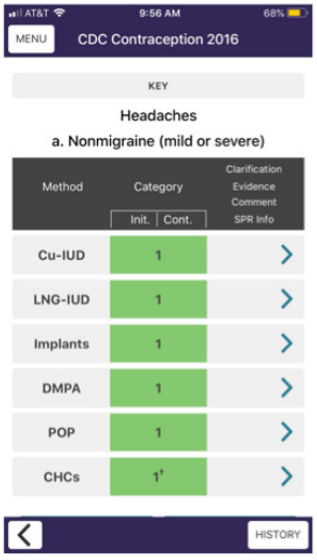
PEARL #5

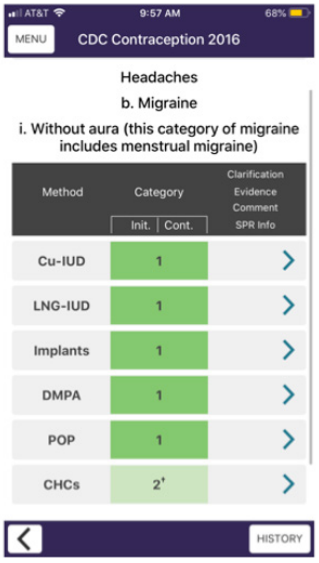
A 16-year-old has daily chronic headaches and wants to start combined OCPs. Is this safe for her to do?

Yes. The US Medical Eligibility Criteria for Contraceptive Use offers excellent guidance on the use of combined hormonal contraception (OCPs, patch, ring) in women with headaches. For adolescents who have chronic headaches and migraines without aura, there are no medical contraindications to use.

It is recommended that adolescents who have migraines with aura avoid estrogen-containing products as these patients are considered to have a baseline increased risk of VTE, and the addition of a combined hormonal method may increase their risk further.

Here are the screen shots from the USMEC app on this topic:





GREAT RESOURCES

- CDC US Medical Eligibility for Contraceptive Use

PEARL #6

A 14-year-old is on extended dose OCPs. She is into the sixth week of her active pills and has been bleeding for two weeks straight. What should she do?

She should stop taking active pills for five days and allow for a hormone-free interval. Then she should restart her active pills.

(This is not recommended during the first 21 days of use, or more often than every 21 days as this may decrease contraceptive efficacy.)

Unscheduled bleeding or spotting (that is, bleeding on ACTIVE pills) is common during the first 3-6 months of extended or continuous dosing. It is not harmful and will decrease with ongoing use.

When patients call with concerns, the provider should consider:

1. Is the patient taking the OCP at the same time each day? Late or missed pills are the most common cause of breakthrough bleeding. Recommend that an alarm be set on her cell phone so she can take it at the same time each day. Weekly reminders for the patch and monthly reminders for the ring are also recommended.
2. Is pregnancy testing or STD testing indicated?
3. Is she interested in considering a different method of contraception? Satisfaction with a method predicts future use. Assure your patient that you can help her find a method that will work best for her.

GREAT RESOURCES

- CDC's US Selected Practice Recommendations for Contraceptive Use -> Combined Hormonal Contraception -> Unscheduled Bleeding with Extended or Continuous Use of Combined Hormonal Contraception
- Review article Management of Unscheduled Bleeding in Women Using Contraception from *UpToDate*

PEARL #7

A 16-year-old patient is on OCPs and wants to know if she really needs to have periods. What is your answer?

No, she does not need to have scheduled periods.

Any OCP, patch, or ring can be used in continuous dosing. This is when a user stays on the active method and has no scheduled, hormone-free intervals. This may be an ideal choice for adolescents with severe dysmenorrhea, or conditions that are exacerbated with menstrual bleeding (such as anemia, headaches, seizures, etc.). It may also be done because this is the patient's preference.

Why is this safe?

All combined hormonal methods contain estrogen and progestin. The progestin is the dominant hormone on the endometrial lining and continued use induces atrophy. (This is in contrast to women who are anovulatory and amenorrheic due to conditions like PCOS, where the endometrium is exposed to estrogen alone and develops hyperplasia.)

Explain to the patient that it is safe not to have periods when on a hormonal contraceptive method (OCP, patch, ring, Depo, LNG-IUD, and implant).

However, missed periods when not on a hormonal method is not normal and should be evaluated by a provider.

What about breaks?

A hormone-free interval is not medically necessary, but may be needed to address unscheduled bleeding. Most users of continuous dosing will have unscheduled, breakthrough bleeding at some point. The user can just continue the method as the bleeding is likely to resolve, or they can do a 5-day hormone-free interval. Unscheduled bleeding episodes will decrease with continued use of the method.

How do I prescribe continuous dosing?

For OCP users, write in the sig: "take an active tab each day, no placebos; needs 4 packs for 3 month supply." Be sure to dispense four packs with at least one year of refills.

Let patient know that there is now a law in Colorado that mandates insurance companies provide a year's worth of generic OCP and generic patch to users who request this.

For patch users, write in the sig: "apply a new patch each week; needs 12 patches for 3 month supply."

For ring users, write in the sig: "insert a new ring each month." The ring contains four weeks of active hormones and so no additional supplies are needed for continuous dosing.

GREAT RESOURCES

- Colorado's Health Coverage of Contraceptives Bill

PEARL #8

What types of IUDs are available?

The two major categories available are levonorgestrel-containing IUDs and the Copper IUD.

In addition to providing excellent contraception, levonorgestel IUDs decrease bleeding and cramping because of the progestin effect on the endometrium. The highest level of suppression is obtained with Mirena or its generic equivalent, Liletta. This IUD is an ideal choice for adolescents who struggle with severe cramps, endometriosis, heavy periods and/or who just would prefer to have much less or no bleeding.

The Copper IUD may increase bleeding and cramping, especially in the first year. It is relatively contraindicated in teens with already painful and/or heavy periods.

The primary contraceptive mechanism of all IUDs is blocking sperm. The IUD prevents sperm from reaching the fallopian tubes, which is where fertilization occurs.

IUD TYPES

TYPE	NAME	Remove/replace = YEARS	
		FDA Label	*Evidence*
Levonorgestrel IUD	Mirena (20 mcg/day)	5	7
	Generic: Liletta	4	5-7
	Skyla (14 mcg/d)	5	-
Copper T IUD	ParaGard	10	12

GREAT RESOURCES

- www.bedsider.org to explore the different IUDs

PEARL #9

A 13-year-old is coming to see you because she got her first period three weeks ago, and is still bleeding enough to soak five super pads per day. What evaluation is indicated?

Girls and teens can become anemic and/or develop iron deficiency from prolonged menstrual bleeding. In this situation, a CBC, ferritin, and urine pregnancy test should be done. (A finger-stick hemoglobin is not a reliable test, and does not detect iron deficiency).

If abnormal uterine bleeding (AUB) is associated with anemia, or there are other personal history factors (like prolonged nosebleeds) or significant family history of a bleeding problem, the patient should also have testing for a bleeding disorder such as von Willebrand's disease. As many as 25 percent of teens with AUB will have an underlying bleeding disorder.

However, aside from pregnancy, the most common cause of AUB in teens is anovulatory bleeding. This can occur when the endometrium becomes thickened and disordered in the absence of regular ovulation and progesterone, which is the hormone released with ovulation, and causes the lining to mature and then shed.

Treatment for AUB depends on the level of severity and the desires of the patient and family. Hormonal therapy with progesterone in some form should be started in patients with anemia and/or who desire treatment. For patients with iron deficiency, an iron supplement should also be started.

GREAT RESOURCES

- Menstruation in Girls and Adolescents: Using the Menstrual Cycle as a Vital Sign, originally published in *Pediatrics*, November 2006
- Children's Hospital Colorado clinical pathway on acute, abnormal uterine bleeding

PEARL #10

Your 14-year-old patient has had severe pelvic, back, and leg pain for the past six months during her period. She has also had nausea, vomiting, and headaches, and has been unable to attend school for 2-3 days each month. What is your diagnosis?

Dysmenorrhea.

Classic, primary dysmenorrhea in adolescents can be diagnosed by history alone. Pain may start one to two days before, or with the onset of menstrual bleeding. It may radiate to the back and legs. It may be associated with nausea, vomiting, and in some cases near syncope. Many girls experience headache, fatigue and other symptoms as well. The pain of dysmenorrhea resolves once menstrual bleeding is finished. An adolescent with primary dysmenorrhea will not have pelvic pain unless just before or during her period.

Treatment with NSAIDs prior to the onset of pain and continued for the first few days of the menstrual cycle is considered first-line treatment. Hormonal therapy is also very safe, common, and effective. About 50 percent of patients with dysmenorrhea will improve greatly with OCPs given in the traditional 21/7 format. Fifty percent will still have cramping and should be offered extended dosing, or another method that induces amenorrhea.

For patients who have dysmenorrhea that does not respond to treatment, or who have non-cyclic pain, a pelvic ultrasound to look for an ovarian cyst or other pathology, as well as other evaluation for GI, GU, neurogenic, musculoskeletal, and psychological causes of pain may be indicated. In patients with chronic pelvic pain, there often are multiple causes.

Endometriosis is a condition that can occur in teens. It can cause dysmenorrhea as well as non-cyclic pelvic pain. Adolescents who do not respond to initial treatment such as NSAIDs and hormonal therapy should be referred to a gynecologist for consideration of this condition and a holistic approach to their pelvic pain.

GREAT RESOURCES

- Dysmenorrhea and Endometriosis in the Adolescent, ACOG Committee Opinion, December 2018